Beliefs and Practices of Quebec Clinicians as Predictors of Recovered Memory Cases

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In recent years recovered memory therapy has become popular as a way of recalling putatively forgotten childhood sexual abuse. Many researchers have argued that under ordinary circumstances memory is somewhat malleable and even more so when people are exposed to suggestion. The techniques which have been advocated (e.g., hypnosis) to aid memory retrieval are ones which make use of imaginative elaboration of suggestions. It has been claimed that when these techniques are used in a context of "memory recovery" they can lead clients to mistake the fantasies they create for memories of external events. Some evidence exists that this type of therapy is engaged in by a sizable proportion of American and British clinicians. In the present study 900 questionnaires were mailed to a randomly selected sample of Quebec therapists: 300 psychiatrists, 300 psychologists, and 300 social workers. A total of 220 usable questionnaires were returned: 85 from social workers, 76 from psychologists, and 59 from psychiatrists. Respondents provided demographic information as well as details about: (a) their background, (b) the numbers and types of clients they saw, (c) the memory recovery techniques they used and (d) and their beliefs about the validity of recovered memory

of child sexual abuse. Fifty-two percent of the respondents reported having clients with recovered memories in the previous two years. More specifically, subjects reported that an overall mean of 4.23% of their clients recovered memories. Stronger support for the validity of recovered memories was associated with greater use of recovered memory techniques, and use of such techniques was associated with higher proportions of recovered memory cases. Among professions, psychiatrists expressed the most skepticism of the validity of recovered memories and social workers expressed the most support. Nevertheless, professions did not differ on the proportion of cases encountered.

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Psychologists claim to be distinguished from other mental health professionals (e.g., social workers and psychiatrists) by their training in the science of psychology (Barlow, 1981; Garfield, 1966; Perry, 1979). Nevertheless, one psychologist (Sechrest) has charged that "thousands and thousands" of clinical psychologists graduating from training programs are only "peripherally acquainted with the discipline of psychology" (cited in Hayes, 1989, p. 8) Another (Yapko, 1994a, 1994b) has asserted that ill-informed psychologists sometimes present their personal opinions to the public as if the opinions were established psychological theories. However, these opinions differ from legitimate theories in not being informed by empirical research. Dawes blames the neglect of research evidence for "a series of fads in the area of mental health" (Dawes, 1994, p.20). One of the fads to which Dawes' statement could refer is the recovered memory movement (cf. Lindsay & Read, 1994; Loftus, 1993, Loftus & Ketcham, 1994; Ofshe & Watters, 1994; Pendergrast, 1995; Wakefield & Underwager, 1992).

The origins of the recovered memory fad are to be found partially in concern for child sexual abuse. The modern concept of familial child sexual abuse was formulated in an article published in 1975 by Sgroi. Previously, "incest" referred to intercourse only. Sgroi's article treated incest as a form of abuse, similar to physical abuse. Understood in this way the concept became more inclusive

(Blume, 1990, Hacking, 1992). This article was followed by a wave of publications both in the popular press (e.g., Armstrong, 1978) and in academic publications (e.g., Finkelhor, 1979; Herman, 1981; Herman & Hirschman, 1977).

A further development was introduced into the area some time between 1981 when Herman published Father-Daughter Incest (Herman, 1981) and 1987, when Herman and Schatzow published an article on sexual abuse survivors. In their 1987 article Herman and Schatzow reported that several of their clients recovered repressed memories of child sexual abuse as a result of therapy. The idea that memories of child sexual abuse were often repressed and recovered was not addressed in the 1981 publication. This "new" element was, of course, borrowed from Freudian theory. It took on the dimensions of a social movement with the publication of The Courage to Heal in 1988 (Bass & Davis, 1988). The Courage to Heal was written by a creative writing teacher (Bass) and her student (Davis). It instructed women in a variety of exercises designed to help them uncover memories of past sexual abuse, abuse they had no memory for as adults. The book was overwhelmingly successful. By 1994 it was already on its third edition. The intense concern with child sexual abuse was now applied to events which were no longer remembered.

After the publication of The Courage to Heal many adult children accused their parents of child sexual abuse on the basis of recovered memories (Loftus, Grant, Franklin, Parr &

Brown, 1996). However, the validity of these accusations did not go unchallenged. In 1992 a group of accused parents created a name for a new "syndrome" when they formed the False Memory Syndrome Foundation (FMSF). They claimed that their adult children had acquired false beliefs about the past, not memories of actual events. Many of the adult children making accusations had been in psychotherapy. Their therapists had worked with them in a way specifically designed to help them remember previously forgotten sexual abuse (Wakefield & Underwager, 1992). Following the formation of the FMSF many experts found themselves in a heated debate about the validity of recovered memories of child sexual abuse and the therapeutic techniques used to elicit them (e.g., Briere, 1995; Loftus, 1993). One journal, Consciousness and Cognition, dubbed this controversy the "recovered memory/false memory debate" (Banks & Pezdek, 1994).

The arguments supportive of memory recovery therapy vary. However, some of them concern the purported function of sexual abuse in society. From the beginning (Finkelhor, 1979; Hacking, 1992; Herman & Hirschman, 1977; Rush, 1980) the research on sexual abuse was fuelled in part by the desire to correct a power imbalance between the genders. Feminist theory, in its radical form, sees child sexual abuse as a weapon used by men in the effort to dominate women (Solomon, 1992). According to this position "[t]he family is an oppressive social institution within which men

are socialized to dominate women, and women are socialized to be docile and to be sex objects" (Solomon, 1992; p. 476). On this view child sexual abuse is only the most extreme of the forms that this domination can take (Lazerson, 1992).

Given feminist views of a fundamentally political nature of child sexual abuse, it follows that many of these authors question the motives of those who disagree with them. Feminists have claimed that their critics' motives are political and/or sexist (Berliner & Williams, 1994), or that they attempt to silence victims and to protect guilty men (Bass & Davis, 1994). Sometimes it is simply claimed that the reality of child sexual abuse is too distressing to acknowledge (Fredrickson, 1992).

Related to the view that sexual abuse is a political act, radical feminist theorists have also rejected the use of traditional therapeutic techniques and diagnoses. It is believed that traditional approaches implicitly blame women for their problems (Chesler, 1972). Feminist theorists argue that the psychological problems of women are largely the result of social factors, and women's lack of power (Laidlaw & Malmo, 1991).

Statements about the role of therapy made by those who argue against the validity of recovered memory therapy take a position with a different emphasis. These writers talk about the dangers of seeing oneself as a victim (Crews, 1994; Ganaway, 1992; Wakefield and Underwager, 1992). Authors critical of the validity of recovered memory take

the position that problems may be partially caused by social conditions, but solutions to psychological distress are not to be found in blame but in personal responsibility and action.

The two sides in the debate clearly disagree about the relative dangers of recovering false memories and of failing to recover accurate memories of abuse. Authors who defend memory recovery techniques argue or assume that it is only by acknowledging that one has been a victim that one can overcome victimhood (Bass & Davis, 1994; Blume, 1990; Harvey & Herman, 1994; Herman & Schatzow, 1987). The important goal is to arrive at some coherent narrative about one's life (Borch-Jacobson, 1995; Harvey & Herman, 1994; Spence, 1994) which accounts for one's present condition. The secondary importance of the historical accuracy of the memories which form part of the therapeutic narrative is expressed in statements indicating that their veridicality is less important than their "personal meaning" (Olio, 1989, p. 98).

Perhaps part of the neglect of historical truth is explainable by the belief that child sexual abuse is revealed in a variety of symptoms in the adult (Bass & Davis, 1988; Blume, 1990). Once truth is revealed in symptoms then it is no longer necessary to be concerned with the accuracy of memory. This faith in the diagnostic power of symptoms is criticized by supporters of the false memory theory (Loftus & Ketcham, 1994; Ofshe & Watters, 1994;

Pendergrast, 1995). They point out that the symptoms which are believed to indicate a child sexual abuse history have such high base rates in the population as to be of no diagnostic value. Moreover, opposite behaviours are frequently considered symptoms of a sexual abuse history (Courtois, 1988). For example, Blume (1990) considers both "need to be perfect" and "need to be perfectly bad" symptoms of child sexual abuse (p. xviii). In addition, as the above example illustrates, the symptoms are so vague as to lose any diagnostic power they might otherwise have had. The most fundamental objection to the use of symptoms to diagnose a history of child sexual abuse is that there is no evidence of a strong correlation between child sexual abuse and any specific adult symptoms (Kendall-Tackett, Williams & Finkelhor, 1993).

One reason for support for the recovered memory theory comes from the fact that the prevalence of child sexual abuse was underestimated in the past (Levitt & Pinnell, 1995; Lindsay, 1994). Supporters of recovered memory validity insist that this continues to be the case (e.g., Summit, 1988). In addition, they often use Freud's abandonment of the seduction theory as a historical example of the failure to acknowledge the consequences of abuse (Briere & Conte, 1993; Herman & Hirschman, 1977; Herman & Schatzow, 1987; Williams, 1994). The historical precedent of underestimates of child sexual abuse creates a context of hostility and distrust for some. In fact, certain authors

seem to believe that because the prevalence of sexual abuse has been underestimated, recovered memories of such abuse must be accurate (e.g., Herman & Schatzow, 1987).

In addition, accounts of extreme behaviours such as satanic ritual abuse is sometimes taken as evidence that prevalence estimates of abuse continue to be too low (e.g., Bass & Davis, 1994, Summit, 1988). Estimates of "true prevalence" are increased by confidence in such accounts. To deal with the paradox of such atrocious crimes being combined with a surprising lack of physical evidence (Lanning, 1992), believers in satanic ritual abuse argue that the conspiracy is so widespread that evidence can be made to disappear. In this way the noticeable lack of physical evidence becomes associated with even worse crimes. Moreover, behavioral symptoms (appearing often after therapy has begun) become more convincing evidence than the evidence traditionally relied upon in criminal investigations (Goodman, Qin, Bottoms & Shaver, 1994; Mulhern, 1994; Ofshe, 1992; Ofshe & Watters, 1994).

In agreement with authors supportive of the validity of recovered memories, critics state that child sexual abuse has been underestimated in the past and that it is undesirable (Lindsay, 1994; Lindsay & Read, 1994; Loftus, 1993; Loftus & Ketcham, 1994; Pendergrast, 1995). There is, however, disagreement over the present estimates of prevalence of child sexual abuse (Briere & Conte, 1993; Ceci, Huffman, Smith & Loftus, 1994; Lindsay & Read, 1994;

Smith & Loftus, 1994), and over the gravity and intractability of its consequences (Kendall-Tackett et al., 1993; Levitt & Pinnell, 1995).

Beliefs about the true prevalence and the sequelae of abuse are almost inseparable from beliefs about the validity of recovered memories. For example, if one believes, as Blume (1990) does, that as many as 50% of abused women no longer remember their abuse, then one will expect abuse prevalence to be higher than if one does not share her dour views. In addition, if one believes that sexual abuse has traumatic consequences then it is not difficult to believe that a variety of behaviours are symptoms of abuse. A series of recent changes in the definitions of the parameters of child sexual abuse both reflect and affect support for the validity of recovered memory. "Incest" has come to include not only sexual intercourse but any sexual touching or exhibitionism (Courtois, 1988; Gelinas, 1983; Hacking, 1992), or even lewd looks or untoward comments (Blume, 1990). All sexual abuse is now considered "traumatic" (Briere & Runtz, 1988; Finkelhor, 1988; Herman, 1992; Herman & Schatzow, 1987). These elasticized notions of both abuse and its consequences promote the acceptance of higher prevalence estimates, and of evidence of abuse history based on symptoms rather than memory. So it is not surprising that the same people find evidence for relatively higher prevalence rates, more severe consequences, and more confidence in memory recovery validity (e.g., Blume, 1990;

Herman & Schatzow, 1987) while others find evidence of lower prevalence, less dire consequences and more unreliability in recovered memories (Lindsay & Read, 1994; Ofshe & Watters, 1994; Poole, Lindsay, Memon & Bull, 1995).

If it is true that recovered memories are not reliable, then the social context in which they arise, and the motivation for questioning them, does not change their unreliability. It seems clear that no matter how much consideration is given to the parameters of sexual abuse, its aftermath, and its treatment, the argument for the validity of recovered memories stands or falls with the nature of memory itself.

Bartlett (1932) suggested that memory is not simply a matter of the inert storage of copies of experienced events. He argued, rather, that people reconstruct their memories using a combination of (a) fragments or traces associated with an event and (b) their beliefs about how those fragments must relate to the actual event. If Bartlett was correct, memories should be influenced either by changing the fragments on which they are partially based, or by changing the beliefs which relate the event to the fragments.

Beginning in the mid-1970's many experiments tested the malleability of autobiographical memory. These studies examined the effects of misleading or suggestive information about a past or future event (Kenney, 1989; Loftus, 1975; Loftus & Palmer, 1974; Loftus, Miller, & Burns, 1978). They

showed that a certain number of reports of past or future (Kenney, 1989) events are influenced by postevent misinformation or by suggestion. In one well known study, Loftus and Palmer (1974) showed subjects a film of a staged accident. They then asked subjects to estimate the speed at which one of the cars depicted in the film was going when it ran into another one. Subjects gave higher estimates when the word "smashed" was used than when the word "hit" was used. The susceptibility to suggestive phrasing or to misleading information has been replicated many times (Gibling & Davies, 1988; Gudjonsson, 1986; Hammersley & Read, 1986; Kenney, 1989; Loftus & Hoffman, 1989; Register & Kihlstrom, 1988; Smith & Ellsworth, 1987; Zaragoza & Koshmider, 1989; Zaragoza, McCloskey & Jamis, 1987).

Part of the effect may be accounted for by compliance or by a response bias (McCloskey & Zaragoza, 1985; Zaragoza et al., 1987). However, there is reason to believe that part of it is attributable to features of the subjects' internal representation (Gibling & Davies, 1988; Loftus, Donders, Hoffman & Schooler, 1989). For the misinformation effect to be able to change not only reports, but actual memories, some change must occur in the way people represent the event to themselves. One possibility is that inaccurate memory traces successfully compete with accurate traces without destroying them (Bekerian & Bowers, 1983; Bowers & Bekerian, 1984, Gibling & Davies, 1988; Hammersley & Read, 1986). Another possible process is that new details fill in

for missing ones (McCloskey & Zaragoza, 1985; Wells & Turtle, 1987), or in some way add to or alter the original trace so that it cannot be resuscitated (Loftus, 1979, Loftus, 1989; Loftus et al., 1989; Zaragoza et al., 1987).

None of these processes are necessarily mutually exclusive. All of them require that information arising from the original experience be superceded by new information or by misinformation. Marcia Johnson (Dodson & Johnson, 1993; Johnson, Hashtroudi & Lindsay, 1993; Johnson & Ray, 1981; Lindsay & Johnson, 1989) argues that subjects make judgments about the sources of their memories. She points out that all experience is capable of being remembered. That is, both internally generated events (thoughts or fantasies) and externally generated events (perceived events) are internally represented by the subject. She argues that people are generally able to distinguish between memories for internally generated events and externally generated events. Moreover, she believes that the ability to distinguish the sources of our memories is what prevents perceived events from becoming hopelessly entangled with our thoughts about those events (Johnson & Raye, 1981). However, people also make mistakes. Therefore, "an adequate model must be able to account for both confusion and discrimination between past imaginations and past perceptions" (Johnson & Raye, 1981; p. 69). Johnson calls the process of arriving at a decision about the origin of one's memories "source monitoring." "Reality-monitoring"

refers to that type of source monitoring in which we distinguish between internally and externally generated events (Johnson et al., 1993).

Johnson and her colleagues have shown that the size of the misinformation effect can be changed by manipulating the degree of reality-monitoring subjects engage in (Dodson & Johnson, 1993; Lindsay & Johnson, 1989; Zaragoza & Koshmider, 1989). These researchers found that when subjects were encouraged to increase attention to the source of a memory, the size of the misinformation effect decreased.

Johnson believes that reality-monitoring decisions are the result of several different processes. One type of process involves comparing the attributes of memory traces to the attributes believed to characterize different types of internally generated versus externally generated representations. For example, people tend to believe that more familiar mental fragments are more likely to arise from remembered than imagined experiences (Dodson & Johnson, 1993). They also appear to believe that greater sensory detail is more characteristic of a memory of an external event than of an imagined event (Johnson et al., 1993).

In addition, Johnson believes that people puzzle out the origins of their memories by using various kinds of knowledge. For example, a memory of an improbable or impossible event is more likely to be the memory of a dream than a perceived (externally generated) event. Other memory

traces of a related event which are associated with the target memory and activated at the same time may give information about the target event. A person's understanding about how his or her memory works (metamemory assumptions) also affects reality-monitoring decisions. For example, subjects tend to believe that they will remember the act of generating thoughts or responses. If subjects cannot remember the process of generating a figure as a response in an experiment then they are more likely to say that they perceived rather than imagined the figure (Finke, Johnson & Shyi, 1988; Johnson, Hashtroudi & Lindsay, 1993; Johnson & Raye, 1981).

We have seen that it is possible to change the size of the misinformation effect by interfering with the subject's reality-monitoring processes. It is also possible to influence the rate of acceptance of misinformation by manipulating the characteristics of the relevant traces. By increasing the similarity between an internally generated event and one which was externally derived Johnson and colleagues have been able to increase acceptance of misinformation (Durso & Johnson, 1980; Johnson, Foley, & Leach, 1988; Johnon, Raye, Wang, & Taylor, 1979; Lindsay, Johnson, & Kwon, 1991; Rabinowitz, 1989).

To summarize, Johnson's work implies that remembering involves judgments about which experience is at the source of a memory trace. Mistakes occur because people confuse the origins of their memories. In making memory judgments

subjects appear to evaluate the qualities of memory traces and the likelihood of events having occurred in a certain way. We have also seen that the evaluation process can be manipulated experimentally. This manipulation can alter subjects' conclusions about a memory's source.

Theorists who question the validity of recovered memory of child sexual abuse refer to the research on the malleability of memory (Garry & Loftus, 1994; Loftus, 1993; Loftus & Ketcham, 1994) and the research on reality-monitoring (Lindsay & Read, 1994) to support their arguments. These authors argue that memory is open to error and distortion, and can therefore be deliberately or inadvertantly manipulated.

Critics also object to what they consider to be misconceptions about the ability to remember events from infancy (Ceci et al., 1994; Kandyba, 1996). Earliest memories generally date from the third or fourth year of life (Howe, Courage & Peterson, 1994; Kihlstrom & Harackiewicz, 1982). It has never been demonstrated that anyone can recall events which occurred before about two years of age (Usher & Neisser, 1993). When Usher and Neisser compared subjects' memories for salient events (e.g., the birth of a sibling) to mothers' accounts they found accurate memories dating back to age two only. In addition, memories from very early childhood are sketchy and there are very few of them, as opposed to memories for later childhood which are more numerous (Kandyba, 1996).

Some charge that criticism of the validity of recovered memory is based on laboratory research which has little to do with the kind of real-life trauma which resurfaces in recovered memories (Olio, 1994; Terr, 1994). The argument that laboratory research on memory lacks ecological validity is used to support the assertion that memory works in an unusual way in the case of child sexual abuse. According to this view of memory, forgetting(1) sometimes follows special rules. One important exception to the generally reconstructive nature of memory which has been proposed is that trauma is remembered differently and more perfectly than ordinary events. It has been demonstrated that emotionally arousing events tend to be remembered over a longer period of time than more neutral events (Christianson, 1992). Laboratory experiments and naturalistic studies of crime victims and witnesses support this conclusion. Naturalistic studies have shown that victims and witnesses provide very stable accounts of the crimes in which they were involved. In addition, their accounts tend to lose comparatively little detail over time (Christianson, 1992).

Experimental studies generally compare the recall of subjects exposed to neutral and to emotionally arousing

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[1] "Forgetting" as I use it includes temporary difficulty in finding information ("retrieval failure"), or a permanent loss of information ("storage failure"). "Forgetting" is also frequently used in common language to mean "not thinking about something" so when subjects say they "forgot" this should be interpreted with caution.

scenes. The scenes are similar except for the traumatic target event or image. For example, one study used slides depicting a bicycle accident as a target event (Christianson & Loftus, 1991). Another study used photographs of an autopsy (Christianson & Nilsson, 1984). In these experiments details which were part of the emotionally arousing event were well retained. Details which were unrelated (e.g., the color of a car in the background) were less well remembered in the traumatic condition than in the neutral condition (Christianson, 1992; Christianson & Loftus, 1987; Christianson & Loftus, 1991). From this literature it appears that traumatic events are better remembered than less salient events. However, they are not without error; nor is it necessary to invoke special mechanisms to account for the greater durability of events which are more salient (Howe et al., 1994).

Another research literature which bears on the permanence of "traumatic memory" looks at memories for the moment when subjects learned of public disasters. Brown and Kulik (1977) interviewed subjects about their memories for President Kennedy's assassination. The accounts of the subjects were clear and detailed, and they appeared to be very stable. Brown and Kulik called the memories "flashbulb memories" and proposed a biological "print now" memory mechanism to explain their special nature. Although all agree that subjects are very confident about their flashbulb memories, later research has shown that flashbulb memories

contain a surprising number of errors (Frankel, 1994; Neisser, 1982; Neisser & Harsch, 1992). Again, there is no evidence that the mechanisms by which flashbulb memories are encoded and remembered differ from the memory processes associated with more mundane events. What makes them special is more likely to be their salience and their frequent rehearsal (Christianson, 1992).

The argument that traumatic events are remembered more perfectly than more ordinary events serves only to support the notion that some memories last long enough to be recovered years later. But if one wishes to show that these memories can also disappear and reappear one requires some special forgetting process. There are two unconscious defenses which have been offered as accounts of how this could occur. Freud (1905/1953) suggested that memories which are unacceptable are kept out of conscious awareness (repressed). Under the proper conditions Freud believed that repressed memories became accessible. (ibid). Repression has been used to account for the recovery of veridical memories. Holmes (1990) points out that the concept of repression has been used in many ways and is therefore difficult to define. He believes, however that in common usage

> "the concept of repression has three elements: (1) repression is the selective forgetting of materials that cause the individual pain; (2) repression is not under voluntary control; and (3) repressed material is

not lost but instead is stored in the unconscious and can be returned to consciousness if the anxiety that is associated with the memory is removed." (p.86)

Several other authors (e.g., Spiegel & Scheflin, 1994) have argued that the mechanism of dissociation, proposed by Janet (1889), separates traumatic memories from conscious awareness, thus preserving them for later recovery. This belief is supported by evidence from hypnotic amnesia and psychogenic amnesia. It has been used to explain how people can become aware of traumatic past events only years later (Bass & Davis, 1994; Terr, 1994).

As already noted, one characteristic of memory of trauma is that it is frequently rehearsed (Christianson & Loftus, 1987; Rubin & Kozin, 1984). Another is that such memories tend to be intrusive (e.g., Pynoos & Nader, 1988; Pynoos & Nader, 1989; Spiegel & Scheflin, 1994). Clearly, neither of these could be true of repressed or dissociated memories. Some theorists (e.g., Terr, 1994) claim that memories for trauma are only intrusive when the trauma is a single event. They argue that dissociation is a skill which can be learned and perfected as trauma gets repeated (Summit, 1988). Dissociation then preserves the memory intact but out of awareness in a separate part of the mind.

Although the concept of repression has a long history, both its history and its validity are quite contentious. The justifiability of applying the concept to intense and

traumatic experiences has been questioned (Orne & Singer, 1994). Moreover, Holmes, in a review of 60 years of research on the concept, has found that there is no good experimental evidence to support its existence. Instead, what Holmes uniformly found was that what sometimes looks like repression could be explained by other processes such as focusing attention away from the material, or the "interfering effects of stress" (p. 91).

The argument that dissociation can explain how memories can be kept out of awareness does not have good support either. Psychogenic amnesia and hypnotic amnesia have been used as models of dissociative processes. However, a defining feature of hypnotic amnesia is its ability to be breached (Kihlstrom & Evans, 1979). If it were easy to breach amnesia for child sexual abuse the application of special therapeutic techniques to achieve recall would be superfluous.

