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THE
RECOVERED MEMORY DEBATE:
THE PRESS'S COVERAGE AND THE IMPACT ON SURVIVORS

by

CAROLYN B. ALLARD, B.A

A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfilment
of the requirements for the degree of

Master of Arts

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Abstract

For the past several years a controversy surrounding the validity of adults' recovered memories of child abuse has arisen in the wake of the newly coined, nosologically unrecognized, 'false memory syndrome' (FMS). The current study is concerned with the press coverage of this controversy and the impact of the debate on female survivors of child sexual abuse. Articles about the FMS debate were collected from 6 major Canadian newspapers between January 1992 and January 1994 (N = 66), and content analyzed. To the extent that society regards journalists' articles as being more reliable than readers' opinions, and associates more authority, reliability, and credibility with men than women, evidence of a pro-FMS bias was found. A survey completed by 112 female survivors of child sexual abuse (M age = 34.2 years) indicated that on the whole, survivors were only mildly adversely affected by the recovered memory debate, as indicated by measures of their revictimization, confidence in memories for the abuse, the therapy experience, and their recovery process. When various potential moderating factors were considered, such as the amount of exposure to the debate, the extent of their memory loss for the abuse, and especially the stage of their recovery, the adverse effects of the debate became more apparent. The implications of the findings for members of the media, mental health practitioners, and society at large, are discussed.

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I dedicate this work to all those who are, or have been exposed to abuse, and all who are working towards its eradication.

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The Recovered Memory Debate:

The Press's Coverage and the Impact on Survivors

During the last five years or so, criminal and civil court proceedings for childhood sexual abuse cases have included the testimony of adults who say they have recovered their memories of being sexually abused as children (Loftus & Rosenwald, 1993; Shorten, 1994). The inclusion of this testimony was a new form of evidence, one facilitated by the extension of the Statute of Limitations to several years after abuse is remembered and/or after it is understood there was damage done by the abuse (Wakefield & Underwager, 1992).

In 1992, the 'False Memory Syndrome' (FMS) Foundation was founded by a couple whose adult daughter confronted them with her recently recovered memories of abuse by her father (Freyd, 1993). They banded together with other parents who claimed to be in the same situation, as well as with professionals in such areas as memory (e.g., Dr. Elizabeth Loftus) and psychiatry (e.g., Dr. Harold Lief). The aim of the FMS Foundation is to support the alleged innocence of their supposed 15,000 members¹ (FMS Foundation, 1995) by challenging the veracity of recovered memories. While the validity of memories of childhood sexual abuse, especially those recovered after a lengthy period of amnesia for the abuse, is being seriously challenged by some

¹ This membership count is inaccurate, however. As founding member Peter Freyd (personal communication, April 16, 1995) admitted, "the FMS Foundation has been contacted by 16,000 families. About 25%, close to 4000, of those families make some contribution to the Foundation. At least 2500 have enrolled as full-time members".

people, it is also being strongly defended by others, especially survivors and those who work with them (e.g., therapists, lawyers). As a result, what is referred to as "the recovered memory debate" has become a popular and controversial topic in the media, the courts, counselling offices, and the research literature.

The last decade or so has seen an increase in society's general awareness and willingness to try to address the problem of child abuse. An increasing number of people, mostly women, have come forward with their stories of abuse, hoping that society will come to realize the frequency and impact of childhood sexual abuse. Large scale survey studies have found that approximately one in three to one in four women have been sexually abused before the age of 18 (e.g., Bagley & Ramsay, 1985; Russell, 1986). The varied symptomatology associated with child sexual abuse has also been well documented and includes severe depression, difficulties in interpersonal functioning, avoidance behaviours such as dissociation or substance abuse, sexual dysfunction, and longterm physical effects ranging from hyperarousal to chronic pelvic pain (e.g., Courtois, 1988; Finkelhor & Browne, 1985; Fry, 1993; Herman & Schatzow, 1987). As argued by many, however, a new wave of suppression has garnered from all corners of society, as has been witnessed in the past many times (e.g., Herman, 1992; Olafson, Corwin, & Summit 1993). The current backlash against survivors is evidenced in many ways, including challenges to the incidence of child sexual abuse (e.g., Lief, 1993; Lindsay &

Read, 1994) and appeals to the newly formulated diagnosis called "FMS" to dismiss the validity of recovered memories of childhood sexual abuse.

The term "FMS" was coined by the foundation of the same name; it is not a medically or scientifically established or recognized syndrome in that a set of specified signs and symptoms has never been established or tested in clinical trials (Calof, 1993). Nonetheless, this theoretical 'syndrome' has been described as "a condition in which a person's identity and interpersonal relationships are centered around a memory of traumatic experience which is objectively false but in which the person strongly believes" (Kihlstrom, 1992, cited in FMS Foundation, n.d.), often resulting from "a disastrous 'therapeutic' program" (FMS Foundation, n.d.). This condition is advanced to provide an alternative explanation for a person's accounts of supposedly recovered memories of child sexual abuse.

On the other side of the debate lies a group of people, mainly researchers and clinicians who work with survivors, who support the validity of recovered memories of child abuse. Proponents of recovered memories (e.g., Bass & Davis, 1994; Herman & Harvey, 1993; van der Kolk, 1994) assert that research findings, including neurobiological studies of memory, speak to both the validity of recovered memories and the prevalence of forgetting among survivors of trauma. Furthermore, it has been suggested that FMS "is a thinly veiled backlash against the rights and well-being of women and children. It is a way to deny the reality of child abuse, just as Freud did 100 years ago"

(Recovered Memory Task Group, 1994).

It is not yet possible to prove unequivocally that people can experience longterm amnesia for their experience of abuse and then recover accurate memories. It is also not possible to prove unequivocally that false memories of abuse can be created. The perfect empirical study would involve randomly assigning babies to be raised in abusive or nonabusive families, and then observing the children's mental and physical health, as well as their memory processes, over time. Such research would not only be unquestionably unethical, it would be impossible for a number of practical reasons. For one, there would be no way to ensure that the children in the nonabusive group were not abused. Moreover, the problem of measuring memory through an individual's self-report would remain. Similarly, it would be unethical and impossible to attempt to implant false memories of childhood abuse in a random sample of adults². As a result, researchers are limited to anecdotal, correlational, and quasi-experimental designs to examine the relation between childhood trauma and memory.

The two sides of the debate are not mutually exclusive, however. It is possible, for example, that some people are recovering true memories of abuse while others are recovering false memories. More accurately, it is the *likelihood* that a recovered memory is true and the factors affecting this

² Spanos, Menary, Gabora, DuBreuil, and Dewhirst (1991) claim to have evaded this ethical problem by using a hypnotic past-life regression procedure. A discussion of the results of this study is forthcoming.

likelihood, that are being debated (Belicki, Correy, Boucock, Cuddy, & Dunlop, 1995; Kristiansen, 1994). For example, one FMS proponent (Lief, 1993) claimed that about 25% of recovered memories of childhood sexual abuse are likely to be false, although he was unable to explain the basis of his claim. Advocates for the validity of recovered memories, however, argue that at most 5% are likely to be false, an estimate based on the percentage of allegations of other major crimes assumed to be false (Straton, 1994) and the percent of children's allegations known to be false (Everson & Boat, 1989). Nevertheless, people act as though they take one position or the other, and because the research has yet to be conclusive, the position that they take must necessarily be mostly sociopolitically motivated rather than solely based on scientific factors (Kristiansen, Gareau, & DeCourville, 1994). This is supported by other reviews of the literature (e.g., Enns, McNeilly, Corkery & Gilbert 1995), and research on attitudes and beliefs associated with FMS, which will be discussed shortly (see Kristiansen, Gareau, Mittleholt, DeCourville, & Hovdestad, 1995). This debate, then, is not really a debate in the traditional, dichotomous sense, in that the parties on either side are not disinterested. Rather, it is often a heated, emotionally laden discourse very much imbedded within a larger social and political context. In the following sections, an attempt will be made to distinguish the scientific debate from the political one.

The Scientific Debate

Because the scientific debate is not the central concern of the current

study, the following review will be brief. More extensive and thorough reviews are presented elsewhere (e.g., Enns et al., 1995; Kristiansen, 1994).

The FMS perspective. Proponents of FMS concentrate on several concerns, including the malleability of memory, suggestibility, and the power and use of hypnosis in memory retrieval efforts. In regard to the malleability of memory, they argue that memory is not like a 'video tape recorder' (e.g., Loftus, 1993; Loftus & Hoffman, 1989). Rather, memory should be viewed as an active process that is constantly reconstructed by the current schemata used to process incoming information. Research in this area (e.g., Christianson & Loftus, 1987, 1991; Loftus & Hoffman, 1989) reveals that memory for the peripheral details of an emotional event (e.g., scenes of a boy getting hit by a car on the way to school) can be easily manipulated by suggestion. It also reveals, however, that memory for the essence or central details of an emotional event is more robust and durable than memory for the essence of a neutral event (e.g., scenes of a boy going to school). Oddly, FMS advocates often use such findings to support their claim that memory is unreliable (Yapko, 1993), seemingly overlooking the fact that memory recall for the essence of the emotion-evoking events was better than for the essence of the neutral events. These findings are also used to argue that people do not easily forget traumatic events, which is one of the primary reasons why recovered memories are often treated with suspicion (e.g., Loftus, 1993).

Typically, the research pertaining to the power of suggestion in memory

re-construction (e.g., Loftus, Feldman, & Dashiell, in press; Hyman, Husband, & Billings, in press) consists of participants being given false suggestions about events in their past by researchers or family members, such as being lost in a shopping mall at the age of 5 years. These studies revealed that while some of the participants (about 10%) came up with a specific elaborated memory of what had been suggested to them, and after repeated questioning 15% reported having a sense that the event occurred, while the majority (about 75%) did not develop a false memory.

FMS proponents are also greatly concerned with therapists using 'memory inducing' methods, such as hypnosis. Studies attesting to the suggestibility of people under hypnosis (e.g., Laurence & Perry, 1983) have generally revealed that hypnotic suggestions of neutral events (e.g., being woken by a loud bang in the middle of the night) were accepted by about half of the highly hypnotizable study participants.

There are several limitations to the applicability of these types of research to memories of child sexual abuse. Most fundamentally, the scenes and events used in these studies can hardly be termed traumatic or equated with experiences of child sexual abuse so that the findings of such research may not generalize to memories of childhood abuse. As Olio (1994, p. 442) noted, "research conclusions are not applicable to phenomena and subject populations different from the ones originally studied." As will be discussed shortly, the distinction between the memory of different types of experiences

and even different types of trauma is an important one. Further, it is conceivable that many people could relate to having heard a loud bang in the middle of the night, or even having been lost as a child, and would therefore regard such an event as plausible. This plausibility is no doubt enhanced when the event is described by a trusted relative.

One study (Spanos et al., 1991) attempted to overcome this generalizability obstacle by using past-life regression methods. After telling 14 moderately to highly hypnotizable students that child abuse was more prevalent and severe in past times, 11 reported a past-life identity and higher levels of abuse than a group of students who were not provided with abuse frequency expectations. The abuse reported for the most part consisted of nothing more severe than spankings, however, and it was not reported whether the participants still believed they were abused in a past life post hypnosis. Moreover, like other hypnosis studies, these findings are limited to people who are at least moderately hypnotizable.

Finally, it is a questionable assumption that a substantial number of therapists both use suggestion-inducing methods such as hypnosis with their clients *and* suggest to clients that they were sexually abused. One study (Yapko, 1994), in which 90% of 869 participants were recruited from psychotherapy conventions including that of the American Society of Clinical Hypnosis (ASCH), reported that 53% of respondents used hypnosis in their work. It was not assessed whether these therapists used hypnosis in

conjunction with suggestions of abuse. Other than such studies which employ potentially biased recruitment practices, only a few anecdotal cases (Loftus & Herzog, 1991, cited in Loftus, 1993) are used to support the above assumption.

The recovered memory perspective. The research used to support the veracity of recovered memories includes studies of, among other things, the incidence of amnesia for child abuse, the corroboration for recovered memories of abuse, and the psychobiological mechanisms of traumatic memory. As Kristiansen (1994) noted, the majority of research suggests that approximately 50% of people reporting sexual abuse during childhood claim to have had full or partial amnesia for the abuse at some point in their lives (e.g., Belicki et al., 1995; Briere & Conte, 1993; Herman & Schatzow, 1987).

In regard to corroboration, two studies report that 60-83% of their samples of adult survivors of child sexual abuse who attempted to get corroborating evidence for their memories of abuse were able to do so (Belicki et al., 1995; Herman & Schatzow, 1987). The ability to obtain corroboration was independent of the degree of these women's amnesia (Herman, 1993).

The shortcomings of retrospective self-reports are an understandable criticism of these studies (Briere, 1992). In an effort to avoid this concern, Williams (1994) conducted a prospective study of 129 women who had been treated in a hospital emergency ward for sexual abuse approximately 20 years earlier. When interviewed, thirty-eight percent of these women did not report

this abuse experience, even though many of them reported other very personal experiences, including sexual assaults by other perpetrators

Finally, proponents of the validity of recovered memories argue that different types of experiences and even different types of traumas have different effects on memory, a finding observed by many clinical researchers (e.g., Goodwin, 1990; Herman, 1992; Terr, 1991; van der Kolk, 1987, 1994). Terr (1991) for example, reported that memories of Type I trauma, which consists of a single traumatic blow, were much like typical, everyday memories. Memories for Type II trauma, which involves longstanding repeated exposure to extreme events, on the other hand, were retained in parts rather than clear wholes, and could be lost over a period of years (see also Briere & Conte, 1993; Herman & Schatzow, 1987). Cases of childhood sexual abuse typically fall within this latter type of trauma (Terr, 1991). Research with animals (e.g., van der Kolk, 1994) suggests that the neurophysiological mechanisms involved in the encoding of memory for traumatic events differ from those involved in the encoding of normal everyday experiences. Whereas normal everyday experiences are processed by the explicit memory system, which involves conscious awareness, repeated traumatic events, such as child abuse, are processed by the implicit memory system, which lacks conscious awareness (e.g., Kihlstrom & Hoyt, 1990; van der Kolk, 1994). Unlike explicit 'normal' memories, implicit memories are processed in sensorimotor or iconic forms such as images or sensations rather than in symbolic or language form.

Thus, the results of studies concentrating on the malleability of everyday explicit memory do not necessarily generalize to the processes associated with the implicit sensorimotor memories of trauma.

In sum, the available research is by no means definitive. As Kristiansen et al. (1994) and others (e.g., Ofshe & Watters, 1993; Olio & Cornell, 1993; Terr, 1994) have argued, the present clinical research lacks internal validity in that it consists mostly of retrospective self-reports or anecdotal evidence, and the experimental research lacks external validity because the events studied by experimentalists are in many ways not comparable to actual experiences of child sexual abuse. Therefore, the recovered memory debate may be largely a sociopolitical issue.

The Sociopolitical Debate

The FMS perspective. On the one side, you have people who want to defend and prevent parents from being falsely 'accused'.³ Indeed, expert witness and former FMS Foundation advisory board member, Ralph Underwager (1985, p.14) stated, "it is more desirable that a *thousand* [emphasis added] children in abuse situations are not discovered than it is for one innocent person to be convicted wrongly." Given that perpetrators often abuse more than one child (Bass & Davis, 1994), the number of children that may be sacrificed for the protection of one possible innocent is daunting. This

³ It should be noted here that the vast majority of people who recover memories of child sexual abuse do not bring their alleged abusers to court (e.g., Courtois, 1988; Herman, 1992). Rather, their primary concern is to work on their problems by dealing with and validating their experiences of abuse

trade off nonetheless seems more than acceptable to some.

The FMS Foundation and its supporters claim they are attempting to restore order in a society turned upside down by the 'victim epidemic' (e.g., Underwager, cited in Wasserman, 1992). In order to achieve this goal, the FMS Foundation advances a variety of arguments. They suggest that overzealous therapists may be creating memories of abuse in their clients, for such reasons as assuring a long recovery process which would include many (paid) sessions of therapy, or simply because therapists have erroneous beliefs (e.g., Calof, 1993; Lief, 1993). They claim that alleged survivors sometimes turn to childhood sexual abuse as an easy excuse for their current problems in life (e.g., Freyd, 1991; Yapko, 1993). While they assure people that they do not doubt the existence of child sexual abuse, FMS advocates often underestimate the prevalence of abuse by neglecting to consider more stable estimates based on large scale epidemiological studies (e.g., Bagley & Ramsay, 1985; Finkelhor, 1984; Russell, 1986), and arguing that the statistical estimates of its prevalence are so varied that they are practically worthless (e.g., Freyd, 1991; Lief, 1993). Lindsay and Read (1994) suggest that most studies overestimate the prevalence of sexual victimization as a result of their broad definitions of sexual abuse. They purport that because noncontact sexual abuse does not appear to have long lasting negative effects on people, such abuse should not be included in prevalence rates of child sexual abuse. Furthermore, Lindsay and Read (1994) and other FMS advocates (e.g., Ofshe

& Watters, 1993) claim that there is little or no evidence for the idea that childhood trauma, including child sexual abuse, causes mental distress. Accordingly, Gardner (1991) argued that there were many women who have had sexual encounters with their fathers that did not affect their lives detrimentally.

