Characteristics, context and consequences of memory recovery among adults in therapy*

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Background There are concerns that memories recovered during therapy are likely to be the result of inappropriate therapeutic techniques.

Aims To investigate systematically these concerns.

Method One-hundred and eight therapists provided information on all clients with recovered memories seen in the past three years, and were interviewed in detail on up to three such clients.

Results Of a total of 690 clients, therapists reported that 65% recalled child sexual abuse and 35% recalled other traumas, 32% started recovering memories before entering therapy. According to therapists' accounts, among the 236 detailed client cases very few appeared improbable and corroboration was reported in 41%. Techniques to aid recall were used in 42%, but only in 22% were they used *before* memory recovery started.

Conclusions Some of the data are consistent with memories being of iatrogenic origin, but other data clearly point to the need for additional explanations.

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Despite the continuing debate in the scientific and professional literature, it remains unclear how reports detailing periods of forgetting traumatic incidents are to be explained (e.g. Brewin, 1996; Mollon, 1998). Concern has been expressed that memories of trauma recovered during therapy may be iatrogenic, arising from the use of inappropriate therapeutic techniques rather than corresponding to actual events (e.g. Brandon *et al*, 1998). Alternative explanations for genuine forgetting and memory recovery have been put forward, based on ideas derived from psychoanalysis and cognitive psychology (Freyd, 1996; Brewin & Andrews, 1998). One of the difficulties in evaluating competing explanations for the forgetting of trauma is the lack of detailed systematic investigations of memories recovered during therapy. Existing investigations, in the main, have been based on small numbers of individual cases (Schooler *et al*, 1997; Cheit, 1998) or have used relatively crude self-report questionnaires (Andrews *et al*, 1995; Poole *et al*, 1995).

AIMS

By interviewing a large number of therapists, the aim was to collect systematic data on: therapists' reports of the content and characteristics of their clients' recovered memories, as well as their plausibility and validity; therapeutic involvement in the production of recovered memories; and the consequences of memory recovery for the clients' relationships with supposed perpetrators.

METHOD

In the present study a recovered memory is defined as the recovery of a traumatic event (whether real or illusory) where there was no previous conscious memory, or recovery of a significant new piece of information about a partially remembered trauma. Not included are recovery of forgotten feelings surrounding an event that had always been remembered.

The sample

Participants were followed up from a previous questionnaire survey of 810 practitioner members of the British Psychological Society (BPS; Andrews *et al*, 1995). Of the 291 who reported having at least one client who recovered a traumatic memory in therapy in the previous year, 208 (71%) identified themselves for further research. Of those, the first 180 on the list were contacted for interview in the time available (the study was funded for one year). Sixteen said that they had mistakenly identified themselves as having had clients with recovered memories. Of the remaining 164, 72% were interviewed, 9% could not remember the client in question, 17% declined and 2% could not be traced. Upon interview, 10 turned out not to have clients with recovered memories according to our criteria and were excluded.

The mean age of the 108 respondents with valid interviews was 48 years, and 61% were women. The representativeness of the interviewed sample was investigated by comparing responses to the 19 original survey questions between: those with valid interviews (n=108); those self-identified but not interviewed (n=74); and those who did not identify themselves for further research (n=83). The 19 questions included demographics, therapeutic approach and practice, case-load, experience of memory recovery clients and satanic/ritual abuse clients, and beliefs. Significant group differences involved case-load ($F(2,260)=5.6$, $P<0.01$), satanic abuse clients ($\chi^2(2, n=262)=10.9$, $P<0.01$) and belief in the accuracy of recovered memories ($F(2, 246)=4.9$, $P<0.01$); there was no significant group difference in the belief that memories could be false. In *post hoc* comparisons, the interviewed group had higher case-loads than those who did not identify themselves, and the self-identified groups (both interviewed and non-interviewed) reported a greater belief in the accuracy of recovered memories and more satanic/ritual abuse clients than those who did not identify themselves.

