The Poole et al. (1995) Surveys of Therapists: Misinterpretations by Both Sides of the Recovered Memories Controversy*

D. Stephen Lindsay, Ph.D.
University of Victoria

Debra A. Poole, Ph.D.
Central Michigan University

Synopsis

Olio (1996) critically reviewed an article by Poole, Lindsay, Memon, and Bull (1995) that reported surveys of clinicians' beliefs and practices regarding their clients' memories of childhood sexual abuse. Olio's article made several apt points that correctly identified limitations on the kinds of conclusions that can be drawn from the Poole et al. data, but it also made several erroneous claims. Some of these errors have been repeated in articles citing Olio by Pope (1996, 1997) and Brown (1998). In this commentary, we respond to those of Olio's criticisms with which we disagree, then briefly comment on limitations of the Poole et al. data, and then turn to a more general discussion of ways in which the Poole et al. data have sometimes been misinterpreted by both sides of the controversy regarding recovered-memory experiences.

Introduction

Olio critically reviewed Poole, Lindsay, Memon, and Bull's article reporting surveys of clinicians' beliefs and practices regarding their clients' memories of childhood sexual abuse (CSA).[1] Olio's article made several apt points that correctly identified limitations on the kinds of conclusions that can be drawn from the Poole et al. data, but it also made several erroneous claims. Some of these errors have been repeated in articles citing Olio by Pope and Brown.[2] In this commentary, we first respond to some of Olio's criticisms with which we disagree, then briefly comment on limitations of the Poole et al. data, and then turn to a more general discussion of ways in which the Poole et al. data have sometimes been misinterpreted by both sides of the controversy regarding recovered-memory experiences.

Rebuttals of Some of Olio's Critiques

The central issue Olio raised was whether or not the Poole et al. findings justified their conclusions. Contrary to Olio's criticisms, Poole et al. did not claim that all respondents who met their criteria for "memory-focused" clinicians had necessarily used dangerously suggestive approaches, nor did they claim that all recovered-memory cases reported by "memory-focused" respondents were "false memories." Quite the contrary, Poole et al. explicitly noted that their data did not indicate whether respondents who met their criteria for "memory-focused" clinicians used memory recovery techniques in single-minded and highly suggestive ways, in open-minded and highly cautious ways, or somewhere between these extremes. Poole et al. also emphasized that "Our findings do not indicate whether or not therapy-induced illusory memories contributed to the high rates of memory recovery reported by memory-focused respondents because these clinicians may have uncovered accurate memories of abuse."[3]

---

* In press, *Journal of Psychiatry & Law*. Correspondence regarding this article can be addressed to D. Stephen Lindsay, Department of Psychology, University of Victoria, PO Box 3050, Victoria, BC, V8W 3P5, Canada. Electronic mail can be sent to slindsay@uvic.ca.

Also contrary to Olio's criticisms, Poole et al. did not claim that their findings provide precise estimates of the prevalence of particular approaches to psychotherapy. Because of their modest return rates and restriction of the U.S. samples to doctoral-level clinicians listed in the National Register of Health Service Providers in Psychology (NRHSP) who reported having conducted individual therapy with 10 or more women clients in the preceding 2 years, Poole et al. did not claim that their findings were representative of U.S. psychotherapists as a whole. Rather, they noted that "Our findings are best viewed as illustrating the variability that exists among highly trained psychotherapists, rather than as definitive estimates of the proportion of all practitioners who endorse particular beliefs and practices."[4]