The recovered memory perspective. The recovered memory movement, in contrast, regards the efforts of the FMS Foundation and its supporters as an attempt to maintain the current social patriarchal order and suppress awareness of the sexual abuse of children, just as Freud did when he recanted his seduction theory of hysteria (Herman & Harvey, 1993; Olafson et al., 1993; Recovered Memory Task Group, 1994). The evidence of a backlash against survivors is strong (see Enns et al., 1995, for a review). Indeed, as more victims try to hold their abuser accountable, it is natural to expect a backlash from the abusers (Herman & Harvey, 1993). The backlash membership, however, is not limited to people who are directly involved in abuse allegations. The recovered memory movement suggests that we, as a society, may choose to reject our knowledge of child sexual abuse as a mechanism of survival, preferring to live in a nice world where these terrible things do not happen, and to believe that we are not the type of people who do these sorts of things (Bass & Davis, 1994; Herman, 1992; Olafson et al., 1993; Wylie, 1993). Even if many people were willing to take the first steps to awareness, however, the backlash might be perpetuated simply because full

realization of the prevalence and impact of childhood sexual abuse would necessitate costly preventive and therapeutic interventions (Olafson et al., 1993). This realization has evidently not been made; even though many studies have consistently revealed that an astounding proportion of the population have been abused during childhood (e.g., Bagley & Ramsay, 1985; Russell, 1986), funds allocated to child protective services and anti-abuse research do not reflect the importance of this problem (Olafson et al., 1993).

More importantly, the image of family and society as we know it is crumbling in the wake of its victims' stories. As one critic of recovered memories argues, books such as *The Courage to Heal* (Bass & Davis, 1988), a self-help book for people who have experienced child sexual abuse, "turns the basis of Western civilization on its ear" (Underwager, cited in Wasserman, 1992, p. 18). When incest survivors speak, they not only challenge the patriarchal belief that the family is a safe and harmonious unit, they also challenge political, economic, and social power structures because the accused frequently belongs to them (Wasserman, 1992). For one, the majority of reported abusers are male, while the majority of reported victims are female (e.g., Russell, 1986; Walker, 1989). "If her word is taken over his, then, it is being given more value than his. In effect, she gains power and he loses it" (Wasserman, 1992, p. 18). Thus, the attempt to discredit survivors' stories (e.g., by the FMS Foundation) can, at least in part, be viewed as an effort to preserve existing patriarchal power structures that serve the needs of men and

maintain the status quo at the expense of women, children, and social development. Furthermore, fundamental structures of thought are at stake when the roles that sexual coercion and violence play in shaping cultural and personal identity are considered (Olafson et al., 1993). For example, the traditional medical notion that mental illness results from personal, biological deficiency rather than social dysfunction and violence, is undermined.

The Backlash Hypothesis

Several investigators have argued that the backlash against survivors exists not because child sexual abuse is peripheral to major social interests, but because it is so central to social interests that we as a society have chosen to ignore rather than change it (e.g., Olafson et al., 1993). The FMS movement, as a form of backlash against survivors, is designed to shift the focus of energy and attention away from the central problem, that of child sexual abuse (Cronin, 1994), toward safer issues such as overzealous, incompetent therapists (Courtois, 1988). Indeed, little progress has been made in identifying and treating abusive parents and preventing abuse (Flicker, 1993).

Ironically, questioning the validity of memories is the same tactic Freud used at the beginning of the century to protect his clients' parents - some powerful in his community, some neighbours -- and to safeguard his own social and scientific standing, as well as his father's, in an anti-Semitic era (Masson, 1984). According to his personal correspondence it appears that Freud himself

had memories of being abused by his father and that he was afraid he might abuse his own daughter (Masson, 1984). Others contributed to the suppression of childhood sexual abuse by thwarting the publication of work by people who suggested a connection between childhood traumas and adult psychological problems (e.g., Ferenczi's (1955) *Confusion of Tongues Between Adults and the Child*; Olafson et al., 1993). In fact, a historical review of studies by physicians and government investigators, exposés by reformers, accounts by victims, family members and perpetrators, court records, and popular folklore has revealed repetitive cycles of awareness and suppression of child sexual abuse (Olafson et al., 1993). It seems that the prevalence of sexual abuse of children more than a century ago was very similar to that of today. Since then, it has repeatedly surfaced and resurfaced into public and professional awareness, only to be suppressed and resuppressed by the waves of negative reaction it elicited (Herman, 1992; Olafson et al., 1993). The historical review also revealed many erroneous beliefs about child sexual abuse that are still prominent today, such as its relationship with lower socioeconomic class, a tendency to blame the victims, using unbelievability as a rationale for discounting survivors' stories, and the stereotype of the perpetrator as an abnormal, evil stranger rather than a cherished family member. These beliefs no doubt facilitated the social denial of abuse.

This backlash against survivors is no doubt part of the more general backlash against women's fight for equality, as outlined by Faludi (1991). For

the most part, sexual abuse is an issue being addressed by women. This is in part due to the fact that the majority of reported survivors are female, and that violence is the epitome of the feminist critique of society that draws attention to the unequal power and control that certain people have and exert over others in our society. As Walker (1989) explained, even though women sometimes abuse other women, children, and men, the underbelly of interpersonal violence is the socialized androcentric need for power.

Indeed, the backlashes against women and survivors have long been understood as being one in the same. In this regard, Firestone (1972, cited in Dworkin, 1974, p. 190) proposed that,

the special tie women have with children is recognized by everyone. I submit, however, that the nature of this bond is no more than shared oppression. And that moreover this oppression is intertwined and mutually reinforcing in such complex ways that we will be unable to speak of the liberation of women without also discussing the liberation of children.

Olio and Cornell (1993) have pointed out that, in the past and currently, in both professional and public arenas the character of female victims has been routinely questioned and their credibility disparaged. Such practices do not appear to have been or to be currently used to the same extent when the victim is male (e.g., in the Reverend Porter case in the U.S.A). In the late 1800s and early 1900s jail terms were longer for petty theft and assaults on boys than for sexual assaults on girls (Olafson et al., 1993). More beds were provided for women during the century's asylum-building boom, while medical science connected insanity with sexual misbehaviour, rather than sexual

victimization (Olafson et al., 1993). More recently, Herman and Schatzow (1987) noted that many of the survivors of child sexual abuse in their study would have earned a DSM-III personality disorder diagnosis, the most common being histrionic, had they been officially diagnosed.

Olafson and colleagues (1993) suggested that the emergent social and medical sciences of the late Victorian era unwittingly incorporated self-serving prejudices into their explanatory models to define categories such as class, race, gender, and normal sexuality. Scientists convinced themselves and the public of these 'scientific' definitions, so that the masculine valorization of the gender battles of the time survived into the 20th century, disguised as science. Indeed, conceptualizing the sexual abuse of children in gender-neutral terms, as family systems theorists and others have done, may have facilitated its inclusion in child protective legislation (Olafson et al., 1993). But now, in psychology and psychotherapy, the women's movement has opened the Pandora's box, and like Pandora and Eve, women are being blamed for the evils they have exposed (Cronin, 1994).

Supportive of this backlash hypothesis, Kristiansen et al. (1994) found that authoritarian university students with less positive attitudes toward women's equality were more likely to believe in FMS, required more stringent legal evidence to support charges of abuse, and had more erroneous incest beliefs. Interestingly, although the FMS Foundation and its proponents march under the banner of family security and law and order (FMS Foundation,

1993), the value of 'law and order' was unrelated to students' beliefs, and students who assigned more priority to 'family security' were less, rather than more likely to endorse FMS. These results, which were subsequently replicated with a sample of community adults (Kristiansen et al., 1995), are in accord with Faludi's (1991) contention that the New Right rhetorically appeals to traditional 'family' values to justify their opposition to women's programs, an opposition that really rests on their opposition to women's equality. This strategy helps them draw broad public support for a movement that is really concerned with maintaining "every man's right to rule supreme at home" (Faludi, 1991, p. 238).

Herman and Harvey (1993) and others (e.g., Flicker, 1993; Olio & Cornell, 1993) suggested that the notions propagated by the backlash movement are easily accepted because they appeal to common prejudices. For example, Herman and Harvey (1993) stated that the ability of therapists to implant scenarios of horror in the minds of their clients is believable because it resonates with popular fears of manipulation by powerful therapists and with popular stereotypes of women as irrational, suggestive, or vengeful. Benedek and Schetky (1987, p. 917) warn against "anxious *mothers* [italics added]" who may read more into a gesture made by an adult toward their child. "What may have been sexually overstimulating to the child but not necessarily intended to sexually gratify the adult becomes abusive in the mother's eyes." They hypothesized that the mother's anxiety about the other adult is then sensed

and copied by her child, which further confirms her own beliefs.

A law firm in California went so far as to introduce another syndrome, parental alienation syndrome (PAS), to describe *mothers* using their children in claims of child sexual abuse to get back at their husbands while filing for divorce (Suzanne, 1993). Loftus (1993) suggested that reported cases of recovered memories are one of the outlets for women's rage over sexual violence, and many others would agree. For example, Gardner (1991) suggested that men can serve as useful targets for women's hostility and warned of feminist, fanatical therapists and/or survivors whose vengeful purpose is to humiliate, destroy and incarcerate every man. In fact, Walker (1989) was once disallowed from testifying in court on the grounds that, because she is a feminist, her knowledge of battered women is not credible. Ganaway (cited in Wylie, 1993) suggested that the reporting of recovered memories of abuse perpetrated by their parents is really a long-delayed adolescent rebellion by women against their parents due to internal turmoil about feeling dependent and wanting detachment .

Other longstanding, well-entrenched beliefs, such as those minimizing the impact of child sexual abuse on its victims and those which take the responsibility for the crime away from the abuser, have aided the backlash efforts. These include erroneous beliefs that male sexual violence is normal, that children fantasize about having sexual encounters with their relatives, that the victim was somehow responsible for the abuse, and that the mother is

'evidence' from unattributed sources. Likewise, Salter (cited in Bass & Davis, 1994), who has served as an expert witness for survivors in court, asserted that, "I've been in court on cases that I didn't recognize on television" (p. 14). Cronin (1994) also suggested that the representation of experts is skewed in favour of the FMS side, interviews with alleged abusers and their family are included while survivors' and therapists' perspectives are ignored or relegated to the letters pages, and sources belonging to the FMS Foundation are often not identified as such, so that accused abusers are allowed the support of educated opinion while accusers are passed off as hysterical (Cronin, 1994; Herman, 1994). Indeed, the media's depiction of women as mentally unstable is a "well-worn backlash tradition" (Faludi, 1991, p. 98).

Pro-FMS arguments reportedly commonly found in news articles include the complaint that therapists and researchers exaggerate the prevalence and incidence of childhood sexual abuse, that memory is faulty, that repression does not exist, and that therapists are capable of implanting new memories (Suzanne, 1993; Cronin, 1994; Herman, 1994). Challenges to the validity of FMS as an actual syndrome, by comparison, are rarely discussed. Further, Herman (1994, p. 44) noted the irony "that in a story hinged on credibility, so many reporters uncritically promoted the highly partisan arguments of the FMS Foundation." She also argued that the stories in the mainstream press are constructed from a set of three questionable propositions: 1) that false claims of sexual abuse are common and increasing, 2) that claims based on delayed

recall are especially likely to be spurious, and 3) that an epidemic of fictitious memories of abuse are being implanted in a large population of gullible people by bogus therapists (Herman, 1994).

In sum, recovered memory advocates argue that the press is choosing to peddle the backlash against survivors of child sexual abuse rather than probe it, just as it did the backlash against women in the eighties (Faludi, 1991). There are many reasons offered for the press's alleged fragmentary and omissive coverage of the recovered memory debate. A journalist at *Philadelphia Magazine* (Fried, cited in Herman, 1994), for example, explained that biased stories are not only compelling, but easy to produce. Balanced stories, on the other hand, can be intellectually challenging and emotionally wrenching, and require much more effort on the part of the journalist. Cohen and Young's (1981) manipulative model of the press implies that the criteria for news worthiness include the event's or story's unusualness and the simplicity with which it can be reported. In order to make a story 'readable,' reality is thus simplified and translated into stereotypes. The slant of the news coverage may also be determined by who the journalist or editor knows or talks to first (Herman, 1994). The problem may also lie in the basis of traditional public and political debates, where both sides are expected to aggressively advocate and defend their side of the story (Herman, 1994). However, as Herman (1994) goes on to suggest, this system cannot work fairly if one side wants to avoid conflict, such as is often the case with those

remembering having been abused by their parents. This system thus rewards those who want to fight, namely the abusers, and punishes the survivors who are more interested in recovering.

The news coverage of social science issues in particular seems to have its own particular set of problems. Weiss and Singer (1988) argued that the partiality and contingencies of social science research are too often ignored, that there is a tendency to deal with conflicting findings by presenting them as discrete and disconnected entities with no reference to the disagreement, that the research reported on is often chosen for its dramatic value rather than its integrity and scientific significance, and finally, that an unknown proportion of reportedly 'scientific' studies do not constitute legitimate research at all. In a study of 88 journalists, Weiss and Singer (1988) observed that only half contacted the researcher who had done the study they were covering. Further, only one in five contacted another social scientist about the study, and this person's remarks were not necessarily incorporated into the story. Of the 33 editors in their study, only a few mentioned research quality as a criterion for a study's news worthiness, while slightly over a third identified the extrinsic qualities of the researcher, such as interpersonal skills, as evidence for the research's validity. The lack of objectivity and accuracy associated with the news coverage of social science may, at least in part, be due to the fact that journalists have little or no knowledge of this field and because they assume that the reader is uninformed and would rather learn of something new and

exciting than objective and scientifically important (Weiss & Singer, 1988).

The selection criteria and reporting tactics mentioned above are not the only factors that are likely to affect news reporting, however. Some media researchers draw attention to the fact that certain events and issues get completely and purposely overlooked by the media, such as was the case with the invasion of East Timor in the mid-seventies (e.g., Cohen & Young, 1981; Wintonick & Achbar, 1994). Chomsky and Herman's (1988) propaganda model of the press suggests that the fragmentary and omissive coverage of the news is the direct result of one of the mass media's main functions in society; namely, "to inculcate individuals with the values, beliefs and codes of behaviour that will integrate them into the institutional structures of the larger society" (p. 1). The principal components of their propaganda model include the size of the wealthy, concentrated ownership and profit orientation of the dominant mass media institutions, advertising as their primary income source, and their reliance on information provided by the government, businesses, and their approved and compensated 'experts.' Because virtually everything in our society, including the media, is owned and controlled by a relatively concentrated network of economically and politically powerful corporate entities, it follows that the consent being manufactured by the media would be in the interests of these few.

As early as in the forties, the Commission on the Freedom of the Press recognized the communications revolution that has made the press big

business and depicted it as acting increasingly like big business and increasingly in alliance with the interests of other big business (Lyons, 1965). Recently, it has been reported that only one quarter of newspapers' financial support is raised by public sales, while three quarters comes from advertisements (e.g., Lyons, 1965; Chomsky & Herman, 1989). The New York Times has reported that advertisements make up 60% of its newspaper, admitting that this is even below average (Wintonick & Achbar, 1994). In light of this information, it is not too much of a stretch to suppose that newspapers "act first and foremost to increase profits no matter what the consequences are to individuals or to the nation" (Cirino, 1971, p. 234). In fact, there are a few documented cases where news media have accepted bribes to cover topics favourably (Cirino, 1971). In addition, various forms of 'legalized' bribery, such as providing all-expense-paid trips for media personnel and their families, occur more often. Moreover, when it comes right down to it, and this is true of any domain including academia, even if journalists try to be fair and impartial, some personal bias will be conveyed whether intended or not (Cirino, 1971).