Interview procedure

Interviews took place between 1995 and 1996. Respondents were instructed to calculate in advance the total number of clients

*A fuller version of this paper is available on request from the first author.

seen since April 1993 (the year before the questionnaire survey) who had recovered memories of child sexual abuse (CSA) and other trauma in therapy with them, and recovered any trauma memories prior to any therapy. They were further instructed to consult their clinical notes in advance on up to three such clients for more detailed questioning. This procedure generated 236 detailed client cases (82% female and 18% male) with a mean age of 35.9 years. In 55% information was based on respondent's notes and, failing that, in a further 5% the case was current. In 40% the patients were no longer in treatment and notes were not consulted. To check that reliance on memory was not biasing the results, cases for which notes were consulted were compared with cases where they were not, for all the variables reported in this article, but no significant differences were found (P=0.17–0.98; details available from the author upon request).

It is possible that the instructions for selecting clients may have led to unrepresentative sampling of therapists' cases. However, this could only apply to therapists with more than three recovered memory clients. The 55% with three or fewer clients with recovered memories in the study period could only report on those they had. Those 45% with more than three appropriate clients made a choice in selecting clients, and certain client types might have been selected systematically over others. To test this possibility, client cases of respondents with three or fewer were compared with cases of those with four or more on all the variables in the analyses. With one exception, client selection bias was not apparent (P=0.07–0.90; details available from the author upon request). The one significant group difference is discussed in the relevant Results section.

The interviews were conducted by telephone and were tape-recorded, with the respondent's permission, for later transcription. The interview schedule was structured, with clarification where requested and probes to encourage elaboration where relevant. In terms of the variables reported in this article, for each client selected the interview covered the context of the beginning of memory recovery, a description of the trauma recovered, the degree of prior amnesia, corroboration, the use of specific techniques before and after initial memory recovery and the consequences of memory recovery.

RESULTS

Description of recovered memories

Ninety-nine of the 108 respondents provided full information concerning the total number of clients with recovered memories seen since April 1993. Of a total of 690 clients they reported that 46.7% recalled CSA, 17.8% both CSA and other trauma and 35.5% only non-CSA trauma. Details of what was involved in the memories come from the 236 detailed client cases.

Of these detailed cases, respondents reported that in 69% memory recovery was from prior total amnesia and in 31% there was a prior partial memory. Respondents with four or more recovered memory clients reported fewer cases of total amnesia (63%) than those with three or fewer (78%) ($\chi^2(1, n=213)=4.9$, $P<0.05$). In all the following analyses, we therefore investigated and ruled out any confounding effects attributable to degree of amnesia.

Among the 64 detailed cases where the report solely involved non-CSA trauma, 41% involved childhood maltreatment that included physical abuse and other forms of cruelty, 16% involved traumatic medical procedures and 14% involved witnessing a death or trauma of someone close. Smaller proportions involved events surrounding the death or separation of someone close (6%), bomb explosions (6%) and car accidents (5%). A proportion of other traumatic events (13%) could not be categorised easily but mainly involved guilt or shame-provoking events.

Plausibility of recovered memory accounts

Age at earliest trauma and repeated trauma

The mean age at the earliest reported traumatic event recovered in the memory was 7.9 (s.d.=7.4), with 4% in the first year of life, 9% in the first three years and 36% in the first five years. Sixty-two per cent of the clients' recovered memories involved repeated events. Just 2% of the traumatic events in the clients' memories were reported to have started *and* finished before age 3 years.

Ritual abuse and other unusual elements

Respondents were asked whether their clients' memories contained any unusual elements such as ritual/satanic abuse, alien abduction or past life experiences. Memories of ritual cult abuse were reported in 5% (n=11) of the 236 client cases. Just one client recalled an alien abduction and no memories of past life experiences were reported.

Corroborative evidence

Respondents were asked whether the client's memory had been corroborated by some outside source. Overall, in 41% of the client cases it was reported that the client had found some kind of corroboration. In 11% of these the respondents reported having seen and/or heard the evidence at first hand. Table 1 details the types of corroboration reported.

There was a lower reported rate of corroboration for memories from total amnesia (36%) than from partial memory (57%) ($\chi^2(1, n=222)=7.65$, $P<0.01$). Table 2 shows the relationships between reported corroboration and trauma type, age at trauma, repeated trauma and ritual cult abuse. Corroboration rates just for cases with prior total amnesia are given in parentheses. The only variable significantly related to reported corroboration was trauma type. Among all the cases, the lowest corroboration was for CSA and the highest was for other trauma.