In another article, Lindsay and Poole wrote, "In our view there are solid grounds to fear that tens of thousands of people have developed illusory memories or false beliefs about CSA through suggestive memory recovery techniques and ancillary practices in psychotherapy, self-help, or group therapy."[5] Articles by Olio, Pope, and Brown quoted parts of this sentence and claimed that Lindsay and Poole based an estimate of the prevalence of false memories on the Poole et al. data.[6] Obviously, Lindsay and Poole were not offering a precise prevalence estimate, but rather expressing their view that there are good reasons to fear that tens of thousands of people have developed illusory memories or false beliefs through suggestive influences. Moreover, Lindsay and Poole did not base this ballpark estimate of the number of false memory cases on the Poole et al. data. As support for their view, they cited four sources.[7] Some of these sources referred to the Poole et al. surveys, along with related surveys by other researchers, but they also drew on a mass of converging evidence of different kinds that support concerns about potentially suggestive approaches to trauma-memory-oriented psychotherapy. It is also worth noting that Lindsay and Poole's statement occurred in the context of arguing that the number of victims of "false memories" is dwarfed by the vastly larger number of victims of CSA.

Olio claimed that Poole et al. sent surveys to 1,900 clinicians, of whom 1,600 were selected from the NRHSP. In fact, Poole et al. sent surveys to 900 clinicians, of whom 600 were selected from the NRHSP (the remaining 300 were selected from the British Psychological Society's Registry of Chartered Clinical Psychologists). The source of Olio's error is readily apparent: The Procedure section of Poole et al. began with a sentence saying: "For Survey 1, 300 psychotherapists were selected from the [NRHSP] . . ." Evidently, Olio misread this as "For Survey 1, 1,300 psychotherapists were selected from the [NRHSP] . . ."

In an earlier article, Pope[8] called on readers to "scrutinize the assumptions" underlying the Poole et al. research, on the grounds that (a) the findings were reported to two decimal places, (b) the results might reflect Type I errors rather than real effects, and (c) the samples were too small to be representative of the large population of therapists. In an apparent coincidence (given that neither author cited the other), Olio (1996) also offered these criticisms. A comment by Lindsay, Poole, Memon, and Bull,[9] responding to Pope, rebutted these criticisms, noting that (a) reporting to two decimal places beyond the unit of measurement is standard practice; (b) the primary import of the Poole et al. data is descriptive, not inferential, and their article explicitly noted that they deliberately chose not to adjust for the test-wise error rate for the numerous comparisons between samples yet found very few differences; and (c) representativeness is determined almost entirely by sample size rather than by proportion of the population sampled, and the Poole et al. sample sizes were adequate for their conclusions.

Olio also implied that sexist bias led Poole et al. to limit their sample to therapists who had worked with at least 10 women clients in the previous 2 years and to ask questions only about women clients. Pope repeated this insinuation.[10] As stated in the introduction to Poole et al., "The questionnaires asked about adult female clients because this group has been the primary focus of popular and professional books and articles on memory recovery."[11]

Poole et al. asked respondents to indicate if they had used any of a list of techniques during the past 2 years to help clients remember CSA. Olio indicated that the lead-in to this question was suggestive, stating that "participants were first told that other 'therapists use special techniques to help clients remember childhood abuse'."[12] As noted in a commentary by Poole, Lindsay, Memon, and Bull,[13] responding to Pope's[14] citation of this criticism, Olio's partial quotation insinuates that Poole et al. suggestively told respondents that "other" therapists use the listed techniques. In fact, the lead-in said that "some" therapists use such techniques. Olio deleted the first word of the quoted sentence, "some," and replaced it with "other."

More generally, Olio argued that the Poole et al. surveys' use of multiple-choice questions rather than free-recall questions was inherently suggestive. Pope[15] cited this criticism of Olio's as well. In their reply to Pope, Poole et al.[16] noted that properly used checklists have well-established advantages over open-ended questions in survey research (e.g., respondents are likely to be non-exhaustive when responding to free recall questions). Checklists are problematic when they bias respondents to use listed items as responses to subsequent open-ended questions. With the exception of a question asking respondents to indicate which of the listed techniques should not be used to help clients remember CSA, no subsequent question asked about memory recovery techniques. The checklist should not have influenced responses to questions about the importance of remembering abuse or the frequency of memory recovery, because those questions preceded the checklist. Second, the memory literature to which Olio alluded distinguishes between recognition probes (which are generally highly sensitive measures of memory) and suggestions (in which an authority suggests that particular events occurred in the past). Third, Olio's argument implied that clinicians are so suggestible that the mere presence of the list led them to report using techniques to help clients remember CSA that they had in fact not used. This concern indicates a great (if selective) sensitivity to the frailties of memory. Homologous checklists have been used in innumerable surveys, and we think it is telling that Olio and Pope limited their criticisms of checklists to the Poole et al. studies alone.