Consistent with their power, achieved through capitalism, is their right-wing ideology, which suggests that the news media tend to be anti-economic change, anti-labour, and anti-social change (Chomsky, 1989; Faludi, 1991). This, together with the findings indicating that right-wing authoritarians have negative attitudes toward women's equality (Haddock & Zanna, 1994; Kristiansen et al., 1995), suggests that the media's representation of the

recovered memory debate would be one that attempts to maintain the status quo. Endorsing FMS and minimizing the incidence and aftereffects of child abuse, for example, would eliminate the need for social change or social action. Indeed, Cohen and Young (1981) asserted that certain news is excluded when it is dangerous to the status quo. As Faludi (1991) put it, the press is a large business institution, and like any other, highly susceptible to the prevailing political currents, including that established by the New Right.

Indeed, the 'uncontrolled' and 'uncensored' distribution of news is a major dilemma of a democratic and capitalist society hugely dependent upon a press in private hands, which is inevitably controlled by powerful institutions whose interests are not always compatible with those of the rest of the population. Given this, it is ironic that while some readily question the motives of survivors and their therapists, this same cynicism is not applied to the mass media's arguments about incest and memory (Cronin, 1994). As Faludi (1991) warned, the statistics that the media promote most heavily are those that should be viewed most cautiously because they are likely to be the ones consistent with the media's preconceptions. What is particularly problematic, however, is that the news media claim to present an objective and accurate exposé of reality written for the purposes of public education and interest (Cirino, 1971; Cohen & Young, 1981). It is argued, then, that the citizen is not equipped with the information and discussion necessary to act responsibly in the community (Cohen & Young, 1981). In regard to the recovered memory

debate, this lack of information may facilitate the ongoing backlash against survivors and perpetuate the resuppression of awareness concerning the prevalence and effects of child sexual abuse.

According to Chomsky (1989), reporters actually engineer the consent of their audience by shaping and controlling the kinds of opinions and arguments that appear in their news media. Cirino (1971) listed several tactics used to achieve this. The source of the news, for example, from wire services or the handouts by government agencies and departments, is often biased before it is even sent to the news agencies. One of the most effective and easy ways of implanting bias is in the selection of news, because the public could never be aware of what new stories the editors decide not to print on any given day. Bias through the omission of news may also occur once a story has been selected, through the culling of the parts of the story that the editor does not want the reader to know about. The average citizen cannot possibly be aware of what was omitted even if they stopped to critically analyze the edited story. As Cirino (1971, p. 141) remarked, "the editors leave no blank spaces." Journalists can decide who gets interviewed and the amount of coverage they receive, and may easily interpret their words depending on their own personal agenda. The attention of news breaks too big to ignore can be minimized using placement tactics, such as placing the story in the back pages of the newspaper, or by giving it a small amount of coverage. Bias through 'coincidental' placement can be found when a headline or photograph that is

favourable to one person or group is placed in close proximity to an unflattering headline or photograph of an opposing individual or group. Headlines can be very effective suggestion tools, not only because of the importance of first impressions, but also because many readers only scan headlines to get an overview of news. In fact, Cirino (1971) refers to studies showing that even the most educated and active readers can be influenced by headlines. Certain words can be used and images created to either discredit disliked people and organizations, or exalt those respected, for example by using positive, negative, or neutral descriptives. The selection of photographs can have a very powerful effect on readers because they look more at photographs than at anything else in newspapers (Cirino, 1971). Bias in the captions accompanying photographs can be used to manipulate the reader's attitude toward the subject of the photograph. Editorials can be used to distort facts, and can be particularly effective if they are delivered by highly authoritative journalists who are respected for their alleged objectivity and seldom suspected of misrepresenting facts. Hidden editorials, which are editorials disguised as news items, can be even more effective than editorials in maintaining or changing attitudes. Appearing under the pretence of a genuine news item, the editorial is not restricted to the seldom read and suspect editorial page. Moreover, the necessity of giving equal time to opposing viewpoints is avoided. The press may also present the opinions of people from special interest groups as if their testimony were as valid as that

of a disinterested scientist. Finally, one of the most powerful techniques of persuasion used by the news media to draw attention to some events or issues while ignoring others, is the use of dramatic or tragic human interest stories to symbolize a larger social condition. For the most part, the conditions and factors that might embarrass the supporters of the status quo, which the media owners find so profitable, are purposely ignored in such stories.

Although this list of persuasion tools and tactics seems extensive and effective, the real problem lies not in the fact that news media use them, but that not all viewpoints have equal access to them (Cirino, 1971). In regard to the recovered memory debate, and as suggested by critics of the FMS movement (e.g., Herman, 1991), survivors who have recovered memories may be the ones lacking this equal access.

The Impact of the Recovered Memory Debate on Survivors

If indeed the media coverage of the recovered memory debate is pro-FMS biased, and reflecting a societal backlash against survivors of child sexual abuse, it may well have the effect of revictimizing and resiliencing survivors. This public questioning of recovered memories may be having the same effect that Freud's change of heart had about a century ago. After having announced that behind every neurosis there was incest, Freud subsequently described his clients' allegations as repressed fantasies of incest (Masson, 1984). His clients and others since have undergone numerous tests, been given numerous diagnoses and received numerous treatments, including

drug administration, institutionalization, and lobotomies, as well as being told they were lying, imagining the abuse, or fantasizing about it (e.g., Hartman & Burgess, 1993; Olafson et al., 1993; Putnam, 1993). Whether the media's portrayal of the recovered memory debate is pro-FMS biased or not, however, the possible impact of the debate on survivors must be considered. It has been suggested that even a balanced coverage may lead public audiences to believe that false memories are just as likely as true memories (Belicki et al., 1995). This would still result in many survivors being doubted on the basis of their recovered memories. Just the mere presence of a debate, then, may be sufficient to revictimize and resilience the ignored victims within the recovered memory debate, the survivors of child sexual abuse (Herman, 1994; Suzanne, 1993).

The Present Study

The present research consists of two rather distinct parts. First, the presentation of the recovered memory debate by the Canadian press was examined to determine if the portrayal of the FMS controversy is consistent with the aforementioned right-wing backlash hypothesis. Newspapers were chosen as the focus of this media analysis because of the ease with which the print media can be content analyzed, its accessibility and availability to the researcher, and the enormity of its audience (Benn Business Information Services, 1994). Furthermore, it has been found that news material presented in print is remembered better than identical material presented in audio or

audiovisual format (Furnham & Gunter, 1989), especially when the information is complex (Chaiken & Eagly, 1976). Having described the nature of the press' coverage of the recovered memory debate, the second part of this research examined the impact of the recovered memory debate on women who have been sexually abused as children.

PART I: THE CONTENT ANALYSIS

The purpose of the present study was to describe the portrayal of the recovered memory debate by the Canadian press during its introductory phase to the public. Newspaper articles dealing with the recovered memory debate were analyzed on several measures of newsplay (i.e., amount of attention they were given), content, and overall bias. It was hypothesized that: 1) pro-FMS articles would be given more newsplay than anti-FMS articles, 2) the majority of anti-FMS articles would be letters to the editor, and 3) female authors and sources cited in the articles would more likely be anti-FMS, while males would more likely be pro-FMS. The types of arguments presented in the articles, and by whom they are presented, will also be investigated.

Method

Materials and Procedure

Units of Analysis

A total of 66 articles related to the FMS debate that were published between January 1992 and January 1994 were collected from six major Canadian newspapers (*The Toronto Star*, *The Ottawa Citizen*, *The Vancouver Sun*, *The Calgary Herald*, *The Montréal Gazette*, and *The Globe and Mail*). These papers were chosen because of their accessibility, and also because they make up the most widely read group of newspapers in Canada (Benn Business Information Services, 1994), they have varied focuses and targeted audiences (e.g., whereas *The Globe and Mail* concentrates more on national,

international, and business news, *The Ottawa Citizen* tends to focus on local news, for example), and they represent four different news companies (Southam Inc., Pacific Press Ltd., The Globe & Mail, and Toronto Star Newspapers Ltd.). Although *The Calgary Herald*, *The Montreal Gazette*, and *The Ottawa Citizen* are all owned by the same company, Southam Inc., only one of the 66 articles examined in this study was a partial repeat of another

The articles were located with the help of an on-line Lexis-Nexus search using 'false memory,' 'repressed memory,' and 'recovered memories' as key phrases. All news items were collected, regardless of size or type (i.e., letters to the editor and Dear Abby-type letters were included), and each article was independently coded on several measures of newsplay and content by two raters. The coding sheets appear in Appendix A.

Measures of Newsplay

Several measures of newsplay were used to evaluate the amount of attention devoted to each article. Newsplay measures included Budd's (1964) Attention Score, which ranged from 0 to 5 with higher numbers representing greater attention, and was based on headline size, page placement, length, and location within a newspaper. For page placement a score of 1 was given if the article's first line was above the centre fold of the page, and 0 if it was below. A score of 0 was given to an article whose headline size was less than two columns' width, 1 if it was the width of two columns or more, or 2 if it was more than the width of half the columns on the page. If the length of the

article was less than three quarters the length of the page it received a score of 0, and a 1 if it was at least this long. Finally, the article scored 1 point if it was on the front page, or an editorial, and 0 if not.

This attention score is especially useful when more than one newspaper is involved in the analysis because it considers differences in the format of each. The mean Budd Attention Score represents the average amount of attention given to a set of articles, while the sum of Budd scores indicates the absolute attention given to a total set of articles. One drawback to Budd's attention score is that it is not relative to the size of the newspaper that the article appears in (Budd, 1964), so the page number on which each article appeared relative to the total number of pages in the paper was also noted. The number of words making up the article and the number of visuals accompanying the article were also recorded as indices of newsplay.

Measures of Content

The subject matter of each article was analyzed along the following dimensions, using the coding sheets presented in Appendix A and as described below.

Accuracy of headlines and visuals. This section was concerned with the accuracy of the articles' headlines, illustrations and their captions. Each headline was rated for its accuracy in representing the content of the article, using a 'yes' or 'no' format. The perspective of the headline was rated with a 1 for 'pro-FMS', 2 for 'neither or both', or 3 for 'anti-FMS.' Similarly, any visuals,

and their captions, accompanying an article were coded for whether they accurately reflected the content of the article and their perspective.

Article type, author gender, and concluding comments. The article's type (i.e., whether it was an article written by a journalist, or a letter to the editor or in an advice column) and its author's gender were recorded. Whether the article suggested that the matter was closed one way or the other, and whether suggestions were given in the article as to how to resolve the controversy, were also noted in this section.

Overall bias. The overall bias of the article, that is, the side of the debate it favoured, was rated using a 5-point scale, from 1 to 5, with the labels 'totally pro-FMS,' 'moderately pro-FMS,' 'balanced,' 'moderately anti-FMS,' and 'totally anti-FMS.'

Nature of sources. A source was defined as the person or persons making each of the arguments presented in the articles. One article could cite any number of sources, each of which was evaluated in regard to gender and bias (i.e., pro- or anti-FMS), and they were categorized into one of the following types: (1) professional, including researchers, clinicians, lawyers, doctors and peace officers, (2) alleged survivor, abuser, or their respective support groups, such as the FMS Foundation (3) author of the article, and (4) other sources. Finally, the credibility of each source was rated on a 4-point scale ranging from 1 (not at all credible) to 4 (very credible). Indices of credibility included the types of credentials the sources were introduced with,

any descriptive characteristics accompanying them, and whether their arguments were rebutted and to what extent.

Nature of arguments. Arguments were any points, opinions, or arguments presented in the articles. Each argument was coded as pro- or anti-FMS and classified into one of 5 general types: (1) memory, (2) suggestibility, (3) abuse, (4) societal issues, and (5) personal experiences. Arguments involving memory issues, for example, included memory reconstruction research findings, suggestibility arguments included the contention that therapists use powerfully suggestive methods with their clients, and arguments concerning abuse included those dealing with the prevalence and impact of child sexual abuse. Personal experiences included recapitulations of convincing personal attestations of innocence, and arguments about societal issues included those suggesting that FMS is a backlash against survivors or women and children, or that the recovered memory movement is a modern day 'witch hunt.' It was also noted whether these arguments were based on relevant research findings or not.

Results

The first set of analyses examined the reliability of the coding procedures and the way the press portrayed the recovered memory debate generally, as reflected by the overall descriptive statistics. The next analyses examined the relation between the bias of each article and the indices of newsplay and content. All Tables for this part of the study appear in

Appendix B.

Inter-Rater Reliability

Because there is no general theory of symbolic communication and no universal set of categories that can be applied to all content analyses, coding characteristics and categories are unique to each analysis and depend on its purpose and theoretical perspective. Content analysis is an iterative process that involves an interaction between the specification of the characteristics or dimensions to be measured and the definition of the rules that are used to identify and code them. As an index of the success of this approach, Cohen's (1960) 'Kappa' was calculated to assess the reliability between two independent coders' analyses of a random sample of 30 articles. This method is a particularly appropriate index of reliability because it does not require that the proportion of observations in each category be known for the entire sample and it does not assume that all coders have the same distribution of responses over categories (Craig, 1981).

Perfect inter-rater reliability was achieved for 12 of the 16 coding dimensions. Table 1 displays the Kappa values for the four dimensions (source credibility, type of argument, and headline accuracy and perspective) for which less than 100% agreement between the two coders was attained. These values illustrate that agreement was high on these dimensions, with rates of 93% or more, and levels of Kappa achieving statistical significance.

Descriptive Statistics for Measures of Newsplay and Content

Budd's Attention Score. As shown in Table 2, the mean Budd Attention Score, 2.21, was in the middle of the possible range of 0 to 5. Further, on average the articles appeared close to the beginning of the paper, visuals appeared in half of the articles, and they had an average length of 828.79 words. Based on these various indices, articles about the recovered memory debate were given a moderate amount of newsplay.

Accuracy of headlines and visuals. Each article's main and subheadline scores were amalgamated to obtain average accuracy and perspective ratings. Similarly, all visual and caption scores were amalgamated for each article. As shown in Table 3, headlines visuals and captions were generally accurate and represented both sides of the debate.

Article type, author gender, and concluding comments. As displayed in Table 4, almost 70% of the newspaper items were actual 'articles' written by journalists, while the rest were letters written to the editor or to an advice column. Table 4 also reveals that, while the author's gender could not be determined for seven of the articles, about half (55.9%) of the articles where gender was known ($N = 59$) were written by females.

None of the articles prematurely concluded that the debate was resolved or closed. Suggestions for resolving the debate were offered in only 6 (9.1%) articles, and included the need for more research, more sophisticated methods for distinguishing fact from fiction, and the licensing of therapists.

Overall bias. On the 5-point scale from 1 (totally pro-FMS) to 5 (totally anti-FMS), the mean bias over all articles lay between 'moderately pro-FMS' and 'balanced' ($M = 2.83$, $SD = 1.71$). As shown in Table 4, an equal number of articles were 'totally pro-FMS' and 'totally anti-FMS,' while 25.8% were rated as 'moderately pro-FMS' and 9.1% as 'moderately anti-FMS.' Only one article, a 75 word letter to the editor that recommended that more research be done and that proponents of both sides be open-minded, was rated as 'balanced.' The 'balanced' category was therefore excluded from further analyses. The nonsignificant results of two one-way analyses of variance (ANOVAs) revealed that bias ratings did not differ by newspaper or as a function of date of publication.

Nature of sources. The number of sources presenting arguments in each article ranged from 0 to 19, with a mean of 3.64 ($SD = 3.44$) and on average, sources were portrayed as credible rather than not ($M = 3.48$, $SD = .78$) on the scale from 1 to 5. The most frequently cited sources were professionals, such as therapists or lawyers, who appeared on average more than four times per article and at least once in 96.7% of articles (see Table 5). These were followed by people directly involved in the debate (i.e., alleged survivor or abuser) or their support groups (e.g., FMS Foundation or RMTG), who were cited .79 times per article, on average. Of note, the news articles' authors used themselves as sources on average .65 times per article, and at least once in 41.7% of the articles. Other sources included events, books, and

movies.

Nature of arguments. Although on average each article presented just over 7 arguments ($M = 7.23$, $SD = 6.85$, range = 0 to 38), less than one of these arguments was based on actual research ($M = .64$, $SD = 1.26$). The frequencies for the various types of arguments are presented in Table 6. The most common arguments concerned suggestibility issues, which appeared an average of 2.03 times per article and at least once in 62.1% of the articles. Second in frequency were arguments about issues of memory, appearing on average 1.97 times per article and at least once in 74.2% of the articles. These were followed by arguments concerning abuse issues, and then by arguments in the form of personal experiences. The least used arguments were those dealing with societal issues.