Therapeutic involvement in the production of recovered memories

Therapeutic context

Ninety-five of the 108 respondents provided information about the context of the first memory recovered for all the clients they had seen who had recovered memories in therapy with them since April 1993. Out of 634 clients, 32% were reported to have recovered their first memory before entering any kind of therapy.

Table 1 Types of corroborative evidence among cases with reported corroboration (n=97)

	%	(n)
Someone else reported abuse	52	(50)
Someone confirmed	43	(42)
Abuser confessed	13	(13)
Official records confirmed	12	(12)
Court records confirmed	9	(9)
Medical records confirmed	6	(6)

Categories sum to more than 100% because there was more than one type of corroboration in 34% of the cases.

Table 2 Characteristics of recovered memory and reported corroboration for all clients (and for clients with prior total amnesia)

	% Corroboration		$\chi^2(3)$ Any amnesia
	Any amnesia	(Total amnesia)	
Type of trauma (n=230)			
Child sexual abuse (CSA)	32	(27)	11.63*
CSA and other trauma	50[1]	(51)	
Child maltreatment	46	(35)	
Other trauma	62	(47)	
Ritual cult abuse (n=231)			$\chi^2(1)$
Yes	36	(40)	0.15
No	42	(36)	
Trauma started in first three years of life (n=205)			
Yes	47	(46)	0.56
No	44	(38)	
Repeated trauma (n=205)			
Yes	45	(44)	0.30
No	41	(29)	

Note: n varies in the analyses because of missing values.
1. Corroboration=19% CSA alone, 10% other trauma alone and 21% both CSA and other.
*$P<0.01$.

Use of therapeutic techniques

Respondents were asked whether they had used any techniques from a list (shown in Table 3) with the client in question to help him or her remember past experiences. Where the respondent indicated having used a specific technique, but for purposes other than to aid memory recovery, this was noted. In addition, if the client's first reported memory was recovered in therapy with the respondent, he or she was asked whether the technique was used before or after the memory had been recovered. Overall, in 67% of the client cases at least one of the listed techniques had been used for some purpose either before or after the first reported memory was recovered. This proportion decreased to 42% when techniques were considered only if they were used specifically to help the client to remember past experiences, with a further decrease to 21.5% when only techniques to aid recall before the first memory was recovered were considered.

Table 3 lists the different types and the proportions of client cases with whom the technique had been used to aid recall either *before* or *only after* reported memory recovery. Clients reported to have recovered their first memory in therapy with the respondent are distinguished from clients reported to have recovered their first memory prior to therapy with the respondent. Among clients who had recovered their first memory in therapy with the respondent, in just under one-third at least one technique to aid recall had been used before the first memory had been recovered. In a further 14% such a technique had been used only after the first memory was recovered. Among these clients, techniques were no more likely to have been used where memories involved CSA than where memories only involved other trauma; rates were 28% for CSA, 19% for both CSA and other trauma, 42% for child maltreatment and 39% for other trauma ($\chi^2(3, n=165)=4.5$, $P>0.05$). At least one technique to aid recall was also used with just over one-third of the clients who had already recovered their first memory prior to therapy with the respondents.

Clients with whom techniques had been used before the first reported memory recovery were no less likely to have found corroborating evidence, according to the respondents, than clients with whom no techniques had been used before memory recovery. Corroboration rates were 38%

Table 3 Therapeutic techniques used to aid recall in the client cases

	First memory recovered		
	In therapy with respondent (n=166)		Before therapy with respondent (n=67)
	Before recall (%)	Only after recall (%)	After recall (%)
Hypnosis	8	1	3
Age regression	10	1	5
Dream interpretation	3	2	3
Guided imagery	7	6	6
Use of family photos	5	4	3
Relaxation	7	3	6
Instructions to remember	10	7	13
Interpreting physical symptoms	10	8	9
Writing/artwork	4	2	5
Other techniques	5	3	5
Overall use of techniques	30	14	34

for clients with techniques used to aid recall, 45% for clients with techniques used for other reasons and 43% for clients with whom no such techniques were used ($\chi^2(2, n=231)=0.49$, $P>0.05$).