The literature on psychogenic amnesia offers no more support for this type of amnesia than does hypnotic amnesia as a model for dissociated memories. The typical clinical picture of psychogenic amnesia involves forgetting which occurs immediately after an upsetting event and which is pervasive enough to be immediately apparent to the amnesic (Abeles & Schilder, 1935; Kaszniak, Nussbaum, Berren & Santiago, 1988). People with psychogenic amnesia typically do not know where they are, and often they do not know who they are. What they do know is that something is amiss

(Coriat, 1907; Kaszniak et al., 1988; Schacter, Wang, Tulving, & Freedman, 1982). This state typically lasts no more than a few hours or days (Abeles & Schilder, 1935). Some experts qualify the typical presentation of psychogenic amnesia itself as a "refusal" to remember (Parfitt & Gall, 1944), implying that it is, in fact, possible for amnesics to remember. The differences between cases of psychogenic amnesia and the putative dissociation of memories of one specific class of experience (sexual abuse over the course of many years) are great. This leads some skeptics to reject the notion that recovered memories of child sexual abuse constitute an example of psychogenic amnesia (e.g., Wakefield & Underwager, 1992).(2)

Memory recovery therapists often advocate the use of special memory retrieval techniques (Blume, 1990; Fredrickson, 1992; Bass & Davis, 1988). These clinicians believe that techniques like hypnosis allow defense mechanisms to be bypassed (Blume, 1990; Courtois, 1988; Darken, 1992; Frederickson, 1992; Olio, 1989). Hypnosis has been credited by these authors with the power of eliciting accurate memories of events which could not otherwise be

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2 The effort to resolve these discrepancies has apparently led at least one author to adjust the way he believes psychogenic amnesia should be defined. Lowenstein (1991) argues that the adjective "sudden" should be deleted from the diagnostic criterion: "sudden inability to recall important personal information" (American Psychiatric Association, 1987, p. 275). The only evidence that onset of psychogenic amnesia is not always sudden however comes from studies conducted with people who had already recovered memories (Lowenstien, 1991; Coons & Milstein, 1992).

remembered by willing subjects (Blume, 1990; Darken, 1992; Fredrickson, 1992). If this is true then it contradicts the underlying argument of the bulk of the research cited above: (a) That memory is a reconstructive process rather than a reproductive one, and (b) that forgetting can involve either or both the disintegration of mnemonic traces and of the narrative which binds them into a coherent whole. It seems illogical to view ordinary remembering as a reconstructive process, while believing that hypnosis allows a copy of the original experience to be reinstated.

Critics have argued that the special techniques used to "help" clients to recover memories of former sexual abuse have been shown to be suggestive and capable of eliciting "memories" for events which never occurred (Lindsay, 1994; Lindsay & Read, 1994; Loftus, 1993). In addition, they argue that it is impossible to distinguish between accurate and inaccurate recall without external sources of information (Laurence & Perry, 1988; Lindsay, 1994; Neisser & Harsch, 1992).

Numerous studies have found that hypnosis is associated with more memory errors than the normal wake state (Dinges, Whitehouse, Orne, Powell, Orne, & Erdelyi, 1992; Dywan, 1988; Putnam, 1979; Register & Kihlstrom, 1987; Whitehouse, Dinges, Orne, & Orne, 1988). For example, in response to leading questions, but not to neutral ones, Putnam (1979) found that hypnotized subjects made more memory errors than subjects who were not hypnotized. On the other hand, useful

information has sometimes been elicited during hypnosis which was not obtained during waking interrogations (Smith, 1983).

Dinges et al. (1992) have tried to explain the above findings. Previous research (Whitehouse et al., 1988) suggested that one effect of hypnosis is to increase willingness to report a memory by reducing the stringency of decision criteria. Dinges and his colleagues compared the performance of a hypnotized group to that of a forced-recall control group. This eliminated any advantage obtained by the application of a looser decision criterion. They found that accurate memory was no greater for hypnotized subjects than for the control group; however hypnotized subjects expressed more confidence in their erroneous answers than non-hypnotized control subjects.

Memory errors associated with hypnosis are not confined, however, to mistakes about the details of remembered events. Hypnosis has also been used to induce subjects to create memories for whole events which never occurred. Thus, Laurence and colleagues (Labelle, Laurence, Nadon, & Perry, 1990; Laurence, Nadon, Nogrady, & Perry, 1986; Laurence & Perry, 1983), based on a procedure used by Orne (1979), found that subjects could be led to create new memories. Following a hypnotic suggestion, subjects reported hearing noises during a night they had previously indicated had been quiet and uneventful. About 40% of Laurence and Perry's (1983) highly hypnotizable subjects

reported a pseudomemory for noises following hypnosis. Some of these subjects apparently remained convinced of the accuracy of their hypnotically induced memories even after being debriefed. Other researchers (Barnier & McConkey, 1992; Lynn, Milano, & Weekes, 1992; Lynn, Weekes, & Milano 1989; Sheehan, Statham, & Jamieson, 1991) found that the size of the pseudomemory effect could be changed by manipulating different variables: hypnotizability, how publicly verifiable the event was, response format, experimental demand characteristics, contextual cues and item content.

During hypnosis subjects are asked to make use of their imaginative abilities. In fact, hypnosis has been characterized as "believed-in imaginings" (Sarbin & Coe, p. 11, 1972). It is therefore not surprising to find that hypnotic subjects produce much fantasied material. Research suggests that hypnosis may increase memory errors by affecting the quality of mental imagery, making it more vivid (Lindsay, 1994). Hypnosis also appears to decrease the stringency of the decision criteria used in reality-monitoring (Dinges et al., 1992). Thus, any technique which lowers a person's decision criteria, or which boosts the quality of mental images, may increase source confusion. Thus, for example, Perry and Nogrady (1985) warn that guided imagery may induce memory confusions which are very similar

in effect to hypnosis.(3)

Thus far we have seen that the view that memories of child sexual abuse can be forgotten and then retrieved requires that we accept that certain types of events leave permanent traces in our minds. This has been shown to be highly unlikely.

One can accept that no memories are completely without error, yet still contend that memories are basically accurate. The reconstructive nature of memory may lead us to make mistakes about the details of an event, while not affecting our ability to recall its main features. This is certainly likely to be true. As Johnson and Raye (1981) point out, the consequences of a memory system with little relation to actual external events would be devastating. It is also true that memory distortion is not the same as memory creation. In the latter case what is "remembered" cannot properly be called a memory at all. Several writers supportive of the validity of recovered memory (Berliner & Williams, 1994; Olio, 1994; Pezdek, 1994) point out that memory creation is different from memory revision. As Johnson's research has made explicit, however, the plasticity of memory itself, combined with a human ability to create images and explanations, can make it difficult to determine the source of our mental representations.

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[3] Guided imagery can be procedurally similar to hypnosis and can elicit similar degrees of imaginative elaboration and absorption. However, because it is not called "hypnosis" it cannot be said to be the same thing.

It is not always clear when memory distortion turns into memory creation. For example, Pynoos and Nader (1989) interviewed children whose classmates had been present at a shooting in a schoolyard. Two of these children said that they remembered being present at the scene when, in fact, they were not at school. Loftus (1993) considers this an example of memory creation because the children's memory was based on media accounts. Clearly, however, the children had not invented a memory for the shooting itself, but of their role in it. Jean Piaget, on the other hand, recounted that he invented the complete memory of an attempt to kidnap him which took place when he was a baby. Later he discovered that the governess who "rescued" him had made up the story (Piaget, 1962; pp. 187-188). In this case the event was completely fictional, but based on a story Piaget heard as a boy. Even though he later knew that this memory was not based on an externally generated event, Piaget retained the memory of the imagined event, along with its feel of something he had lived.

Loftus demonstrated that a memory for a totally fictional event could also be induced in an older subject. In this case study one subject's brother, in conversation with the subject, referred to an occasion during the subject's childhood when he was allegedly lost in a shopping mall. Though the subject did not at first "remember" the event he later "recovered" a rather detailed memory of it (Loftus & Coan, 1994). Clearly, not only can memory

modification take place, but memories for completely imaginary events can be mistaken for memories of real events. Moreover, this process may be facilitated by techniques which explicitly invite imaginative elaboration, although this is by no means a necessary condition of memory creation (Garry & Loftus, 1994).

When the research findings concerning memory and memory recovery techniques (e.g., hypnosis) are applied to the clinical context the conclusions for the practice of therapy are somewhat disquieting. Johnson's work (Johnson et al., 1993; Johnson & Raye, 1981) has shown that subjects naturally engage in reality-monitoring, presumably because they are aware that they could make mistakes about the sources of their memories. However, the fact that memory distortion can be so reliably produced experimentally implies that therapists (like experimental psychologists) could inadvertantly confuse their clients about the sources of their memories. There are at least three ways in which this could be done:

1. Giving clients misinformation about the likelihood of real-world events could make fantasied events seem more like memories.

2. Misleading clients about the nature of memory itself could produce confusion between memory and fantasy.

3. Helping clients to create fantasies which have proportionally more of the attributes of memories of externally generated events and fewer of the attributes of

internally generated events could produce confusion between memory for the two types of experience.

More specifically, one of the disagreements between recovered memory theorists and false memory theorists concerns the prevalence of child sexual abuse and its consequences. If clients are told that they demonstrate the symptoms of abuse and that child sexual abuse is common this may increase the chances that they will come to believe that they have been abused.

Clients are sometimes told that it is possible to forget that they have been abused and that it is possible to recover these memories with the aid of special techniques (Bass & Davis, 1994; Blume, 1990, Courtois, 1988; Fredrickson, 1992; Lindsay, 1995; Loftus & Ketchum, 1994; Ofshe & Watters, 1994; Pendergrast, 1995). Because this has not been shown to be true, this statement can be taken as an example of misinformation about memory. When clients believe such statements however, they are more likely to engage in memory recovery techniques and to define the results as memory. Another example of a piece of misinformation is to indicate that one can have accurate memories of one's infancy, or even birth.

The memory recovery techniques which appeal to imaginative capacities (hypnosis, relaxation, visualization, etc.) may lead clients to have fantasies without the subjective impression of having tried to remember (Dywan, 1988; Laurence & Perry, 1983; Laurence et al., 1986; Ofshe &

Watters, 1994). Since the memory of the processes associated with generating thoughts is one of the clues in reality-monitoring (Dodson & Johnson, 1993; Johnson et al., 1993; Johnson & Raye, 1981) this could lead to source confusion. Clearly, given the right conditions, it is quite possible for therapists to lead clients to confuse memories of actual events with memories of fantasies.

We have seen that several assumptions must be made about the way memory works if we are to accept that recovered memories are as accurate as other memories. These assumptions do not appear to hold. It is important now to consider the experimental evidence which bears specifically on the accuracy of recovered memories of child sexual abuse. If veridical memories are to be recovered then two things must happen: First the child has to forget the abuse, and second, the adult has to remember it.

There is some evidence that sexual abuse can be forgotten. For example, Williams (1994) interviewed 129 women with documented sexual abuse histories. At the time of the original abuse report each child had also been assigned a rating indicating a health-care provider's estimate of the reliability of the complaint. Williams reports that 38% of the total sample, when interviewed as adults, failed to report the episode of abuse which had been documented or any other incident with the same offender. This figure appears very high. However, she also reports that only 12% of the entire sample when specifically queried

on the issue "reported that they were never sexually abused in childhood" (p. 1174), thus suggesting that at most only 12% had truly forgotten having been abused. Williams fails to describe the pertinent characteristics of these subjects, however. For example we do not know how many were under two or three years of age at the time of the relevant incident. In addition, Williams does not report the reliability rating received by those subjects in this group. Nevertheless, it is possible that up to 12% of Williams' sample entirely forgot being abused; and that while it is possible, it is not common to forget the experience of sexual abuse.

It is debatable whether dramatic events can be totally out of awareness, and seemingly irretrievable, yet accessible through special memory recovery techniques. Three studies could be taken to support the argument that memories of sexual abuse can be recovered. Briere and Conte (1993) studied a sample of 450 subjects recruited through a sexual abuse treatment referral network. The subjects were all apparently victims of sexual abuse. They were given a questionnaire to establish their level of psychological function and to get information about the nature and context of their abuse. In addition, subjects were asked if there had been a time when "you could not remember the forced sexual experience" (Briere & Conte, 1993, p. 24). Fifty-nine per cent of their sample replied "yes" to this question. This seems to offer support for the contention that child sexual abuse can be forgotten and recovered.

However, this study has some methodological problems which make it difficult to draw conclusions. One weakness is that it is hard to know how to interpret "a time when you could not remember the forced sexual experience." This statement is not likely to be understood in the same way by all subjects. Thus, it is difficult to know whether the 59% positive response indicates that 59% of the subjects were unable to remember their abuse or whether they had simply not thought about it.

An even more important problem with this study is that the subjects were all recruited from therapists in a sexual abuse treatment referral network. This means that it is quite likely that many of these therapists were themselves memory recovery therapists and that their clients had already participated in memory recovery therapy. Given these ambiguities the results from this study cannot be taken as evidence either for or against the validity of recovered memories of child sexual abuse.

In a somewhat similar study Loftus, Polonsky, and Fullilove (1994) interviewed 105 women who had been addicted to alcohol or other drugs. Fifty-seven of the women reported having been sexually abused and fifty-two of these answered a question about the persistence of their memory for the abuse. Subjects were asked: "When you think about your memory for your abuse, how would you describe the memories?" They were then supposed to indicate whether:

1. They had "always remembered their abuse throughout

their lives, even if they never talked about it."

2. They had "remembered parts of the abuse their whole lives, while not remembering all of it."

3. They had forgotten "the abuse for a period of time, and only later [had] the memory return." (Loftus et al., 1994; p. 75)

Sixty-nine per cent of the abused women who answered the question said that they had always remembered the abuse. Twelve percent remembered parts of their abuse, and 19% said that they had forgotten the abuse during some period. As the authors themselves point out, however, even this question was ambiguous. This means that the study suffers from one of the same difficulties of interpretation from which the Briere and Conte (1993) study suffered. Loftus et al. (1994) suggest adding response choices which include, for example, "There was a time when I would not have been able to report the abuse because I had no idea that it had even happened to me." (p. 81). This underscores the ambiguity of the term "memory recovery" as well as the difficulty of relying on a single question to assess forgetting. Nevertheless, the study seems to suggest that a certain number of women might forget their sexual abuse histories temporarily.

Herman and Schatzow (1987) make the stronger claim that they have demonstrated that memories of abuse can be forgotten and then recovered. Their subjects were a group of 53 women who participated in group therapy for incest

survivors. Out of the 53 women 28% originally had no memory of sexual abuse. Sixty-four percent had some memory of abuse but also uncovered new memories. Seventy-four per cent of the 53 women were reported to have found evidence corroborating their childhood sexual abuse. Evidence consisted of admissions of guilt by the "perpetrator", diaries, photographs, and statements of other family members. However, the strength of the evidence found in the Herman and Schatzow (1987) study was unclear from the article. The authors give some convincing examples of evidence. However, it is not certain that the evidence was as strong in the cases on which they did not elaborate. For example, photographs and statements of other family members can range from very explicit and unequivocal to very ambiguous. In some cases very ambiguous clues are taken as evidence of abuse (Goodman et al., 1994; Ofshe & Watters, 1994).

Moreover, in spite of the fact that 28% of these women originally had no memory of abuse at all, Herman and Schatzow assumed that all of the 53 women had been abused. They therefore made no distinction in their article between the evidence gathered by those with never-forgotten memories and those who originally had no memories. Thus, we do not know which of the 54 women found corroborative evidence. In other words, this does not address the critical question of whether women with no memory of sexual abuse can recover

corroborated memories of their abuse.(4)

In spite of serious methodological weaknesses in most of these studies, it seems apparent that memories of sexual abuse can be forgotten. The reasons for forgetting are still a subject of debate between those who believe that accurate and reliable memories of abuse can be recovered and those who do not. At issue here is how the processes of forgetting and remembering affect the quality of what is remembered. The concepts of repression and dissociation allow us to explain how memories can be separated from consciousness without affecting the quality of the memory itself. However, many cognitive psychologists (Ceci et al., 1994; Ceci & Loftus, 1994; Garry, Loftus & Brown, 1994; Holmes, 1990; Lindsay, 1994) argue that forgetfulness of child sexual abuse can be explained by the same processes which affect forgetfulness for other events: "normal forgetting, deliberate avoidance, attentional overfocusing and infantile amnesia" (Ceci & Loftus, 1994; p.352) depending on the case. Loftus (1993) has pointed out that people forget numerous apparently significant events from their pasts. For example, more than a quarter of 1500 people who had been in hospital one year previously did not remember their hospitalization (U.S. government studies,

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4 This study illustrates a point I made earlier. Herman and Schatzow report that those women who originally had no memories were the ones with the worst histories. They clearly take this as evidence of the validity of recovered memory. A critic of recovered memory would be more likely to take this as evidence of memory creation.

cited in Loftus, 1982). There is to date no convincing support for the possibility that forgetting is ever the result of special mechanisms (Holmes, 1990), nor that accurate memories of sexual abuse can be reliably retrieved after having been forgotten. In addition, the research on sexual abuse of children finds no evidence of amnesia (Kendall-Tackett et al., 1993).

Note that many skeptics of recovered memory (Lindsay, 1994; Lindsay & Read, 1994; Loftus, 1993) say clearly that they are not suggesting that veridical memories of child sexual abuse can never be lost and yet recovered. They simply argue that the techniques being used are also highly likely to create some false beliefs and "memories." I would like to add that (a) child sexual abuse occurs, (b) child sexual abuse can be forgotten, and (c) a certain number of adults recover what they believe to be memories of child sexual abuse. Therefore, even in cases where "memory" recovery is independent of past experience it is likely that a small number of people who recover memories actually were abused and forgot it. However, this cannot be used as an argument supporting the use of memory recovery techniques.

Schooler (1994) gave an account of how memories of child sexual abuse could be retrieved in therapy. His account made reference only to normal memory mechanisms. He suggested that by deliberately avoiding thinking about a certain event it becomes less clear. Then, due to variability in the retrievability of the memory a person

could come to think about that event - in therapy - when he or she had not thought about it at other times. This type of memory is not what I would call "recovered memory", and its retrieval does not require the use of special techniques. One would expect a memory recalled in this way to have the characteristics of other memories which resurface after a long period with no rehearsal. That is, it should be somewhat vague and degraded.

In the Loftus et al. (1994) study referred to earlier, it was found that 19% of their abused subjects claimed to have forgotten their abuse for a time. In this study there was no attempt made to verify the accuracy of the subjects' assertions that they had been abused. For this reason it is possible that subjects who reported having forgotten abuse had not really experienced it in the first place. However, what is particularly noteworthy in this study is that the reported quality of the retrieved memories was poorer than for those subjects who reported continuous memory. This seems to fit the account of possible memory retrieval given by Schooler. It is also quite different from some of the descriptions of memories recovered in the context of memory recovery therapy, which are sometimes remarkably clear and detailed.

Several authors who defend the validity of recovered memories acknowledge that inaccurate memories can occur in memory recovery therapy, while claiming that it is a very low probability event (Bass & Davis, 1994; Enns, McNeilly,

Corkery & Gilbert, 1995; Olio, 1994, Pezdek, 1994). Others claim that inaccurate remembering happens only in the therapy of less talented clinicians (Lindsay, 1994; Pendergrast, 1995; Poole et al., 1995; Yapko, 1994a, 1994b). The assumption is that with care and skill it is possible to recover reasonably accurate memories of long forgotten events. Yet, the techniques used to do this are the very ones most likely to induce erroneous memories (Gar.y & Loftus, 1994; Laurence & Perry, 1983; Lindsay, 1995; Orne, 1979). There is no careful way to use imaginative elaboration to recover memories. Moreover, many experts agree that once the accounts have been produced it is impossible to distinguish between those which are accurate and those which are not (Laurence & Perry, 1988; Orne, 1979; Yapko, 1994b).

It should be clear that arguments in favor of the validity of recovered memory are not well enough supported to justify confidence in recovered memories nor the techniques used to elicit them. The confidence expressed by some clinicians (e.g.,Darken, 1992; Fredrickson, 1992; Olio, 1989) seems to be misplaced, prompting Yapko to say that "too many psychotherapists treat their patients on the basis of their personal beliefs and philosophy, and not according to an objective consideration of the facts." (1994a, p. 169).

Some attempt has been made to establish the prevalence of agreement with arguments favoring the validity of

recovered memories. In 1980 Loftus and Loftus conducted an informal survey of support for the permanence of memory. Seventy-five of their subjects had graduate training in psychology. They were asked to choose from the following two statements the one which best reflected their view on how human memory works:

1. "Everything we learn is permanently stored in the mind, although sometimes particular details are not accessible. With hypnosis, or other special techniques, these inaccessible details could eventually be recovered."
2. "Some details that we learn may be permanently lost from memory. Such details would never be able to be recovered by hypnosis, or any other special technique because these details are simply no longer there."

Eighty-four percent of the psychology graduates endorsed statement number one, indicating a high degree of support for the idea that memory involves the permanent storage of information.

Recently, four formal surveys have examined therapist beliefs and therapeutic and diagnostic practices in relation to recovered memory. Two of these concerned recovered memory in general (Poole et al., 1995; Yapko, 1994a, 1994b), the two others concerned satanic ritual abuse (SRA) specifically (Bucky & Dalenberg, 1992; Goodman et al., 1994).

Goodman et al. (1994) surveyed 19,272 therapists in a

stratified random sample of clinical members of the American Psychological Association, the American Psychiatric Association, and the National Association of Social Workers (from the United States). They received 6,910 usable responses. They were interested in the nature and prevalence of cases of satanic ritual abuse as reported by clinicians. However they also included questions about all types of religion-related abuse in order to make comparisons. A second survey was conducted of 2,136 subjects who reported cases of repressed memory of satanic ritual abuse on the first survey. Of these, 797 were returned.

Goodman et al. (1994) found that the severity of the abuse reported by these subjects was particularly extreme. Their other important finding was that the physical evidence for other types of religion-related abuse was in general, far more compelling than for satanic ritual abuse, which tended to be ambiguous. In addition, they discovered that "[s]ocial workers had the highest rate of acceptance of abuse allegations among all professions, while M.D.'s had the lowest rate of acceptance....Overall, regardless of these differences, respondents' acceptance of both the allegations of ritual and religion-related case elements was very high." (p.6) They also found that 1.4% of respondents who reported cases of either satanic ritual abuse or religion-related abuse had seen over a hundred of such cases each.

In 1990 Bucky and Dalenberg (1992) conducted a survey of 4,500 therapists from San Diego County. Their questionnaire referred only to satanic ritual abuse (SRA) and multiple personality disorder (MPD). They set out to discover whether a majority of cases reported by therapists came from a small percentage of therapists and whether frequency of report was linked to level of training and attendance at a related workshop. The return rate in this study was about 10%, giving them 433 usable questionnaires to analyse. Twenty-three percent of subjects were psychologists, 22% social workers, 18% marriage, family and child counsellors, 6% psychiatrists, and 10% other.

In this study it was found that the professions did not differ from each other as to the number of multiple personality disorder and satanic ritual abuse cases they encountered. On the other hand, they did find a significant association between attendance at workshops and the identification of relevant cases (multiple personality disorder [MPD] or satanic ritual abuse [SRA]). There were not enough psychiatrists to include them in the analysis. It was found, however, that M.A.-level therapists were strongly influenced by MPD workshops and both Ph.D. and M.A.-level therapists were strongly influenced by SRA workshops. For example, only 21% of untrained M.A.'s reported seeing a case of MPD in the previous two years, whereas 46% of the trained M.A.'s did so. In addition they found that 2% of the clinicians accounted for the majority

of cases, "each reporting over 100 victims." (p. 234)

Michael Yapko (1994a, 1994b) conducted a survey of 869 psychotherapists' beliefs about the nature of autobiographical memory and hypnosis during 1992. He also asked respondents whether they used hypnosis to recover memories in therapy and whether they tried to distinguish between their clients' true and false memories. In order to conduct this survey Yapko constructed two questionnaires: the Memory Attitude Questionnaire (MAQ) and the Hypnosis Attitude Questionnaire (HAQ). Agreement with each statement of belief was rated by the respondents on a four-point Likert scale, ranging from strongly agree to strongly disagree.

Yapko's (1994a, 1994b) subjects were attending conferences or private workshops. Sixty-four percent of his subjects held masters degrees, 24% held doctorates, 4% were psychiatrists and 5% had bachelor degrees. The rest of the subjects either held some other degree or did not answer.

The results of Yapko's (1994a, 1994b) survey suggested that many therapists entertain misconceptions both about memory and about hypnosis. He also found that about 56% of his subjects used hypnosis (at least occasionally) to help clients recover memories (1994b, p. 231; p. 234) Only about 37% reported that they attempted to distinguish between their clients' true and false memories (1994b, p. 233). In addition, 19% reported knowing of cases where a client's trauma had been the result of suggestion rather than "a

genuine experience" (p. 236).

Poole et al. (1995) conducted two mail surveys of Ph.D.-level psychologists. The first was conducted in the United States and a second sampled psychologists from both the U.S. and Britain. The questionnaire employed for this study asked respondents about their therapeutic practices, their clients, and their beliefs "regarding memories of child sexual abuse." They analyzed results for those respondents who saw at least 10 adult female clients in the previous two years. This yielded a total sample size of 202 respondents.

The Poole et al. (1995) study found that respondents reported having made use of a mean of 3.16 indicators of sexual abuse. Seventy-one percent of these clinicians used at least one memory recovery technique and 58% reported using two or more. They also found that 71% of respondents in the second survey reported "memory recovery in at least some clients." (p. 432). They found, too, that 91% of these respondents agreed that "it is possible for a client to come to 'believe that she was sexually abused as a child if no abuse had actually occurred'" (p. 432).