Newsplay and Content as a Function of Article Bias

Budd's Attention Score. The next set of analyses examined the relation between the pro- versus anti-FMS bias of each article and the various measures of newsplay and content. Table 7 shows the mean and sum of Budd's Attention Score by article bias. An ANOVA on the Budd Attention Scores revealed a significant effect due to bias, $F(3,48) = 3.36$, $p < .05$. However, multiple comparisons using Scheffé's post-hoc method failed to identify any significances between the group means. A two-way Chi-square contingency test revealed that type (or direction) of bias was independent of degree (or strength) of bias, $\chi^2(1) = 2.58$, ns. Similarly, degree of bias was

independent of the type of bias in terms of the sum of Budd's Attention Score, $\chi^2(1) = 3.00$, ns. However, the degree of bias was contingent on the type of bias in terms of the number of articles, $\chi^2(1) = 2.36$, $p < .05$. To reduce the probability of Type I errors, the criterion for the level of significance was divided by the number of multiple comparisons being made. Using an alpha of .01, then, no difference between the number of pro- and anti-FMS articles were revealed.

As shown in Table 8, one-way ANOVAs on the other indices of newsplay by type of bias yielded comparable findings. Bias was unrelated to the page number on which articles appeared relative to the total number of pages in the paper, the number of visuals, and the number of words in each article.

Accuracy of headlines and visuals. As presented in Table 9, the accuracy of headlines, visuals and captions did not vary as a function of the articles' pro- versus anti-FMS bias. The perspective of both headlines and visuals differed with the bias of the article, and Scheffé post-hoc comparisons revealed that the perspective of both headlines ($F(1,61) = 33.72$, $p < .001$) and visuals ($F(1,61) = 10.29$, $p < .01$) was indeed consistent with the overall bias of the articles. This was not the case for the perspective of captions, although none of the means differed from neutral, as revealed by a series of one-sample two-tailed t -tests.

Article type and author gender. In the total sample there were more

'articles' than letters ($\chi^2(1) = 10.24, p < .001$). Again, using an alpha of .01 and, as shown in Table 10, while the anti-FMS items were nearly evenly distributed among 'articles' and letters, $\chi^2(1) = .04, ns$, the majority of the pro-FMS items were actual articles, $\chi^2(1) = 17.79, p < .001$. Further, while nearly the same number of letters were pro- as anti-FMS, $\chi^2(1) = 2.58, ns$, actual articles were more likely to be pro- than anti-FMS, $\chi^2(1) = 7.04, p < .01$.

Although males and females authored an equal number of articles, $\chi^2(1) = .83, ns$, and the author's gender was independent of article bias, as revealed by an overall two-way Chi-Square, $\chi^2(1) = 2.30, ns$, females authored an equal number of pro- and anti-FMS articles, while male authors wrote marginally more pro- than anti-FMS articles, $\chi^2(1) = 5.54, p = .02$, at the corrected alpha of .01 (see Table 11).

Nature of sources. While there was no difference between the number of female and male sources, $t(65) = 1.07, ns$, or the number of pro- and anti-FMS sources per article, $t(65) = .68, ns$, multiple comparisons revealed interesting relationships between source bias and gender (see Table 12). An overall analysis was not possible because more than one source could appear in each article, which was the unit of analysis. Thus, four paired t -tests were performed, using Dunn's correction for planned non-orthogonal comparisons, resulting in an alpha criterion of .01. Female sources made more anti- than pro-FMS arguments per article, $t(65) = -2.59, p < .01$. Conversely, male

sources made more pro- than anti-FMS arguments per article, $t(65) = 4.41$, $p < .001$. Further, more of the pro-FMS sources were male than female ($t(65) = -2.66$, $p < .01$), and more of the anti-FMS arguments were presented by female than male sources ($t(65) = 3.36$, $p < .001$).

The mean portrayed credibility of sources supporting either side of the debate, by gender, is displayed in Table 13. Again because an overall ANOVA was not possible, a set of paired t -tests were performed revealing no differences in portrayed credibility between male and female, pro- and anti-FMS, or any combination of sources at the corrected significance level of .01.

Table 14 presents how often the different types of sources were used to support each side of the recovered memory controversy. All of the source groups presenting arguments in the articles offered as many pro- as anti-FMS opinions, as revealed by a series of paired t -tests, except for the author of the news item where authors were almost twice as likely to present pro- rather than anti-FMS opinions ($p = .03$). Of interest, the FMS Foundation was used as a pro-FMS source on average .36 times per article and in 25.8% of the articles at least once. Further, and their phone number was provided in 5 of the 66 articles, while no comparable anti-FMS 'foundation' or support group was cited.

Nature of arguments. The number of general arguments presented in each article did not differ as a function of their pro- versus anti-FMS bias, $t(65) = 1.36$, ns. Nor was there any difference in the number of research-based

arguments made for either side of the debate, $t(65) = -.23$, ns.

The kinds of arguments presented in support of each side of the debate are displayed in Table 15. Again, an overall ANOVA could not be computed because more than one argument could be made in each article, thus a corrected alpha of .01 was used for the individual t -tests. Arguments concerned with suggestibility issues were more than twice as often pro- than anti-FMS. On the other hand, that there were more than twice as many anti- than pro-FMS arguments dealing with abuse issues, approached a level of significance ($p = .02$). The frequency of the other types of arguments did not differ by bias, but while pro-FMS arguments most frequently dealt with issues of therapy, the most frequently used anti-FMS arguments dealt with memory.

Discussion

As a whole, articles dealing with the recovered memory debate were given a moderate amount of attention during the two year period January 1992 and January 1994. Pro- and anti-FMS articles were presented in equal numbers in the press and, as suggested by various indices of newsplay, such as page placement, size and word count, received equal levels of prominence in the newspapers. There were, however, several subtle indicators that suggested that the press was biased in a pro-FMS direction.

The findings that more of the 'articles' were pro- than anti-FMS, and more of the pro-FMS pieces were 'articles' than letters, support the perceptions of the proponents of recovered memory who claim that the majority of anti-

FMS pieces are written by readers rather than journalists (e.g., Cronin, 1994; Suzanne, 1993). It may be that more journalists wrote more pro- than anti-FMS articles or that editors chose to publish more of the pro-FMS pieces. In either case, because letters to the editor and other such 'opinion' pieces are less influential than actual news pieces (Cirino, 1971), these findings suggest that readers were more likely to be swayed toward a pro-FMS opinion. This, of course, is consistent with the hypothesis that the press is engaged in a backlash against survivors (Herman, 1994).

That the backlash against survivors can be construed as a part of the backlash against women more generally (e.g., Faludi, 1991; Herman, 1994, Kristiansen et al., 1994; Olafson et al., 1993) is further supported by the present study's findings regarding the gender of the authors and the sources cited in the articles. Although males far outnumber females in the news media (Wood, 1994), there were as many males as females writing about the recovered memory debate. Further, males were more likely to author pro- than anti-FMS articles and were cited more frequently as pro- than anti-FMS sources. Female sources, on the other hand, were more often anti- than pro-FMS and accordingly, while pro-FMS sources were more often male than female, anti-FMS sources were more often female than male. These findings are not only consistent with the backlash hypothesis, but they are also important to the extent that society attributes more authority, reliability, and credibility to men than women (e.g., Lucas & Benson, 1985; McGuire, 1985;

Wood, 1994). Therefore, although male and pro-FMS sources were not *portrayed* as being more reliable or credible than female and anti-FMS sources, they may still have been *perceived* as such, and may therefore have lent more weight to the pro-FMS side of the debate.

Finally, many of the allegations made by advocates for the validity of recovered memories about the nature of the media's portrayal of the recovered memory debate were supported (e.g., Cronin, 1994; Herman, 1994; Suzanne, 1993). For one, the finding that the news items' authors presented their own arguments and opinions in almost half of the articles, and made more pro-than anti-FMS arguments, is consistent with the claim that the coverage is filled with opinion-based pieces. Second, that professionals appeared as sources seven times more often than those directly affected by the recovered memory debate may have enhanced the credibility of the arguments in the articles, but it also suggests that the structure of the debate is silencing or overlooking its integral players, such as the survivors of childhood sexual abuse and alleged perpetrators.

Also as argued (e.g., Cronin, 1994), pro-FMS arguments regarding suggestibility issues, for example that therapists can and do implant false memories of childhood sexual abuse in their clients, were the most common arguments even though the research supporting these claims is at best controversial (e.g., Loftus & Herzog, 1991 cited in Loftus 1993; Yapko, 1994). But in the areas where there is a large body of research, such as in the

neurobiology of traumatic memory (e.g., Hovdestad & Kristiansen, in press; Krystal, Kosten, Southwick, Mason, Perry & Giller, 1989; van der Kolk, 1994), and prevalence and aftereffects of abuse (e.g., Bagley & Ramsay, 1985; Russell, 1986), pro-FMS arguments were less often presented. On the other hand, these were the two categories in which anti-FMS arguments lay most often. Again, the personal experiences of people directly involved in the recovered memory debate, such as those recovering memories or those being remembered as the abusers, were the second least often presented in the articles.

That anti-FMS arguments concerning societal issues surrounding the debate were some of the least often presented in articles was revealing in light of the feminist assertion that 'the personal is the political' (e.g., Kitzinger & Perkins, 1993). The need for social rather than individual change is emphasized because often these problems stem from greater social ills. The present study's findings suggest that the recovered memory movement is not using this approach, or that the press downplayed this sociopolitical level of analysis.

Perhaps the most challenging charge that can be made about the press coverage is not its biases, omissions, or chosen emphases, because these are really unavoidable; rather, it is the fact that press purports to be unbiased, objective, and accurate. The standard code of journalistic ethics (Associated Press, cited in Herman, 1994) states that newspapers must be committed to

the accurate reporting of facts and safeguard against errors through systematic verification of facts and corroborating crucial information, and in matters of significant controversy, an honest and vigorous effort must be made to include reasonable opposing views. This leads press audiences to have confidence in what they read in the press. It is rarely suspected by the reading public, for example, that newspapers, like any business-based media, may also have political motives in addition to their obligation of fidelity to the public interest. Vipond (1992), for example, suggests that the press has two main political responsibilities: 1) implanting values of good citizenship, and 2) disseminating news, opinion and debate necessary to the proper functioning of a democratic government.

There are many ways in which these political issues have influenced the press' coverage of the debate. Certainly, the FMS Foundation's and their proponents' alleged reasons for challenging recovered memories, such as the preservation of the family and law and order, are in accord with the current New Right atmosphere (Faludi, 1991). Furthermore, members of the powerful medical lobby often does not support the findings of research that suggests that abuse results in many heretofore unexplained psychological problems (e.g., Gordon & Alexander, 1993). As evidenced by the number of pro-FMS conferences funded or co-presented by pharmaceutical companies and psychiatric hospitals or departments of Universities, the psychiatric institution, like many others (e.g., Loftus, 1993; Ofshe & Watters, 1993), prefers to regard

psychological disorders as rooted in biological deficiencies. Although there is much evidence for the altered neurobiology of many psychologically disturbed people, there is also much evidence for the relation between these neurobiological alterations and traumatic experiences (e.g. Krystal, Kosten, Southwick, Mason, Perry & Giller, 1989; van der Kolk, 1994). That the medical and psychiatric institutions support FMS, then, may be understood as a way of downplaying the prevalence of survivors of childhood sexual abuse or other trauma, especially in its patient population. Indeed, Whipp (1991) reported that, in general, psychiatric institutions in the Ottawa region failed to take past traumatic background, such as sexual abuse, into consideration when making diagnoses and treating their clients. This was usually the case even when past sexual abuse was voluntarily disclosed by clients.

Some limitations of the present study merit discussion. For one, although the sample of newspapers examined was representative of a wide range of Canadian newspapers, it is not presumed that the present study's findings are generalizable to all newspapers. This research has, however, offered a glimpse into the information the public was provided with, and the general atmosphere of the media's portrayal of the debate.

Certainly, another limitation of this study lies in researcher bias, especially because of the nature of content analyses. Although the researcher acknowledges this bias, the use of a second coder with drastically different views about the recovered memory debate and child abuse, and the high inter-

rater reliability nevertheless achieved, suggests that this research could be reliably replicated regardless of a researcher's own opinion on the debate.

In any case, and for whatever reason, the coverage of the recovered memory debate was found to have a pro-FMS bias during the two-year period studied, and many of the findings from the present research are consistent with the backlash and social denial hypotheses. Inasmuch as the media can be seen as a thermometer of societal attitudes and beliefs, an important consideration is whether the recovered memory debate is affecting survivors of child sexual abuse, and if so, how.

PART II: THE IMPACT OF THE RECOVERED MEMORY DEBATE ON A SAMPLE OF SURVIVORS

The purpose of this portion of the research was to investigate and describe the impact of the recovered memory debate on adult women who were sexually abused as children. It was hypothesized that the debate negatively affected survivors of child sexual abuse on a number of aspects, including their recovery, their ability to talk to others about their abuse, their confidence in their memories of their abuse, their therapy process, and their posttrauma symptoms. It was also hypothesized that greater exposure to the debate, more memory loss for the abuse, and being at a lower stage in recovering from the abuse, would all result in the debate having a more detrimental impact on survivors.

Method

Participants

One hundred and twelve female adult survivors of child sexual abuse (M age = 34.2, SD = 8.3 years) were recruited by way of posters displayed at various locations of Carleton University including the women's, international, and health centres, student association office, and several bulletin boards in various buildings across campus. Local community centres (including women's, lesbian/gay, cultural, health, information, and resource centres), shops, therapist offices, hospitals, newspapers, cable television community news, and internet bulletin boards also posted recruitment notices. These

notices read as follows: "Survivors' Study: We are looking for female survivors of child sexual abuse to participate in a 2 hour questionnaire survey of your experiences, your memories and your recovery process. Confidentiality assured."

Women most frequently (22.7%, $n = 20$) reported having learned of the study from community resource or information centres. Nineteen percent ($n = 17$) heard about it through word of mouth from the researcher or interviewers, 12.5% ($n = 11$) saw the poster at the Ottawa Women's Bookstore, 10.2% ($n = 9$) learned about it from their therapist's office, 8.0% ($n = 7$) from local newspapers, and 6.8% ($n = 6$) from posters at Carleton University. Others learned of the study from the Freenet, cable television, and posters at unspecified locations.

Three criteria were used to determine a participant's inclusion in the study. A participant had to have been sexually abused prior to 18 years of age, be presently at least 18 years of age, and be female. Sexual abuse was not defined in the recruitment poster nor in the questionnaire battery and was therefore self-defined by the volunteering participants. The decision to limit the study to women was partly based upon previous findings that sexual victimization results in somewhat different issues for males and females (e.g., the added stigma of homosexuality is added because many of the perpetrators are male; Finkelhor, 1979), because of the interviewers' (who were all female) heightened apprehensions in having to travel alone to men's houses, and

because the concentration of FMS claims are being made against women (Pendergrast, 1995). However, it is not the intention of the present study to downplay the need for more research concerning male survivors in this area.

Materials

Participants completed a battery of 11 randomly ordered questionnaires that was compiled for a number of research purposes, including the present study. Survey questions were collected and adapted from many different sources, including Westerlund's (1992) Incest Survivors' Questionnaire and the Trauma Symptom Checklist (Briere & Runtz, 1989), with the help of survivors and therapists. Once the survey was compiled, a pilot study was performed with four volunteer survivors, to test for its suitability, adequacy, clarity, and completeness. In addition, three therapists read the questionnaire and gave critical feedback. These seven women completed the questionnaires and provided feedback and comments on each individual item and in general. Revisions were made accordingly.

The questionnaires relevant to the present study obtained information about the participants' demography, recovery process, memories for the abuse, and their knowledge of the recovered memory debate and its impact on them. The questionnaires that were not used in this particular study asked about participants' therapy background, physical health, the nature of their abuse, views about their future and identity, and the symptoms they experienced during different periods of their life. The parts of the questionnaire package

used in the present study appear in Appendix C, which includes the consent form and written debriefing statement given to each woman.

A section entitled 'Background Information' asked about participants' demographic characteristics, including their age, education, employment status, family income, sexual orientation, relationship status, and number of children.