Later in her article, Olio likened the list of memory recovery techniques in the Poole et al. surveys to checklists of symptoms propounded to identify people with hidden histories of CSA (e.g., Fredrickson[17]). Here again, Pope[18] cited this criticism of Olio's, and the Poole et al.[19] reply to Pope rebutted it. Symptom checklists such as Frederickson's include such a hodgepodge of alleged "indicators" that the vast majority of people would likely rack up points and thereby receive a "diagnosis" of repressed memories. In contrast, the purpose of the Poole et al. checklist was to collect descriptive information about clinicians' use of techniques that have been highlighted as potentially risky in the literature.

Olio argued that there is a major difference between reporting that it is "important" or "very important that a client who was sexually abused acknowledges or remembers the abuse in order for therapy to be effective," on the one hand, and the claim in Poole et al. that 25% of

respondents indicated that they believe that recovering memories is an important part of therapy, on the other.[20] Olio's plaint is that Poole et al. asked only about clients the therapist believed had been sexually abused rather than about all clients, but surely no therapist would indicate that it is important for non-abused clients to acknowledge or remember abuse. It also bears emphasizing that the Poole et al. conclusion was not based merely on responses to the question regarding the importance of acknowledging/remembering abuse, but also on responses to questions regarding confident suspicions of abuse after a single session with a client who did not report an abuse history and reported use of two or more techniques to help clients remember abuse.

Olio also claimed that in the Poole et al. studies:

> A therapist who allows one client to keep a journal and bring in family photos as a way to decrease the anxiety and pain of the remembering process is categorized in the same group as the therapist who repeatedly coerces clients with all the listed techniques.[21]

Poole et al. did not ask about "allowing" clients to do certain things, but rather about clinicians' use of particular techniques. Furthermore, they did not ask about using techniques to decrease anxiety and pain, but rather about using them to help clients remember childhood sexual abuse. Moreover, categorization of respondents as "memory-focused" clinicians was not based solely on reported use of two or more techniques to help clients remember abuse, but also on reported beliefs regarding the importance of acknowledging/remembering abuse and reports of being "fairly certain" of non-reported abuse after a single session.

Poole et al. claimed that their data indicated that some clinicians believe they can identify clients who were sexually abused as children even when those clients deny an abuse history. Olio questioned this conclusion, writing: "However, the actual question on one of the surveys asks about instances where the 'client did not explicitly report any abuse'–not instances where the client denied an abuse history."[22] Olio also wrote:

> Clinicians indicating that sometimes they had suspected a history of abuse with a client who had not explicitly reported an abuse history (or even that they were "fairly certain" in some instances) is very different from Poole, Lindsay et al.'s claim that 25% of clinicians think they can "identify clients with hidden memories during the initial session."[23]

Olio failed to acknowledge that in Poole et al.'s Survey 1 the question asked about clients who denied a history of abuse, and that the Poole et al. conclusion was not based solely on responses to this question, but also on reported belief that acknowledging/remembering abuse is important for therapy with abuse survivors and reported use of two or more techniques to help clients remember CSA.