In the Poole et al. (1995) study theoretical orientation was related to the importance respondents' accorded to the role of remembering abuse in therapy. Behavioral therapists assigned less importance to memory and psychodynamic therapists, more. The number of symptoms thought to be indicative of abuse, the number of techniques

used, and the proportion of clients who recovered memories did not vary by theoretical orientation. The study found that there was a correlation ranging between .31 and .40 between the number of techniques used and the percentage of female clients who recovered memories of child sexual abuse during therapy (as reported by subjec nally, Poole et al. found that 25% of their respondents had a focus on memory recovery: they used more than two memory recovery techniques and they indicated that memory recovery was an important goal of therapy. Eight percent were cautious regarding memory recovery, disagreeing that memory recovery was an important goal and not using any recovery techniques.

Present Study

The goal of the present study was to elucidate the relations between therapist characteristics, beliefs, use of memory recovery techniques, and the prevalence with which they report seeing cases of recovered memory. I wanted to know whether certain therapist characteristics (e.g., profession, training) would be associated with level of support for the validity of recovered memories. In addition, I expected to find that beliefs supportive of recovered memory would be related to the frequency with which therapists employed memory recovery techniques. Moreover, because the use of such techniques has been shown to lead to memory creation (Laurence & Perry, 1983; Labelle et al., 1990; Kandyba, 1996) I predicted that greater use of techniques would be associated with greater frequency of

reported cases.

Therapists were mailed questionnaires regarding their beliefs, their practices, and the number of recovered memory cases they encountered. The survey differed from previous ones in a few ways:

1. The questionnaire included a wide variety of items. Forty-four of them tapped beliefs and knowledge relating to memory and recovered memory. Thirty items asked for demographic information, characteristics of therapeutic practice, and prevalence of cases. This permitted a more thorough analysis of the associations between beliefs, practices, and the prevalence of reported cases of recovered memory than earlier studies.

2. It sampled psychiatrists at the same rate as psychologists and social workers. The only previous study to do this was the Goodman et al. (1994) study. However, that research was concerned with satanic ritual abuse specifically rather than with recovered memory in general.

3. It was conducted in Quebec rather than the United States or Britain.

In order to arrive at a description of the relations between variables, three stages of analysis were carried out. In the first stage I examined descriptive data on the respondents and compared professions. I was interested in the prevalence of agreement with arguments supportive of recovered memory, attendance at training workshops, the endorsement of a variety of behaviours as symptoms of sexual

abuse, the use of memory recovery techniques, and the frequency with which respondents of different professions encountered recovered memory cases. There were three specific issues relating to this phase:

1. Psychologists, because they study normal psychological processes, should demonstrate more factual knowledge of memory than social workers or psychiatrists (Barlow, 1974; Garfield, 1966; Perry, 1979). On the other hand Sechrest (cited in Hayes, 1989) and Dawes (1994) have argued that clinical psychologists are poorly informed about the subject matter of their science. I wanted to know how knowledgeable psychologists were about memory compared to social workers and psychiatrists.

2. Social workers are not expected to be familiar with the subject matter of psychology (e.g., memory processes). Therefore, I wanted to know whether they would be more convinced by arguments unrelated to memory: ones which appeal to (a) the motivation of the critics of recovered memory and, (b) the relative importance of personal experience and external reality (cf. Bucky & Dalenberg, 1992).

3. Bucky and Dalenberg (1992) found no differences in between professions in the number of cases reported. This suggests that, if the Bucky case is similar to ours, there should be no differences between professions in the endorsement of symptoms of child sexual abuse nor in the number of recovered memory cases found. Although Bucky and

Dalenberg did not ask about memory recovery techniques it also seemed probable that those more inclined to report seeing cases would also report using more techniques. On the other hand, Goodman et al. (1994) found that of the three professions surveyed (social workers, psychologists, and psychiatrists) social workers most frequently accepted reports of abuse allegations, and psychiatrists least frequently. If the present case is similar to the Goodman et al. study, social workers should report a larger number of cases, and psychiatrists should report fewer cases of recovered memory.

A second, and related, stage in the analysis was to examine specific predictors of diagnostic tendencies. Certain characteristics of the respondents (theoretical orientation, attendance at training workshops, level of research involvement, feminism) were analyzed to see if they were associated with (a) the number of symptoms endorsed, (b) the number of memory recovery techniques employed, and (c) the frequency with which cases of recovered memory were reported. There were several questions related to this stage of analysis:

1. Poole et al. (1995) found that therapists who identified themselves as using a behavioral orientation were less supportive of the importance of remembering abuse in therapy than therapists who identified themselves as using a psychodynamic approach. However, they did not find any association between theoretical orientation and number of

symptoms or techniques endorsed, or number of cases encountered. I wanted to know whether therapists endorsing a cognitive or behavioral orientation would exhibit less agreement with arguments supportive of recovered memory validity than other therapists.

2. Dawes (1994) implicates pseudo-professional training as a source for misinformation about psychology. Dawes' criticism of workshop-delivered training was supported by the findings of Bucky and Dalenberg (1992). They found that their subjects' attendance at workshops on satanic ritual abuse and multiple personality disorder was associated with more frequent reports of satanic ritual abuse and multiple personality disorder cases made by these subjects, especially for certain professions and levels of training. It was therefore predicted that attendance at workshops on areas related to recovered memory would be associated with greater endorsement of memory recovery techniques.

3. Dawes (1994) believes that a neglect of research is responsible for the existence of mental health fads. If this is true, then respondents with more involvement in scientific research should exhibit more skepticism of recovered memory than those with less research involvement.

4. I predicted that respondents who identified themselves as feminist would support political and social arguments supportive of recovered memory validity. Thus, I expected statements impugning the political motivations of

critics, and those suggesting that personal experience is more important than external reality would garner more support from feminists than non-feminists. However, I did not anticipate that this would necessarily affect knowledge about memory, the endorsement of symptoms, use of techniques, or number of cases found.

The third stage of the analysis was to examine the statistical relations between respondents' beliefs about the validity of recovered memory, the number of techniques they used, and the frequency of recovered memory cases they saw. Three predictions related to this stage of the analysis:

1. I expected that therapists confident in the validity of recovered memory would be more likely to believe that clients were abused even without memories. In addition, I thought that greater confidence in recovered memories would be associated with more frequent use of memory recovery techniques. For both these reasons I expected that stronger endorsement of beliefs favorable to the validity of recovered memory would be associated with a higher frequency of recovered memory cases.

2. It has already been argued that when suggestive techniques are used with clients some will have fantasies which they believe to be memories. For this reason it was predicted that the use of memory recovery techniques would be associated with a higher number of cases. Because the behaviour of a person who recovers memories can be exactly what would be expected from a person describing real events,

the behaviour of such a person is often taken as evidence of the memories' validity by the therapist (Borch-Jacobson, 1995; Ofshe & Watters, 1994). For this reason I anticipated that the use of memory recovery techniques would predict cases even for therapists uncommitted to the validity of recovered memories.

3. I also expected that the predicted relationship between belief, use of memory recovery techniques, and recovered memory cases would be reflected in other ways. Specifically, I thought that subjects who reported many cases would be the same ones who used a large number of techniques, and who strongly endorsed arguments favorable to recovered memory validity.

Method

Subjects

Nine hundred therapists were selected from professional lists of Quebec psychiatrists, clinical psychologists, and social workers. The goal of the selection process was to obtain a random sample of people who did clinical work with adults. As long as it seemed reasonable to assume that the subject worked with adults that person was eligible for selection. Thus, for example, clinical neuropsychologists were not excluded; however, social workers who worked only for the Conseil Permanent de la Jeunesse were. Nevertheless, available information about the respondents was limited, and it varied for the different professions. The most complete information was available for psychologists. Therefore, the choice of psychologist-respondents probably best reflected the target population. The actual selection was made, after ineligible subjects were excluded, by beginning with some randomly chosen name and then choosing every nth(5) subject from the professional lists, such that 300 from each profession were selected. These lists were in alphabetical order. Subjects were 220 therapists who returned questionnaires.

Measure

Development of the questionnaire.

A number of statements of belief were written to

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[5] For social workers this meant taking every tenth name; for psychiatrists, every third; and for psychologists, every twentieth name.

paraphrase arguments found in articles and books which concerned topics related to the validity of recovered memory. Other statements came from questionnaires written by Yapko (1994a, 1994b) on beliefs about hypnosis and recovered memory. Moreover, items tapping demographic information and the therapeutic practices of respondents were included. Some of these items were taken from Poole et al. (1995). A preliminary questionnaire was derived based on this pool of items.

The questionnaire was reviewed by a group of 12 people (10 graduate students, and two professors, all working in fields related to recovered memory). These reviewers checked the items for clarity of expression and coverage of the important arguments.

The resulting document was translated into French and both the French and the English versions were reviewed again for clarity of expression and similarity of meaning by myself, two other graduate students, and one professor. All of those who revised the French version were native French speakers.

A pilot study was conducted by mailing the English form of the questionnaire to 30 English-speaking mental health professionals and the French form was sent to 30 French-speaking professionals. One third of the pilot subjects were social workers, one third were psychologists, and one third were psychiatrists. The questionnaire was revised on the basis of the results of the pilot study. Six items were

dropped because of lack of clarity and because of the secondary nature of their importance to the debate; fifteen were revised to improve clarity. Two items were added after the English pilot questionnaire was returned and tested in the French pilot.

Final questionnaire.

The final questionnaire consisted of 74 items designed to get information on a variety of issues enumerated below. (See Appendices A and B). The definition of child sexual abuse employed by Poole et al. (1995, p. 427) was used: "Physical sexual contact perpetrated against someone 16 years of age or younger by a person 6 or more years older than the victim."

Belief.

Forty-four items requested that subjects rate their agreement or disagreement with a statement of belief on a five-point Likert scale where -2 indicated strong disagreement, 2 strong agreement, and 0 no opinion (uncertain). This section of the questionnaire was designed to tap the level of agreement with a variety of different arguments, all related to the validity of recovered memories. Responses to this section of the questionnaire were used to derive a measure of the degree of a respondent's support for the validity of recovered memory.

Out of 44 belief statements, 40 entered into this Belief score. Three statements (items 33, 34 and 35) were excluded from the calculation of the total score because

they were not directly related to support for the validity of recovered memory(6). One further item (#37) was excluded because it asked that the subjects offer their own answers. This item was not scored in the same way as the others and could not be included in the total score. Statements which were supportive of the validity of recovered memories were scored positively and statements supportive of criticism of recovered memory were scored negatively. Items which the subject did not answer were scored as 0 (uncertain). Higher scores indicated greater agreement with the recovered memory theory, and lower scores indicated less agreement. Since scores were based on a five-point Likert scale where -2 was strongly disagree and 2 was strongly agree a negative total score was indicative of overall disagreement with recovered memory validity. A positive total score indicated overall agreement. The maximum score possible was 80, and the minimum was -80.

This section of the questionnaire was also used to calculate several subscale scores:(7) (Consult Appendix C for the list of items in each subscale).

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[6] The items began with the root "Forgetfulness for experiences occurring before the age of about three (childhood amnesia) is most likely to be caused by..." and three endings which follow made up the three items:
33. immature cognitive development. 34. immaturity of the nervous system. 35 immature language skills. Item 37 said "other (please specify)."

[7] When items were missing from subscales the subject was dropped from the entire scale. This was not true of the calculation of overall Belief. The reason for this was that the subscales incorporated fewer items and were therefore more vulnerable to distortion when substituting for missing data.

1. A measure of knowledge about memory was created. This was a scale composed of five statements having to do with the malleability of memory and five statements relating to the permanence of memory (Traces). Each statement was either factually correct or incorrect. These 10 items together made up the Knowledge scale. It is impossible to distinguish logically between the truth value of different levels of agreement (e.g., strongly agree vs agree). Therefore, the two levels of agreement and disagreement were collapsed. Items were scored so that a higher score indicated better overall knowledge, and a lower score indicated that the subject entertained misconceptions about memory processes. Consequently, items were scored in an opposite direction for the total Belief score and for the Knowledge subscale score. The maximum score possible on Knowledge was 10 and the minimum was -10.

2. A second subscale score was called Social Context. Five items on this scale had to do with judgments about what therapy should accomplish and how, i.e., the relative importance of truth versus experience. (This was called Values). Five items tapped beliefs about the motivation for the recovered memory/false memory debate (Motivation). The ten items together made up the Social Context score. In calculating this score the distinction between agreement and strong agreement was maintained. Higher scores indicated greater support for arguments having to do with the social context of abuse. The maximum score

possible was 20 and the minimum was -20.

3. Forgetting grouped nine statements which gave explanations for why abuse could be forgotten. This differed from the full Belief scale in which the three "naturalistic" explanations already referred to were not included. The maximum score was 18 and minimum was -18.

4. Distress was composed of items which addressed the relation of emotional distress to memories of sexual abuse. The maximum score was 6 and the minimum was -6.

5. Credulity was made up of statements which seemed likely or unlikely to be true, even without any specific knowledge. The maximum score was 6 and the minimum was -6.

6. Diagnosis combined questions relating to the notion that symptoms can be used to detect a history of child sexual abuse. The maximum score was 8 and the minimum was -8.

7. RecMem contained four items intended to summarize the respondents' support specifically for recovered memory validity. The maximum score was 8 and the minimum was -8.

Only the Knowledge scale collapsed levels of agreement and disagreement. And only that scale was scored in a direction opposite to the total Belief score.

Workshops.

One item concerned the number of workshops the respondent attended which were related to recovered memory. It said that "some clinicians find workshops helpful in keeping up to date. If you have participated in workshops

dealing with any of the following subjects at some time during the last five years please indicate this by checking any which apply." Subjects were given a list of four possible topics for workshops and they were given a chance to add others. Any workshop concerning memory recovery techniques, or disorders directly connected to trauma or memory recovery (e.g., posttraumatic stress disorder), was counted. General theoretical approaches were not counted, nor were disorders with only an indirect connection to recovered memory (see Appendix D).

Symptoms.

One question asked that respondents identify, from a list of 24, those symptoms of a history of child sexual abuse which they believed indicated either definite or possible abuse (or they could leave it blank). (See Appendix E for the list of symptoms).

Techniques.

Another item informed subjects that "the following techniques are sometimes used in order to help clients remember events from childhood. Please place a check by any technique that you yourself use or for which you refer clients in order to help them remember childhood events." Thirteen techniques were named and subjects could add others. (See Appendix F). Subjects were also asked to "draw a line through any technique that [they believed] should not be used to help clients remember events from childhood."

Research involvement.

Two measures of research involvement were obtained. For one, respondents were asked to indicate the proportion of their professional time spent in research. For the other, they were asked to indicate the type of training they had received. Those who indicated that their training had been experimentally oriented, both experimentally and clinically oriented, or medical, were considered to have had some research training.

Feminism.

Feminism was evaluated on the basis of subjects' responses to three items on the questionnaire (see Appendix G). A high score on items 13 and 14 indicated support of feminism, while a high score on item 15 indicated disagreement with feminist views. Therefore, the three items were combined by adding the scores on items 13 and 14 together and subtracting the score on item 15. This created a variable with a maximum score of 13 and a minimum score of -1.

Recovered memory cases.

Two types of recovered memory cases were reported:

1. Clients who entered therapy with no memories of child sexual abuse, and who then acquired such memories during the course of therapy (whole memory cases).

2. Clients who remembered being abused when they entered therapy but who "uncovered" new episodes following the use of memory recovery techniques in therapy (recovered

incidents).

In order to arrive at a measure of the first type of recovered memories subjects were asked how many adult clients (18 years or older) they had treated in therapy over the past two years and how many of these clients reported experiencing some type of sexual abuse during childhood. In addition to the number of abused clients they had seen, subjects were asked (a) how many of such clients, at the beginning of therapy, "had no memory or suspicion of child sexual abuse (i.e., they were consulting you for some other reason)"(8) (b) how many, at the beginning of therapy, thought they had been abused without having any specific memories of the abuse; and (c) "how many already remembered being abused when therapy began." The total of the numbers given in answer to (a) and (b) was taken as the number of clients with recovered memories of child sexual abuse (whole memory cases).

In order to arrive at a measure of the second type of recovered memory (recovered incidents) subjects were asked "Out of those clients who remembered being sexually abused in childhood when therapy began, did any come to uncover new episodes of abuse during the course of therapy?" They were then asked "how many did so spontaneously" and "how many did so following therapeutic efforts to aid the return of memories." Those clients who were reported to have

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8 There was a mistake on the 13 English questionnaires, and the part that said "at the beginning of therapy" was left out. This was not true of the 297 French questionnaires.

recovered new incidents of child sexual abuse following therapeutic efforts were considered cases of recovered incidents.

Reliability.

Because of the multidimensional nature of the subject matter it would not have been informative to calculate the internal consistency of the questionnaire. Instead, the test-retest reliability was measured for the belief section of the questionnaire. (The other parts of the instrument consisted of questions which are generally assumed to be reliable.) This abbreviated (English) version was given to 27 undergraduate psychology students on two occasions, four weeks apart. This yielded a test-retest reliability coefficient of .85 ($p < .01$).

Procedure

Three hundred subjects from each category of professional were mailed questionnaires on October 30, 1995. A cover letter explained the study and invited the subjects' participation (Appendices H and I). A stamped and addressed return envelope was provided in which to mail the completed questionnaire. In addition, a response card with the subject's name was included so that subjects could indicate whether or not they were returning the questionnaire (Appendix J). This card was stamped and addressed so that it could be returned separately from the questionnaire. Thus, respondents could indicate that they had returned the questionnaire without revealing their identity on the

questionnaire itself, which thus remained completely anonymous.

A reminder notice was mailed four weeks after the questionnaire (November 28, 1995) to all those who did not return a response card (Appendix K). Starting on the following day (November 29, 1995) subsamples of social workers and psychologists were contacted by telephone in order to encourage them to participate. (Telephone numbers were not available for psychiatrists.) See Appendix L for the telephone script.

Three hundred questionnaires were sent to social workers. Of this number, three were returned by the postoffice because they were undeliverable. Two reminder cards were returned for the same reason, making a minimum of five undeliverable questionnaires. Eighty-seven questionnaires and 46 response cards with refusals were returned by social workers. This added up to a return rate of 45% for response cards and questionnaires combined, and 29% for completed questionnaires only. Eighty-five of these questionnaires were usable. The returned response cards indicated that 21.5% of the social workers who returned questionnaires were from Montreal.

Three hundred questionnaires were also sent to psychologists. Fourteen of these were returned by the postoffice because they were not deliverable, and three reminder cards were returned for the same reason. Seventy-six questionnaires and 24 response cards with refusals were

returned. This added up to a total response rate for psychologists of 35%, and a return rate of 27% for completed questionnaires. Thirty-one percent of the returned questionnaires came from Montreal.

Out of the three hundred questionnaires mailed to psychiatrists three were returned by the postoffice, as were two reminder cards, meaning that at least five questionnaires were not delivered. Fifty-nine completed questionnaires were returned by psychiatrists, as were 20 response cards with refusals. Thus, the total response rate for psychiatrists was 27%, 20% for completed questionnaires. Thirty-five percent of the questionnaires returned by psychiatrists were from Montreal.

The total number of response cards which indicated a refusal to participate for all professions combined was 90. The total number of returned questionnaires was 222, yielding an overall combined response rate of 36%, and an overall response rate for completed questionnaires of 25%.

Results and Discussion

Characteristics of the Respondents

As stated above, the overall return rate was 25%, yielding a sample size of two hundred and twenty subjects. On average, respondents were 46.15 years old (SD = 9.80), had practiced for 17.42 years (SD = 9.83) and fifty-six percent were female. Thirty-seven percent were social workers, 35% psychologists, and 27% were psychiatrists. (For more descriptive information on subjects consult Appendix M).

Beliefs about the validity of recovered memories.

The first phase of analysis was to describe the prevalence of beliefs supportive of the validity of recovered memory, workshop attendance, endorsement of symptoms, use of memory recovery techniques, and cases of recovered memory for different professions in Quebec. The mean total Belief score for the whole sample (N = 220) was 1.65 with a standard deviation of 19.93. The lowest score was -59 and the highest score was 54.

Analyses of variance (ANOVA's) were used to compare scores for different professions. Because sample sizes were unequal I used a weighted means model. This model weights means according to sample size, so that the F-ratio used conforms more precisely to the sampling distribution of F. It is also a slightly more stringent test (Keppel, 1991; p. 288).

Total scores on Belief were highest for social workers,

followed by psychologists, and by psychiatrists (M's = 11.31, 0.88, -11.27; SD's = 12.97, 21.90, 18.13); (Weighted Means Model: F(2, 217) = 27.96; MSE = 318.70, p < .001). Tukey's Honestly Significant Difference (HSD) was used as a post hoc test. This revealed that each of the groups was significantly different from the other (p < .001).

As mentioned above, I wanted to know whether psychologists would demonstrate more knowledge of memory processes than other professions. This was tested by comparing Knowledge scores for the professions. Psychiatrists obtained the highest Knowledge scores and social workers the lowest (F [2, 205] = 24.71; MSE = 13.31; p < .001; HSD p < .01). Mean Knowledge scores for social workers, psychologists, and psychiatrists were, in order, -0.05, 1.97, and 4.40 (SD's = 3.41, 4.17, 3.24).

Social workers, on the other hand, expressed the strongest agreement with statements concerning the motivation for the debate and the importance of personal experience: they obtained the highest scores on Social Context, and psychiatrists the lowest, with psychologists falling in the middle (F [2,193] = 20.32; MSE = 47.21; p < .001; HSD p < .05). Mean Social Context scores for social workers, psychologists and psychiatrists were 3.66, -0.62 and -4.12 respectively (SD's = 5.46, 7.87, 7.34).

The only scale score which did not differ significantly between the professions was Distress (F [2,208] = 2.55, MSE = 0.99, p = .08). Using Tukey's HSD as a post hoc test,

with alpha set at .05, it was found that Credulity was significantly higher for social workers than for psychologists and psychiatrists, who did not differ from each other (F [2,201] = 7.02, MSE = 0.94, $p < .001$). On the other scale scores (Forgetting, Diagnosis, RecMem) psychiatrists were significantly more critical of the arguments supportive of recovered memory than psychologists, who were more critical than social workers (Forgetting: F [2,209] = 25.07, MSE = 0.81, $p < .0001$; Diagnosis: F [2,204] = 11.73, MSE = 0.91, $p < .0001$; RecMem: F [2,211] = 12.35, MSE = 0.90, $p < .0001$) In order to allow for easy comparison Table 1 reports mean standardized scores for each scale by profession.

In addition to scoring lowest on Belief, psychiatrists also differed from other groups in having a lower proportion of females (X^2 = 50.79 [df=2; N = 219], $p < .0001$). Social workers, psychologists and psychiatrists were 76%, 62%, and 17% female respectively. This means that the differences observed between the professions could be due to the difference in their respective proportions of females. In fact, female subjects did score higher than male subjects on Belief (t [217] = 5.40; $p < .001$; M's = 7.74, -6.06 and SD's = 18.80, 18.79 for female and male subjects, respectively). However, when both Profession and Gender are used to predict Belief scores, Profession adds 11% of unique variance. Gender, on the other hand, adds only 3% of unique variance to the prediction of Belief by Profession. This implies

Table 1

Standardized Scores and Significance Tests of Scale Scores for Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.)

	S.W.		Psy		M.D.	
Scale	M	(SD)	M	(SD)	M	(SD)
Belief	0.49	(0.65) /	-0.05	(1.10) /	-0.64	(0.91)*
n	85		76		59	
Knowledge	-0.47	(0.84) /	0.03	(1.03) /	0.63	(0.80)*
n	79		72		57	
Mall	-0.48	(0.95) /	0.02	(0.96) /	0.64	(0.73)*
n	79		73		57	
Traces	-0.33	(0.84) /	0.04	(1.05) =	0.40	(0.99)*
n	81		73		59	
Social	0.47	(0.73) /	-0.10	(1.05) /	-0.57	(0.98)*
n	77		68		51	
Values	0.42	(0.79) /	-0.06	(0.96) /	-0.53	(0.91)*
n	80		71		56	
Motive	0.44	(0.74) /	-0.12	(1.07) /	-0.53	(1.02)*
n	81		69		52	
Forget	0.47	(0.83) /	0.01	(1.05) /	-0.63	(0.79)*
n	79		74		59	
Distress	0.18	(0.97) =	-0.04	(1.02) =	-0.20	(0.97)
n	82		73		56	

Table 1 continued

Scale	S.W. M	(SD)		Psy M	(SD)		M.D. M	(SD)
Credulity	0.30	(0.77)	/	-0.08	(0.98)	=	-0.33	(1.19)*
n	77			73			54	
Diagnosis	0.26	(0.81)	=	0.10	(1.02)	/	-0.53	(1.04)*
n	80			74			53	
RecMem	0.29	(0.79)	=	0.08	(1.08)	/	-0.50	(0.97)*
n	81			74			59	

Note. Mall = Malleability. Malleability and Traces are subscales of Knowledge. Social = Social Context. Motive = Motivation. Values and Motivation are subscales of Social Context. Forget = Forgetting.