To obtain information about the nature of these women's memories for their experiences, participants answered questions about their memories for their abuse for each of their abusers; that is, as many of the perpetrators that they wished to report on. Only one question (number 7) from this section is relevant to the present study. This question, derived from Loftus, Polonsky, and Fullilove (1994), asked the respondent to indicate which of the following three statements was most applicable to each of their abuse experiences: (1) 'I have always remembered *this* abuse throughout my life, even though I never talked about it,' (2) 'I have remembered parts of *this* abuse my whole life, while not remembering all of it,' or (3) 'I forgot *this* abuse for a period of time, and only later remembered.'

A section entitled 'Stage of Recovery' contained questions designed to evaluate the extent to which participants were involved in each of various stages of recovery from their childhood trauma. Herman (1992) described recovery as unfolding in three stages, although not necessarily in a linear manner, as survivors will often oscillate between, or spiral through, all three

stages. The recovery process has been conceptualized similarly by others (e.g., Brown & Fromm, 1986; Janet, 1988; Putnam, 1989; Scurfield, 1985). The central task of the first stage is the establishment of safety, and the extent to which participants were in this stage was assessed by four questions asking them to rate the extent to which they were currently experiencing safety or self-abuse issues, such as suicidal feelings, self-injury, or dangerous risk-taking, abusing drugs or alcohol, feeling safe and able to trust themselves, and feeling safe and able to trust others. The degree to which participants were in the second stage, remembrance and mourning, was assessed by two items asking them to rate the extent to which they still recovered new memories of their abuse, and currently mourned their childhood losses. The extent to which participants were in the third and final stage, reconnection with ordinary life, was assessed by three questions asking them to rate the extent to which they currently limited their activities and friendships so as to make time and energy to deal with their issues and recovery process, currently limited these activities in order to feel safe and comfortable, and whether their recovery process was well on its way, allowing them to "live again." Participants used scales ranging from 1 (never) to 5 (almost always) to answer these questions.

In a section dealing with the recovered memory debate, participants were asked to rate the amount of their exposure to the debate from 'not at all; never heard of it' (0) to 'a great deal' (4). Participants who had heard of the recovered memory debate were then asked when and where they first learned

of the debate, and to state in their own words, their initial thoughts, feelings, and reactions when they first learned of the debate and their current thoughts about the debate.

Participants were then asked to rate the impact the debate had on them in a number of different ways. They were first asked if anyone had ever accused them of having false memories. In the form of an open-ended question, as well as along a 7-point bipolar scale ranging from 'extremely detrimental' (1) to 'extremely helpful' (7), participants were asked to describe any impact the debate had on their recovery process in general.

Participants next used a 7-point bipolar scale to rate the impact of the debate on the extent to which they could talk to friends about the abuse (1 = 'I talk much less about it' to 7 = 'I talk much more about it'), and their confidence in the overall accuracy of their memories for the abuse (-3 = 'much less confident' to +3 = 'much more confident'). The impact of the debate on participants' confidence in the accuracy of their memories of the abuse in general, who the abuser was, where and when it took place, what it involved, and of their memories of their subjective experiences at the time of the abuse were also assessed (i.e., feelings, thoughts, and bodily sensations they experienced during the abuse). The first set of questions assessed the explicit memory processes, as described earlier, and the second set assessed participants implicit memories for their abuse.

Participants who were in therapy when they learned of the debate were

asked to rate the impact of the debate on a number of aspects of therapy. Using scales ranging from 1 (not at all) to 5 (a great deal), participants rated the extent to which the debate affected their relationship with their therapist, issues of trust, suspicion that therapist may doubt them, the distance between them and their therapist, the therapy's pace, the power balance/imbalance, what participants said in therapy, feelings participants felt in therapy, such as causing self-doubt or fear, and the impact of the debate on making participants change therapists or terminate therapy completely.

A modified version of Briere & Runtz's (1989) Trauma Symptom Checklist (TSC-40) was used to rate the extent to which participants were retraumatized by the debate. Validation research by Elliott & Briere (1992) revealed that the TSC-40 subscales were found to be internally consistent, with alphas ranging from .62 to .90, and discriminated between sexually abused and nonabused women. Rather than rating the frequency of each symptom, this modified TSC-40 asked participants to rate the impact of the debate on each of the series of symptoms using 7-point scales ranging from 'occurred much less often' (-3) to 'occurred much more often' (+3). The TSC-40 has six subscales which provide indices of the major problem areas associated with trauma. The first, dissociation, is made up of six items, assessing the extent to which flashbacks or sudden vivid distracting memories are experienced. Anxiety is comprised of nine items, such as dizziness. Depression is assessed by the frequency of uncontrollable crying and eight other such items. Six items

assess the extent that sleep disturbances are experienced, including waking up in the middle of the night. Sexual problems include bad thoughts or feelings during sex and six other related items. And finally, post sexual abuse trauma is comprised of seven items assessing symptoms such as nightmares.

Finally, participants who felt the debate affected them were asked to describe any things, people, or activities that helped them cope with its impact, and whether there were any other types of support or resources that might have helped them cope.

A category labelled "other" always accompanied the multiple choice questions, and the open-ended questions were included in an attempt to better understand the impact of the debate from participants' own perspectives. This qualitative approach was included because of the inadequacy of quantitative data to capture the complexities of childhood sexual abuse experience and the impact of the recovered memory debate on its survivors. As Westerlund (1992) suggested, with newly emerging research areas, and especially areas as shrouded in myth as the present one, the research method of choice is qualitative because the specification of variables required in quantitative research cannot possibly be complete for lack of information. Moreover, providing participants with the opportunity to speak in their own voices was especially important in view of their silencing in the past.

Procedure

Upon initial contact, potential participants underwent a brief, telephone

pre-interview screening session to assess the extent to which they were currently experiencing safety and abuse issues (e.g., suicidal feelings, self-injury, or high-risk taking behaviour). As a precautionary measure, anyone who reported currently experiencing such issues was asked to call back to participate once they were feeling safer and more controlled. There were only three such occurrences, two of whom decided on their own to not participate after realizing the intensive and potentially triggering nature of the survey. Finally, it was suggested to women who were currently in therapy that they discuss their intention to participate in the study with their therapist. Two women, after speaking with their therapist, decided to not participate at this time.

Each participant then met with one of 10 interviewers at a mutually agreed upon time and location. The interviewer, trained in grounding techniques, was present for support and/or crisis intervention because of the sensitive nature of the questionnaire, and to review the consent form, answer questions, supply additional forms if necessary, and for debriefing purposes. Questionnaire completion took 1.3 to 28.0 hours ($M = 3.1$, $SD = 3.0$ hours). Upon completion, the interviewer ensured that the participant was grounded, reviewed the debriefing statement pointing out the phone numbers of organizations where participants could turn to for support or help, and answered any questions the participant may have had. On-call support was available through the Sexual Assault Support Centre of Ottawa for those

women who did not have other support systems currently in place.

Results

The initial analyses consisted of factor analyses and analyses of the internal consistency of all scales. Descriptive information was next examined in regard to participants' background information, their knowledge of the recovered memory debate, and the impact of the debate on their lives. One-tailed correlations were performed to examine the extent to which participants' reactions to the debate varied as a function of their exposure to the debate, the nature of the memory, and the stage of their recovery. Finally, participant characteristics were correlated with all impact items and their potential moderators in order to assess the generality of the findings. All Tables for this part of the study appear in Appendix D.

Sample Characteristics

Tables 16 and 17 display the quantitative and qualitative characteristics of the sample⁴. As mentioned earlier, the 112 participants were on average 34.2 years of age. Most had at least a high school education, and 41.1% had a nonuniversity certificate, while one-third had a bachelor's degree. Many were employed full-time, and one-third were homemakers. Their mean family income was between \$25 000 and \$44 999, but this ranged from under \$15 000 for 29.9% to over \$65 000 for 12.1% of the women, with about half (53.8%) of these having family incomes over \$75 000. Thus the participants in

⁴ In most cases, participants could give more than one response to each question, which explains why there were more responses than the total number of participants.

this study represented a range of socioeconomic backgrounds. Because the interviewers reported having administered the survey to only five women of visible minorities; one of each Asian and East Indian decent, and three Aboriginal women, the sample was effectively limited to white women.

Most of the sample was heterosexual, while 18.0% described their sexual preference as lesbian and 10.8% reported being celibate. More than one-third reported living with a life partner and 22.5% had no current relationship. The 49 women who reported having children had an average of 2.27 children each.

Seventy-five percent ($N = 84$) of the women answered the open-ended question asking if there was anything else they would like to share about their background. A myriad of problems in their background was reported by 65.5% ($n = 36$) of respondents, such as running away from home, a dysfunctional family structure, early pregnancy, strict and/or religious parents, alcoholism, and transience. Several current problems were identified by 52.7% ($n = 29$) of the women, including struggling with sexual identity, relationship, employment, and financial problems. Interestingly, 16.4% ($n = 9$) mentioned that they came from large families (one reported having 18 siblings), 14.5% ($n = 8$) reported something positive in their present lives, and 5.5% ($n = 3$) described their cross-cultural backgrounds.

The women had been sexually abused as children by an average of 3.41 abusers each, ranging from 1 for 39.8% of the women, to over 10 abusers

for 6.9% of the sample. The total number of abusers for the sample was 351, but because many participants understandably chose to report on fewer abusers than they had, the number of abusers reported on in detail was 253. Only 8.1% reported never having had any form of counselling, and those who did have therapy could report on any number of their counselling experiences. A total of 267 counselling experiences were reported on in detail.

The three following variables were considered as potential moderators of the impact of the recovered memory debate on participants: 1) the extent of their amnesia for the abuse, 2) their stage of recovery, and 3) the amount of their exposure to the debate. Descriptive information for these variables appears in Table 18.

Extent of memory loss. Participants' memory for each of the abuse experiences they chose to report lay, on average, between full and partial, indicated by a mean of 1.94. Most (41.9%) of the reported abuse experiences were always entirely remembered by participants, 22.4% were always remembered but only in parts, and 35.8% had been completely forgotten for a period of time.

Stages of recovery. A principle components analysis and scree test performed on the nine recovery items resulted in one factor. Table 19 presents the unrotated factor loadings from this analysis and shows that the item assessing substance abuse did not load on this factor. Recovery scores therefore excluded this item. Given clinicians' distinctions between the

different stages of recovery (e.g., Herman, 1992; Putnam, 1989), all subsequent analyses involving recovery stage were performed using all eight items deemed important by the factor analysis to represent the overall stage of recovery, as well as the three separate stages of recovery as described by Herman (1992), less the substance abuse item from the first stage.

The internal consistency of the 8-item overall recovery scale was high, with a mean interitem correlation of .35 and an alpha of .81. The homogeneity of the items assessing the first stage, safety, was sufficient with a mean interitem correlation of .26 and an alpha of .50. The two items assessing the second stage, remembering and mourning childhood losses, were intercorrelated at .33. The three items assessing the last stage, reconnecting and living again, had a mean interitem correlation of .48, and an alpha value of .73. All three stages were intercorrelated ($r(111) = .32$ for the safety and remembering stages, $r(111) = .58$ for safety and reconnecting, and $r(112) = .49$ for remembering and reconnecting, $ps < .001$), as one would expect given that people spiral through the stages of recovery (Herman, 1992).

As presented in Table 18, on the whole, participants described themselves as occasionally to often engaged in the process of recovering in general ($M = 3.64$ along the scale ranging from 1 to 5). More specifically, participants reported that they were occasionally to often safe ($M = 3.64$) and reconnecting ($M = 3.22$), and only occasionally in the remembering and mourning stage ($M = 2.96$). As expected given the participant selection

criteria, then, these women were reasonably to well along in their recovery process.

Awareness of the Debate

Participants reported having had moderate to a good deal of exposure to the recovered memory debate (see Table 18), with only 6.4% of the sample reporting having never heard of it. Those who knew of the debate ($N = 102$) first learned about FMS one to two years prior to the study; typically during the middle of 1992. Most ($n = 49$, 46.1%) of these women first learned of the debate via the television or radio, 31 (30.4%) first learned about it from newspapers, and 30 (29.4%) from magazines. Other sources included friends ($n = 25$, 24.5%), therapists ($n = 9$, 8.8%), support centres ($n = 8$, 7.8%), school ($n = 5$, 4.9%), family members ($n = 4$, 3.9%), and perpetrators ($n = 1$, 1.0%). Four participants (3.9%) did not specify or could not remember where they first learned of the debate.⁵

The results of content analyses of participants' responses to the two open-ended questions asking about the participants' first reactions and current thoughts to the debate are presented in Table 20. Most described their first reactions to the debate in terms of emotional responses such as disbelief, shock, anger, fear, and confusion. Almost half believed that FMS was a form of backlash against survivors and/or women and children, or a societal coping

⁵ Again, because participants could check as many different sources as they felt was necessary, the sum of responses does not equal the sum of respondents

mechanism which served to deny the abuse and protect perpetrators by silencing and invalidating survivors. More than a third reported that it had an immediate negative impact on them in that they began doubting themselves and their memories, became fearful of not being believed, felt resiliated and revictimized, and experienced decreases in self-esteem. Twenty-one percent stated that at that point they believed in the validity of recovered memories, for example, by emphasizing that the feelings and sense that the abuse took place that accompanied their memories could not possibly be implanted in people, and by pointing out that each individual had their own coping mechanisms and that one of them may result in the loss of memory for the abuse. One woman asked, "How do they know? I know it doesn't apply to me but who is anyone to tell anyone else that their memories aren't real? How about all the people who remembered and were convinced that they hadn't [been abused]?" Some respondents believed that FMS was possible but each qualified this with such statements as 'when hypnosis is used,' 'only temporarily,' or 'but only in very few cases.' Some reported experiencing something not necessarily negative when they first learned of the debate; they became more cautious and aware of issues (e.g, therapy to be wary of), for example. A handful reported being worried about the impact on other survivors, 3.9% felt the need to point out that theirs was not a case of FMS and attempted to prove it, and one woman reported trying to ignore it altogether.

When describing their *current* thoughts about the recovered memory

debate, more than a third described them in terms of emotional responses, just as most described their initial reactions. Most women, however, reported that they had formed opinions about the debate by this time. Nearly all felt it was a form of backlash and/or societal denial, 50.5% discussed the validity of recovered memories, and 29.0% reported a belief in the possibility of FMS, which was again qualified. For example, one participant who acknowledged that there may be some cases of inaccurate accusations of abuse also pointed out that, "nobody suggests we wipe out psychiatry or dentistry or medical science because there is some abuse, incompetence and misdiagnoses in their system. Yes explore, investigate, address it when it happens but do not suppose that all or even most or even a lot of cases are wrong because some are wrong." About one-third reported that it still had a negative impact on them, and 18.3% had come to worry about the impact of the debate on others. Some women, however, said they now realized that they had gained something not necessarily negative (e.g., 20.4% became more cautious and aware of issues, and 11.8% were determined to fight against abuse and the backlash). Four percent now expressed the need to point out that theirs was not a case of FMS and attempted to prove it, and still one woman reported trying to ignore the debate altogether.

Impact of the Debate

General impact. Half ($n = 61$, 54.5%) of the women reported having been accused of having false memories. Of the 56 respondents who

elaborated, most ($n = 29$, 51.8%) reported being accused by a member of their family other than the abuser, 16.1% ($n = 9$) by their abuser, and the rest by friends ($n = 7$, 12.5%), therapists ($n = 6$, 10.7%), and unspecified others ($n = 5$, 8.9%). This attests to some of the *indirect* impact of the debate being experienced by survivors (i.e., through others learning about it).

The following analyses examined the more *direct* impact of the debate on several aspects of the participants' lives. Along the 7-point scale, the debate was reported to have had no effect to a somewhat detrimental impact on their recovery process in general ($M = 3.38$, $SD = 1.06$), an impact that differed significantly from 3 (no impact), as revealed by a one-sample two-tailed t -test, $t(93) = 3.51$, $p < .001$. At most, the debate resulted in a slight reduction in the extent to which participants talked to people about their abuse ($M = 3.63$, $SD = 1.42$), although this too was reliably different from no impact, $t(93) = 4.28$, $p < .001$.

Most (83.9%, $N = 94$) of the participants answered the open-ended question about the impact of the debate on their recovery process. Many (42.6%, $n = 40$) of these women wrote that the debate had little or no effect on their recovery process. One woman elaborated on this by saying that the debate had no impact on her recovery process, "as I allow others their belief and I believe what I believe." Most participants (72.3%, $n = 68$), however, felt it adversely affected their recovery by negatively affecting their sense of self, making them doubt themselves, lowering their self-esteem, and making them

feel crazy, frustrated, and alone; in essence, by breaking their spirit. Twenty-three percent ($n = 22$) wrote that their recovery process was indirectly affected by the debate, through its effect on friends, family members, therapy, and the courts. Some (11.7%, $n = 11$) simply stated that their recovery slowed or stopped as a result of the debate, a few (4.3%, $n = 4$) indicated an increase or decrease in recovering memories, and 6.4% ($n = 6$) expressed concern about its impact on others. Almost a third (29.3%, $n = 28$) suggested that the debate aided their recovery by helping them understand people's reactions and increasing their determination to heal, speak out and help others, and to become educated about bad therapy.