We reject Olio's criticisms of the Poole et al. claim that "memory-focused" respondents indicated belief that they could detect abuse in clients who denied an abuse history. We note, however, that the Poole et al. questions regarding suspicions of non-reported abuse were ambiguous in another way. Specifically, it is not clear how often "memory-focused" clinicians in Survey 1 were reporting they had been at least "fairly certain" of abuse <u>after</u> the client denied any memories of abuse. That is, some clinicians might first have been "fairly certain" that a client

was an abuse survivor, then asked the client and received a denial that they accepted as accurate. It was clear from written comments volunteered by some "memory-focused" respondents that they sometimes continued to be confident of the existence of non-remembered abuse despite clients' denials (e.g., "To deal with denied abuse—must face the event" or "For a few, denial works"). These respondents clearly indicated a belief in their ability to detect hidden abuse histories in clients who denied an abuse history (e.g., one does not know that denial "works" for a client unless one "knows" that a client who denies abuse was actually abused). Unfortunately, only some respondents chose to volunteer comments, and the Poole et al. quantitative data do not reveal whether this belief was held by all respondents who indicated that they had been at least "fairly certain" after the initial session that a client who denied abuse had really been abused.

To appreciate the range of opinions represented by the clinicians in the Poole et al. sample, one must attend to the minority of respondents who indicated belief that they can detect non-reported abuse, belief that it is important for abused clients to acknowledge or remember abuse, and use two or more techniques to help clients remember CSA. As Olio noted (and was clear in Poole et al.'s article), it is very likely that even within this minority of "memory-focused" respondents there was considerable variability in terms of the frequency and suggestiveness of memory-recovery oriented practices. One must also attend to the majority of respondents, who often volunteered comments that expressed caution and concern about memory malleability, such as "Don't push clients to remember," "Historical truth . . . is not vital and always involves some distortion," and "Some of those techniques may encourage 'remembering' things which may not have happened." It bears emphasizing that most of Poole et al.'s respondents indicated that they did not engage in highly suggestive searches for trauma memories.

Matters of Interpretation

Although many of the specific claims that Olio made regarding Poole et al. were inaccurate or misleading, there is room for debate regarding the central question she raised: Did the Poole et al. findings justify concern about the prevalence of "memory-focused" clinicians? Although Poole et al. did not claim to have demonstrated that "memory-focused" clinicians had in fact used approaches that caused their clients to develop false memories, they did argue that their findings were consistent with such concerns and that their results indicated an urgent need for research on the safety and efficacy of trauma-oriented therapies.

Olio was correct in saying that there has been no scientific experiment testing the hypothesis that the constellation of self-reported beliefs and practices that Poole et al. used to categorize respondents as "memory-focused" puts clients at substantial risk of developing illusory memories of CSA. Of course, no such experiment will ever be conducted: Above and beyond the methodological challenges inherent in such an experiment (e.g., determining that participants had not experienced CSA), such research cannot be done because testing the hypothesis that these approaches can lead individuals to develop devastating illusory memories would be grossly unethical.

Poole et al. argued that existing scientific knowledge supports concerns regarding potential risks of approaches in which the therapist believes it is important for abused clients to remember their abuse, is sometimes fairly certain after the initial session that a client who did not

report was in fact abused, and uses two or more techniques to help clients remember abuse. We stand by that argument, for which Poole et al. cited several sources of evidence. Recent articles add further insights regarding the malleability of human memory.[24] Nonetheless, Olio and others are well within the standards of scholarship to argue that some or all approaches that meet these broad criteria are risk free. In the absence of high-quality research directly assessing the safety of trauma-memory oriented therapies, individuals wishing to hold informed opinions on this issue must read the relevant research literature on memory and social influence and make their best judgments regarding the extent to which scientific evidence indicates that particular therapeutic approaches put clients at substantial risk of developing illusory memories or false beliefs.

Other Misinterpretations of Poole et al.