* overall F-test was significant at $p < .01$

/ Tukey HSD showed groups differed at $p < .05$

= Tukey HSD showed groups did not differ ($p > .05$)

that although gender is important, it does not account for the entire effect of profession on Belief.

In addition to analyzing the subscale scores, each belief statement was looked at separately. Several significant differences emerged between the professions. To make these comparisons, both levels of agreement (strongly agree and agree) were combined, as were both levels of disagreement. Chi-squares were then calculated on these frequencies. To avoid cells with low frequencies, the missing data and the uncertain categories were excluded from the analyses. (See Appendix N. In addition, Appendix O gives the complete breakdown of responses for each item by profession.) The analyses indicate whether there were differences in the pattern of response by profession, when only those respondents who had an opinion are considered. This means that sample sizes vary and that percent agreement was higher than if the uncertain and missing data responses had been included.

There was a marked tendency for psychiatrists to differ from psychologists and social workers. The responses of the psychiatrists tended to be more critical of the validity of recovered memory, social workers tended to be the most supportive, and psychologists generally feli in the middle, but closer to the social workers.

Workshops.

Because the number of workshops attended did not follow a normal distribution, the Kruskal-Wallis nonparametric test

statistic was used to compare the number of workshops attended by respondents of different professions. Kruskal-Wallis has the advantage of using ordinal-level data so that as little information as possible about group differences is lost (Siegal & Castellan, 1988). On average, respondents attended 0.61 workshops which related to memory recovery (N = 220; SD = 0.82). When responses were ranked from low to high numbers of workshops no differences were found between professions on average ranks (H [2, N = 220] = 2.42, p = .30; Mdn = 0). See Table 2 for details, and Appendix P for the complete breakdown.

Symptoms.

Respondents answered, on average, that 1.36 symptoms indicated definite abuse (N = 218; SD = 2.92). The average number of symptoms of possible abuse endorsed was 13.92 (N = 217; SD = 7.41). Psychologists endorsed fewer symptoms of definite abuse than social workers, but psychiatrists were not distinguished from either group (H [2, N = 218] = 14.76, p < .001). The median number of symptoms of definite abuse endorsed by social workers, psychologists, and psychiatrists were 1.00, 0.00, and 0.00 symptoms respectively. The professions did not, however, differ from each other on the number of symptoms of possible abuse (see Table 2). Respondents endorsed a median of 13.00 possible symptoms. For a detailed breakdown see Appendix Q.

Techniques.

Respondents reported employing a mean of 3.04

Table 2

Number of Workshops Attended, Symptoms and Techniques Endorsed and Techniques Rejected by Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.)

	S.W. M (SD)	Psy M (SD)	M.D. M (SD)
		Workshops	
	0.49 (0.73)	0.66 (0.81)	0.71 (0.95)
n	85	76	59
		Symptoms	
Definite*	1.92 (3.39) /	0.77 (2.26)	1.31 (2.80)
n	85	74	59
Possible	14.77 (7.11)	13.20 (7.18)	13.59 (8.08)
n	84	74	59
		Techniques	
Endorsed*	3.26 (2.35)	3.45 (2.54) /	2.26 (2.20)
n	74	74	58
Rejected*	1.52 (1.86)	3.01 (3.62) /	4.74 (4.31)
n	73	74	58

* overall Kruskal-Wallis was significant at $p < 01$.

/ adjacent groups differ at $p < .05$.

techniques per subject (N = 206; SD = 2.42) and rejected a mean of 2.97 techniques (N = 205; SD = 3.57). Consult Table 2. The distribution of the number of techniques endorsed by subjects was positively skewed. For this reason nonparametric tests were conducted to compare the frequency with which different professions endorsed memory recovery techniques. Social workers and psychologists endorsed more memory recovery techniques than psychiatrists did ($H(2, N = 206) = 9.75$, $p < .01$; Mdn's = 3, 3 and 2, for social workers, psychologists and psychiatrists respectively). Social Workers and psychologists rejected significantly fewer techniques than psychiatrists ($H [2, N = 205] = 20.53$, $p < .001$; Medians = 1, 2 and 4). See Table 2, and Appendix R for further details.

Recovered memory cases.

Out of the whole sample, 205 subjects, (93%) reported seeing adult clients. Of this number 192 respondents (94% of those with clients) reported seeing at least one with a history of child sexual abuse during the last two years (see Table 3). I calculated both (a) the number of respondents who reported seeing at least one case of recovered memory (whole memories and incidents), and (b) the number of adult clients reported to have recovered memories of child sexual abuse.(9) The mean number of abused clients seen by a

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9 Some respondents reported having seen recovered memory cases but did not give an estimate of their number. When this happened data was not available to determine the number of clients who recovered memories. However, the number of respondents who had at least one case could be calculated.

Table 3

Number and Percentage of Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.) Reporting at Least One Case of Recovered Memory

	S.W.		Psy		M.D.	
	(n)	%	(n)	%	(n)	%
Recovered Memory Clients						
No	(27)	34	(30)	43	(24)	43
Yes	(43)	54	(37)	53	(26)	46
Missing	(9)	11	(3)	4	(6)	11

single clinician (based on N = 192) was 16.14 (SD = 40.46). One hundred and six respondents (52% of those who had clients) indicated that at least one of those clients recovered memories of child sexual abuse.

In order to compare the number of respondents in different professions who reported seeing recovered memory cases Chi-square tests of independence were conducted. The professions did not differ in the number of respondents who reported having recovered memory clients, nor did they differ in the number of such clients seen by a single clinician (N = 172; GM = 2.84). For frequencies consult Table 4, for totals see Table 5. For the breakdown of types of memories by profession consult Appendix S.

The number of cases of recovered memory which an individual encounters is likely to be affected by the number of clients seen by that person. In order to adjust for this I calculated a rate of memory recovery. The proportion of clients who recovered memories during the course of therapy was calculated by comparing them to the total number of clients seen. This yielded a rate of memory recovery expressed as a percentage of total clients. The variable which was created in this way was positively skewed. Because of this, nonparametric tests were used to compare the proportion of recovered memory cases reported by the different professions (see Table 4). Professions did not differ from each other on this dimension either (Mdn = 0.61%; GM = 4.23%). Thus, our results were consistent with

Table 4

Mean Numbers of Clients of Different Categories Seen by Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.)

	S.W.		Psy		M.D.	
	M	(SD)	M	(SD)	M	(SD)
Female	68.24	(107.32)	39.41	(37.31)	119.38	(381.16)
n	69		69		53	
Abused	19.07	(60.53)	9.61	(15.34)	20.75	(25.66)
n	72		69		52	
Cases	3.46	(7.45)	2.82	(6.31)	2.04	(3.84)
n	61		67		45	
Rate	4.20%	(5.59%)	5.28%	(12.08%)	2.66%	(4.24%)
n	57		67		44	
Total Clients	109.64	(159.41)	61.89	(39.41)	192.48	(548.22)[a]
n	67		70		52	

Note. Female = female clients; Abused = clients who report a history of child sexual abuse. Cases = number of clients who recovered memories. Rate = percentage of clients who recovered memories.

[a]One psychiatrist reported seeing 4,000 clients. Without him M's of Female, Abused, and Clients for psychiatrists would be 69.16 (45.00), 20.38 (10.00), 117.82 (104.53) respectively.

Table 5

Total Numbers of Clients of Different Categories Seen by All Respondents

Client Categories	Total Clients Reported	N
Women	13,686	190
Abused	3,115	193
With Memories	1,988	182
Recovered Whole Memories	417	179
Recovered Incidents	94	185
Recovered Total	492	173
Total Clients	21,687	189[a]

Note. N = all subjects for whom there was data. Discrepant N's are due to missing data.

[a] One psychiatrist reported seeing 4,000 patients.

the Bucky and Dalenberg (1992) finding that professions did not differ on the number of cases reported. However, they were inconsistent with the result from the Goodman et al. (1994) study that social workers reported more cases than psychiatrists.

To conclude the section describing the characteristic responses of the sample, and comparing professions: The level of psychologists' knowledge proved to be inferior to that of psychiatrists. Social workers were more supportive of arguments couched in social terms than other professions. Despite differences in expressed support for the validity of recovered memory, there were no differences between professions in number of cases reported. This was consistent with one previous study (Bucky & Dalenberg, 1992) and inconsistent with another (Goodman et al., 1994).

Predictors of Diagnostic Tendencies

The second phase of the analysis was to use a variety of respondent characteristics as predictors of Belief, symptom endorsement, memory recovery techniques, and recovered memory cases. I call these indices "diagnostic tendencies".

Orientation.

Those respondents who endorsed either cognitive, behavioral, cognitive-behavioral, or social-learning as their first choice of theoretical orientation were considered cognitive-behavioral therapists. Those who endorsed psychodynamic, psychoanalytic, or interpersonal

Table 6

Social Workers' (S.W.), Psychologists' (Psy) and Psychiatrists' (M.D.) First and Second Choices of Theoretical Orientation

	S.W.		Psy		M.D.	
	1st	2nd	1st	2nd	1st	2nd
	n	n	n	n	n	n
Cog/Beh	2	12	17	13	7	9
Humanist	15	15	26	20	2	2
Systems	42	29	4	10	3	6
Freudian	13	7	23	18	29	22
Medical	0	0	0	0	12	5
Feminist	3	2	5	1	2	0
Missing	10	20	1	14	4	15

Note. 1st = first choice; 2nd = second choice. Cog/Beh = behavioral, cognitive, cognitive-behavioral, social-learning; Humanist = humanist, client-centred, existential; Systems = systemic, psychosocial; Freudian = psychoanalytic, psychodynamic, interpersonal.

orientations first were considered Freudian. Therapists who endorsed humanist/client-centred or existential orientations were called humanist, and those who endorsed either psychosocial or systemic orientations were considered systemic therapists. Those who chose medical-pharmacological orientation first (a subsample of the psychiatrists) were so classified. Respondents who ranked Feminist as their first choice were also so classified.

Psychologists reported the highest number of cognitive-behavioral and humanist therapists. Psychiatrists reported the most Freudians, and social workers the highest proportion of systemic therapists ($\underline{X}^2$ [4, $\underline{N}$ = 183] = 88.48, $\underline{p}$ < .001). Feminist therapists were excluded from this analysis because there were only three of them. Medical orientation was also excluded because it only applied to psychiatrists (see Table 6).

Cognitive-behavioral therapists obtained lower Belief scores than all but the medically-oriented therapists ($\underline{F}$ [4, 190] = 7.42, $\underline{p}$ < .0001; HSD $\underline{p}$ < .05). (See Appendix T for scale scores). In spite of the differences between theoretical orientations in expressed support for the validity of recovered memory, no difference was found in the number of techniques endorsed, nor in the number of techniques rejected. Yet cognitive-behavioral therapists did report encountering a lower proportion of cases of recovered memory than humanist therapists ($\underline{H}$ [4, $\underline{N}$ = 153] = 18.37; $\underline{p}$ < .01), but did not differ significantly from other

Table 7

Number of Cases of Recovered Memory Reported by Cognitive-Behavioral (C/B), Freudian (Freud), Systemic (Sys), Humanist (Hum) and Medically-Oriented (Med) Respondents

	C/B	Freud	Sys	Hum	Med
Cases*					
M	0.65	1.81	1.79	5.22	5.00
(SD)	(2.15)	(2.61)	(3.36)	(9.25)	(6.65)
n	23	54	34	37	9
Rate*					
M	0.56%	3.98%	2.75%	6.50%	3.16%
(SD)	(1.30%)	(4.83%)	(4.19%)	(7.89%)	(3.59%)
n	23	54	32	35	9

Note. Cases = number of clients who recovered memories. Rate = percentage of clients who recovered memories.

* overall Kruskal-Wallis significant at $p < .01$.

Underline means that the group was different from cognitive-behavioral therapists, $p < .05$.

orientations (see Table 7).

The Poole et al. (1995) finding that theoretical orientation had some impact on support for the importance of remembering in therapy but not the use of techniques nor number of cases was partially replicated in the present study.

Workshops.

The total number of recovered memory-related workshops attended by respondents showed a small but significant correlation with number of techniques used(10) (r_s [203] = .16, $p < .05$). Although significant, the relation was too weak to agree with Bucky and Dalenberg's (1992) finding that workshop attendance predicted diagnostic tendencies.

Research Involvement.

A higher proportion of professional time spent in research predicted lower Belief scores (r_s [216] = -.25; $p < .05$). However, although significant, this relation was weak. (For other correlations see Table 8). Although more time spent in research was associated with more techniques rejected (r_s [202] = .25; $p < .05$), the relation between time in research and number of techniques endorsed was nonsignificant. Time spent in research also failed to predict the rate at which recovered memory cases were

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[10] I report the results of correlations of interest including small but significant ones. However, because of the ease with which significant correlations are produced when large sample sizes are used (Meehl, 1990; Standing, Sproule & Khouzam, 1991) I have decided not to interpret correlations which are smaller than .30.

Table 8

Spearman Ranked Correlations Between Percentage Time in Research and Scale Scores

Scale	r_s	n	p
Belief	-.25	218	*
Knowledge	.18	207	*
Social Context	-.21	175	*
Forgetting	-.17	210	*
Distress	-.14	209	n.s.
Credulity	-.25	203	*
Diagnosis	-.05	205	n.s.
RecMem	-.28	213	*

* $p < .05$

reported.

Respondents who reported having received research training as part of their education were compared with those who did not report this background. Subjects who reported having received research training scored lower on Belief than those who did not (*t* [217] = 7.56, *p* < .0001; *M*'s = -10.60, 8.42; *SD*'s = 19.21, 16.97). Because of lack of normality in the distributions of number of symptoms endorsed these groups were compared using a Mann-Whitney U test (*M-W*). Research training did not distinguish either the number of definite symptoms or of possible symptoms endorsed. It did, however, predict endorsement of fewer memory recovery techniques (*M-W* [*N* = 205] = 5981.50; *p* < .01; *Mdn*'s = 2, 3) and more frequent rejection of techniques (*M-W* [*N* = 204] = 3145.00; *p* < .001; *Mdn*'s = 4, 1), but not proportion of recovered memory cases.

Overall, research training seemed to have some slight relation to endorsement and (especially) rejection of techniques, but not to the number of cases reported.

Feminism.

The maximum and minimum scores obtained by combining the three items which tapped feminism in the way described in the methods section were two and 12. Social workers, psychologists, and psychiatrists did not differ on Feminism. The mean score was 5.94 (*SD* = 1.94).

Both Feminism and the Belief and subscale scores followed a normal distribution quite well. Because they

could also be treated as continuous variables, the predictive power of Feminism was evaluated using Pearson product-moment correlations. In this way information was not sacrificed in the process of creating artificial treatment groups.

Feminism predicted Social Context scores (r [ ] = .18; $p < .05$), implying that it was related to support for arguments concerning therapeutic values and the motivation for critiques of recovered memory. However, the relation was weak, explaining only four percent of the variance, and no stronger than those for Diagnosis or Forgetting with Feminism (r [201] = .20 and r [205] = .18, respectively: $p < .05$). (See Table 9).

Feminism did not predict the number of either type of symptoms endorsed by respondents, nor the number of techniques rejected. The relation with techniques endorsed was significant but very small (r_s [200] = .12, $p < .05$). Clearly, the relation between Feminism and diagnostic tendencies as measured in this study is not strong.

Prediction of Recovered Memory Cases

The third stage of analysis was to elucidate the contribution of Belief and Techniques to prediction of recovered memory Cases. Stronger endorsement of beliefs supportive of recovered memory predicted both (a) a wider variety of techniques endorsed (r_s [204] = .31, $p < .01$), and a higher rate of memory recovery (r_s [166] = .37; $p < .01$). Greater use of memory recovery techniques was also

Table 9

Pearson Product-Moment Correlations Between Feminism and Scale Scores

Scale	r	n	p
Belief	.15	215	*
Knowledge	-.06	204	n.s
Social Context	.18	192	*
Forgetting	.18	207	*
Distress	.04	208	n.s.
Credulity	.06	200	n.s.
Diagnosis	.20	203	*
RecMem	.06	210	n.s.

* $p < .05$

associated with higher rate of memory recovery (r_s [164] = .35; $p < .01$).

Regression analyses.

A multiple linear regression was used to examine the relative contributions of Belief and Techniques to Cases. The total number of clients seen should affect the number of cases reported. Therefore, to adjust for total clients seen, this variable was entered first in the regression equation. It was found that when Belief was entered after the total number of clients it had a significant effect on the number of cases reported (R [N = 168] = .21, $p < .05$). However, the amount of total variance explained was slight (4.4%), and the amount of unique variance even smaller (4.1%, $p < .05$). When Techniques entered the equation immediately after Belief it contributed 14% of unique variance to the prediction of number of cases of recovered memory seen ($p < .0001$). The equation Cases = Constant + Clients + Techniques accounted for 18.1% of the variance in Cases, whereas the equation Cases = Constant + Clients + Techniques + Belief accounted for 18.4%, a unique contribution of Belief of only 0.3% ($p = .46$). Thus, one can conclude that Techniques contribute the bulk of the variance in predicting Cases. Although Belief does contribute to prediction, it adds no information above and beyond Techniques.

Identifying extremes.

In a further effort to explore the relation between

predictors (belief, use of techniques) and number of cases identified, subjects who were extreme in some way were identified and compared. Three types of extremes were identified:

1. Those who accounted for the majority of cases of recovered memory. There was a total of 492 cases of recovered memory reported by the 205 respondents who saw clients. Fourteen of these respondents (7%) accounted for 271 cases (55%). For more details consult Appendix U. These respondents received higher scores on Social Context than other subjects (t [181] = 3.03; $p < .01$), and reported using more memory recovery techniques than the rest of the sample (M-W [N = 200] = 445.00, $p < .0001$; Mdn's = 5.5, 3). Other differences were not significant.

2. Those who demonstrated a memory focus, and those who were cautious about memory recovery. Subjects who focused on memory recovery agreed that "It is very important that a client who was sexually abused remember that abuse in order for therapy to be effective" and that "a history of child sexual abuse can be detected in someone who has no memories of abuse" and disagreed that "no symptoms are specifically and reliably associated with a history of child sexual abuse." They also endorsed more than two memory recovery techniques. Those who rejected a memory recovery focus were identified by opposite responses to the same three items and by their failure to use any memory recovery techniques. For details of subjects exhibiting a memory focus and those who

Table 10

Frequencies of Reported Cases of Recovered Memories

Cases	n	Sum	Cumulative
0	83	0	0
1	22	22	22
2	24	48	70
3	7	21	91
4	6	24	115
5	8	40	155
6	1	6	161
7	4	28	189
8	4	32	221
10	5	50	271
13	2	26	297
14	1	14	311
18	1	18	329
20	1	20	349
25	1	25	374
33	1	33	407
40	1	40	447
45	1	45	492

Note. n = total number of subjects who reported a given number of recovered memory cases. Sum = cases x n.

did not, see Appendix V.

Eighteen subjects (9% of those who saw clients) exhibited a memory recovery focus. Only 14 of these subjects reported whether or not they had cases of recovered memory. These subjects together reported a total of 108 recovered memory cases. Five subjects (2%) rejected this focus. Only four of these subjects saw clients. These four reported a total of one case of recovered memory. Those cautious about memory recovery obtained lower scores on Belief (t [21] = 7.34; $p < .001$) and most other scale scores. However, there were no differences between them in the rate of memory recovery. Other differences were not significant either. See Appendix V.

3. Those who obtained the highest and the lowest scores on Belief. The 5% of subjects who received the highest Belief scores were compared with the 5% who received the lowest scores. This yielded 11 low scorers and (because of tied ranks) 12 high scorers. The average Belief score for the Lows was -46.00 (SD = 7.14) and for the Highs it was 37.92 (SD = 6.91).

Highs and Lows were composed of different proportions of social workers, psychologists, and psychiatrists (X^2 [2, N = 23] = 9.47, $p < .01$). Fifty-eight percent, 25%, and 17% of the Highs were social workers, psychologists, and psychiatrists respectively; whereas for Lows those proportions were 0%, 45%, and 55%. Related to the difference in frequency of the professions was a difference

in the frequency of scientific training between the two groups. Where "scientific training" included medical school, low scorers more frequently had scientific training (Fisher exact test [N = 23]; p < .05). Seventy-three percent of low scorers had some type of scientific/medical professional training, whereas only 17% of the high scorers did. Also related to the different proportions of each profession, Lows included fewer female subjects than Highs did, 36% and 83% respectively, (Fisher exact test [N = 23], p < .05). Only low scorers included subjects who endorsed cognitive-behavioral approaches as their first choice. Cognitive-behavioral therapists made up 27% of the low scorers and none of the high scorers.

Because each subscale of the questionnaire correlated with the total Belief score it was expected that the extreme scorers on Belief would also differ on the subscales. This proved to be the case (see Appendix W). The difference in score was significant for each subscale.

Highs endorsed more symptoms of definite abuse than Lows (M-W [N =23] = 13.00; p < .001; Mdn's = 2, 0) but did not differ on symptoms of possible abuse. Lows rejected more memory recovery techniques than Highs (M-W [N = 23] = 110.50; p < .001; Mdn's = 9, 0). Highs also reported a higher rate of memory recovery (M-W [N = 21] = 18.50, p < .05). Five percent of the clients seen by Highs were reported to have recovered memories, whereas 1% of the clients seen by Lows did so.

To summarize the results concerning high and low scorers: although the two groups were equivalent in terms of the numbers of techniques used, a larger proportion of the abused clients of Highs recovered memories of child sexual abuse compared to Lows.

The three different types of extremes did not identify exactly the same subjects. Of the 14 subjects who accounted for the majority of recovered memory cases, only three were also found in the group of subjects exhibiting a memory recovery focus, and none were among the top 12 scorers on Belief. Of the 18 subjects who exhibited a memory recovery focus only three were also among the 12 top scorers on Belief. On the other hand, four out of five of those rejecting a memory recovery focus were among the 11 lowest scorers on Belief.

Comparison of Results with Other Surveys

The studies which were most similar to the present one were those by Yapko (1994a, 1994b) and Poole et al. (1995). For a summary of demographic information from these studies consult Appendix X.

Belief.

There is suggestive evidence for consistent agreement with the idea that experience is permanently stored in memory. In 1980 Loftus and Loftus found that 84% of American psychology graduates thought that information was

permanently stored in the mind.(11) In the present study 65% agreed with that idea (see Appendix O).

The Quebec respondents resembled Yapko's (1994a, 1994b) in their response to "Hypnosis can be used to recover memories of actual events from as far back as birth." About half of each of these groups agreed with the above statement (see Table 11), implying that they believe that permanent memory traces exist from birth.

Quebec respondents were more conservative than Yapko's (1994a, 1994b) on the issue of whether "hypnosis enables people to accurately remember things they otherwise could not." Thirty-eight percent of the Quebec sample agreed with this statement, whereas 75% of Yapko's sample agreed. Several other differences in response were also found on items which were worded differently in the Yapko study than in the present one (see Table 11).

Techniques.

Respondents from the U.S., Britain (Poole et al., 1995), and Quebec (present study) tended to endorse the use of a small number of memory recovery techniques and to reject a small number as well. Mean numbers of techniques endorsed were 2.39, 1.68 and 3.04 for U.S., Britain, and Quebec respectively. Means for techniques rejected were

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[11] The statement Loftus used was: "Everything we learn is permanently stored in the mind, although sometimes particular details are not accessible. With hypnosis, or other special techniques, these inaccessible details could eventually be recovered."

Table 11

Comparable Items From the Present Study and the Yapko Study, Reported With Percent Agreement

Present		Yapko	
Item	%	Item	%
It is very important that a client who was sexually abused remember that abuse in order for therapy to be effective.	42%	It is necessary to recover detailed memories of traumatic events if someone is to improve in therapy.	19%
Hypnosis can be used in such a way as to create confabulated memories.	49%	There is legitimate basis for believing that hypnosis can be used in such a way as to create false memories.	64%
Hypnotically obtained memories are less reliable than simple remembering.	24%	Hypnotically obtained memories are more accurate than simply just remembering.	43%*

Table 11 continued

Present		Yapko	
Item	%	Item	%
People cannot lie when in hypnosis.	21%	People cannot lie when in hypnosis.	18%
Hypnosis can be used to recover memories of actual events from as far back as birth.	46%	Hypnosis can be used to recover memories of actual events from as far back as birth.	54%
Hypnosis enables people to accurately remember things they otherwise could not.	38%	Hypnosis enables people to accurately remember things they otherwise could not.	75%

Note. Agreement is reported as percent of total sample and missing data is included in the calculations.

*These questions are opposites of each other.

2.22, 2.40, 2.97.