As shown in Table 21, a principle components analysis with varimax rotation of the items measuring the impact of the debate on participants' confidence in the accuracy of their memories of the abuse yielded two factors. Although two of the cross-loadings are higher than .44, the factor loadings of each item are substantial. As expected, the first factor was made up of the explicit memory items (e.g, concerning the physical details of the abuse), and the second factor consisted of the implicit memory items (e.g., those assessing memories of sensorimotor sensations and feelings). Item analyses revealed that both the explicit and implicit categories were internally consistent, with mean interitem correlations of .73 and .96, and alphas of .93 and .99, respectively.

Along the scale ranging from -3 to +3, the debate made participants only

slightly less confident in the accuracy of both their explicit memories ($M = -.27$, $SD = 1.04$), and implicit memories ($M = -.21$, $SD = .99$), although these scores differed significantly from no impact for both explicit, $t(96) = -2.58$, $p < .01$, and implicit memories, $t(94) = -2.07$, $p < .05$.

On therapy. Table 22 displays the mean impact of the debate on several dimensions of therapy for the 66 women who reported being in therapy when they first heard of the recovered memory debate. As rated on the scales ranging from 1 to 5, the debate had no effect to a moderately negative impact on therapy with item means ranging from 1.13 to 2.00. The greatest impact on therapy was that it slowed it down, created more 'roadblocks,' and made participants doubt themselves and feel more frightened. Interestingly, the least impact the debate had on therapy was in negatively affecting the relationship between participants and their therapists, and in making them terminate therapy or change therapists. The mean impact for all of these items, however, differed significantly from no impact, as shown in Table 22.

On symptomatology. Item analyses of the subscales of the modified TSC-40 yielded mean interitem correlations ranging from .35 to .55 and alpha values ranging from .81 to .87. As shown in Table 23, participants reported between no change and a slight increase in their symptomatology as a result of the debate. The greatest impact was on dissociation, depression and post sexual abuse trauma, while anxiety and sexual problems were least affected. All impact means nonetheless differed significantly from no impact.

Moderating Effects

One-tailed tests of the hypotheses were performed by way of correlations between the amount of participants' exposure to the debate, the average extent of their memory loss for abuse across abusers, and stage of recovery, variables which may potentially buffer the impact of the recovered memory debate, and survivors' reports of the impact in general, on therapy, and on their symptomatology, were calculated (see Tables 24 to 26)⁶.

Exposure to the debate. The extent of participants' exposure to the debate was unrelated to all of the general impact items and the revictimization indices based on the TSC-40 (see Tables 24 and 26, respectively). As shown in Table 25, however, the more exposure to the debate participants had, the more the debate made them less likely to disclose some things to their therapist and the more they reported changing therapists because of the debate.

Extent of memory loss. As displayed in Tables 24 and 25, respectively, the greater the participants' mean memory loss over all abuse experiences reported on, the more the debate had a detrimental impact on their recovery process and the more they doubted themselves in therapy. The degree of participants' memory loss also moderated the extent to which they were revictimized by the debate (see Table 26). The greater the average

⁶ Two-tailed correlations revealed similar findings, although they resulted in an average increase in probability levels to .08 (SD = .01) for 11 of the 38 correlations which were deemed significant by one-tailed correlations.

memory loss for all abuse experiences, the more difficulties participants experienced with dissociation, anxiety, depression, and sleep disturbances as a result of the debate.

Stage of recovery. The moderating patterns of stage of recovery appear in Tables 24 to 26. While the extent of participants' overall recovery was unrelated to their confidence in their memories or talking with others about their abuse, those less further along in their recovery reported that the debate had a more detrimental impact on their recovery process (see Table 24). In regard to therapy, as shown in Table 25, the less along in their recovery process participants felt, the more the debate negatively affected their relationship with their therapists, made their therapy slow down, and the more it increased the feeling of a power imbalance between them and their therapists. Further, as shown in Table 26, the less recovered women were, the more dissociation, anxiety, depression, post-sexual abuse trauma, sleep disturbances, and sexual problems they experienced because of the recovered memory debate.

Participants' recovery stage scores gave more detailed insight into the moderating effect of their stage of recovery on the impact of the debate (see Tables 24 to 26). The extent to which participants felt safe did not moderate the impact of the debate on participants' general recovery, the extent to which they talked to others about their abuse, or the extent to which they were retraumatized. Level of safety did, however, moderate the extent to which the

debate had an impact on their confidence in the accuracy of their implicit memories for the subjective experiences at the time of the abuse (see Table 24). That is, the less they felt safe, the less confident participants felt about their implicit, but not their explicit, memories of the abuse. Further, the less participants felt safe, the more negatively the debate affected aspects of their therapy process in terms of their relationship with their therapist, the pace of therapy, and changing their therapist (see Table 25).

Although participants' involvement in stage two, remembering and mourning childhood losses, was unrelated to the general impact items (see Table 24), it was found to moderate the impact of the debate on one aspect of their therapy (see Table 25). The less participants were remembering and mourning, the more likely the debate increased the feeling of a power imbalance between the women and their therapists. The degree to which participants were in the remembering and mourning stage of recovery was also related to participants' symptomatology, as illustrated in Table 26. Indeed, the more participants were in the remembering and mourning stage, the more dissociation, anxiety, depression, post-sexual trauma, sleep disturbances, and sexual problems they experienced because of the recovered memory debate.

The moderating effects of the extent to which these women were engaged in the third and final stage of recovery, reconnecting and living again, appear in Tables 24 to 26. As shown in Table 24, the less participants felt they were reconnecting with the world, the more they reported that the debate

made them talk less to people about their abuse and the more detrimental its impact on their general recovery process. No moderating effect was found on the impact on the confidence in the accuracy of memories for the abuse, however. The less in the reconnecting stage participants were, the more the debate negatively affected their relationship with their therapists and the more it made their therapy slow down (see Table 25). Further, Table 26 reveals that the less women were in the third stage, the more dissociation, anxiety, depression, post-sexual trauma, and sleep disturbances they attributed to the recovered memory debate.

Finally, hierarchical regression analyses revealed that the extent of participants' exposure to the debate did not moderate the relation between the degree of memory loss and stage of recovery on the impact of the debate.

The Role of Sample Characteristics

The relationship between the sample characteristics and the impact items and moderating variables was assessed to look for confounds and potential alternative explanations for the present findings (i.e., resulting from any correlation of sample characteristics with both impact items and their moderators). This was also done to investigate any interesting relationships between participant characteristics and to assess the generality of the current findings across demographic variables.

Of the 580 correlations that were calculated between the sample characteristics and all the impact items and moderating variables, only 48

(8.3%) were significant ($r_s = .19$ to $.37$). When more than one sample characteristic was correlated with an impact item or moderator, simultaneous multiple regression analyses were done to identify the unique relations between them. Using this method, only 26 (4.0%) correlations were significant, suggesting that caution be used when interpreting the following results. More amnesia for their abuse was uniquely related to participants being celibate ($\beta = .19$, $t(99) = 1.98$, $p < .05$) and having more perpetrators ($\beta = .19$, $t(99) = 1.93$, $p = .06$), $R^2 = .077$, $F(2,99) = 4.10$, $p < .05$.

The extent of participants' recovery was also related to a few sample characteristics. The further along the women were in their overall recovery process, the higher their education level ($\beta = .21$, $t(82) = 2.12$, $p < .05$, and the more likely they were on disability leave ($\beta = -.26$, $t(82) = -2.48$, $p < .05$), $R^2 = .198$, $F(5,82) = 4.05$, $p < .01$. Those further along in the safety stage also reported more education ($\beta = .27$, $t(90) = 2.71$, $p < .01$) and being employed full time ($\beta = .21$, $t(90) = 2.13$, $p < .05$), $R^2 = .122$, $F(3,90) = 4.16$, $p < .01$. More remembering and mourning was related to being younger ($\beta = -.23$, $t(86) = 2.37$, $p < .05$), having a higher income ($\beta = .20$, $t(86) = 2.16$, $p < .05$), not being on disability benefits ($\beta = -.19$, $t(86) = -1.99$, $p < .05$), and being decided as to what their sexual orientation was ($\beta = -.26$, $t(86) = 2.49$, $p < .01$), $R^2 = .247$, $F(5,86) = 5.64$, $p < .001$. Finally, greater reconnection was associated with higher incomes, ($\beta = .21$, $t(83) = 2.02$, $p < .05$; $R^2 = .162$, $F(4,83) = 4.02$, $p < .01$).

Some sample characteristics were also related to the impact of the debate on participants. Interestingly, the more perpetrators participants reported, the less the debate made them lose confidence in their implicit memories ($\beta = .24$, $t(85) = 2.30$, $p < .05$; $R^2 = .100$, $F(2,85) = 4.70$, $p < .01$). Higher levels of dissociation were attributed to the debate by participants who were part-time students ($\beta = .30$, $t(92) = 3.13$, $p < .01$) and celibate ($\beta = .23$, $t(92) = 2.41$, $p < .05$), $R^2 = .193$, $F(3,92) = 7.33$, $p < .001$. Celibacy was also related to more sleep problems, $r(98) = .21$, $p < .05$, and more sexual problems were experienced by participants who were undecided about their sexual preference, $r(95) = .23$, $p < .05$. More importantly, however, part-time student status was also related to greater anxiety ($\beta = .22$, $t(93) = 2.28$, $p < .05$; $R^2 = .127$, $F(3,93) = 4.50$, $p < .01$), depression ($\beta = .26$, $t(93) = 2.70$, $p < .01$; $R^2 = .143$, $F(3,93) = 5.16$, $p < .01$), post sexual abuse trauma ($r(96) = .27$, $p < .01$), experiencing a more negative impact on their recovery process ($r(94) = -.25$, $p < .05$), as well as the following detriments in therapy: bringing up problems of trust ($r(65) = .26$, $p < .05$), slowing the pace ($\beta = .24$, $t(62) = 1.95$, $p < .05$; $R^2 = .115$, $F(2,62) = 4.01$, $p < .05$), and making participants limit what they told their therapists ($r(64) = .27$, $p < .05$) and doubt themselves ($r(66) = .37$, $p < .01$). Finally, participants were more likely to change therapists as a result of the debate if they were on disability benefits ($r(65) = .29$, $p < .05$), and those who had children were less likely to tell some things to their therapist ($r(64) = .27$, $p < .05$), felt more frightened in therapy ($r(66) = .24$, $p < .05$), and

were more likely to terminate therapy altogether ($r(66) = .26, p < .05$), as a result of the debate.

Of the 120 possible situations where sample characteristics could be correlated with *both* impact items and their potential moderators, only 5 (4.2%) were statistically reliable. Volunteering was related to both participants' safety level and whether the debate made them change therapists, thus a partial, one-tailed correlation was performed between the degree of participants' engagement in the safety stage and the effect of the debate on making them change therapists, controlling for whether participants reported volunteering or not. Although this resulted in a nonsignificant correlation ($r(61) = -.17, p = .09$), the change from the original nonpartialled correlation's significance level ($r(65) = -.25, p = .02$) was not great. Similarly, being celibate was related to both the extent of participants' amnesia for their abuse and the impact of the debate on the dissociation, anxiety, depression, and sleep TSC-40 subscales. One-tailed correlations between the extent of amnesia and these four syndrome scales partialling out celibacy, however, did not alter the findings. The results from this study, then, do not appear to be confounded by demographic variables.

Participant Suggestions on Coping with the Debate

Women's responses to the open-ended questions asking them to describe any things, people, or activities that helped them cope with the FMS debate, and to describe any other types of support or resources that might

have helped them cope, are presented in Table 27. The most frequently given answer to the first question was education, of both the self and the public, about the prevalence and impact of childhood sexual abuse, who is behind the FMS Foundation, and healing techniques. Twenty-seven percent reported that good therapy by a trusted therapist helped, and being believed and supported from loved ones and others, such as self-help groups and lawyers, was mentioned by 22.7%. Twenty-three percent of the respondents said that they especially found solace in hearing stories similar to their own, 7.6% reported that getting corroborating evidence or a confession from the perpetrator eased their recovery, and self-supporting exercises such as journal writing, remembering, and trusting oneself were reported to have helped 19.7%. One woman reported that total avoidance of the debate was helpful, while 12.1% said that nothing helped.

Similar responses were made when participants were asked what else might have helped them cope with the impact of the debate. Again, the majority of the responses suggested that more self and public education, especially more accessible and reliable information, might have helped. Support from loved ones and organizations (more of which were felt to be needed) were suggested by almost half of the respondents, and the aid of a good therapist was suggested by 13.0%. Hearing similar stories and connecting with other survivors were mentioned by 9.3%, while the same number suggested supporting oneself, and 16.7% replied that nothing else

would have helped.

Discussion

First, it is important to note that these women reported having had a moderate to good deal of exposure to the recovered memory debate, having first learned about FMS in the one or two years prior to the present study. This, and the fact that a third of the participants reported having first learned of the debate from newspapers, adds to the relevance of the findings from the earlier study of the press.

Second, before discussing the impact of the debate it is useful to get a sense of survivors' thoughts on the debate and the implications of their thoughts for the notion of FMS. In sharing their initial and current thoughts about the debate, participants revealed various opinions and feelings. Most of these were described as emotional sensations such as anger and confusion, especially upon initial exposure to the debate. But many more complete thoughts and opinions were also shared, especially when participants were describing their current thoughts about the debate. Although many suggested that FMS was a form of backlash or social denial and believed that recovered memories are valid, a substantial number of the women acknowledged the possibility of falsely believing one was abused. This, together with the fact that many women reported doubting themselves and their memories, goes contrary to FMS proponents' (e.g., Ofshe & Watters, 1993; Yapko, 1993) claims that women unquestionably accept their memories, or suggestions, of sexual abuse

in order to explain away their current problems.

Although the recovered memory debate did have an impact on these women, on the whole, it was only a slightly adverse one. More than half of the women were indirectly affected by the debate, however, by being accused of having false memories, usually by a family member. It might therefore be of interest to examine the effect of the media coverage of the debate on the attitudes and beliefs of those people who are a part of the survivors' lives. As one participant put it, "the only impact that it [the debate] will have on my recovery is that I believe that when I go to court both criminal and civil, my father will use false memory syndrome to try and get off on his charges. I will not be able to describe the full impact until after the court process." Surprisingly, and again contrary to the FMS Foundations' assertions, about one in ten of these false memory accusations were made by the participants' therapists.

Participants spontaneously offered several accounts of the impact of the recovered memory controversy. Such adverse effects included greater self-doubt, fear and suspicion, feelings of being silenced and revictimized, and decreases in self-esteem. Further, when asked directly about the impact of the debate on their recovery process, most felt it had a negative effect by slowing it down or halting it altogether, breaking their spirit, or, once again, through its effect on others around them. Participants also reported that the debate resulted in decreasing the extent to which they talked to others about their

abuse, their confidence in the accuracy of their memories and the effectiveness of their therapy, and that it elevated their trauma symptoms.

To get a more accurate picture of the impact of the debate on survivors, it was important to consider the amount of exposure participants had to the debate, the extent of their memory loss, and their stage of recovery. The extent of participants' exposure to the debate was largely unrelated to its impact except that women who reported more exposure were less likely to tell some things to their therapist and were more likely to change therapists because of the debate. Exposure to the debate was not, however, necessarily all negative: greater exposure to the recovered memory debate may be helpful to survivors in that it makes them more vigilant in their selection of an appropriate therapist, as reported spontaneously by some of the participants.

The amount of participants' memory loss regarding the abuse was also related to the impact of the recovered memory debate on therapy in that the greater amnesia participants had, the more the debate made them doubt themselves during counselling sessions. Not surprisingly, greater memory loss was also related to a more negative impact on general recovery, as well as an increased frequency of several trauma symptoms such as dissociation, anxiety, depression, and sleep disturbances. These findings no doubt are directly related to the fact that the FMS debate is essentially a debate of the validity of memories that were at one time lost and later recovered.