Authors who emphasize accurate recovered memories. As noted above, Pope (1995) presaged some of Olio's criticisms, and Pope (1996, 1997) echoed others (as did Brown, 1998).[25] As another example, in a 1996 posting to the Professional Forum for Child Abuse Issues e-mail list server, Ross E. Cheit stated that in the article by Poole et al., "A therapist could be considered 'memory focused' if they reported ever using more than one of eight 'memory recovery techniques[26].'" As noted above (and as Cheit acknowledged in a subsequent posting[27]), this is incorrect; categorization of respondents as "memory-focused" was based on a constellation of reported beliefs and practices, not solely on reported use of techniques to help clients remember CSA (58% of respondents reported using two or more techniques for this purpose). Cheit also claimed that the sampling procedure used by Poole et al. was non-random, the implication being that non-random sampling led to non-representative findings. To sample for the first study, Poole et al. haphazardly entered the NRHSP and sampled every 54th name, with the constraint that each individual selected hold a doctoral degree and reside in the United States (a similar procedure was used for the U.S. sample for Survey 2, with the added constraint that individuals sampled in Survey 1 be excluded). Although each selection was not entirely independent of prior selections, we invite the reader to identify how this procedure could have resulted in any systematic bias.

Authors who emphasize false recovered memories. Some critics of memory-recovery work in psychotherapy have also mischaracterized the findings reported by Poole et al. or have gone far beyond the data without making this sufficiently clear. For example, Crews[28] indicated that 25% of the Poole et al. respondents "admitted" that they "place emphasis on recovering memories of abuse [and] that they have sometimes overridden their clients' denials." This claim goes far beyond the Poole et al. data. Some might argue that the criteria for memory-focused clinicians were sufficiently stringent to justify Crews's claim that such respondents "place emphasis on recovering memories of abuse," but others might reasonably question this interpretation, and nothing in the Poole et al. data justifies the conclusion that this subset of respondents "overrode" their clients' denials (some may have done so, but the data do not speak to that issue because they do not indicate whether or how often memory techniques were used with clients who initially denied an abuse history, let alone whether or not or how often this was done in ways that might properly be characterized as "overriding" clients' denials).

Pendergrast[29] used the Poole et al. finding that 25% of respondents met their criteria for "memory-focused" clinicians, together with Baker's[30] estimate that there are 256,000 licensed

therapists in the US, to arrive at an estimate of approximately 62,500 "hard-core, memory-focused" therapists (referred to, in the first edition of Pendergrast's book, as "True Believers"). Although one might wish that the Poole et al. (1995) surveys provided a basis for such prevalence estimates, the fact is that they do not. The problem is not just the restricted samples and modest return rates, nor is it only Poole et al.'s reliance on retrospective self-report (although these are important considerations when evaluating the validity and reliability of the findings). The central problem is that Poole et al. did not ask the kinds of questions that would provide a basis for estimating the prevalence of prolonged, multifaceted, highly suggestive searches for suspected hidden memories (i.e., searches of the sort Pendergrast described as "hard-core"). It is clear from other evidence (e.g., comments volunteered by some "memory-focused" respondents in Poole et al.'s samples; therapy notes released in court cases) that some clinicians have taken such approaches but, as Poole et al. clearly noted, their criteria for "memory-focused" practitioners were too broad to limit this subgroup only to those who used "hard-core," highly suggestive approaches to memory-recovery work.

Pendergrast also used the Poole et al. findings to estimate the prevalence of recovered-memory cases in the U.S. He began with the findings that 25% of respondents were classified as "memory-focused" and that this subgroup reported working with an average of 50 women clients per year. Next, using the finding that this subgroup of respondents reported, on average, that 34% of their clients who did not initially report any CSA eventually came to remember such abuse, Pendergrast arrived at an estimate of more than 1 million cases of recovered memories each year (62,500 memory-focused therapists x 50 clients x 34% who recover memories). Pendergrast appeared to imply that all such cases would be iatrogenic illusory memories, which is not necessarily the case. Moreover, there is a logical error in the math: The 34% figure was not the percentage of the total number of women clients (M = 50) but rather the percentage of the subset of women clients who did not initially report CSA. The Poole et al. data were not collected with the aim of estimating the prevalence of iatrogenic illusory memories of CSA, and they are insufficient as a basis for such an estimate.