Poole et al. (1995) also found a correlation between the number of techniques used and the proportion of recovered memory cases similar to the one found in the Quebec sample. Poole et al. used a different formula for determining the proportion of recovered memory cases: whole recovered memory cases/total number of clients seen who originally had no memory of abuse. Using this formula Spearman ranked correlation between number of techniques endorsed and rate of memory recovery for the Quebec sample was .33 (175); $p < .01$. This compared to r's = .31, .40, and .31 for the three samples in the Poole study. Both methods of calculating rate of memory recovery yielded similar correlations (for Quebec: r_s = .33 by the Poole method and .35 by mine.)

Recovered memory cases.

Quebec respondents less frequently reported seeing cases of recovered memory than did the American and British respondents from the Poole et al. (1995) study (52% for Quebec and 71% for Poole et al.). Poole et al. surveyed only Ph.D.-level psychologists who reported seeing at least 10 female clients in the previous two years. When the same proportion was calculated with those Quebec psychologists who saw 10 women or more, 64% reported having at least one case of recovered memory. This is still less than Poole et al. Moreover, it should be noted that this subgroup of Quebec respondents was different from Poole's in being

largely masters-level psychologists.

Representativeness of the Sample

It is difficult to know how well these data reflect the views and the practices of Quebec clinicians unless we have some idea of how representative the sample is of the population. One way to get some notion of this is to consider return rates. The return rate for the present study (25% for questionnaires) seems to be comparable to those reported for other studies. They are somewhat lower than the rates reported for the Poole study, (35% to 43%) (Poole et al., 1995). However, Poole et al. report that 38% of their responses were from subjects who indicated that they were outside the target population. These subjects were not included in the analyses. This implies that overall response rates reported for the Poole study were only slightly higher than the present study. It is not surprising to find a slightly higher return rate for the Poole et al. study than for the present one, however. The longest version of the questionnaire used in that survey contained 30 items, whereas our questionnaire used 74 items.

Goodman et al. (1994) report a return rate of 36%, which is somewhat higher than ours. However, this was a postcard survey, and was therefore much easier to respond to. On their follow-up questionnaire survey they obtained a response rate of 37%. However, this was not a random survey, because they only sent questionnaires to people who reported seeing cases. The response rate for the present

study was higher than for Bucky et al. (1992) who reported return rates of about 10%. I consider these rates of return comparable because the response rates were only higher than ours where the questionnaires used were shorter.

The important issue is that those subjects who respond should not reflect systematic bias. The above comparison of response rates gives some indication that the results of the present survey are at least no more biased than any of the similar surveys. This is not to say that we know what non-responders think or do, simply that based on return rates there is no evidence of systematic bias.

In order to get some further indication of the representativeness of the sample I compared those subjects I knew were late-responders to the rest of the subjects (see Tables 12 & 13). None of the differences were significant. The lack of significance could be explained by a lack of power. Some mean differences are large. For example, Knowledge scores are quite high for the late responders. If we take the overall mean and standard deviation as equal to the population of respondents then the mean score of the late respondents is one half a standard deviation above the mean. This is worrisome, suggesting that late responders may be more knowledgeable than the bulk of the subjects. On the other hand, late subjects endorsed slightly more techniques and rejected slightly fewer. There seems to be little reason to think that there is systematic bias in the way late subjects answer as compared to early subjects.

Table 12

Characteristics of Late Respondents and Early respondents

	Early M (SD)	Late M (SD)	Total M (SD)
Age	46.10 (9.68)	47.38 (13.30)	46.15 (9.80)
n	210	8	218
Prac	17.30 (9.81)	20.38 (10.68)	17.42 (9.83)
n	207	8	215

	Early (n) %	Late (n) %	Total (n) %
Women	(116) 55	(6) 75	(123) 56
Profession			
S.W.	(82) 96	(3) 4	(85) 100
Psy	(72) 95	(4) 5	(76) 100
M.D.	(58) 98	(1) 2	(59) 100

Note. Prac = Number of years in practice. S.W. = social worker. Psy = psychologist. M.D. = psychiatrist.

Table 13

Scores of Late Respondents and Early Respondents

	Early	Late	Total
	M (SD)	M (SD)	M (SD)
Belief	0.01 (1.00)	-0.15(1.03)	0.00 (1.00)
n	212	8	220
Knowledge	-0.01 (1.00)	0.53 (1.26)	0.00 (1.00)
n	204	4	208
Social C.	0.00 (1.01)	0.17 (0.79)	0.00 (1.00)
n	191	5	196
Workshops	0.60 (0.83)	0.75 (0.46)	0.61 (0.82)
n	212	8	220
Definite	1.38 (2.96)	1.00 (1.20)	1.36 (2.92)
n	210	[illegible]	218
Possible	13.89(7.43)	14.86(7.24)	13.92 (7.41)
n	210	7	217
Technique	3.01 (2.40)	4.14 (2.85)	3.04 (2.42)
n	199	7	206
Rejected	2.99 (3.59)	2.29 (3.20)	2.97 (3.57)
n	198	7	205
Cases	2.92 (6.30)	0.40 (0.55)	2.84 (6.22)
n	168	5	173
Rate	4.32%(8.70%)	1.25%(2.28%)	4.23%(8.59%)
n	163	5	168

Table 13 continued

Note. Social C. = Social Context. Belief, Knowledge, Social Context, and RecMem are z-scores. Definite = number of definite symptoms. Possible = number of possible symptoms. Rejected = number of techniques rejected. Cases = number of clients who recovered memories. Rate = percentage of clients who recovered memories.

Discussion

The results of the present study suggest that Quebec clinicians resemble other groups of clinician-subjects in their frequent use of suggestive memory recovery techniques. They also report similarly high numbers of recovered memory cases. Subjects (therapists answering a survey) reported that an average of 4.23% of their clients recovered memories. However, the rate at which recovered memory cases were reported was not evenly distributed across respondents. Although 52% of the respondents reported having seen at least one case during the previous two years, only seven percent of them accounted for the majority of cases (55%). This pattern was similar to previous studies (Bucky & Dalenberg, 1992; Goodman et al., 1994; Poole et al., 1995), which reported that a small proportion (1.4 to 5%) of therapists sampled accounted for the bulk of satanic ritual abuse cases. Despite these similarities, the proportion of respondents who reported seeing at least one case of recovered memory (52%) was somewhat lower than that reported by Poole et al. (71%).

The present survey found a good predictor of rate of memory recovery: the number of techniques used (e.g., hypnosis) which involve imaginative elaboration. The degree of agreement with arguments supportive of the validity of recovered memory also contributed to prediction of the rate of memory recovery cases. However, information about this last variable did not contribute to prediction of cases once

the number of different techniques used was known.

The three professions surveyed: social workers, psychologists and psychiatrists, did not differ in number of recovered memory cases reported. Nevertheless, psychiatrists were the most skeptical of the arguments supportive of recovered memory therapy, and social workers were the least. Moreover, psychiatrists showed greater conservatism than social workers and psychologists in their reported use of memory recovery techniques.

Therapists' theoretical orientations cut partially across professional lines. It was found that cognitive-behavioral clinicians reported using a similar number of techniques to others. Nevertheless, they were more critical of arguments supportive of recovered memory validity than most orientations(12). They also reported a lower percentage of recovered memory cases than Humanist therapists.

Several anticipated relations were in the predicted direction but nonsignificant. Most notably, workshop attendance did not predict diagnostic tendencies (symptoms and techniques endorsed, and cases) to any interesting degree. Feminism also failed to predict level of agreement with arguments supportive of recovered memory validity to any extent. Those subjects who demonstrated a memory recovery focus did report a higher rate of memory recovery

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[12] Psychiatrists who reported being medically-oriented did not differ from cognitive-behavioral clinicians.

cases than those who rejected this focus; however the difference only approached significance.

The high rate of memory recovery reported by respondents in this and in other studies (Bucky & Dalenberg, 1992; Poole et al., 1995) suggests that many clinicians are inadequately informed about the risks of false memory recovery. The frequency with which Quebec therapists (a) endorse a variety of behaviours as symptoms of child sexual abuse, and (b) report employing techniques which tend to elicit confabulated "memories" corroborates the picture seen elsewhere. Respondents in the Poole et al. study generated a mean of 3.16 symptoms of abuse. This implies that they too were willing to take a variety of behaviours as symptoms of an abuse history. Similar to the Quebec sample, they appeared willing to employ suggestive techniques to aid memory recovery. Respondents in both studies appeared to be overly confident about their ability to help clients by facilitating recovery of forgotten events.

It seems logical that greater knowledge about (a) the weakness of the relation between any symptoms and a history of child sexual abuse, (b) the impermanence of memory and, (c) how remembering is affected by trauma and by special retrieval techniques, would prevent this overconfidence. Many respondents held false opinions about these matters. Consider, for example, that a large proportion of respondents (40%) disagreed with the statement that "no symptoms are specifically and reliably associated with a

history of child sexual abuse."(13), agreed that all experience is permanently stored in the brain(14) (65%), and disagreed (63%) that "hypnotically obtained memories are less reliable than simple remembering."

Nevertheless, some familiarity with the malleability of memory seemed to be widespread. Subjects from all professions tended to agree that memory was malleable. For example, 85% agreed that "postevent information can alter a person's recall of an event" and 80% agreed that "imaginary events can seem subjectively real when they are frequently rehearsed." Other items which tapped malleability did not exhibit the same level of agreement, however. Two of those items referred specifically to the reliability of memories obtained with the aid of hypnosis(15). Another referred specifically to the creation of traumatic memories(16). Clearly, the widespread notion that memory is malleable is often not applied by therapists to the specific contexts of hypnosis and memory of trauma.

Likewise, a majority of respondents (even many who believed that false memory recovery is very rare) agreed

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[13] The percentages reported here are based on the total sample, and are therefore very conservative when there were many subjects who said they were uncertain or who did not answer. See Appendix O for the complete breakdown of these items.

[14] "Everything one experiences is permanently recorded in one's brain."

[15] "Hypnotically obtained memories are less reliable than simple remembering" and "Hypnosis can be used in such a way as to create confabulated memories."

[16] "It is possible for people to create memories for traumatic events which they have heard described but did not experience."

that "clients can come to believe that they were abused when in reality they were not." This is reminiscent of the results obtained by both Poole et al. (1995) and Yapko (1994a, 1994b). They found a similar discrepancy between respondents' recognition that memories could be falsely recovered and their belief that this did not occur in their own practice. Thus, the principle that memory is malleable may be accepted without being applied to the clinician's own case (Dawes, 1995), including those times in which memories are retrieved "under" hypnosis.

Such naivete can constitute a hazard for mental health if therapists test the efficacy of special memory recovery techniques on clients. The evidence reviewed earlier (Laurence & Perry, 1983; Labelle et al., 1990) shows that these techniques can induce false memories by leading clients to misattribute internally generated experiences to an external source. It is impossible to distinguish between true and false memories solely on the basis of the quality of the memories. This means that clients react to their recovered memories in ways similar to the ways they react to memories of external events. Because of this the "memory recovery" process is convincing not only to clients but also to their therapists (Laurence & Perry, 1988; Orne, 1979). Therapists who both use these techniques and have "confidence that their clinical judgments are accurate" (Poole et al., 1995, p. 436) are very likely to be creating false memories in their clients. Clinicians who are

ignorant of their ability to influence clients are likely to assume that their clients "memories" are produced independently of themselves and consequently, to take the "memories" as proof of accurate recovery.

To prevent this from happening, therapists need to be better informed about how the malleability of memory and the power of suggestion apply to the therapeutic context. Two potential sources of such improved sophistication are good formal education and familiarity with the research literature on this subject. Bucky and Dalenberg (1992) suggest that respondents who have participated in critical examination of issues as part of their training are less easily swayed by misinformation. Lack of knowledge may lead one to accept logically coherent systems of belief which are unsupported by empirical evidence. Conversely, familiarity with the scientific method may create a habit of skepticism. Those with scientific training are more likely to believe that only assertions supported with empirical evidence should be seriously considered.

If knowledge about memory does provide protection against misconceptions about memory recovery then the low scores on Knowledge obtained by psychologists in comparison to psychiatrists are sobering. They also lend support to Sechrest's (cited in Hayes, 1989) and Dawes' (1994) contention that clinical psychologists are graduating with little knowledge in their discipline. These results suggest that psychologists know less about memory processes than

psychiatrists do. This is disturbing since autobiographical memory is an area of psychology which is also an essential part of psychotherapy. This is especially true for humanist and psychodynamic therapists.

It is notable that the majority of psychologists in this Quebec study had masters degrees rather than doctorates. Moreover, the vast majority did not report being involved in experimental research or having received training which included experimental research. This is significant given what has been said about the probable role of both formal education and research training in preparing clinicians. It is impossible to know which characteristics of social workers, psychologists, and psychiatrists account for the observed differences in their support for recovered memory. However, type and degree of training may play a role. Social work, psychology, and psychiatry require increasingly higher academic degrees in order to be allowed to practice, and, to some extent, more research training.

Nevertheless, the relation of research involvement to diagnostic tendencies was not as strong as the relation of profession to such tendencies. This suggests that research involvement is not a characteristic which can completely account for differences between professions. On the other hand, very few respondents in any profession reported spending current time on research. Moreover, for non-psychiatrists, it was very unusual to have any empirical research training at all. This means that research

involvement was confounded with profession, making the relation between it and diagnostic tendencies impossible to examine effectively.

Because of the confound between gender and profession an alternative explanation for the differences among the professions is that they merely reflect gender effects. (Only 17% of psychiatrists were women, compared to 76% of social workers). In fact, women did score higher on Belief than men. However, when Profession is added to Gender in predicting Belief, Profession contributes 11% of unique variance. Although gender does predict level of support for recovered memories, it cannot account for the entire effect of Profession.

It is curious to note that psychiatrists did not report a lower proportion of recovered memory cases than the other professions. This was true in spite of markedly weaker theoretical support for recovered memory validity and the use of fewer suggestive techniques than the other professions. In the present study, as with the Poole et al. (1995) study, a moderately strong relation was found between the number of techniques endorsed and the rate of memory recovery. This suggests that these techniques truly are being used by clinicians in Quebec with the aim of recovering memories, and that they are fulfilling that aim. Yet, it is surprising that the relation is not stronger still. Part of the reason for this may be that some clients recover memories without the aid of special techniques,

while others fail to respond to the techniques. An alternative, though not contradictory explanation, is that the number of different techniques endorsed is not a measure of the frequency with which respondents use such techniques. Any future questionnaire should certainly ask about this frequency. A clinician who uses only hypnosis, but who does so frequently, would be more likely to induce "memories" than one who uses a variety of techniques very infrequently.

Although some differences between the professions in the present survey are striking, even psychiatrists were only relatively skeptical of recovered memory. For example, the role of defense mechanisms is strongly supported, even by psychiatrists. Ninety-three percent of the whole sample agreed that "when an adult who was frequently abused as a child has difficulty remembering some of the particular incidents of this abuse, it is likely to be due to defense mechanisms." Very few subjects disagreed or were uncertain about this question.

Despite the high degree of consistency across professions on items which refer to the role of defense mechanisms, scores on the Forgetting subscale do not reflect this. The Forgetting subscale was made up of statements referring to explanations of why people forget. They included items which attributed forgetting to defense mechanisms and others which gave "naturalistic" explanations. The disagreement between psychiatrists and others on Forgetting can be largely explained by the

disagreement on "naturalistic" explanations of forgetting(17). That is, professions agree that defense mechanisms play a role in forgetting but disagree on alternative explanations.

In spite of variations in expressed support for the arguments related to recovered memory, all professions encountered cases remarkably often. The fact that many clients were reported to have no memories other than those triggered in therapy strongly suggests that the memories were inaccurate. The level of support for the validity of such memories, the widespread endorsement of suggestive techniques, and the lack of knowledge, are adequate reasons for alarm. This is especially so when one considers that all surveys to date report similar findings: acceptance of the validity of recovered memories is widespread, and in a certain proportion of therapists memory recovery appears to be actively pursued. Such acceptance poses a threat to the public from which they should be protected through better regulation of therapeutic practice.

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[17] There were three items with the root "Forgetfulness for experiences occurring before the age of about three (childhood amnesia) is most likely to be caused by...." The "naturalistic" explanations were: immature cognitive development, immaturity of the nervous system, immature language skills.

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Appendix A

English Questionnaire

SECTION I

This section contains several questions concerning your professional activities, your theoretical orientation, and your training. In order to make comparisons between respondents we also ask about your age and gender.

DEMOGRAPHIC INFORMATION

1. Age _____

2. Gender: Male _____

   Female_____

PROFESSIONAL BACKGROUND

3. Number of years in clinical practice: _____

4. Highest degree awarded: (e.g., B.A., M.S.W., M.D.) _____

5. In what field were you awarded your highest degree?: _____

6. Would you characterize your training as being primarily (Choose one):

   a. Experimentally oriented _____
   b. Clinically oriented _____
   c. Medically/scientifically oriented _____
   d. Socially oriented _____
   e. Experimentally and clinically oriented _____
   f. Practically oriented (on the job training) _____
   g. Other (please specify) _____

7. Some practitioners find that their academic training was useful to them in practicing therapy; others say that it was not. Please indicate how useful you consider your training to have been by placing a check by the most appropriate choice:

Useless _____ Slightly useful _____ Useful _____ Very useful

Comments on your answer to question #7:_____

_____

_____

8. Some clinicians find workshops helpful in keeping up to date. If you have participated in workshops dealing with any of the following subjects at some time during the last five years please indicate this by checking any which apply:

a. Memory recovery techniques _____
b. Dissociative Identity Disorder (MPD) _____
c. Satanic Ritual Abuse _____
d. Sexual abuse _____
e. Other (please specify)_____

9-12. Therapy orientation (Rank order as many as apply, with 1 being most influential):

a. Behavioral _____
b. Cognitive _____
c. Cognitive-Behavioral _____
d Existential _____
e. Feminist _____
f. Humanistic/Client-centered _____
g. Interpersonal _____
h. Medical/Pharmacological _____
i. Psychoanalytic _____
j. Psychodynamic _____
k. Psychosocial _____
l. Social-learning _____
m. Systemic/Systems oriented _____

Some people think that a therpaist's attitudes towards women and the women's movement influence the way one does therapy, (especially with female clients).

13. Using the following scale, (and regardless of your gender), would you describe yourself as...

+	+	+	+	+	+	+
Anti-feminist		Non-feminist		Feminist		Committed feminist

14. How do you think others would describe you?

+	+	+	+	+	+	+
Anti-feminist		Non-feminist		Feminist		Committed feminist

15. Do you support the objectives of radical feminism ? (eg., dismantling the patriarchal society)

Very much _____ Somewhat _____ Not at all _____

PROFESSIONAL ACTIVITIES

16. Setting(s) in which you work (check all that apply):

a. Hospital	_____	b. Private practice	_____
c. University	_____	d. CLSC	_____
e. School	_____	f. CEGEP	_____
g. Other	_____		

17. About what proportion of your **work** time do you spend on each of the following professional duties?:

a. Administration	_____%	b. Clinical supervision	_____%
c. Research	_____%	d. Teaching	_____%
e. Therapy	_____%	f. Assessment/Diagnosis	_____%
g. Other	_____%		

18. What percentage of your **therapy** time do you spend doing therapy with...

a. Individuals?	_____%	b. Families?	_____%
c. Groups?	_____%	d. Couples?	_____%

19. How many adult clients (18 years or older) have you treated in therapy over the PAST TWO YEARS? _____

20. How many of these were...

a. Women? _____ b. Men? _____

For the purposes of this questionnaire we are defining child sexual abuse as:

Physical sexual contact perpetrated against someone 16 years of age or younger by a person 6 or more years older than the victim.

21. Out of the total number of adult clients(MEN AND WOMEN) you have treated in therapy during the last TWO YEARS, how many reported experiencing some type of sexual abuse during childhood? _____

The next three questions (22, 23, 24) refer to those clients who did report a history of child sexual abuse (question 21).

22. How many had no memory, nor suspicion, of childhood sexual abuse? (i.e., they were consulting you for some other reason.) _____

23. At the beginning of therapy, how many thought they had been abused without having any specific memories of the abuse? _____

24. How many already remembered being abused when therapy began? _____

Out of those clients who **remembered** being sexually abused in childhood when therapy began (question 24) did any come to uncover new episodes of abuse during the course of therapy?

Yes _____ No _____

If **yes**, how many did so...

25. Spontaneously? _____

26. Following therapeutic efforts to aid the return of memories? _____

27. The following techniques are sometimes used in order to help clients remember events from childhoo refer clients in order to HELP THEM REMEMBER childhood events.

a. Hypnosis _____
b. Age regression _____
c. Dream interpretation _____
d. Guided imagery _____
e. Instructions to give free rein to the imagination _____
f. Bibliotherapy _____
(please specify which books)_____
_____
_____
g. Family photographs as memory cues _____
h. Keeping a journal _____
i. Interpretation of physical symptoms (including body memories) _____
j. Relaxation _____
k. Sodium Amytal (or similar medication) _____
l. Support groups (with or without a therapist) _____
m. Rebirth _____
n. Other (please specify)_____

28. On the list above **draw a line** through any technique that you believe SHOULD NOT be used to help clients remember events from childhood.

SECTION II

ATTITUDES AND BELIEFS

The second part of this questionnaire consists of statements which express attitudes and beliefs about memory, sexual abuse, and related issues. They are drawn from current literature on memory and sexual abuse. Please rate your relative agreement with each statement using the following scale:

Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
-2	-1	0	1	2

Please try to give your honest opinion and use the "unsure" response only when you really are not certain of your opinion. If you wish to comment on the statements or explain your answers please do so, either in spaces in the questionnaire or on extra pages. Please try to answer all of the questions.

GENERAL MEMORY

29. Postevent information can alter a person's recall of an event.	-2	-1	0	1	2
30. Everything one experiences is permanently recorded in one's brain.	-2	-1	0	1	2
31. Sensory impressions from early in life (preverbal memories) may form the basis for reliable memories which can be recovered later on.	-2	-1	0	1	2
32. Imaginary events can seem subjectively real when they are frequently rehearsed.	-2	-1	0	1	2

Forgetfulness for experiences occurring before the age of about three (childhood amnesia) is most likely to be caused by...

33. Immature cognitive development	-2	-1	0	1	2
34. Immaturity of the nervous system	-2	-1	0	1	2
35. Immature language skills	-2	-1	0	1	2
36. Defense mechanism (e.g., Repression)	-2	-1	0	1	2

37. Other (please specify) _____

TRAUMATIC MEMORY

38. An adult who was frequently abused as a child is more likely to remember having been abused than one who was rarely abused.	-2	-1	0	1	2
39. Imagined trauma, similar to real trauma, can cause intense distress.	-2	-1	0	1	2
40. Traumatic events create lasting visual images which cannot be altered.	-2	-1	0	1	2
41. It is possible for people to create memories for traumatic events which they have heard described but did not experience.	-2	-1	0	1	2
42. Results from experimental studies of memory (conducted under laboratory conditions) do not apply to traumatic amnesia.	-2	-1	0	1	2

When an adult who was frequently abused as a child has difficulty remembering some of the particular incidents of this abuse, it is likely to be due to...

43. Normal forgetting	-2	-1	0	1	2
44. Defense mechanisms	-2	-1	0	1	2

CONSEQUENCES OF CHILD SEXUAL ABUSE

As noted above, we are defining child sexual abuse as:

Physical sexual contact perpetrated against someone 16 years of age or younger by a person 6 or more years older than the victim.

45. A history of child sexual abuse can be detected in someone who has no memories of abuse.	-2	-1	0	1	2
46. Sexual contact between an adult and a child is not always traumatic.	-2	-1	0	1	2
47. A person who has learned to dissociate may not have any conscious memory of his or her sexual abuse.	-2	-1	0	1	2
48. No symptoms are specifically and reliably associated with a history of child sexual abuse.	-2	-1	0	1	2
49. What used to be called Multiple Personality Disorder (i.e., Dissociative Identity Disorder) is a consequence of severe sexual abuse.	-2	-1	0	1	2

RITUAL ABUSE

50. No satisfactory evidence of widespread satanic ritual abuse has been found to date.	-2	-1	0	1	2
51. Denial of the existence of satanic ritual abuse is similar to denial of horrifying realities like the holocaust.	-2	-1	0	1	2
52. The fact that many patients independently describe the same experiences in satanic cults indicates that the allegations are true.	-2	-1	0	1	2
53. Satanic "cult victims" are people who have been influenced by inapproriate suggestions (eg., books, t.v., etc.)	-2	-1	0	1	2

SOCIAL ISSUES IN MEMORY OF ABUSE

54. A scientific appraisal of the veracity of recovered memories is necessary if we want to get at the truth about their validity.	-2	-1	0	1	2
55. The real experts on traumatic memory are not the researchers who study memory but the victims themselves.	-2	-1	0	1	2
56. Recovered memories must be reliable because no one wants to have been abused as a child.	-2	-1	0	1	2
57. Questioning the veracity of women's memories of sexual abuse is a new way of saying that women are hysterical and unreliable.	-2	-1	0	1	2
58. A primary motivation for the statement that recovered memories are unreliable is to establish a legal defense for sexual abuse.	-2	-1	0	1	2
59. People adopt the false memory theory because it is easier than facing the truth about sexual abuse.	-2	-1	0	1	2

THERAPY

60. Blaming present problems on past abuse may prevent clients from taking responsibility for their own lives.	-2	-1	0	1	2
61. It doesn't really matter clinically whether memories of abuse are accurate or not. What matters is what the client believes.	-2	-1	0	1	2
62. People who suffer from severe mental distress have probably experienced some type of childhood trauma.	-2	-1	0	1	2
63. It is very important that a client who was sexually abused remember that abuse in order for therapy to be effective.	-2	-1	0	1	2

SYMPTOMS OF ABUSE

64-65. From the following list of symptoms please place a check beside any symptom which you believe indicates a history of child sexual abuse.