How far along these women were in their recovery process was an

especially important moderator of the extent to which the debate affected them. Specifically, the less frequently participants felt safe (i.e., the lower they were in the safety stage of recovery), the more they said the debate decreased their confidence in their implicit, affective and sensorimotor memories of the abuse, and the more the debate was perceived to have had a detrimental impact on therapy. That is, the less safe these women were, the more they said the recovered memory controversy slowed the pace of their therapy, had a negative impact on the participant's relationship with their therapist, and caused them to change therapists.

More importantly, the more participants were remembering and mourning, the more they felt the debate increased the power imbalance in their therapy sessions, and the more impact the debate had on all of the TSC subscales.

The extent to which participants were reconnecting and trying to live again was also an important moderator of the impact of the debate. Women who were less actively in the reconnecting stage reported their recovery process as being more negatively affected by the debate, said they talked less about their abuse as a result of the debate, reported more negative effects on their relationship with their therapists, said the debate slowed down the pace of their therapy, and reported more sexual problems because of the debate. In addition, the less reconnecting the women were doing, the more dissociation, anxiety, depression, post sexual abuse trauma, and sleep disturbances they

attributed to the debate.

As expected, the moderating impact of the three different stages of recovery on the impact items were similar to that of the overall stage of recovery. Yet, the fact that more specific information was revealed when the three stages were considered separately, however, provides justification for a stage model of recovery as suggested by Herman (1992). On this note, it is important to remember that, although only some stage scores were correlated with some of the impact items, survivors are likely to encounter the various forms of impact at some point because their progress through the stages of recovery is not linear; rather, they spiral through them (Herman, 1992).

As an aside, it is also interesting to note at this point that the fact that the confidence in accuracy of memory items were factored into two separate categories, explicit and implicit, and that the findings differed for these two types of memories, is consistent with the literature explicating the impact of trauma on the neurobiological processes underlying explicit and implicit memory (e.g., Hovdestad & Kristiansen, in press; van der Kolk, 1994).

Some of the survivors' demographic characteristics also played a role in how the recovered memory debate affected them, as well as their recovery. Of note, more stable education and employment was related to being further along the process of recovery and less affected by the recovered memory debate, and the larger participants' income was, the farther along they were in their recovery. This finding may be related to issues of accessibility to support

services. In our current society, it stands to reason that the less educated and less wealthy have less access to sources of support for dealing with their past experiences and the issues being raised in the recovered memory debate. Indeed, this issue of resource accessibility was addressed by many participants who suggested that more public education and awareness raising, and greater support by people around them, might have helped them better cope with the impact of the recovered memory debate. This speaks to the need for depersonalizing people's problems and concentrating on the sociopolitical and structural contexts in which they are manifested (e.g., society's endorsement of violence toward women), as suggested by Kitzinger and Perkins (1993).

The recovered memory debate, then, has the potential to adversely affect survivors in a number of different ways. It may slow their recovery, result in unproductive therapy, and deprecate their sense of self. Fortunately, some individual characteristics may act as buffers to this impact, but the best way of dealing with it may be to focus attention on the society within which the sexual abuse of children and the recovered memory controversy exist (see Kristiansen et al., 1995).

Having said this, the sample composition should be considered when interpreting the findings of this study so as not to unjustifiably extrapolate them to all survivors. Although an attempt was made to obtain a diverse sample of women who were sexually abused in childhood, the study participants did not

display an even distribution of demographic variables. While the 112 participants in this study came from a wide range of age, socioeconomic, educational, sexual, and relationship backgrounds, well-educated women from the middle to upper socioeconomic strata and women with sexual preferences other than heterosexual were somewhat overrepresented compared to the general population of women. Further, for obvious reasons, women who were not fluent in English were excluded. There are several possible explanations for this uneven distribution of demographic variables.

Although an attempt was made to reach as many different types of women as possible, in a nonthreatening yet straightforward manner, many women may have not responded because of its academic nature or because of their own personal or cultural barriers to addressing their abuse, for example. The locations where posters were distributed were mainly places where the women would turn to for assistance, and indeed many women reported having heard of the study at local community resource centres and therapists' offices. These participants may therefore be representative of survivors who have already started dealing with their abuse experiences, and who were ready to share it with others. Moreover, because women who displayed problems of risk or safety during the preliminary screening process were excluded from the study, the current findings probably best apply to women who are further along in their recovery. To the extent that the debate has a more pronounced effect on women who are attempting to establish safety, the present findings may

minimize the actual impact of the debate on survivors.

Inasmuch as it is not possible to describe the normal population of survivors, and thus to determine whether the sample in the present study is representative of this population, it was not necessarily the intention of the present study to generalize its findings about the impact of the debate to all survivors of childhood sexual abuse. Rather, describing the impact on only *some* survivors was deemed important, even if it was just those willing to talk about it. As it turned out, however, controlling for the few demographic variables that were correlated with both the impact items and their potential moderators did not alter the findings. The results of the present study, then, appear to hold across the sample characteristics assessed in this study.

That the sample was short of women of visible minorities, however, points to several possible shortcomings in the recruiting procedures, and several possible deficits in the present findings. In fact, one woman who called to participate in the study later declined because there were no interviewers of Colour. Therefore, the current findings are not necessarily generalizable to women of ethnic backgrounds other than white.

Further, because the sample is comparable to that in other studies of women sexually abused in childhood, inter-research comparisons can be made. For example, that on average participants reported having been abused by more than three abusers is in agreement with the findings from other studies (e.g., Westerlund, 1992). This finding also serves to support the

revictimization hypothesis that women who have been abused once, are more likely to be abused again (e.g., Herman, 1992), and should enlighten the reader as to the reality of the problem in our society. Likewise, consistent with Kristiansen's (1994) conclusion that about 50% of survivors forget all or part of their abuse, 58.3% of these women's memories were partially or totally lost at some point. Finally, the findings that the more perpetrators participants had, the greater their memory loss, was consistent with Terr's (1991) distinction between shortterm Type I and longterm Type II traumas. Experiences of abuse by more than one perpetrator would most likely fall under the Type II category of trauma, which is related to more amnesia for the abuse.

Finally, there are several noteworthy aspects of the study's methodology which lend to its reliability. The general thoroughness with which the questionnaire was completed speaks to its pertinence, clarity, and use of appropriate language. Several participants commented on the thoroughness and relevance of the questionnaire, and that it was useful in their recovery process in terms of being able to tell their story, and knowing that someone was interested in their story, and important research was being done. Several respondents also reported being impressed with the overall thoughtfulness and sensitivity of the research process, such as the purposeful attention to the empowerment of the participants by letting them control when, where, and how to complete the questionnaire, and the explicit message that the participants' safety and comfort levels were of the foremost importance.

General Discussion and Conclusions

The present study was done with the understanding that social science is not a mirror of the world, rather that it is a story or a proposal about reality. The researcher does not deny her own biases and opinions in conducting this research. Nor does she imply that its findings can be extrapolated to other contexts. Unlike those who adopt the conventional view of social science, whose primary goal is to describe the world as it really is based on the assumption that this can be done by an objective observer 'external' to this world, the present study was influenced by a sociohistorical approach whose primary goal is to describe different accounts of reality, and to understand their social and historical bases and the role they play in people's lives (Sampson, 1991). By not confining research to the methodological priorities of the more traditional, conventional view of social science, designed to control all possible variables, a more comprehensive and accurate understanding of what is being studied can be achieved. This understanding would thus be based on the social and historical context of the phenomenon under scrutiny rather than achieved by its exclusion or control (Sampson, 1991). One step beyond this is the idea that knowledge is best gathered in the midst of social change, wherein the researcher takes an active part (Fine, 1995). Explicit within such research is the study of change, the move toward change, and/or it is provocative of change, so that it has a purpose.

The present study's findings, then, like any other should be considered

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within the context of the current beliefs and attitudes surrounding childhood sexual abuse, women, children, the media, and the current power and control dynamics in our society, as well as the researcher's current perspective

Within this context, a pro-FMS biased press coverage, consistent with the backlash hypothesis, was suggested, which provides an impression of what the general public knows about the recovered memory debate, and what their attitudes and beliefs are about it inasmuch as the media is a reflection of, or prescription to, society. A negative impact on survivors in several different forms was noted, and individual differences among survivors were found to have a role in determining the extent of this impact. Together, the findings of these two studies beseech the press and other media be alerted to and held accountable for their biased coverage of the recovered memory debate and its negative effects on many survivors of childhood sexual abuse. Media audiences should be alerted to the discrepancies between the coverage of the debate and the actual components of it, and how the news media might influence their beliefs. As Eccles and Jacobs (1986) found, irresponsible mass media coverage of social scientific research can lead to serious contributors to a self-fulfilling prophecy. Following the abundance of media coverage of Benbow and Stanley's (1980) conclusions that females' deficient mathematical ability as compared to males was probably due to neurobiological differences between the genders, Eccles and Jacobs (1986) found a notable decrease in mothers' expectations of their daughters' mathematical ability. In addition,

therapists working with survivors should be made aware of the possible ways that their clients may be affected by the debate, and mindful of the different ways that the therapy itself may be setback.

Future research efforts should look more specifically at what it is about the coverage of the recovered memory debate that has the potential to adversely affect survivors. It could be the bias of the coverage, the arguments being presented, or simply the fact that some memories are publicly being questioned, which results in survivors feeling revictimized. The impact that the coverage has on the rest of the population should also be assessed because even balanced coverage of the debate could lead readers to assume that false memories of child sexual abuse are prevalent, or at least as prevalent as true memories. This is especially important in light of Eccles and Jacobs' (1986) findings regarding mothers' lowered expectancies of their daughters, as just discussed above, and because it is these readers who have the potential to affect the policies and legislation regarding abuse issues.

Further, although much is known about the circumstances and impact of childhood sexual abuse, much still needs to be uncovered. For example, in light of the present findings, the stages of women's recovery and the individual and societally based characteristics of survivors that appear to facilitate healing and greater resilience to the recovered memory debate merit study. In the midst of so many deniers and disbelievers, more research in these areas is needed to support clinicians' claims, to back survivors support systems, and to

shed light on the societal context within which abuse occurs and is denied

However valuable it was to conduct this research, then, it is unfortunate that it had to be done in that it has diverted time and attention away from the more important efforts of tackling the problem of childhood sexual abuse. Even though proponents of FMS readily acknowledge that abuse is a serious problem which should in no way be minimized, they are just as quick to question the current and abundant research findings pointing to its prevalence and effects on its survivors (e.g., Yapko, 1994), and because they are busy trying to disprove some people's recovered memories, the focus is once again shifted away from abuse itself toward the survivor. While much research energy is currently being invested in the recovered memory debate, very little progress has been made in discovering abusive parents and treating them before they abuse children, for example (Flicker, 1993).

Unfortunately, however, as observed by Herman (1992, pp. 7,9),

the study of psychological trauma has a curious history -- one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion. ... The study of psychological trauma has repeatedly led into realms of the unthinkable and foundered on fundamental questions of belief. History teaches us that our current knowledge could also disappear ... In the absence of strong political movements for human rights, the active process of bearing witness inevitably gives way to the active process of forgetting. Repression, dissociation, and denial are phenomena of social as well as individual consciousness.

In addition, because one of the tragic consequences of the recovered memory controversy has been the doubt it has cast on the validity of true recollections in others (Schacter, 1995), it is important to achieve a greater understanding of

the contextual and consequential issues surrounding sexual trauma so that the true memories of childhood sexual abuse can no longer be invalidated. This improved knowledge should also aid in prevention and intervention efforts. Indeed, the time may be ripe for politicizing the personal. Although the social denial of child sexual abuse may be helpful to individuals in the short term, "in the end, for society as for the dissociative patient, *recovery* from pathological dissociation is only possible through *discovery* - recognition that the unthinkable may indeed be real - then confrontation and acceptance of the trauma, followed by correction and then, hopefully, transformation" (Wylie, 1993, p. 43).

Fortunately, the present findings attest to the fact that there are some who "will not stop talking until everyone is more tired of the violence than of those who are its victims" (Sigler, 1993, p. 17). Indeed, twelve percent of participants spontaneously mentioned that they now felt more determined than ever to fight the backlash.

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Appendix A

Materials for Part I: The Content Analysis

Newsplay Coding Sheet

1. NEWSPAPER	
2. DATE (dd/mm/yy)	
3. SECTION	
4. NUMBER OF FIRST PAGE	
5. NUMBER OF SECOND PAGE	
6. NUMBER OF PAGES IN SECTION	
7. NUMBER OF PAGES IN PAPER	
8. NUMBER OF WORDS	
9. NUMBER OF VISUALS	
10. HEADLINE SIZE	
11. PAGE PLACEMENT	
12. LENGTH	
13. FRONT PAGE OR EDITORIAL (Y/N)	
14. ARTICLE (1) OR LETTER (2)	

CODES:

Newspapers:

1. Toronto Star
2. Calgary Herald
3. Vancouver Sun
4. Globe and Mail
5. Montreal Gazette
6. Ottawa Citizen

Headline size:

0. less than two columns' width
1. the width of 2 columns or more
2. more than the width of half the columns on the page

Page placement:

0. first line of article below midfold of newspaper
1. first line of article above midfold of newspaper

Length:

0. less than three quarters the length of the page
1. three quarters the length of the page or more

Content Analysis Coding Sheet
Section A

Source _____ Portrayed credibility

	-2	-1	0	1	2
Type _____	not	slightly	can't tell	slightly	very
Gender _____	credible at all				credible

Argument(s) _____ (for each, indicate if research-based (R))

Source _____ Portrayed credibility

	-2	-1	0	1	2
Type _____	not	slightly	can't tell	slightly	very
Gender _____	credible at all				credible

Argument(s) _____ (for each, indicate if research-based (R))

Source _____ Portrayed credibility

	-2	-1	0	1	2
Type _____	not	slightly	can't tell	slightly	very
Gender _____	credible at all				credible

Argument(s) _____ (for each, indicate if research-based (R))

Source _____ Portrayed credibility

	-2	-1	0	1	2
Type _____	not	slightly	can't tell	slightly	very
Gender _____	credible at all				credible

Argument(s) _____ (for each, indicate if research-based (R))

Source _____ Portrayed credibility

	-2	-1	0	1	2
Type _____	not	slightly	can't tell	slightly	very
Gender _____	credible at all				credible

Argument(s) _____ (for each, indicate if research-based (R))

Content Analysis Coding Sheet
Section B

Does the **headline** accurately reflect the content of the article? _____ (Y/N)

Which side of the debate does it support? _____ 1 FMS **N/A**
2 recovered memory
3 neutral

Does the **visual** accurately reflect the content of the article? _____ (Y/N)

Which side of the debate does it support? _____ 1 FMS **N/A**
2 recovered memory
3 neutral

Does the **caption** accurately reflect the visual? _____ (Y/N)

Which side of the debate does it support? _____ 1 FMS **N/A**
2 recovered memory
3 neutral

Content Analysis Coding Sheet Section C

Does the article suggest that the case is closed, all questions have been answered? _____ (Y/N)

Are suggestions presented on how to resolve the debate? _____ (Y/N)

If yes, **specify:** _____

Gender of author: 1. female
2. male
3. unknown

Gender of 2nd author: 1. female
2. male
3. unknown
N/A

Overall bias of article:

Table 6

Descriptive Statistics for Types of Arguments

Source	<u>M</u> per article	<u>SD</u>	% of articles
Suggestibility issues	2.03	2.79	62.1%
Memory issues	1.97	2.47	74.2%
Abuse issues	1.23	1.77	54.5%
Personal experiences	1.17	1.41	54.5%
Societal issues	.97	1.25	51.5%

Appendix B**Tables for Part I: The Content Analysis**

Table 1

Interrater Reliability for Variables for which Agreement was
Less than Perfect

Variable	<u>N</u>	Cohen's Kappa	Z-score	% agree- ment
Source credibility				
(5 point scale)	69	.90	6.40**	95%
Type of argument				
(5 possible answers)	132	.99	22.31**	98%
Headline accuracy				
(2 possible answers)	30	.79	1.85*	97%
Headline perspective				
(3 possible answers)	30	.90	6.72**	93%

* $p < .05$. ** $p < .001$.

Table 2

Descriptive Statistics for the Measures of Newsplay

Newsplay measure	<u>M</u>	<u>SD</u>
Budd's attention score ^a	2.21	1.19
Page number	.10	.10
Number of visuals	.52	.79
Number of words	828.79	694.56

^aN = 52 due to lack of information for 14 articles.