Conclusions

The article by Poole et al. has sometimes been misinterpreted by professionals on both sides of the controversy regarding memory-recovery work and recovered-memory experiences. The foregoing is only a sample of such cases, but it is sufficient to reveal a pattern: Some critics of memory-recovery work have exaggerated the extent to which the Poole et al. findings indicated high rates of potentially risky therapies and false memories, whereas some counter-critics have ridiculed and dismissed those same findings.[**]

The value of the Poole et al. surveys is that they documented that doctoral-level psychotherapists in 1993 reported a wide range of opinions and practices regarding clients' memories of CSA, and that a non-trivial minority of such clinicians reported a constellation of beliefs and practices that many psychologists consider potentially suggestive. The primary

[**] Ironically, we have been told that some trauma-oriented clinicians have used the Poole et al. (1995) data in legal defenses as evidence that use of "memory-focused" approaches to therapy was an accepted community standard in the early 1990s.

conclusion Poole et al. drew from these findings was that further research is needed to assess the safety and efficacy of such approaches. That conclusion still stands.

Despite our criticisms of the ways Olio misinterpreted the measures, findings, and conclusions of Poole et al., we wish to emphasize that we are sympathetic with some of what we take to be her underlying concerns. For example, we agree that the Poole et al. data have sometimes been misused in ways that exaggerate their implications for the prevalence of potentially risky therapies and false memories. We also share the concern that such exaggerated claims may undermine support for genuine victims of abuse.

We are also sympathetic with concerns articulated by critics of potentially suggestive forms of memory-recovery work. In our view, there are compelling reasons to believe that in the last decade substantial numbers of clients and families have been grievously harmed by well-intended but suggestive forms of memory-recovery work. There is no contradiction between being concerned about victims of CSA, on the one hand, and being concerned about victims of suggestive therapies, on the other. Indeed, it is having an exclusive focus on one of these concerns at the expense of the other that is problematic. Happily, there appears to be a growing consensus regarding the validity of concerns on both sides of the controversy about recovered-memory experiences. Collaborative efforts involving psychologists with a variety of perspectives hold the promise of yielding new scientific knowledge that will simultaneously improve support for victims of abuse and lower the risk of iatrogenic illusory memories.[31]

Endnotes

1. K. A. Olio, “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 and Law, 24 (1996): 277; D. A. Poole, D. S. Lindsay, A. Memon, & R. Bull, “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 (1995): 426.

2. K. S. Pope, “Memory, abuse, and science: Questioning claims about the False Memory Syndrome epidemic.” American Psychologist, 51 (1996): 957; K. S. Pope, “Science as careful questioning: Are claims of a false memory syndrome epidemic based on empirical evidence?” American Psychologist, 52 (1997): 997; L. S. Brown, “Sacred space, not sacred cows, or it’s never fun being prophetic.” American Psychologist, 53 (1998): 488.

3. Poole et al. (1995), supra note 1, page 434.

4. Poole et al. (1995), supra note 1, page 434.

5. D. S. Lindsay & D. A. Poole, “Remembering childhood sexual abuse in therapy: Psychotherapists' self-reported beliefs, practices, and experiences.” The Journal of Psychiatry and Law, Fall, (1995): 461 (page 464).

6. Olio (1996), supra note 1. Pope (1997) and Brown (1998), supra note 2.

7. D. S. Lindsay & J. D. Read, "'Memory work' and recovered memories of childhood sexual abuse: Scientific evidence and public, professional, and personal issues." Psychology, Public Policy, and the Law, 1 (1995): 846; E. F. Loftus & K. Ketcham, The Myth of Repressed Memory (New York: St. Martin's Press, 1994); M. Pendergrast, Victims of Memory: Incest Accusations and Shattered lives (Hinesburg, VT: Upper Access, 1995); J. D. Read & D. S. Lindsay, "Moving toward a middle ground on the 'false memory debate:' Reply to commentaries on Lindsay and Read." Applied Cognitive Psychology, 8 (1994): 407.