Consequences of memory recovery for the clients' relationship with supposed perpetrators

There were 118 cases where the reported memory involved some kind of abuse or maltreatment and the supposed perpetrator was still alive and known. Respondents reported that the client confronted or broke contact with that person in 37% ($n=44$) of the cases. In 27 instances, all contact was broken. Among all clients with recovered memories involving abuse or maltreatment, 58% described as having confronted or broken contact were reported to have found corroborating evidence, compared with 33% who did not ($\chi^2(1, n=196)=8.7$, $P<0.01$).

DISCUSSION

The present investigation is the first to explore, in one study, the characteristics, context and consequences of recovered memories among adults in therapy. It includes the largest number of detailed client descriptions that have been reported so far. Combining these aspects in one study allows for an analysis of interrelationships among these factors that has not been possible so far in the existing studies that have adopted a narrower focus. The interview method that was used allowed for tighter clarification of definitions than has been possible so far in questionnaire surveys.

Are recovered memories in therapy limited to childhood sexual abuse?

The results from these in-depth interviews confirm and extend our previous findings that reports of traumatic memories recovered in therapy are not limited to those involving CSA, nor to CSA survivors (Andrews *et al*, 1995). The present, more-detailed study enabled a breakdown of the actual numbers of clients seen in these categories. About two-thirds of memories among all clients with recovered memories seen by our respondents were reported to have involved CSA. Nevertheless, over one-third of these adults in therapy were reported only to have recalled other trauma involving not only childhood but also adulthood experiences.

To what extent are recovered memories plausible and valid?

In only a very small minority of the detailed cases did the memories appear improbable. The proportion with ritual cult abuse (5%) might have been even lower if all eligible respondents from our original survey had been interviewed; compared with those who did not identify themselves for further research, interviewed respondents were more likely to have indicated previously having worked with clients reporting satanic ritual abuse (not necessarily forgotten). The current rates of improbable memories are substantially lower than those reported by False Memory Syndrome Foundation members in the USA (Wakefield & Underwager, 1992) and somewhat lower than those reported by British False Memory Society (FMS) members (Gudjonsson, 1997).

One explanation for the differences may involve cultural variability in the rates of implausible memories. However, cultural differences cannot account for all the variance, because the proportion of the British clients where trauma was reported to have started before age 3 years was still less than half that reported in the British survey of FMS members (9–20%). An additional possibility, therefore, is that the respondents' clients in the present study are more representative of individuals who claim recovered memories than the accusers described by parents in the FMS surveys. In the relevant cases, only a minority had confronted or broken contact with the alleged perpetrators. It is also likely that the present data are more reliable than those in the FMS surveys, because therapists have more knowledge of their clients' recovered memories than accused parents, who usually have limited or no contact with their children (see Andrews, 1997).

Corroborative evidence was reported for over 40% of the memories, often from more than one source. These data should be interpreted with caution, because the evidence of corroboration was not collected first-hand but represents therapists' observations of clients' reports; the therapist actually saw the evidence in only a small minority of cases. Nevertheless, it is notable that this proportion is very similar to those proportions found in two other direct investigations of individuals reporting delayed memories of childhood abuse in the USA (Feldman-Summers & Pope, 1994; Herman & Harvey, 1997).

Corroboration was less likely to have been reported for memories of CSA alone than for memories of other types of trauma, although the rate was not insubstantial (32%). If it is accepted that at least some recovered memories are valid, then a possible explanation for the relatively low corroboration rates may be that CSA is more likely than other forms of trauma to be a private act, involving secrecy and shame. It is, therefore, less likely to have come to the notice of outside observers who could provide later confirmation, particularly if it occurs without any other apparent maltreatment. An alternative explanation is that because of increasing clinical interest in the subject, there is a disproportionate focus on CSA, leading therapists to be more likely to use suggestive techniques where they suspect it, and thus produce false memories. The current findings do not support this, however, because techniques to aid recall were, if anything, slightly less likely to have been used with clients who subsequently recalled CSA. Furthermore, the use of such techniques was not related to a lower rate of reported corroboration.