	Definite abuse	Possible abuse
a. Sexual difficulties	_____	_____
b. Poor relationships	_____	_____
c. Fear of men	_____	_____
d. Low self-esteem	_____	_____
e. Depression	_____	_____
f. Anxiety	_____	_____
g Insomnia	_____	_____
h. Chemical Dependency	_____	_____
i. Amnesia for periods of childhood	_____	_____
j. Denial and/or repression of memories	_____	_____
k. Flashbacks	_____	_____
l. Night terrors	_____	_____
m. Dissociative Identity Disorder (formerly MPD)	_____	_____
n. Body memories	_____	_____
o. Vaginal infection	_____	_____
p. Urinary tract infections	_____	_____
q. Trichotilomania	_____	_____
r. Eating disorders (Anorexia, Bulimia, Obesity)	_____	_____
s. Wearing a lot of clothing	_____	_____
t. Avoidance of mirrors	_____	_____
u. Self-mutilation	_____	_____
v. Stealing	_____	_____
w. Risk-taking behavior	_____	_____
x. Inability to take risks	_____	_____
y. Other (please specify) _____		

HYPNOSIS

66. Hypnosis enables people to accurately remember things they otherwise could not.	-2	-1	0	1	2
67. Hypnotically obtained memories are less reliable than simple remembering.	-2	-1	0	1	2
68. People cannot lie when in hypnosis.	-2	-1	0	1	2
69. Hypnosis can be used in such a way as to create confabulated memories.	-2	-1	0	1	2
70. Hypnosis can be used to recover memories of actual events from as far back as birth.	-2	-1	0	1	2

RECOVERED MEMORIES

71. Recovered memories are more likely to be confabulated than are never-forgotten memories.	-2	-1	0	1	2
72. Clients can come to believe that they were abused when in reality they were not.	-2	-1	0	1	2
73. Some claims of sexual abuse based on recovered memories are false, but these constitute a tiny minority of such claims.	-2	-1	0	1	2
74. Many adult victims of child sexual abuse have not reported it because they have repressed the memory.	-2	-1	0	1	2

Appendix B

French Questionnaire

SECTION I

Vous trouverez dans cette section plusieurs questions concernant vos activités professionnelles, votre orientation théorique, ainsi que votre formation. Afin de faire certaines comparaisons, nous vous demandons d'indiquer votre âge et votre sexe.

RENSEIGNEMENTS DÉMOGRAPHIQUES

1 Âge_____

2. Sexe. homme _____

femme _____

ANTÉCÉDENTS PROFESSIONNELS

3 Nombre d'années d'expérience en pratique clinique: _____

4 Plus haut niveau d'éducation obtenu. (ex: B.A., M.Ps , M.D.) _____

5. Dans quelle discipline avez-vous obtenu votre dip'ôme le plus élevé?_____

6. Votre formation était principalement d'orientation (Ne cochez qu'un seul item):

a. expérimentale _____
b. clinique _____
c. médicale/scientifique _____
d. sociale _____
e. expérimentale et clinique _____
f. pratique (formation en cours d'emploi) _____
g. autre (veuillez préciser) _____

7. Certains cliniciens considèrent que leur formation académique les a bien préparés à devenir des thérapeutes, d'autres pensent que non. Veuillez indiquer comment vous jugez votre propre formation académique:

inutile_____ peu utile _____ utile_____ très utile_____

Commentez s'il y a lieu: _____

_____

_____

8. Certains cliniciens considèrent que les ateliers de formation sont une bonne façon de se tenir à jour. Veuillez indiquer si, au cours des cinq dernières années, vous avez participé à certains des ateliers énumérés ci-dessous:

a. techniques de rappel de souvenirs _____
b. trouble dissociatif d'identité (TPM) _____
c. abus sataniques ritualisés _____
d. abus sexuels _____
e. autres (veuillez préciser) _____

9-12. Orientation en thérapie: (veuillez numéroter par ordre d'importance votre, ou vos, principale(s) orientation(s); 1 ayant le plus d'influence):

a. behaviorale/comportementale _____
b. cognitive _____
c. cognitive-behaviorale _____
d. existentielle _____
e. féministe _____
f. humaniste/centrée sur le client _____
g. interpersonnelle _____
h. médicale/pharmaceutique _____
i. psychanalytique _____
j. psychodynamique _____
k. psychosociale _____
l. socialisation/apprentissage social _____
m. systémique _____

Certains considèrent que les attitudes d'un(e) thérapeute envers les femmes et le mouvement féministe influencent sa façon de travailler en thérapie (particulièrement quand il s'agit de clientes).

13. En vous servant de l'échelle suivante, comment vous décririez-vous?

+	+	+	+	+	+	+
anti féministe		non féministe		féministe		féministe militant(e)

14. Comment les gens qui vous entourent vous décriraient-ils?

+	+	+	+	+	+	+
anti féministe		non féministe		féministe		féministe militant(e)

15. Êtes-vous partisan(e) des objectifs du féminisme radical (ex: abolir la société patriarcale)?

beaucoup _____ un peu _____ pas du tout _____

ACTIVITÉS PROFESSIONNELLES

16. Veuillez numéroter par ordre d'importance les items correspondant aux différents milieux dans lesquels vous travaillez:

a. hôpital	_____	b. pratique privée	_____
c. université	_____	d. CLSC	_____
e. école	_____	f. CEGEP	_____
g. autre	_____		

17. Quel pourcentage de votre temps au travail consacrez-vous à chacune des activités professionnelles suivantes?

a. administration	_____%	b. supervision clinique	_____%
c. recherche	_____%	d. enseignement	_____%
e. thérapie	_____%	f. évaluation/	
g. autre	_____%	diagnostique	_____%

18. Quel pourcentage de votre temps en thérapie consacrez-vous à un travail...

a. individuel?	_____%	b. familial?	_____%
c. de groupe?	_____%	d. de couple?	_____%

19. Combien d'adultes en tout (18 ans et plus) avez-vous traité en thérapie au cours des DEUX DERNIÈRES ANNÉES? _____

20. Combien d'entre eux étaient...

a. de femmes? _____ b. des hommes? _____

Pour les fins de ce questionnaire, nous définissons l'abus sexuel dans l'enfance de la façon suivante:

Un contact sexuel physique perpétré envers une personne de 16 ans ou moins, par une personne âgée d'au moins 6 ans de plus que la victime.

21. Du nombre total de client(e)s adultes que vous avez traité en thérapie au cours des DEUX DERNIÈRES ANNÉES, combien ont rapporté avoir été abusé sexuellement dans l'enfance? _____

Les trois prochaines questions (22, 23, 24) se rapportent uniquement aux client(e)s qui ont rapporté avoir été abusé(e)s sexuellement dans l'enfance (question 21):

22. Combien n'avaient aucun souvenir, ni soupçon d'abus au tout début de la thérapie? (c. à d., consultaient pour d'autres raisons) _____

23. Combien en début de thérapie, avaient l'impression d'avoir été abusé sans avoir de souvenirs précis des abus? _____

24. Combien avaient déjà des souvenirs d'abus au tout début de la thérapie? _____

Des client(e)s qui se rappelaient avoir été abusé(e) sexuellement pendant leur enfance avant le début de la thépapie (question 24), y en a-t-il qui ont retrouvé de nouveaux épisodes?

oui _____ non _____

Si **oui**, combien l'ont fait...

25. spontantément? _____

26. à la suite de techniques thérapeutiques visant le retour en mémoire de souvenirs? _____

27. Les techniques énumérées ci-dessous sont parfois utilisées pour aider les client(e)s à se souvenir d'événements de leur enfance. Veuillez **cocher** les items correspondant aux différentes techniques que vous utilisez personnellement OU que vous recommandez à vos client(e)s afin de les AIDER À SE SOUVENIR:

a. hypnose _____
b. régression d'âge _____
c. interprétation des rêves _____
d. imagerie guidée _____
e. donner libre cours à l'imagination _____
f. bibliothérapie _____
(veuillez préciser quels livres)
_____
g. l'utilisation de photos de famille comme indices _____
h. écrire son journal _____
i. l'interprétation des symptômes physiques (y inclus mémoires du corps) _____
j. relaxation/détente _____
k. sodium amytal (ou équivalent) _____
l. groupes de soutien (avec ou sans thérapeute) _____
m. rebirth _____
n. autre (veuillez préciser) _____

28. De la liste proposée à la question #27, veuillez **rayer** les techniques qui selon vous NE DEVRAIENT PAS être utilisées pour favoriser le rappel d'événements de l'enfance.

SECTION II

ATTITUDES ET CROYANCES

Cette deuxième section vous propose des énoncés sur la mémoire, l'abus sexuel et des sujets connexes. Ces différents énoncés ont été tirés de la littérature courante sur la mémoire et les abus sexuels Veuillez indiquer votre accord avec chacun d'entre eux en utilisant l'échelle suivante:

très en désaccord	plutôt en désaccord	in-certain(e)	plutôt en accord	très en accord
-2	-1	0	1	2

Veuillez répondre le plus honnêtement possible. N'utilizez "incertain(e)" que si vous n'êtes vraiment pas certain(e)s de votre opinion. Si vous désirez commenter soit les énoncés ou vos réponses, vous pouvez le faire directement sur le questionnaire ou sur des feuilles séparées. S'il vous plait, essayez de répondre à chaque question.

MÉMOIRE EN GÉNÉRAL

29. De nouvelles informations, encodées suite à un événement, peuvent venir en modifier le rappel	-2	-1	0	1	2
30. Toute notre expérience de vie est encodée en permanence dans notre cerveau.	-2	-1	0	1	2
31. Les impressions sensorielles vécues à un très jeune âge (avant l'acquisition du langage) peuvent former la base de souvenirs fiables qui pourront émerger plus tard.	-2	-1	0	1	2
32. Des histoires imaginaires peuvent sembler réelles si elles sont répétées fréquemment.	-2	-1	0	1	2

L'oubli des expériences vécues avant l'âge de trois ans (amnésie de l'enfance) est probablement causé par:

33. le développement incomplet du système cognitif	-2	-1	0	1	2
34. le développement incomplet du système nerveux	-2	-1	0	1	2
35. le développement incomplet des capacités langagière	-2	-1	0	1	2
36. mécanisme de défense (ex: refoulement)	-2	-1	0	1	2
37. autre (veuillez préciser)_____					

SOUVENIRS TRAUMATIQUES

38. Un adulte abusé fréquemment dans l'enfance a de meilleures chances de s'en souvenir qu'un adulte qui a rarement été abusé.	-2	-1	0	1	2
39. Les traumatismes imaginaires, tout comme les traumatismes réels, peuvent causer une grande détresse.	-2	-1	0	1	2
40. Les événements traumatisants créent des images visuelles persistantes qui ne peuvent pas être modifiées.	-2	-1	0	1	2
41. En écoutant la description d'un événement traumatisant, une personne peut se créer un souvenir de cet événement sans jamais l'avoir vécu.	-2	-1	0	1	2
42. Les résultats d'études en laboratoire sur la mémoire ne s'appliquent pas à l'amnésie traumatique.	-2	-1	0	1	2

Lorsqu'un adulte qui a été abusé fréquemment dans son enfance a de la difficulté à se souvenir de certains de ces épisodes abusifs, cela est probablement dû à ...

43. des mécanismes d'oubli normal	-2	-1	0	1	2
44. des mécanismes de défense	-2	-1	0	1	2

CONSÉQUENCES DE L'ABUS SEXUEL DANS L'ENFANCE

Comme nous l'avons mentionné plus haut, nous définissons l'abus sexuel dans l'enfance de la façon suivante.

Un contact sexuel physique perpétré envers une personne de 16 ans ou moins, par une personne âgée d'au moins 6 ans de plus que la victime.

45. Un historique d'abus sexuel peut être dé· elé chez les gens qui n'en ont aucun souvenir.	-2	-1	0	1	2
46. Les contacts sexuels entre un adulte et un enfant ne sont pas toujours traumatisants.	-2	-1	0	1	2
47. Quelqu'un qui a appris à dissocier peut n'avoir aucun souvenir conscient de l'abus sexuel.	-2	-1	0	1	2
48 Aucun symptôme n'est lié de façon fiable et spécifique à un historique d'abus sexuel	-2	-1	0	1	2
49. Ce qui s'appelait auparavant le trouble de personnalité multiple (c. à d., le trouble dissociatif d'identité) est une conséquence de l'abus sexuel grave.	-2	-1	0	1	2

ABUS RITUALISÉS

50. À ce jour, l'existence des abus ritualisés sataniques sur une grande échelle n'a jamais été démontrée de façon convaincante.	-2	-1	0	1	2
51. Le déni de l'existence des abus sataniques ritualisés est semblable au déni d'événements horribles comme l'holocauste.	-2	-1	0	1	2
52. Parce que plusieurs client(e)s décrivent de façon indépendante les mêmes expériences vécues au sein de cultes sataniques, ces allégations doivent être vraies.	-2	-1	0	1	2
53. Les personnes qui croient être victimes de cultes sataniques ont été influencées par des suggestions inappropriées (ex: livres, t.v., etc.)	-2	-1	0	1	2

ASPECTS SOCIAUX DES SOUVENIRS D'ABUS

54. Si l'on veut connaître la vérité quant à la validité des souvenirs retrouvés, il est essentiel d'en effectuer une évaluation scientifique.	-2	-1	0	1	2
55. Les véritables experts en matière de souvenirs traumatiques ne sont pas les chercheurs sur la mémoire mais les victimes.	-2	-1	0	1	2
56. Les souvenirs retrouvés sont sûrement fiables car personne ne peut désirer avoir été abusé dans son enfance.	-2	-1	0	1	2
57. Douter de la véracité des souvenirs d'abus sexuel chez les femmes est une nouvelle façon de dire qu'elles sont hystériques et non crédibles.	-2	-1	0	1	2
58. Mettre en doute la validité des souvenirs retrouvés sert en réalité à établir un argument de défense légal pour l'abus sexuel.	-2	-1	0	1	2
59. Les gens acceptent la théorie du syndrome des souvenirs fictifs parce que c'est plus facile que de faire face à la réalité.	-2	-1	0	1	2

LA THÉRAPIE

60 Attribuer leurs difficultés actuelles à des abus antérieurs peut empêcher les client(e)s d'assumer leurs responsabilités face à leur propre vie.	-2	-1	0	1	2
61. En clinique, ce n'est pas important de savoir si les souvenirs retrouvés sont exacts ou non. Ce qui compte c'est que les client(e)s y croient.	-2	-1	0	1	2
62. Une détresse psychologique grave, à l'âge adulte, est probablement causée par des expériences traumatiques vécues dans l'enfance.	-2	-1	0	1	2
63. Pour que la thérapie soit efficace, il est important que les client(e)s abusé(e)s sexuellement se souviennent des épisodes abusifs.	-2	-1	0	1	2

LES SYMPTÔMES D'ABUS

64-65. De la liste de symptômes qui suit, veuillez cocher ceux qui d'après vous suggèrent un historique d'abus sexuel dans l'enfance.

	abus certains	abus possibles
a. difficultés sexuelles	_____	_____
b. difficultés relationnelles	_____	_____
c. crainte des hommes	_____	_____
d. pauvre estime de soi	_____	_____
e. dépression	_____	_____
f. anxiété	_____	_____
g. insomnie	_____	_____
h. dépendance chimique	_____	_____
i. amnésie pour des périodes de l'enfance	_____	_____
j. déni et refoulement des souvenirs	_____	_____
k. flashbacks	_____	_____
l. terreurs nocturnes	_____	_____
m. trouble dissociatif de la personnalité (anciennement TPM)	_____	_____
n. mémoires du corps	_____	_____
o. infections vaginales	_____	_____
p. infections urinaires	_____	_____
q. trichotillomanie	_____	_____
r. troubles alimentaires (anorexie, boulimie, obésité)	_____	_____
s. porter beaucoup de vêtements	_____	_____
t. éviter les miroirs	_____	_____
u. auto-mutilation	_____	_____
v. vol à l'étalage	_____	_____
w. comportements hasardeux	_____	_____
x. incapacité à prendre des risques	_____	_____
y. autres (spécifiez)	_____	

HYPNOSE

66. L'hypnose permet l'émergence de souvenirs exacts qui, autrement, seraient inaccessibles.	-2	-1	0	1	2
67. Les souvenirs obtenus en hypnose sont moins fiables que les souvenirs ordinaires.	-2	-1	0	1	2
68. On ne peut mentir en hypnose.	-2	-1	0	1	2
69. L'hypnose peut être utilisée de façon à créer des souvenirs fictifs.	-2	-1	0	1	2
70. L'hypnose peut être utilisée pour retrouver des souvenirs exacts qui peuvent remonter à la naissance.	-2	-1	0	1	2

LES SOUVENIRS RETROUVÉS

71. Les souvenirs retrouvés sont plus probablement fictifs que les souvenirs qui n'ont jamais été oubliés.	-2	-1	0	1	2
72. Des client(e)s peuvent en venir à croire qu'ils (elles) ont été abusé(e)s alors qu'en réalité, ils (elles) ne l'ont pas été.	-2	-1	0	1	2
73. Il n'y a qu'une faible minorité des affirmations d'abus sexuels basées sur des souvenirs retrouvés qui sont fausses.	-2	-1	0	1	2
74. Plusieurs victimes d'abus sexuel ne rapportent pas ces abus parce qu'elles en ont refoulé le souvenir.	-2	-1	0	1	2

Appendix C

Subscale Items

Subscale Items for Knowledge

Malleability.

29. Postevent information can alter a person's recall of an event.

32. Imaginary events can seem subjectively real when they are frequently rehearsed.

41. It is possible for people to create memories for traumatic events which they have heard described but did not experience.

67. Hypnotically obtained memories are less reliable than simple remembering.

69. Hypnosis can be used in such a way as to create confabulated memories.

Permanence of Memory.

30. Everything one experiences is permanently recorded in one's brain.

31. Sensory impressions from early in life (preverbal memories) may form the basis for reliable memories which can be recovered later on.

40. Traumatic events create lasting visual images which cannot be altered.

66. Hypnosis enables people to accurately remember things they otherwise would not.

70. Hypnosis can be used to recover memories of actual events from as far back as birth.

Subscale Items for Social Context

Values.

55. The real experts on traumatic memory are not the researchers who study memory but the victims themselves.

56. Recovered memories must be reliable because no one wants to have been abused as a child.

60. Blaming present problems on past abuse may prevent clients from taking responsibility for their own lives.

61. It doesn't really matter clinically whether memories of abuse are accurate or not. What matters is what the client believes.

63. It is very important that a client who was sexually abused remember that abuse in order for therapy to be

effective.

Motivation.

51. Denial of the existence of satanic ritual abuse is similar to denial of horrifying realities like the holocaust.

54. A scientific appraisal of the veracity of recovered memories is necessary if we want to get at the truth about their validity.

57. Questioning the veracity of women's memories of sexual abuse is a new way of saying that women are hysterical and unreliable.

58. A primary motivation for the statement that recovered memories are unreliable is to establish a legal defense for sexual abuse.

59. People adopt the false memory theory because it is easier than facing the truth about sexual abuse.

Subscale Items for Forgetting

33. Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused

by immature cognitive development.

34. Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by immaturity of the nervous system.

35. Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by immature language skills.

36. Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by defense mechanisms (e.g., Repression).

38. An adult who was frequently abused as a child is more likely to remember having been abused than one who was rarely abused.

42. Results from experimental studies of memory (conducted under laboratory conditions) do not apply to traumatic amnesia.

43. When an adult who was frequently abused as a child has difficulty remembering some of the particular incidents of this abuse, it is likely to be due to normal forgetting.

44. When an adult who was frequently abused as a child has difficulty remembering some of the particular incidents of this abuse, it is likely to be due to defense mechanisms.

47. A person who has learned to dissociate may not have any conscious memory of his or her sexual abuse.

Subscale Items for Distress

39. Imagined trauma, similar to real trauma, can cause intense distress.

46. Sexual contact between an adult and a child is not always traumatic.

62. People who suffer from severe mental distress have probably experienced some type of childhood trauma.

Subscale Items for Credulity

50. No satisfactory evidence of widespread satanic ritual abuse has been found to date.

52. The fact that many patients independently describe the same experiences in satanic cults indicated that the allegations are true.

68. People cannot lie when in hypnosis.

Subscale Items for Diagnosis

45. A history of child sexual abuse can be detected in someone who has no memories of abuse.

48. No symptoms are specifically and reliably associated with a history of child sexual abuse.

49. What used to be called Multiple Personality Disorder (i.e., Dissociative Identity Disorder) is a consequence of severe sexual abuse.

53. Satanic 'cult victims' are people who have been influenced by inappropriate suggestion (e.g., books, t.v., etc.).

Subscale Items for RecMem

71. Recovered memories are more likely to be confabulated than are never-forgotten memories.

72. Clients can come to believe that they were abused when in reality they were not.

73. Some claims of sexual abuse based on recovered memories

are false but these constitute a tiny minority of such claims.

74. Many adult victims of child sexual abuse have not reported it because they have repressed the memory.

Appendix D

Workshop Topics Related and not Related to Memory Recovery Listed in the questionnaire.

Memory recovery techniques

Dissociative Identity Disorder

Satanic ritual abuse

Sexual abuse

Volunteered by subjects and considered related.

Memory

Integrated body psychotherapy

Brainwashing in new religions

Visualization

Hypnosis

Posttraumatic Stress Disorder

Rebirth

Volunteered by subjects but not considered related.

Psychoanalysis

Systemic approaches

Family mediation

Parent-child relations

Female sexuality

Borderline states

Eating disorders

Conjugal violence

PNL (psychoneurolinguistic therapy)

Appendix E

Symptoms of Sexual Abuse History Listed in the Questionnaire

Sexual difficulties

Poor relationships

Fear of men

Poor self-esteem

Depression

Anxiety

Insomnia

Chemical dependency

Amnesia for periods of childhood

Denial &/or repression of memories

Flashbacks

Night terrors

DID (formerly multiple personality disorder)

Body memories

Vaginal infection

Urinary tract infections

Trichotillomania

Eating disorders

Wearing a lot of clothing

Avoidance of mirrors

Self-mutilation

Stealing

Risk-taking behavior

Inability to take risks

Appendix F

Memory Recovery Techniques Listed in the Questionnaire

Hypnosis

Age regression

Dream interpretation

Guided imagery

Instructions to give free rein to the imagination

Bibliotherapy

Family photographs as memory cues

Keeping a journal

Interpretation of physical symptoms (including body memories)

Relaxation

Sodium Amytal (or similar medication)

Rebirth

Other

Appendix G

Questionnaire Items Tapping Feminism

Items	Response options
13. Using the following scale, (and regardless of your gender), would you describe yourself as	7-point Likert scale with anchors of anti-feminist on one end and committed feminist on the other.
14. How do you think others would describe you?	7-point Likert scale with anchors of anti-feminist on one end and committed feminist on the other.
15. Do you support the objectives of radical feminism? (e.g., dismantling the patriarchal society)	3-point scale with options: very much, somewhat, and not at all.

Appendix H

English Cover Letter

MEMORY AND SEXUAL ABUSE

Dear Respondent,

I am sending you a questionnaire which I hope will interest you This questionnaire is part of a study of the attitudes, beliefs andpractices of mental health specialists concerning memories of sexual abuse. Your name was chosen randomly from a list of social workers, psychologists, and psychiatrists working in Quebec.

Our interest is not restricted to the opinions of experts. If you are not experienced with victims of child sexual abuse, or if you do not have firm opinions on this topic, your participation remains important in order to get a complete picture of clinicians' beliefs and practices. Therefore, I hope that you will take the time to answer and return the enclosed questionnaire

The study is primarily concerned with:

1 The working conditions, backgrounds, and therapeutic practices of clinicians who work with adults.

2 Clinicians' attitudes and beliefs about the nature of memory in general, and more specifically the nature of memory of sexual abuse.

The questionnaire takes 30-45 minutes to complete. If any items are unclear please do your best to answer; however, you may wish to make a note of the difficulty on the questionnaire.

Participation in this study is **strictly anonymous** . No researcher will know your identity

Completion of the questionnaire is your consent to participate in this study.