8. K. S. Pope, "What psychologists better know about recovered memories, research, law suits, and the pivotal experiment." Clinical Psychology: Science and Practice, 2 (1995): 304.

9. D. S. Lindsay, D. A. Poole, A. Memon, & R. Bull, "Rejoinder to Pope's (1995) comments regarding Poole, Lindsay, Memon, and Bull (1995)." Clinical Psychology: Science and Practice, 3 (1996): 363.

10. Pope (1996), supra note 2.

11. Poole et al. (1995), supra note 1, page 427.

12. Olio (1996), supra note 1, page 283, quoting from Poole et al. (1995), note 1, page 430.

13. D. A. Poole, D. S. Lindsay, A. Memon, & R. Bull, "Did Pope (1996) read a different Poole, Lindsay, Memon, and Bull (1995)?" American Psychologist, 52 (1997): 990.

14. Pope (1996), supra note 2.

15. Pope (1996), supra note 2.

16. Poole et al. (1997), supra note13.

17. R. Frederickson, Repressed Memories: A Journey to Recovery from Sexual Abuse (New York: Simon and Schuster, 1992).

18. Pope (1996), supra note 2.

19. Poole et al. (1997), supra note 13.

20. Olio (1996), supra note 1, page 286.

21. Olio (1996), supra note 1, page 289.

22. Olio (1996), supra note 1, pages 286-287.

23. Olio (1996), supra note 1, page 287.

24. M. Garry, C. Manning, E. F. Loftus, & S. J. Sherman, "Imagination inflation." Psychonomic Bulletin and Review, 3 (1996): 208; I. E. Hyman, Jr., & F. J. Billings, "Individual difference and

the creation of false childhood memories." Memory, 6 (1998): 1; I. E. Hyman, Jr., & J. Pentland, "The role of imagery in the creation of false childhood memories." Journal of Memory and Language, 35 (1996): 101; G. A. L. Mazzoni & E. F. Loftus, "When dreams become reality." Consciousness and Cognition, 5 (1996): 442; K. Pezdek, K. Finger, & D. Hedge, "Planting false childhood memories: The role of event plausibility." Psychological Science, 8 (1997): 437; H. L. Roediger III, J. D. Jacoby, & K. B. McDermott, "Misinformation effects in recall: Creating false memories through repeated retrieval." Journal of Memory and Language, 35 (1996): 300; M. S. Zaragoza & K. J. Mitchell, "Repeated exposure to suggestion and the creation of false memories. Psychological Science, 7 (1996): 294.

25. Pope (1995), supra note 8. Pope (1996, 1997) and Brown (1998), supra note 2.

26. R. E. Cheit, electronic posting to the Professional Forum for Child Abuse Issues listserver, ABUSE-L@UBVM.CC.BUFFALO.EDU, 10 January 1996, subject: "The Mythical Million Cases." Cheit's comments were subsequently cross-posted by David H. Gleaves to the Dissociative Disorders list-server, DISSOCIATIVE-DISORDERS@SJUVM.STJOHNS.EDU subject: "The Mythical Million Cases."

27. R. E. Cheit, posting to the Professional Forum for Child Abuse Issues, ABUSE-L@UBVM.CC.BUFFALO.EDU, 17 January 1996, subject: "A Clarification."

28. F. Crews, The Memory Wars: Freud's Legacy in Dispute (New York: New York Review of Books, 1995, page 245).

29. M. Pendergrast, Victims of Memory: Incest Accusations and Shattered Lives (Hinesburg, VT: Upper Access, 1996, 2nd ed.).

30. B. Baker, "The changing face of social work." Common Boundary, Jan/Feb (1994).

31. D. S. Lindsay & J. Briere, "The controversy regarding recovered memories of childhood sexual abuse: Pitfalls, bridges, and future directions." Journal of Interpersonal Violence, 12 (1997): 631; J. D. Read & D. S. Lindsay (Eds.), Recollections of Trauma: Scientific Evidence and Clinical Practice (New York: Plenum, 1997).