It is of interest that the only other factor that we found to be related to reported corroboration was having confronted or broken contact with the supposed perpetrator in cases where reported memories involved abuse or maltreatment. Finding corroborative evidence may have led clients to have more confidence that abuse occurred and prompted confrontation and/or a decision to break contact. However, it is also possible that confrontation increased the likelihood of confirmation from someone else. Further investigation is needed to determine the causal direction of any link between confrontation and corroboration. It has been argued that independent documented evidence is necessary and should be sought before cases of recovered memory can be considered seriously (Pope & Hudson, 1995). Confrontation may be one way of obtaining such evidence, as suggested by the present findings. However, confrontation can also cause serious disruption of family ties (Gudjonsson, 1997).

Role of therapy in recovered memories

The results of our survey of respondents confirm our previous speculation that a

sizeable proportion of clients' recovering memories in therapy had already begun the process beforehand (Andrews *et al*, 1995). It is also noteworthy that, contrary to popular assumption, most (78%) of the clients' initial recovered memories either preceded therapy or preceded the use of memory recovery techniques used by the respondents. Techniques seemed to be used more to help the clients to elaborate the memories than to facilitate their initial recovery. This unexpectedly low rate of using techniques for the initial recovery of memories (22%) does not appear to be explained by cultural differences if account is taken of Poole *et al*'s (1995) questionnaire survey: the most commonly cited and complete source of information about the use of memory recovery techniques. The 57 British therapists who took part in that study (all BPS members) were as likely as their American counterparts to indicate that they had used at least one technique to aid recall of CSA, with an overall rate of 71%. Similarly, in two-thirds of the client cases in the present study at least one technique had been used for some purpose at some time. The lower estimate of 22% was arrived at after taking account of the stage at which it had been used (before or after first memory recovery) and the respondents' intentions when using it. The stage at which techniques were used has not been considered in detail in existing questionnaire surveys (Poole *et al*, 1995; Polusny & Follette, 1996), and Poole *et al* did not specifically exclude their use with clients who had never forgotten abuse.

Furthermore, the majority of the memory recovery techniques implicated by some theorists as 'risky' (e.g. Loftus, 1993; Lindsay & Read, 1994) are commonly used for reasons other than memory retrieval. It is possible that some respondents in these questionnaire surveys may have been checking techniques that they had used, but not specifically for memory recovery purposes. Indeed, one other survey has mentioned this as a possibility (Polusny & Follette, 1996). There is a danger that variability in the interpretation of paper-and-pencil survey items may lead to unreliable estimates of particular practices, beliefs and experiences in this relatively new and contentious area (Olio, 1996; Pope, 1997).

Methodological issues

One limitation of the present study involves the two-stage sampling procedure, and evidence for some selection bias in our sample should be noted. The interviewed therapists in the present study differed from therapists who did not identify themselves for further research from the earlier survey in having higher case-loads, having seen more clients reporting satanic abuse and having a greater belief in the accuracy of recovered memories. These differences may have biased the results in a number of ways. The influence of differences in satanic abuse cases has already been mentioned. The difference in level of belief in recovered memory may have led to an overestimation of corroboration and an underestimation of techniques used to recover memories. However, this is not at all certain, because beliefs about the occurrence of false memories did not differ between the interviewed and non-identified groups.

Another limitation was that, in common with many clinical studies, information was derived from therapists' observations of client reports, rather than directly from individuals who had recovered memories, and that the reliability of therapists' observations and memories is unknown. Nevertheless, the accounts document a range of experiences from trained psychologists in different locations using different therapeutic approaches. Furthermore, in the majority of cases, material regarding memory recovery in therapy was recorded around the time it occurred. As a further check on validity, it was reassuring that there were no significant differences in the

CLINICAL IMPLICATIONS

- An exclusive focus on child sexual abuse (CSA) in the recovered memory debate is unwarranted, given the sizeable proportion of non-CSA memories of trauma recovered in therapy.
- Popular assumptions that memories recovered in therapy are usually implausible, false and invariably produced using 'recovered memory' techniques are not borne out by the data.
- Memories recovered in therapy appear far more heterogeneous than has hitherto been suggested. There is considerable variation in what is remembered, when it is remembered and what happens after remembering.

LIMITATIONS

- The two-stage sampling procedure may have led to selection bias in therapists. Although certain sources of bias were successfully ruled out, it is difficult to know how representative respondents were of professional psychologists who encounter recovered memories in their practice.
- Information was derived from therapists' observations of client reports. However, there are no existing data to contradict the assumption that such information is as reliable as information from the clients themselves.
- Respondents were qualified practitioner members of a recognised professional society and results cannot be generalised beyond accounts given by such therapists.