This research is being conducted by Ellen Legault, B.A , of the Department of Psychology at Concordia University, in conjunction with her advisor, Jean-Roch Laurence, PhD. The study is supported by both the Social Sciences and Humanities Research Council of Canada (SSHRC) and the Medical Research Council of Canada (MRC)

The data from this study may be published. This means that comments written on the questionnaire may be quoted. However, since the questionnaire is anonymous, the authors of the comments could not be identified

A return postcard is enclosed with this questionnaire. By filling out the postcard and returning it to us you can let us know that you have sent the questionnaire and whether you want to receive a summary of the results. Since only the postcard has your name on it we will be able to send you a reminder if we do not receive a postcard from you and still safeguard your complete anonymity.

If you have any questions you can contact us at one of the following numbers:

Telephone 514-848-2213 E-mail:ELLEG@ALCOR.CONCORIA.CA

IF you are able to mail this form within one week of its receipt, it will be much appreciated. If this is impossible please return it as soon as practicable.

THANK YOU FOR YOUR TIME AND PARTICIPATION!

N.B In order to make the questionnaire more readable, the word "client" is used to indicate any person receiving treatment

Appendix I

French Cover Letter

LA MÉMOIRE ET L'ABUS SEXUEL

Cher participant, chère participante,

Je vous fais parvenir un questionnaire qui, je l'espère, saura vous intéresser Il s'agit d'un sondage qui évalue les attitudes, les croyances et les pratiques thérapeutiques des professionnels de la santé mentale face aux souvenirs d'abus sexuels Votre nom a été tiré au hasard d'une liste de travailleurs sociaux, de psychologues et de psychiatres du Québec.

Nous ne cherchons pas uniquement les opinions des spécialistes Si vous n'avez que peu d'expérience, ou vous n'êtes pas encore certain de vos opinions à ce sujet, il est d'autant plus important que vous répondiez à ce questionnaire. Nous espérons ainsi brosser un tableau complet des croyances et pratiques des cliniciens

La présente étude examine principalement les aspects suivants:

1.Les milieux de travail, les antécédents, et les pratiques thérapeutiques des cliniciens qui traitent des adultes.

2.Les attitudes et les croyances des cliniciens quant à la nature de la mémoire en général et plus particulièrement, la nature des souvenirs d'abus sexuels

Le questionnaire demande de 30-45 minutes à compléter Si un item ne vous semble pas clair, veuillez répondre de votre mieux Vous pouvez également nous faire part de vos commentaires directement sur le questionnaire.

Votre participation est **strictement anonyme** Aucun des chercheurs ne pourra connaître votre identité

En complétant le questionnaire ci-joint, vous donnez votre consentement à participer au sondage.

La responsable de cette étude est Mme Ellen Legault, B A , du département de psychologie de l'université Concordia, en collaboration avec son superviseur de thèse, M Jean-Roch Laurence, PhD. Cette recherche est subventionnée par le Conseil de recherches en sciences humaines du Canada (CRSH) ainsi que le Conseil de recherches médicales du Canada (CRM)

Les données de cette étude pourraient être publiées Cela signifie que les comment. os écrits en réponse aux differentes questions pourraient être cités Cependant, les auteurs de ces commentai.. ne peuvent être identifiés

Vous trouverez aussi dans cet envoi une carte postale qui vous demande si vous nous avez envoyé le questionnaire complété et si vous désirez recevoir un résumé des résultats. Votre nom apparaît uniquement sur cette carte En nous la renvoyant séparément, nous pourrons ainsi vous faire parvenir une carte de rappel si cela est nécessaire tout en préservant l'anonymat quant au questionnaire

Si vous avez des questions, vous pouvez communiquer avec nous a l'un des numéros suivants téléphone 514-848-2213 courrier électronique ELLEG@ALCOR CONCORDIA CA

Je vous serais gré de bien vouloir nous retourner le questionnaire dans la semaine suivant sa réception, sinon, le plus rapidement possible

MERCI DE VOTRE COLLABORATION

N.B Pour faciliter la lecture du questionnaire, nous n'utiliserons que le mot "client(e)" pour indiquer une personne en thérapie.

Appendix J

French and English Response Cards

_____ I HAVE returned the questionnaire and I WOULD like a copy of the results. (Allow one year for completion and return of results summary.)

_____ I HAVE returned the questionnaire but I do NOT want a copy of the results.

_____ I WILL NOT be returning the questionnaire.

_____ Je préférerais compléter un questionnaire en français.

From:

Address correction:

_____

_____

_____

_____

_____

_____ J'ai DÉJÀ retourné le questionnaire et J'AIMERAIS recevoir une copie des résultats du sondage. (Les résultats devraient être prêts dans l'année qui vient.)

_____ J'ai DÉJÀ retourné le questionnaire et je NE VEUT PAS une copie des résultats.

_____ Je NE RETOURNERAI PAS le questionnaire.

_____ I would prefer an English questionnaire.

De:

Correction d'addresse:

_____

_____

_____

_____

_____

Appendix K

Reminder Card

Dear Respondent,
Three weeks ago you received a questionnaire on adult memories of child sexual abuse. If you intended to return it but have not done so yet then it is not too late! This research is really important and we need your participation.
Thank you to all respondents!

Cher participant, chère participante,
Il y a trois semaines, vous avez reçu un questionnaire sur les souvenirs d'abus sexuels pendant l'enfance. Votre participation à cette recherche est très importante pour nous. Si vous planifiez de nous retourner le questionnaire, serait-il possible de le faire dans les plus brefs délais?
Merci! Ellen Legault

Appendix L

Telephone Script

Bonjour, mon nom est _____ . J'appel de l'université Concordia. Je vous ais envoyé un questionnaire sur les souvenirs d'abus sexuels le 30 octobre. Est-ce que vous l'avez reçu? Comme on n'a pas eu de reponse encore pourriez vous nous retourner le questionnaire completé, ou retourner la carte de réponse si vous n'avez pas l'intention de le faire. Ceci nous permettra de complèter nos données. Vous pouvez me rejoindre à (514) 848-2213 ou laisser un message. Merci beaucoup de votre collaboration. Bonjour.

Appendix M

Descriptive Statistics for Respondents

Characteristics of Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.)

	S.W. (n) %	Psy (n) %	M.D. (n) %
Gender			
Female	(65) 76	(47) 62	(10) 17
Male	(20) 24	(29) 38	(48) 81
Unknown	(0) 0	(0) 0	(1) 2
Highest Academic Degree			
B.A.	(47) 55	(0)	0
M.A.	(37) 44	(61) 80	0
Ph.D.	(1) 1	(15) 20	0
M.D.	(0)	(0)	(59) 100
Academic Training			
Clinical	(82) 98	(57) 79	(0)
Scientific	(2) 2	(15) 21	(59) 100
Principal Place of Work			
Hospital	(27) 32	(12) 16	(41) 69
Private	(12) 14	(27) 36	(9) 15
University	(1) 1	(7) 9	(3) 5
CLSC	(26) 31	(7) 9	(1) 2

School	(3) 4	(6) 8	(0) 0
CEGEP	(2) 2	(1) 1	(0) 0
Other	(11) 13	(8) 11	(0) 0
Missing	(3) 4	(8) 11	(5) 8
	Principal Mode of Therapy[a]		
Individual	(62) 82	(67) 94	(51) 91
Family	(9) 12	(2) 3	(2) 4
Couples	(1) 1	(0) 0	(1) 2
Group	(3) 4	(0) 0	(0) 0
Missing	(4) 1	(1) 3	(2) 4
	M (SD)	M (SD)	M (SD)
Age	45.71 (8.37)	42.72 (7.70)	51.24 (11.96)
Practice	16.90 (8.18)	13.20 (6.76)	23.60 (12.08)

Note. Clinical = respondents indicated that the orientation of their training was either clinical, social, or it was on the job training. Scientific = either experimental, clinical and experimental, or medical. Practice = number of years in clinical practice.

[a]Data is given only for those who reported conducting therapy with clients.

Appendix N

Significance and Agreement of Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.) with Belief Statements

Significance of Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.) Agreement with Belief Statements

Statement	S.W. (n) %	Psy. (n) %	M.D. (n) %	χ^2
		Knowledge (Malleability)		
29. Postevent information can alter a person's recall of an event.	(65) 90 =	(70) 97 =	(51) 96	3.74
32. Imaginary events can seem subjectively real when they are frequently rehearsed.	(59) 86 =	(61) 87 =	(56) 97	4.59
41. It is possible for people to create memories for traumatic events which they have heard described but did not experience.	(36) 52 /	(45) 70 /	(44) 86	15.91*
67. Hypnotically obtained memories are less reliable than	(8) 16 =	(16) 47 /	(29) 71	30.37*

simple remembering.

69. Hypnosis can be used in such a way as to create confabulated memories.	(24) 53 /	(39) 78 /	(45) 94	20.78*

Knowledge (Traces)

30. Everything one experiences is permanently recorded in one's brain.	(65) 84 =	(52) 71 /	(26) 51	16.71*
31. Sensory impressions from early in life (preverbal memories) may form the basis for reliable memories which can be recovered later on.	(51) 71 =	(41) 61 /	(26) 49	6.12*
40. Traumatic events create lasting visual images which cannot be altered.	(16) 21 =	(10) 15 =	(9) 18	0.84
66. Hypnosis enables	(41) 65 /	(26) 41 =	(17) 36	11.11*

people to accurately remember things they otherwise would not.				
70. Hypnosis can be used to recover memories of actual events from as far back as birth.	(44) 80 =	(37) 67 /	(21) 46	13.91*
		Social Context (Values)		
55. The real experts on traumatic memory are not the researchers who study memory but the victims themselves.	(46) 73 /	(32) 52 /	(13) 27	23.89*
56. Recovered memories must be reliable because no one wants to have been abused as a child.	(40) 54 /	(17) 27 =	(9) 16	22.14*
60. Blaming present problems on past abuse may prevent clients from taking responsibility for their own lives.	(30) 37 /	(38) 55 =	(37) 70	14.25*

61. It doesn't really matter clinically whether memories of abuse are accurate or not. What matters is what the client believes.	(52) 67 =	(41) 63 /	(23) 44	7.04*
63. It is very important that a client who was sexually abused remember that abuse in order for therapy to be effective.	(36) 49 =	(31) 48 =	(25) 52	0.18
Social Context (Motivation)				
51. Denial of the existence of satanic ritual abuse is similar to denial of horrifying realities like the holocaust.	(43) 67 =	(36) 67 /	(20) 44	6.92*
54. A scientific appraisal of the veracity of recovered memories is necessary if we want to get at the truth about	(20) 29 /	(33) 51 =	(33) 66	17.16*

their validity.

57. Questioning the veracity of women's memories of sexual abuse is a new way of saying that women are hysterical and unreliable.	(55) 68 /	(31) 44 =	(17) 30	20.15*
58. A primary motivation for the statement that recovered memories are unreliable is to establish a legal defense for sexual abuse.	(52) 71 /	(33) 51 /	(14) 30	19.27*
59. People adopt the false memory theory because it is easier than facing the truth about sexual abuse.	(41) 66 /	(24) 44 =	(19) 39	9.54*
		Forgetting		
33. Forgetfulness for experiences occuring before the age of about	(42) 68 =	(51) 75 /	(52) 93	11.35*

three (childhood amnesia) is most likely to be caused by immature cognitive development.				
34. Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by immaturity of the nervous system.	(20) 36 /	(34) 57 /	(50) 91	35.24*
35. Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by immature language skills.	(31) 53 /	(47) 73 =	(48) 84	14.40*
36. Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be	(62) 87 =	(55) 80 =	(40) 75	3.00

caused by defense mechanisms (e.g., Repression).				
38. An adult who was frequently abused as a child is more likely to remember having been abused than one who was rarely abused.	(28) 35 =	(24) 35 /	(35) 70	18.14*
42. Results from experimental studies of memory (conducted under laboratory conditions) do not apply to traumatic amnesia.	(5) 17 =	(8) 22 =	(9) 26	0.67
43. When an adult who was frequently abused as a child has difficulty remembering some of the particular incidents of this abuse, it is likely to be due to normal forgetting.	(18) 27 =	(29) 46 =	(16) 39	4.95

44. When an adult who was frequently abused as a child has difficulty remembering some of the particular incidents of this abuse, it is likely to be due to defense mechanisms.	(82) 100 =	(70) 99 =	(52) 95	5.34
47. A person who has learned to dissociate may not have any conscious memory of his or her sexual abuse.	(66) 89 =	(68) 94 =	(45) 87	2.38
		Distress		
39. Imagined trauma, similar to real trauma, can cause intense distress.	(74) 90 =	(69) 95 =	(51) 94	1.35
46. Sexual contact between an adult and a child is not always traumatic.	(27) 35 =	(26) 37 =	(14) 29	0.73

62. People who suffer from severe mental distress have probably experienced some type of childhood trauma.	(60) 80 =	(46) 67 /	(25) 47	15.03*
		Credulity		
50. No satisfactory evidence of widespread satanic ritual abuse has been found to date.	(28) 62 =	(26) 65 =	(29) 69	0.45
52. The fact that many patients independently describe the same experiences in satanic cults indicates that the allegations are true.	(41) 67 =	(31) 60 /	(13) 35	9.93*
68. People cannot lie when in hypnosis.	(25) 52 /	(12) 24 =	(10) 21	13.02*
		Diagnosis		
45. A history of child sexual abuse can be detected in someone who	(60) 83 =	(53) 87 /	(29) 64	9.03*

has no memories of abuse.				
48. No symptoms are specifically and reliably associated with a history of child sexual abuse.	(28) 40 =	(33) 52 /	(41) 75	15.02*
49. What used to be called Multiple Personality Disorder (i.e., Dissociative Identity Disorder) is a consequence of severe sexual abuse.	(25) 45 =	(30) 55 =	(21) 44	1.43
53. Satanic 'cult victims' are people who have been influenced by inappropriate suggestion (e.g., books, t.v., etc.).	(14) 24 =	(11) 24 /	(19) 56	12.92*
	RecMem			
71. Recovered memories are more likely to be confabulated than are never-forgotten memories.	(13) 19 =	(13) 20 /	(21) 53	16.66*

72. Clients can come to believe that they were abused when in reality they were not.	(39) 53 /	(47) 72 /	(48) 89	18.81*
73. Some claims of sexual abuse based on recovered memories are false but these constitute a tiny minority of such claims.	(51) 82 =	(45) 80 /	(19) 59	6.86*
74. Many adult victims of child sexual abuse have not reported it because they have repressed the memory.	(57) 75 =	(50) 76 =	(38) 75	0.03

Note. Percentages represent agreement vs disagreement, excluding undecided.

* overall F-tests significant, $p < .05$

= Tukey HSD $p > .05$ for adjacent groups

/ Tukey HSD $p < .05$ for adjacent groups

Appendix O

Responses of Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.) to Individual Belief Items

Responses by Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.) to Individual Items:

"Postevent information can alter a person's recall of an event."

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	14	35	16
Agree	51	35	35
Uncertain	12	4	6
Disagree	6	2	2
Strongly Disagree	1	0	0
Missing Data	1	0	0

"Everything one experiences is permanently recorded in one's brain"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	28	21	10
Agree	37	31	16
Uncertain	6	3	8
Disagree	11	16	17
Strongly Disagree	1	5	8
Missing Data	2	0	0

"Sensory impressions from early in life (preverbal memories) may form the basis for reliable memories which can be recovered later on"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	16	15	6
Agree	35	26	20
Uncertain	12	9	6
Disagree	19	21	20
Strongly Disagree	2	5	7
Missing Data	1	0	0

"Imaginary events can seem subjectively real when they are frequently rehearsed"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	19	18	24
Agree	40	43	32
Uncertain	15	6	1
Disagree	10	8	2
Strongly Disagree	0	1	0
Missing Data	1	0	0

"Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by immature cognitive development"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	8	15	16
Agree	34	36	36
Uncertain	15	4	3
Disagree	8	9	3
Strongly Disagree	12	8	1
Missing Data	8	4	0

"Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by immaturity of the nervous system"

	S.W. n	Psy n	M.D. n
Strongly Agree	3	10	20
Agree	17	24	30
Uncertain	19	9	2
Disagree	21	18	4
Strongly Disagree	14	8	1
Missing Data	11	7	2

"Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by immature language skills"

	S.W. n	Psy n	M.D. n
Strongly Agree	6	18	13
Agree	25	29	35
Uncertain	15	9	2
Disagree	20	13	8
Strongly Disagree	8	4	1
Missing Data	11	3	0

"Forgetfulness for experiences occuring before the age of about three (childhood amnesia) is most likely to be caused by defense mechanisms (e.g., Repression)"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	29	19	13
Agree	33	36	27
Uncertain	9	3	5
Disagree	9	12	10
Strongly Disagree	0	2	3
Missing Data	5	4	1

"An adult who was frequently abused as a child is more likely to remember having been abused than one who was rarely abused"

	S.W. n	Psy n	M.D. n
Strongly Agree	5	8	10
Agree	23	16	25
Uncertain	5	8	8
Disagree	38	32	12
Strongly Disagree	13	12	3
Missing Data	1	0	1

"Imagined trauma, similar to real trauma, can cause intense distress"

	S.W. n	Psy n	M.D. n
Strongly Agree	37	42	29
Agree	37	27	22
Uncertain	2	3	4
Disagree	6	4	2
Strongly Disagree	2	0	1
Missing Data	1	0	1

"Traumatic events create lasting visual images which cannot be altered"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	3	0	1
Agree	13	10	8
Uncertain	6	8	8
Disagree	50	40	30
Strongly Disagree	12	18	12
Missing Data	1	0	0

"It is possible for people to create memories for traumatic events which they have heard described but did not experience"

	S.W. n	Psy n	M.D. n
Strongly Agree	7	10	11
Agree	29	35	33
Uncertain	15	12	7
Disagree	24	14	6
Strongly Disagree	9	5	1
Missing Data	1	0	1

"Results from experimental studies of memory (conducted under laboratory conditions) do not apply to traumatic amnesia"

	S.W. n	Psy n	M.D. n
Strongly Agree	0	3	2
Agree	5	5	7
Uncertain	54	37	20
Disagree	20	20	16
Strongly Disagree	4	9	10
Missing Data	2	2	4

"When an adult who was frequently abused as a child has difficulty remembering some of the particular incidents of this abuse, it is likely to be due to normal forgetting"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	1	6	2
Agree	17	23	14
Uncertain	4	3	5
Disagree	28	21	17
Strongly Disagree	20	13	8
Missing Data	15	10	13

"When an adult who was frequently abused as a child has difficulty remembering some of the paricular incidents of this abuse, it is likely to be due to defense mechanisms"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	47	36	23
Agree	35	34	29
Uncertain	1	4	3
Disagree	0	1	2
Strongly Disagree	0	0	1
Missing Data	2	1	1

"A history of child sexual abuse can be detected in someone who has no memories of abuse"

	S.W. n	Psy n	M.D. n
Strongly Agree	16	9	3
Agree	44	44	26
Uncertain	13	14	12
Disagree	12	5	12
Strongly Disagree	0	3	4
Missing Data	0	1	2

"Sexual contact between an adult and a child is not always traumatic"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	5	3	2
Agree	22	23	12
Uncertain	6	5	9
Disagree	23	20	13
Strongly Disagree	28	25	21
Missing Data	1	0	2

"A person who has learned to dissociate may not have any conscious memory of his or her sexual abuse"

	S.W. n	Psy n	M.D. n
Strongly Agree	2	26	18
Agree	44	42	27
Uncertain	10	4	7
Disagree	7	2	6
Strongly Disagree	1	2	1
Missing Data	1	0	0

"No symptoms are specifically and reliably associated with a history of child sexual abuse"

	S.W. n	Psy n	M.D. n
Strongly Agree	6	13	15
Agree	22	20	26
Uncertain	14	11	4
Disagree	32	23	11
Strongly Disagree	10	8	3
Missing Data	1	1	0

"What used to be called Multiple Personality Disorder (i.e., Dissociative Identity Disorder) is a consequence of severe sexual abuse"

	S.W. n	Psy n	M.D. n
Strongly Agree	5	4	8
Agree	20	26	13
Uncertain	29	21	11
Disagree	25	19	16
Strongly Disagree	5	6	11
Missing Data	1	0	0

"No satisfactory evidence of widespread satanic ritual abuse has been found to date"

	S.W. n	Psy n	M.D. n
Strongly Agree	4	10	11
Agree	24	16	18
Uncertain	36	35	14
Disagree	16	11	10
Strongly Disagree	1	3	3
Missing Data	4	1	3

"Denial of the existence of satanic itual abuse is similar to denial of horrifying realities like the holocaust"

	S.W. n	Psy n	M.D. n
Strongly Agree	10	9	8
Agree	33	27	12
Uncertain	19	22	10
Disagree	17	11	13
Strongly Disagree	4	7	12
Missing Data	2	0	4

"The fact that many patients independently describe the same experiences in satanic cults indicates that the allegations are true"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	6	4	2
Agree	35	27	11
Uncertain	20	24	17
Disagree	16	16	14
Strongly Disagree	4	5	10
Missing Data	4	0	5

"Satanic 'cult victims' are people who have been influenced by inappropriate suggestion (e.g., books, t.v., etc.)"

	S.W. n	Psy n	M.D. n
Strongly Agree	2	3	7
Agree	12	8	12
Uncertain	23	30	21
Disagree	33	28	12
Strongly Disagree	11	7	2
Missing Data	4	0	5

"A scientific appraisal of the veracity of recovered memories is necessary if we want to get at the truth about their validity"

	S.W. n	Psy n	M.D. n
Strongly Agree	2	13	19
Agree	18	20	14
Uncertain	14	6	8
Disagree	38	25	15
Strongly Disagree	12	7	2
Missing Data	1	5	1

"The real experts on traumatic memory are not the researchers who study memory but the victims themselves"

	S.W. n	Psy n	M.D. n
Strongly Agree	19	7	4
Agree	27	25	9
Uncertain	20	11	9
Disagree	14	19	24
Strongly Disagree	3	10	12
Missing Data	2	4	1

"Recovered memories must be reliable because no one wants to have been abused as a child"

	S.W. n	Psy n	M.D. n
Strongly Agree	10	4	1
Agree	30	13	8
Uncertain	9	9	2
Disagree	28	32	26
Strongly Disagree	6	14	20
Missing Data	2	4	2

"Questioning the veracity of women's memories of sexual abuse is a new way of saying that women are hysterical and unreliable"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	21	8	9
Agree	34	23	8
Uncertain	2	2	3
Disagree	18	21	18
Strongly Disagree	8	19	21
Missing Data	2	3	0

"A primary motivation for the statement that recovered memories are unreliable is to establish a legal defense for sexual abuse"

	S.W. n	Psy n	M.D. n
Strongly Agree	19	4	6
Agree	33	29	8
Uncertain	11	7	12
Disagree	17	16	16
Strongly Disagree	4	16	16
Missing Data	1	4	1

"People adopt the false memory theory because it is easier than facing the truth about sexual abuse"

	S.W. n	Psy n	M.D. n
Strongly Agree	12	6	3
Agree	29	18	16
Uncertain	21	17	9
Disagree	17	17	18
Strongly Disagree	4	13	12
Missing Data	2	5	1

"Blaming present problems on past abuse may prevent clients from taking responsibility for their own lives"

	S.W. n	Psy n	M.D. n
Strongly Agree	9	6	10
Agree	21	32	27
Uncertain	2	4	6
Disagree	33	19	10
Strongly Disagree	18	12	6
Missing Data	2	3	0

"It doesn't really matter clinically whether memories of abuse are accurate or not. What matters is what the client believes"

	S.W. n	Psy n	M.D. n
Strongly Agree	16	10	5
Agree	36	31	18
Uncertain	5	8	6
Disagree	18	19	24
Strongly Disagree	8	5	5
Missing Data	2	3	1

"People who suffer from severe mental distress have probably experienced some type of childhood trauma"

	S.W. n	Psy n	M.D. n
Strongly Agree	17	10	5
Agree	43	36	20
Uncertain	9	4	5
Disagree	11	19	18
Strongly Disagree	4	4	10
Missing Data	1	3	1

"It is very important that a client who was sexually abused remember that abuse in order for therapy to be effective"

	S.W. n	Psy n	M.D. n
Strongly Agree	7	5	4
Agree	29	26	21
Uncertain	10	9	11
Disagree	34	23	15
Strongly Disagree	4	10	8
Missing Data	1	3	0

"Hypnosis enables people to accurately remember things they otherwise could not"

	S.W. n	Psy n	M.D. n
Strongly Agree	6	4	4
Agree	35	22	13
Uncertain	18	11	12
Disagree	18	26	16
Strongly Disagree	4	11	14
Missing Data	4	2	0

"Hypnotically obtained memories are less reliable than simple remembering"

	S.W. n	Psy n	M.D. n
Strongly Agree	0	4	9
Agree	8	12	20
Uncertain	29	24	17
Disagree	35	27	10
Strongly Disagree	8	7	2
Missing Data	5	2	1

"People cannot lie when in hypnosis"

	S.W. n	Psy n	M.D. n
Strongly Agree	3	2	5
Agree	22	10	5
Uncertain	32	23	12
Disagree	17	22	22
Strongly Disagree	6	17	15
Missing Data	5	2	0

"Hypnosis can be used in such a way as to create confabulated memories"

	S.W. n	Psy n	M.D. n
Strongly Agree	5	13	15
Agree	19	26	30
Uncertain	35	24	11
Disagree	15	10	2
Strongly Disagree	6	1	1
Missing Data	5	2	0

"Hypnosis can be used to recover memories of actual events from as far back as birth"

	S.W.	Psy	M.D.
	n	n	n
Strongly Agree	12	7	4
Agree	32	30	17
Uncertain	26	18	13
Disagree	8	9	10
Strongly Disagree	3	9	15
Missing Data	4	3	0

"Recovered memories are more likely to be confabulated than are never-forgotten memories"

	S.W. n	Psy n	M.D. n
Strongly Agree	0	2	6
Agree	13	11	15
Uncertain	13	10	19
Disagree	41	38	16
Strongly Disagree	14	13	3
Missing Data	4	2	0

"Clients can come to believe that they were abused when in reality they were not"

	S.W. n	Psy n	M.D. n
Strongly Agree	7	12	16
Agree	32	35	32
Uncertain	8	9	5
Disagree	29	14	6
Strongly Disagree	5	4	0
Missing Data	4	2	0

"Some claims of sexual abuse based on recovered memories are false but these constitute a tiny minority of such claims"

	S.W. n	Psy n	M.D. n
Strongly Agree	11	10	3
Agree	40	35	16
Uncertain	19	18	27
Disagree	10	7	8
Strongly Disagree	1	4	5
Missing Data	4	2	0

"Many adult victims of child sexual abuse have not reported it because they have repressed the memory"

	S.W. n	Psy n	M.D. n
Strongly Agree	15	10	12
Agree	42	40	26
Uncertain	5	8	8
Disagree	17	13	10
Strongly Disagree	2	3	3
Missing Data	4	2	0

Appendix P

Frequencies and Percentages of Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.) Attending Workshops Related to Recovered Memory of Child Sexual Abuse (CSA)

	Profession					
	S.W.		Psy		M.D.	
	N = 85		N = 76		N = 59	
Workshop	(n)	%	(n)	%	(n)	%
Memory Recovery	(2)	2	(5)	7	(4)	7
DID	(3)	4	(6)	8	(11)	19
SRA	(1)	1	(0)	0	(2)	3
Sexual Abuse	(26)	31	(23)	30	(20)	34
Other	(6)	7	(13)	17	(6)	10

Note. DID = Dissociative Identity Disorder. SRA = Satanic ritual abuse.