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variables analysed between those using notes and those who did not. Again, although the reliability and validity of information contained in therapists' notes are unknown, at present there are no data to contradict the assumption that information from the therapists is as representative and reliable as information from the clients themselves.

As with previous surveys of therapists, those in the present study were qualified practitioner members of a recognised professional society, and the results concerning the content of the clients' memories and therapeutic involvement in their production cannot be generalised beyond the accounts given by such therapists. Examples of unqualified practitioners using risky practices abound in anecdotal accounts in the general literature in this area, and further in-depth research is required with different populations of therapists and from representative groups of individuals who claim to have recovered memories, both within and outside therapy.

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REFERENCES

Andrews, B. (1997) Can a survey of British False Memory Society members reliably inform the recovered memory debate? *Applied Cognitive Psychology*, **11**, 19–23.

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

Brandon, S., Boakes, J., Glaser, D., et al (1998) Recovered memories of childhood sexual abuse. Implications for clinical practice. *British Journal of Psychiatry*, **172**, 296–307.

Brewin, C. R. (1996) Scientific status of recovered memories. *British Journal of Psychiatry*, **169**, 131–134.

— & Andrews, B. (1998) Recovered memories of trauma: phenomenology and cognitive mechanisms. *Clinical Psychology Review*, **18**, 949–970.

Cheit, R. E. (1998) Consider this, skeptics of recovered memory. *Ethics & Behavior*, **8**, 141–160.

Feldman-Summers, S. & Pope, K. S. (1994) The experience of 'forgetting' childhood abuse: a national survey of psychologists. *Journal of Consulting and Clinical Psychology*, **62**, 636–639.

Freyd, J. J. (1996) *Betrayal Trauma: The Logic of Forgetting Childhood Abuse*. Cambridge, MA: Harvard University Press.

Gudjonsson, G. H. (1997) Accusations by adults of childhood sexual abuse: a survey of the members of the British False Memory Society. *Applied Cognitive Psychology*, **11**, 3–18.

Herman, J. L. & Harvey, M. R. (1997) Adult memories of childhood trauma: a naturalistic clinical study. *Journal of Traumatic Stress*, **10**, 557–571.

Lindsay, D. S. & Read, J. D. (1994) Psychotherapy and memories of childhood sexual abuse: a cognitive perspective. *Applied Cognitive Psychology*, **8**, 281–338.

Loftus, E. F. (1993) The reality of repressed memories. *American Psychologist*, **48**, 518–537.

Mollon, P. (1998) *Remembering Trauma. A Psychotherapist's Guide to Memory and Illusion*. Chichester: Wiley.

Olio, K. (1996) Are 25% of clinicians using potentially risky therapeutic practices? A review of the logic and methodology of the Poole, Lindsay et al. study. *Journal of Psychiatry & Law*, **24**, 277–298.

Polusny, M. & Follette, V. (1996) Remembering childhood sexual abuse: a national survey of psychologists' clinical practices, beliefs, and personal experiences. *Professional Psychology: Research and Practice*, **27**, 41–52.

Poole, D. A., Lindsay, D. S., Memon, A., et al (1995) Psychotherapy and the recovery of memories of childhood sexual abuse: U.S. and British practitioners' opinions practices and experiences. *Journal of Consulting and Clinical Psychology*, **63**, 426–437.

Pope, H. G. & Hudson, J. I. (1995) Can memories of childhood abuse be repressed? *Psychological Medicine*, **25**, 121–126.

Pope, K. (1997) Science as a careful questioning: are claims of a false memory syndrome epidemic based on empirical evidence? *American Psychologist*, **52**, 997–1006.

Schooler, J. W., Bendiksen, M. & Ambadar, Z. (1997) Taking the middle line: can we accommodate both fabricated and recovered memories of sexual abuse? In *False and Recovered Memories* (ed. M. Conway), pp. 251–292. Oxford: Oxford University Press.

Wakefield, M. A. & Underwager, R. (1992) Recovered memories of alleged sexual abuse: lawsuits against parents. *Behavioral Sciences and the Law*, **10**, 483–507.