Appendix Q

Number of Symptoms of Abuse Endorsed by Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.)

Frequencies and Percentages of Social Workers' (S.W.), Psychologists' (Psy) and Psychiatrists' (M.D.) Endorsement of Various Indicators as Definite and Possible Symptoms of a Child Sexual Abuse History

Definite Symptoms

	Profession					
	S.W.		Psy		M.D.	
	N = 85		N = 74		N = 59	
	(n)	%	(n)	%	(n)	%
Sexual difficulties	(5)	6	(1)	1	(3)	5
Poor relationships	(4)	5	(1)	1	(2)	3
Fear of men	(9)	11	(1)	1	(8)	14
Poor self-esteem	(4)	5	(3)	4	(3)	5
Depression	(6)	7	(1)	1	(2)	3
Anxiety	(3)	4	(1)	1	(0)	0
Insomnia	(2)	2	(1)	1	(0)	0
Chemical dependency	(3)	4	(1)	1	(3)	5
Amnesia for periods of childhood	(12)	14	(3)	4	(6)	10
Denial &/or repression of memories	(17)	20	(6)	8	(7)	12
Flashbacks	(31)	36	(13)	18	(11)	19
Night terrors	(6)	7	(3)	4	(1)	2
DID	(15)	18	(7)	9	(13)	22

Body memories	(11)	13	(7)	9	(4)	7
Vaginal infection	(2)	2	(2)	3	(0)	0
Urinary tract infections	(2)	2	(0)	0	(0)	0
Trichotillomania	(1)	1	(1)	1	(0)	0
Eating disorders	(6)	7	(1)	1	(4)	7
Wearing a lot of clothing	(5)	6	(2)	3	(0)	0
Avoidance of mirrors	(2)	2	(0)	0	(2)	3
Self-mutilation	(9)	11	(1)	1	(5)	8
Stealing	(1)	1	(0)	0	(0)	0
Risk-taking behavior	(2)	2	(0)	0	(1)	2
Inability to take risks	(2)	2	(0)	0	(1)	2
Other	(4)	5	(1)	1	(0)	0

Possible Symptoms

	Profession		
	S.W.	Psy	M.D.
	N = 84	N = 74	N = 59
	(n) %	(n) %	(n)%
Sexual difficulties	(76) 90	(69) 93	(47) 80
Poor relationships	(56) 67	(51) 67	(42) 71
Fear of men	(65) 77	(66) 89	(44) 75
Poor self-esteem	(65) 77	(52) 70	(40) 68
Depression	(53) 63	(46) 62	(38) 64
Anxiety	(51) 31	(42) 57	(38) 64

Insomnia	(46) 55	(34) 46	(39) 66
Chemical dependency	(55) 65	(40) 54	(35) 59
Amnesia for periods of childhood	(69) 82	(56) 76	(41) 69
Denial &/or repression of memories	(53) 63	(49) 66	(33) 56
Flashbacks	(38) 45	(40) 54	(39) 66
Night terrors	(55) 65	(50) 68	(40) 68
DID	(50) 60	(50) 68	(32) 54
Body memories	(45) 54	(37) 50	(24) 40
Vaginal infection	(51) 60	(26) 35	(23) 39
Urinary tract infections	(51) 60	(26) 35	(24) 40
Trichotillomania	(33) 39	(17) 23	(23) 39
Eating disorders	(55) 65	(48) 65	(34) 58
Wearing a lot of clothing	(48) 57	(37) 50	(26) 44
Avoidance of mirrors	(44) 52	(30) 41	(24) 40
Self-mutilation	(52) 62	(42) 57	(33) 39
Stealing	(45) 54	(21) 28	(26) 44
Risk-taking behavior	(47) 56	(24) 32	(30) 51
Inability to take risks	(40) 40	(23) 31	(22) 37
Other	(16) 46	(12) 16	(10) 17

Appendix R

Techniques Endorsed and Rejected

Frequencies and Percentages of Social Workers' (S.W.), Psychologists' (Psy) and Psychiatrists' (M.D.) Endorsement and Rejection of Various Memory Recovery Techniques

	Techniques Endorsed		
	Profession		
	S.W.	Psy.	M.D.
	N = 74	N = 74	N = 58
	(n) %	(n) %	(n) %
Hypnosis	(14) 19	(12) 16	(6) 10
Age regression	(18) 24	(9) 12	(3) 5
Dream interpretation	(20) 27	(38) 51	(22) 38
Guided imagery	(21) 28	(26) 35	(6) 10
Imagination	(18) 24	(28) 38	(16) 28
Bibliotherapy	(4) 5	(8) 11	(3) 5
Family photographs	(18) 24	(20) 27	(7) 12
Keeping a journal	(28) 38	(36) 49	(17) 29
Physical symptoms	(26) 35	(28) 38	(12) 21
Relaxation	(29) 39	(29) 39	(12) 21
Sodium Amytal, etc.	(0) 0	(0) 0	(5) 9
Support groups	(27) 36	(15) 20	(14) 24
Rebirth	(3) 4	(1) 0	(1) 2
Other	(11) 15	(7) 9	(1) 2

Techniques Rejected

	Profession		
	S.W.	Psy.	M.D.
	N = 73	N = 74	N = 58
	(n) %	(n) %	(n) %
Techniques Rejected			
Hypnosis	(8) 11	(18) 24	(20) 34
Age regression	(13) 18	(26) 35	(35) 43
Dreams	(6) 8	(13) 18	(15) 26
Guided imagery	(6) 8	(15) 20	(21) 36
Imagination	(12) 16	(15) 20	(16) 28
Bibliotherapy	(6) 8	(15) 20	(18) 31
Family photographs	(5) 7	(6) 8	(17) 29
Keeping a journal	(0) 0	(7) 9	(9) 16
Physical symptoms	(6) 8	(10) 14	(29) 50
Relaxation	(1) 0	(6) 8	(9) 16
Sodium Amytal, etc.	(22) 30	(33) 45	(17) 29
Support groups	(4) 5	(13) 18	(17) 29
Rebirth	(21) 28	(31) 42	(38) 66
Other	(0) 0	(0) 0	(0) 0

Appendix S

Mean Numbers of Clients Seen by Social Workers (S.W.), Psychologists (Psy) and Psychiatrists (M.D.) with Different Types of Memories of Abuse

	S.W.		Psy		M.D.	
	M	(SD)	M	(SD)	M	(SD)
Never-forgotten						
	9.54	(15.00)	7.71	(13.22)	17.22	(20.66)
n	65		68		49	
Spontaneous Incidents						
	3.46	(15.18)	1.64	(4.66)	0.48	(1.28)
n	69		66		50	
Recovered						
Whole Memories						
	2.79	(5.91)	2.03	(3.36)	2.15	(3.77)
n	63		68		48	
Incidents						
	0.57	(2.08)	0.82	(3.64)	0	(0)
n	68		67		50	
Total						
	3.46	(7.45)	2.82	(6.31)	2.04	(3.84)
n	61		67		45	

Appendix T

Standardized Scale Scores of Cognitive-Behavioral (C/B), Freudian (Freud), Systemic (Sys), Humanist (Hum) Medically-Oriented (Med) Respondents

Standardized Scale Scores of Cognitive-Behavioral (C/B), Freudian (Freud), Systemic (Sys), Humanist (Hum) and Medically-Oriented (Med) Respondents

Scale	C/B	Freud	Sys	Hum	Med
Belief*					
M	-0.85	-0.05	0.30	0.21	-0.40
(SD)	(0.96)	(1.05)	(0.84)	(0.94)	(0.99)
n	26	64	49	43	12
Knowledge*					
M	0.76	0.13	-0.43	-0.17	0.32
(SD)	(0.65)	(0.97)	(0.95)	(0.99)	(1.10)
n	26	64	47	40	11
Malleability*					
M	0.47	0.15	-0.41	-0.16	0.58
(SD)	(0.73)	(0.94)	(1.12)	(0.89)	(0.95)
n	26	64	47	41	11
Traces*					
M	0.82	0.10	-0.31	-0.10	-0.02
(SD)	(0.71)	(1.03)	(0.89)	(0.96)	(1.16)
n	26	64	47	41	12
Social Context*					
M	-0.84	-0.08	0.20	0.32	-0.17
(SD)	(0.92)	(1.00)	(0.88)	(0.98)	(0.90)
n	25	60	45	37	10

Values*					
M	-0.70	-0.06	0.26	0.24	-0.23
(SD)	(0.98)	(0.92)	(0.97)	(1.03)	(0.99)
n	25	65	45	39	10
Motivation					
M	-0.79	-0.08	0.17	0.26	-0.22
(SD)	(0.92)	(1.06)	(0.85)	(0.95)	(0.88)
n		60	47	39	11
Forgetting*					
M	-0.63	-0.04	0.33	0.32	-0.64
(SD)	(0.97)	(1.07)	(0.89)	(0.93)	(0.75)
n	26	63	47	42	12
Distress*					
M	-0.65	-0.26	0.22	-0.08	-0.52
(SD)	(0.82)	(1.06)	(0.98)	(0.93)	(0.92)
n	25	63	46	42	12
Credulity					
M	-0.48	0.02	0.18	0.03	0.07
(SD)	(1.07)	(1.00)	(0.79)	(1.02)	(1.53)
n	26	61	46	42	11
Diagnosis					
M	-0.15	-0.17	0.18	0.01	-0.21
(SD)	(0.99)	(1.12)	(0.89)	0.89	(1.19)
n	26	59	49	42	11
RecMem*					
M	-0.50	0.01	0.10	0.28	-0.59

(*SD*)	(1.07)	(1.08)	(0.93)	(0.82)	(1.07)
n	26	64	47	42	12

Note. Malleability and Traces are subscales of Knowledge. Values and Motivation are subscales of Social Context.

* overall F-test significant at $p < .$

Underlining = Tukey HSD showed that the group was different from cognitive-behavioral therapists, $p < .05$.

Appendix U

Descriptive Statistics Concerning Respondents who Account for the Majority of Reported Cases of Recovered Memory

Characteristics of the Respondents who Account for the Majority of Reported Cases of Recovered Memory

	Majority		Other	
	(n)	%	(n)	%
Gender				
Female	(7)	50	(104)	54
Male	(7)	50	(87)	46
Profession				
S.W.	(6)	43	(73)	38
Psy.	(5)	36	(65)	34
M.D.	(3)	21	(53)	28
Highest Degree				
B.A.	(4)	29	(42)	22
M.A.	(6)	43	(81)	42
PhD	(1)	7	(15)	8
M.D.	(3)	21	(53)	28
Training				
Clinical	(11)	79	(118)	62
Sientific	(3)	21	(73)	38
Approach				
Cog/Beh	(1)	7	(24)	13
Freudian	(2)	14	(61)	32
Medical	(2)	14	(10)	5
Systemic	(2)	14	(40)	21

Humanist	(5)	36	(36)	19
Feminist	(1)	7	(2)	1
Missing	(1)	7	(18)	9
Cases				
Yes	(14)	100	(92)	48
No	(0)		(81)	42
Missing	(0)		(18)	9

Note. S.W. = social worker. Psy = psychologist. M.D. = psychiatrist. Clinical = clinical, social, or on the job training. Scientific = experimental, experimental and clinical, or medical training. Cog/Beh = behavioral, cognitive, cognitive-behavioral, or social learning. Freudian = psychoanalytic, psychodynamic, or interpersonal. System = psychosocial or systemic. Human = humanist/client-centered or existential. Cases = has clients with recovered memories.

Mean Responses of Respondents Accounting for the Majority of Recovered Memory Cases

	Majority		Others	
	M	(SD)	M	(SD)
Age	42.79	(8.56)	46.12	(9.79)
n	14		191	
Practice	14.21	(8.20)	17.48	(9.71)
n	14		188	
Research	1.79%	(3.17%)	3.78%	(9.88%)
n	14		190	
Workshops	0.79	(1.25)	0.61	(0.80)
n	14		191	
Definite	2.50	(4.45)	1.28	(2.85)
n	14		190	
Possible	17.43	(6.60)	13.66	(7.49)
n	14		189	
Techniques	5.79	(2.52)	2.78	(2.30)*
n	14		186	
Rejected	1.93	(2.13)	3.09	(3.68)
n	14		185	
Feminism	6.00	(2.38)	5.96	(1.92)
n	13		188	
Abused	48.36	(31.99)	13.62	(40.04)

n	14		179	
Cases	19.36	(11.93)	1.39	(2.04)
n	14		159	
Rate	18.96%	(21.20%)	2.89%	(4.55%)*
n	14		154	
Total Clients	145.71	(86.35)	112.27	(318.19)
n	14		175	

Note. Practice = years in clinical practice. Research = percent of professional time spent in research. Definite = number of definite symptoms of abuse endorsed. Possible = number of possible symptoms of abuse. Techniques = number of techniques endorsed. Rejected = number of techniques rejected. Abused = clients who report a history of child sexual abuse. Cases = number of clients who recovered memories. Rate = percent of clients who recovered memories.
* $p < .05$.

Standardized Scale Scores and Significance Tests for Respondents Who Account for the Majority of Cases

	Majority		Others	
Scale	*M*	(*SD*)	*M*	(*SD*)
Belief	0.42	(0.85)	-0.05	(1.01)
n	14		191	
Knowledge	-0.29	(0.73)	0.04	(1.01)
n	14		182	
Social Context	0.77	(0.75)	-0.08	(0.99)*
n	13		170	
Forgetting	0.35	(0.79)	-0.03	(1.02)
n	14		183	
Distress	-0.39	(1.09)	0.02	(1.00)
n	13		185	
Credulity	-0.18	(0.92)	0.03	(1.01)
n	13		179	
Diagnosis	0.32	(1.02)	-0.05	(1.02)
n	14		179	
RecMem	0.29	(0.96)	-0.04	(1.01)
n	14		187	

Note. Only subjects for whom number of cases could be calculated are included here. * $p < .05$

Appendix V

Descriptive Statistics Concerning Respondents Exhibiting a Memory Recovery Focus and Those Cautious About Memory Recovery

Characteristics of Subjects Exhibiting a Memory Recovery Focus and Subjects Cautious About Memory Recovery

	Focus		Cautious	
	(n)	%	(n)	%
Gender				
Female	(10)	56	(2)	40
Male	(8)	44	(3)	60
Profession				
S.W.	(6)	33	(0)	0
Psy.	(8)	44	(3)	60
M.D.	(4)	22	(2)	40
Highest Degree				
B.A.	(3)	17	(0)	0
M.A.	(11)	61	(2)	40
Ph.D.	(0)	0	(1)	20
M.D.	(4)	22	(2)	40
Training				
Clinical	(13)	72	(1)	20
Scientific	(5)	28	(4)	80
Approach				
Cog/Beh	(1)	6	(2)	40
Freudian	(6)	33	(2)	40
Medical	(2)	11	(0)	0

Systemic	(4)	22	(0)	0
Humanist	(3)	17	(0)	0
Feminist	(1)	6	(0)	0
Missing	(1)	6	(1)	20
Cases				
Yes	(10)	56	(1)	20
No	(5)	28	(2)	40
Missing	(3)	17	(1)	20

Note. S.W. = social worker. Psy = psychologist. M.D. = psychiatrist. Clinical = clinical, social, or on the job training. scientific = experimental, experimental and clinical, or medical training. Cog/Beh = behavioral, cognitive, cognitive-behavioral, or social learning. Freudian = psychoanalytic, psychodynamic, or interpersonal. System = psychosocial or systemic. Human = humanist/client-centered or existential. Cases = has clients with recovered memories.

Mean Responses of Respondents Exhibiting a Memory Recovery Focus and Respondents Cautious About Memory Recovery

	Focus		Cautious	
	M	(SD)	M	(SD)
Age	38.72	(7.09)	45.00	(11.25)
n	18		5	
Practice	12.06	(6.18)	16.60	(11.82)
n	17		5	
Research	3.06%	(5.72%)	11.00%	(11.40%)*
n	18		5	
Workshops	0.44	(0.62)	0.40	(0.55)
n	18		5	
Definite	4.50	(6.45)	0.20	(0.45)
n	17		5	
Possible	14.22	(6.09)	8.40	(8.26)
n	17		5	
Techniques	4.78	(2.56)	0.0	(0.0)
n	17		5	
Rejected	1.22	(1.11)	9.4	(5.68)*
n	17		5	
Feminism	6.56	(2.23)	6.40	(2.61)
n	17		5	
Abused	16.00	(25.77)	21.60	(37.25)

n	16		5	
Cases	7.71	(12.55)	0.25	(0.50)
n	14		4	
Rate	13.39%	(23.28%)	1.00%	(2.00%)
n	14		4	
Total Clients	55.12	(51.15)	67.80	(65.66)
n	17		5	

Note. Practice = years in clinical practice. Research = percent professional time spent in research. Definite = number of definite symptoms of abuse endorsed. Possible = number of possible symptoms of abuse. Techniques = number of techniques endorsed. Rejected = number of techniques rejected. Abused = clients who report a history of child sexual abuse. Cases = number of clients who recovered memories. Rate = percent of clients who recovered memories.

* $p < .01$

Standardized Scale Scores and Significance Tests for Respondents Exhibiting a Memory Focus and Those Cautious About Memory

	Focus		Cautious	
	M	(*SD*)	*M*	(*SD*)
Belief	0.80	(0.78)	-2.27	(1.07)*
n	18		5	
Knowledge	-0.70	(0.99)	1.32	(0.56)*
n	17		5	
Social Context	0.49	(0.88)	-2.11	(0.20)*
n	18		4	
Forgetting	0.25	(1.04)	-1.84	(0.92)*
n	18		5	
Distress	0.20	(0.88)	-0.61	(1.32)
n	18		5	
Credulity	0.65	(0.88)	-1.66	(0.94)*
n	16		5	
Diagnosis	1.47	(0.57)	-2.03	(1.08)*
n	17		5	
RecMem	0.88	(0.87)	-2.17	(1.03)*
n	17		5	

* $p < .05$

Appendix W

Descriptive Statistics Concerning High and Low Scorers

Characteristics of High and Low Scorers

	High Scorers		Low Scorers	
	(n)	%	(n)	%
Gender*				
Male	(2)	17	(7)	64
Female	(10)	83	(4)	36
Profession*				
S.W.	(7)	58	0	0
Psy	(3)	25	(5)	45
M.D.	(2)	17	(6)	55
Highest Degree				
B.A.	(5)	42	(0)	0
M.A.	(5)	42	(4)	36
Ph.D.	(0)	0	(1)	1
M.D.	(2)	17	(6)	55
Training*				
Clinical	(10)	83	(3)	27
Scientific	(2)	17	(8)	73
Approach				
Cog/Beh	(0)	0	(3)	25
Freudian	(5)	28	(3)	25
Medical	(1)	6	(1)	8
System	(4)	22	(2)	17
Human	(1)	6	(2)	17

Feminist	(1)	6	(0)	0
Missing	(6)	33	(1)	8
Cases*				
Yes	(9)	75	(3)	27
No	(2)	17	(7)	64
Missing	(1)	8	(1)	9

Note. S.W. = social worker; Psy = psychologist; M.D. = psychiatrist. Clinical = clinical, social, or on the job training; Scientific = experimental, experimental and clinical, or medical training. Approach = theoretical approach. Cog/beh = behavioral, cognitive, cognitive-behavioral, social-learning. Freudian = psychoanalytic, psychodynamic, interpersonal. System = psychosocialor systemic; Human = humanist/client-centered or existential. Cases = had clients with recovered memories.

*$p < .05$

Mean Responses of High and Low Scorers

	High Scorers		Low Scorers	
	M	(SD)	M	(SD)
Age	44.92	(9.14)	44.09	(8.08)
n	12		11	
Practice	14.75	(6.80)	14.91	(9.27)
n	12		11	
Research	3.64%	(6.74%)	7.73%	(9.05%)
n	11		11	
Workshops	0.50	(0.67)	0.73	(1.01)
n	12		11	
Definite	2.50	(2.07)	0.09	(0.30)*
n	12		11	
Possible	14.50	(5.92)	10.00	(8.44)
n	12		11	
Techniques	3.09	(2.66)	1.36	(1.75)
n	11		11	
Rejected	1.36	(1.69)	8.64	(4.52)*
n	11		11	
Feminism	6.55	(2.07)	6.18	(1.89)
n	11		11	
Abused	15.73	(20.78)	13.80	(13.80)
n	11		10	

Cases	2.20	(2.49)	0.40	(0.70)*
n	11		10	
Rate	5.00%	(5.00%)	1.00%	(2.00%)*
n	10		10	
Total Clients	77.73	(61.51)	00.55	(97.74)
n	11		11	

Note. Practice = years in clinical practice. Research = percent of professional time spent in research. Definite = number of definite symptoms of abuse endorsed. Possible = number of possible symptoms of abuse. Techniques = number of techniques endorsed. Rejected = number of techniques rejected. Abused = clients who report a history of child sexual abuse. Cases = number of clients who recovered memories. Rate = percent of clients who recovered memories.

* $p < .05$

Standardized Scale Scores and Significance Tests for High and Low Scorers

	High Scorers		Low Scorers	
Scale	*M*	(*SD*)	*M*	(*SD*)
Belief	1.82	(0.35)	-2.39	(0.34)
n	12		11	
Knowledge	-1.41	(0.59)	1.54	(0.37)
n	11		11	
Social Context	1.64	(0.36)	-2.00	(0.29)
n	12		11	
Forgetting	0.99	(0.94)	-1.52	(0.98)
n	12		11	
Distress	0.78	(0.47)	-0.98	(0.59)
n	12		11	
Credulity	0.99	(0.88)	-1.78	(0.82)
n	11		11	
Diagnosis	0.70	(1.07)	-1.71	(0.83)
n	12		11	
RecMem	1.74	(0.52)	-2.04	(0.85)
n	11		11	

Note. Groups differ on all scales at $p < .0001$

Appendix X

Demographic Characteristics of Yapko, Poole, and Present Study, Reported as Means or Percentages

Demographic Characteristics of Yapko, Poole, and Present Study, Reported as Means or Percentages

	Present	Poole			Yapko
		1	2	3	
N	220	86	59	57	869
Age	46	50	51	41	44
Practice	17	-	-	-	11+
Women	56%	31%	39%	61%	-
			Highest Degree		
B.A.	21%	0	0	0	5%
M.A.	45%	0	0	0	64%
Ph.D.	7%	100%	100%	100%	24%
M.D.	27%	0	0	0	4%
Other	0	0	0	0	2%

Note. Poole 1 and 2 refer to American samples, 3 refers to a British sample. Practice = number of years in clinical practice. Women = percent female respondents.