Table 3

Descriptive Statistics for the Accuracy and Perspective of
Headlines and Visuals, per Article

Item	<u>M</u>	<u>SD</u>	<u>N</u>
Headline:			
Accuracy	1.07	.25	66
Perspective	1.83	.87	66
Visual:			
Accuracy	1.02	.10	23
Perspective	2.11	.64	23
Caption:			
Accuracy	1.03	.12	17
Perspective	2.27	.80	16

Note. Possible range for accuracy is 1 (yes) to 2 (no).
 For perspective 1 = 'pro-FMS', 2 = 'neutral', and
 3 = 'ant-FMS.'

Table 4

Descriptive Statistics for Article Type, Author's Gender,
and Overall Bias

	<u>n</u>	Valid percent
Type of article:		
Article	46	69.7%
Letter	20	30.3%
Gender of author:		
Female	33	50.0%
Male	26	39.4%
Unknown	7	10.6%
Overall bias:		
Totally pro-FMS	21	31.8%
Moderately pro-FMS	17	25.8%
Balanced	1	1.5%
Moderately anti-FMS	6	9.1%
Totally anti-FMS	21	31.8%

Table 5

Descriptive Statistics for Types of Sources

Source	<u>M</u> per article	<u>SD</u>	% of articles
Professional	4.48	4.77	96.7%
Person or support group	.79	.95	45.0%
Author of article	.65	.83	41.7%
Other	.38	.74	20.0%

Table 6

Descriptive Statistics for Types of Arguments

Source	<u>M</u> per article	<u>SD</u>	% of articles
Suggestibility issues	2.03	2.79	62.1%
Memory issues	1.97	2.47	74.2%
Abuse issues	1.23	1.77	54.5%
Personal experiences	1.17	1.41	54.5%
Societal issues	.97	1.25	51.5%

Table 7

Budd's Attention Score and Number of Articles as a Function of Article Bias

Budd's	Pro-FMS		Anti-FMS	
	Totally	Moderately	Moderately	Totally
<u>M</u> *	2.24	2.85	2.60	1.59
(<u>SD</u>)	(1.15)	(1.07)	(1.14)	(1.12)
Sum	38.00	37.00	13.00	27.00
n	17	13	5	17
Number of articles *	21	17	6	21

* $p < .05$.

Table 8

Descriptive Statistics for Other Measures of Newsplay as a
Function of Article Bias

Measure	Pro-FMS		Anti-FMS		<u>F</u>
	Totally	Mod.	Totally	Mod.	
Page number	.12	.07	.05	.11	1.25
(<u>SD</u>)	(.12)	(.07)	(.03)	(.10)	
Number of visuals	.52	.71	.67	.33	1.11
(<u>SD</u>)	(1.03)	(.69)	(.82)	(.58)	
Number of words	862	1068	727	667	.76
(<u>SD</u>)	(819)	(687)	(253)	(628)	

Table 9

Mean Accuracy and Perspective of Headlines and Visuals by Article Bias

	Pro-FMS		Anti-FMS		F
	Totally	Mod.	Totally	Mod.	
Headline:					
Accuracy	1.07	1.06	1.17	1.05	.36
(SD)	(.24)	(.24)	(.41)	(.22)	
Perspective	1.05 ^a	1.44 ^a	2.42 ^b	2.76 ^b	52.22**
(SD)	(.22)	(.50)	(.80)	(.54)	
Visual:					
Accuracy	1.08	1.00	1.00	1.00	.44
(SD)	(.20)	(.00)	(.00)	(.00)	
Perspective	1.75 ^c	1.88 ^c	2.67 ^d	2.50 ^d	3.28*
(SD)	(.42)	(.64)	(.58)	(.55)	
Caption:					
Accuracy	1.00	1.13	1.00	1.00	1.10
(SD)	(.00)	(.25)	(.00)	(.00)	
perspective	2.15	1.63	2.33	3.00	2.67
(SD)	(.78)	(.48)	(1.15)	(.00)	

Note. Accuracy was coded 1 (yes) or 2 (no). Perspective, 1 = 'pro-FMS,' 2 = 'neutral,' and 3 = 'anti-FMS.' Means with different (a,b) subscripts differ significantly at $p < .001$. Means with different (c,d) subscripts differ significantly at $p < .05$.

* $p < .05$. ** $p < .001$.

Table 10

Bias by Article Versus Letter Status

	Pro-FMS *	Anti-FMS
Article *	32 (84.2%)	14 (51.9%)
Letter	6 (15.8%)	13 (48.1%)

*p < .001.

Table 11

Author Gender by Bias

	Pro-FMS	Anti-FMS
Female	16 (42.1%)	16 (59.3%)
Male *	19 (50.0%)	7 (25.9%)

* $p < .05$.

Table 12

Mean Numbers of Sources of Each Gender and Bias, per Article

Gender	Pro-FMS *	Anti-FMS **
Female *	.50	1.03
(<u>SD</u>)	(.88)	(1.65)
Male *	.89	.36
(<u>SD</u>)	(1.08)	(.72)

* $p < .01$. ** $p < .001$.

Table 13

Mean Source Credibility for Each Gender by Source Bias

Gender	Pro-FMS	Anti-FMS
Female	3.70	3.41
(SD)	(.76)	(.93)
<u>n</u>	23	33
Male	3.33	3.80
(SD)	(1.15)	(.39)
<u>n</u>	36	17

Table 14

Descriptive Statistics for Source Types by Bias

Source	<u>M</u> per article	<u>SD</u>	% of articles	<u>t</u>
Professional:				
Pro-FMS	2.26	2.61	72.7%	.08
Anti-FMS	2.23	3.14	71.9%	
Person or support group:				
Pro-FMS	.45	.68	36.4%	1.07
Anti-FMS	.33	.64	25.0%	
Author of article:				
Pro-FMS	.41	.58	36.4%	2.27*
Anti-FMS	.24	.43	21.9%	
Other:				
Pro-FMS	.17	.48	12.1%	- .47
Anti-FMS	.21	.60	14.1%	

*p < .05, two-tailed.

Table 15

Descriptives Statistics for Argument Types by Bias

Argument	M per article	<u>SD</u>	% of articles	<u>t</u>
Memory issues:				
Pro-FMS	.92	1.45	42.4%	-.56
Anti-FMS	1.05	1.57	53.0%	
Suggestibility issues:				
Pro-FMS	1.62	2.23	53.0%	5.03**
Anti-FMS	.41	.91	24.2%	
Abuse issues:				
Pro-FMS	.39	.68	28.8%	-2.48*
Anti-FMS	.83	1.46	40.9%	
Personal experiences:				
Pro-FMS	.59	.82	39.4%	.10
Anti-FMS	.58	1.01	33.3%	
Societal issues:				
Pro-FMS	.50	.77	34.8%	.21
Anti-FMS	.47	.95	27.3%	

*p < .05. **p < .001, two-tailed.

Appendix C
Materials for
Part II: The Impact of the Debate on Survivors

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CONSENT FORM: SURVIVORS OF CHILD SEXUAL ABUSE SURVEY

This survey of adult survivors of child sexual abuse is being conducted by Carolyn Allard and Wendy Hovdestad, Master's students, Kathleen Felton, a doctoral student, and Dr. Connie Kristiansen, Associate Professor of Psychology, in the Psychology Department of Carleton University.

In this study you will be given various questionnaires asking you to describe your own experience as a survivor of child sexual abuse. More specifically, the questions will ask about things such as the nature of your abuse, the impact of the abuse on you, how you coped with the abuse, your memories of the abuse, and your recovery process.

It is important that you understand that your participation in this study is completely voluntary. Some of the questions address sensitive issues, and you are free to refuse to answer any questions and may withdraw from the study at any time. Your answers will be totally anonymous and confidential.

We thank you in advance for your participation.

Sincerely,

Kathleen Felton, M.A.

Connie Kristiansen, Ph.D.

Carolyn Allard, B.A.

Wendy Hovdestad, B.Sc.

I acknowledge that I have read the above information and willingly consent to participate in this study, while recognizing that I can stop participating at any time, for any reason.

NAME: (print): _____

NAME: (signature): _____ DATE: _____

- 7) Was this therapist an expert in trauma who sees survivors almost exclusively?

YES NO NOT SURE

- 8) Did this therapist believe that treatment would not work unless traumatic memories were uncovered?

YES NO NOT SURE

- 9) Are you currently in this therapy? YES NO

If no, please explain why: _____

- 10) During this therapy how much time was spent dealing directly with sexual abuse? Estimate a percent between 0 and 100%.

_____ % of the time

- 11) In your opinion was sexual abuse discussed in this therapy:

(Check one) _____ Much too little

_____ Not quite enough

_____ Just enough

_____ A little too much

_____ Much too much

Should you wish to discuss this study you are welcome to contact Kathleen Felton, M.A., doctoral candidate, Carolyn Allard, B.A. or Wendy Hovdestad, B.Sc., Master's students, in Loeb A501, 788-2600 ext. 2679, or Dr. Connie Kristiansen in Loeb A527, 788-2600 ext. 2674 at Carleton University . Should you have any complaints or comments about the way in which this study was conducted or how you were treated, please contact Dr. Lise Paquet, Chair of the Psychology Ethics Committee, in Loeb A533, 788-2600 ext. 2692, or Bill Jones, Chair of Psychology Department, in Loeb B559, 788-2600 ext. 2648.

Thank you for your assistance.

SECTION A: BACKGROUND INFORMATION

- 1) Your age: _____ years.
- 2) Your education: any degrees, certificates, or diplomas you have obtained. (check as many as apply)
- _____ None
 - _____ Elementary school
 - _____ Secondary (High) School graduation certificate
 - _____ Trades certificate or diploma
 - _____ Other non-university certificate or diploma
(community college, CEGEP, institute of technology, etc.)
 - _____ University Bachelor's degree(s) (e.g., B.A., B. Sc., B.A. Sc., LL.B)
 - _____ Master's degree(s) (e.g., M.A., M.Sc., M.Ed.)
 - _____ Degree in medicine, dentistry, veterinary medicine, or optometry (e.g., M.D., D.D.S., D.M.D., D.V.M., D.D.)
 - _____ Doctorate (e.g., Ph.D., D.Sc., D.Ed.)
 - _____ Other - Describe: _____
- 3) Employment/Student Status (circle all that apply)
- 1. Employed full-time (35 or more hours per week)
 - 2. Employed part-time
 - 3. Homemaker
 - 4. Student full-time
 - 5. Student part-time
 - 6. Unemployed
 - 7. Disabled
 - 8. Volunteer

4) Your total family income, per year (check one):

☐ under \$15,000	☐ \$45,000 - 54,999
☐ \$15,000 - 24,999	☐ \$55,000 - 64,999
☐ \$25,000 - 34,999	☐ \$65,000 - 74,999
☐ \$35,000 - 44,999	☐ over \$75,000

5) Sexual orientation (check one):

Bisexual ☐ Heterosexual ☐ Lesbian ☐
Undecided ☐ Celibate ☐

6) Relationship status (check one):

None ☐ No current significant involvement ☐
Current significant involvement ☐
Living with a life partner ☐ Living with a partner ☐

7) Do you have a children? YES NO

If yes, how many? ☐ children

8) Is there anything else you would like to tell us about your background?

SECTION B: THERAPY BACKGROUND

1) Have you ever had any kind of therapy?

(circle) YES NO [If NO, skip to next section.]

* * * * *
 If you have been in therapy at different points in your life or with different therapists, please complete questions 2 to 11 for each period or therapist. To do so, ask your interviewer for more copies of these questions, one copy for each period or therapist.
 * * * * *

2) How old were you when this therapy began? _____ years old

3) How old were you when this therapy ended? _____ years old

4) We would like to know why you entered this therapy. Using the following scale, please rate the degree to which the following issues prompted you to seek this therapy. Write a number to the left of each statement.

1 = Not at all

4 = A good deal

2 = Slightly

5 = A great deal

3 = Moderately

- a) _____ alcohol/drug problems
- b) _____ anxiety
- c) _____ depression
- d) _____ eating problems
- e) _____ felt as if I was going crazy
- f) _____ promiscuity
- g) _____ relationship problems
- h) _____ self-abuse (e.g., cutting, burning)
- i) _____ self-confidence issues
- j) _____ self-esteem issues

1 = Not at all

4 = A good deal

2 = Slightly

5 = A great deal

3 = Moderately

k) _____ sexual abuse issues

l) _____ sexual problems

m) _____ sleep disturbances

n) _____ stress

o) _____ feeling suicidal

p) _____ feeling out of control

q) _____ phobias

r) _____ feeling scared all the time

s) _____ panic attacks

t) _____ other(s) (explain): _____

5) Was this therapy: _____ individual therapy?

(Check ALL that apply) _____ group therapy?

6) Was this therapist or group facilitator a:

_____ medical doctor (M.D.)

_____ social worker

_____ psychiatrist (M.D.)

_____ school counselor

_____ psychologist (Ph.D.)

_____ religious counselor

_____ psychotherapist

_____ addictions counselor

_____ other (explain): _____

- 7) Was this therapist an expert in trauma who sees survivors almost exclusively?

YES NO NOT SURE

- 8) Did this therapist believe that treatment would not work unless traumatic memories were uncovered?

YES NO NOT SURE

- 9) Are you currently in this therapy? YES NO

If no, please explain why: _____

- 10) During this therapy how much time was spent dealing directly with sexual abuse? Estimate a percent between 0 and 100%.

_____ % of the time

- 11) In your opinion was sexual abuse discussed in this therapy:

(Check one)

_____ Much too little

_____ Not quite enough

_____ Just enough

_____ A little too much

_____ Much too much

SECTION E: MEMORIES OF ABUSE

* * * * *

Please complete the following questions (1-16) for EACH perpetrator. To do so, ask your interviewer for more copies of these questions, one copy for each abuser.

* * * * *

- 1) Please read the statements below, then circle the letter of the one statement that most accurately describes your memory process.
 - a. I always remembered the abuse by this perpetrator in its entirety.
 - b. I always remembered the abuse by this perpetrator, but never before defined it as abuse.
 - c. I always remembered the abuse by this perpetrator, but only parts or some aspects of it.
 - d. I was not aware of the abuse by this perpetrator, but I have recovered some memories.
 - e. I was not aware of the abuse by this perpetrator, but now remember completely.
 - f. I have no memory of the abuse by this perpetrator, but have evidence it occurred.
 - g. I have no memory of the abuse by this perpetrator, but I have good reason to suspect it occurred.

- 2) If you circled b-f above, how old were you when your memories of the abuse by this perpetrator first began to surface?

_____ years old.

3) If you remember at least some of your abuse by this perpetrator (if you circled a-e above), have you ever wished you could forget it? (check one)

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Often
- ☐ Almost always

4) How often do you think of saying "this never happened" as a way of stopping the pain? (check one)

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Often
- ☐ Almost always

5) How often do you think of saying "this never happened" as a way of regaining family love? (check one)

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Often
- ☐ Almost always

- 6) Has there been a time, after you realized that you had been sexually abused, that you changed your mind and believed that you actually had not been abused? YES NO

If yes, how many times has this happened?

- (Check one) ☐ Never
 ☐ Rarely
 ☐ Occasionally
 ☐ Often
 ☐ Very often

When you change your mind, for how long do you usually believe you had not been abused?

- (Check one) ☐ Minutes
 ☐ Hours
 ☐ Days
 ☐ Weeks
 ☐ Months
 ☐ Years

- 7) Circle the letter of one of the following experiences that best characterizes your memory of the abuse by this perpetrator?
- a. I have always remembered this abuse throughout my life, even though I never talked about it.
 - b. I have remembered parts of this abuse my whole life, while not remembering all of it.
 - c. I forgot this abuse for a period of time, and only later remembered.
- 8) Was there ever a time when you would not have been able to remember the abuse by this perpetrator, even if you had been directly asked about it? YES NO
- 9) Was there ever a time when you would not have been able to report this abuse because you had no idea that it had even happened to you? YES NO

10) During the period of time between when this first forced sexual experience happened and your 18th birthday, was there ever a time when you could not remember this forced sexual experience? YES NO

11) Did your first memories of your abuse by this perpetrator surface while you were in therapy? YES NO

If yes, please read each of the statements below and circle whether this therapy involved any of the following.

<u>Circumstance</u>	<u>Answer</u>
a) individual psychotherapy	YES NO
b) group therapy	YES NO
c) hypnosis	YES NO
d) visualization or imagery work	YES NO
e) the therapist suggesting you might have been abused	YES NO
f) reading the abuse literature recommended by therapist	YES NO
g) reading abuse literature you chose to read	YES NO
h) substance abuse treatment	YES NO
i) therapist asking if you were abused	YES NO
j) therapist insisting that you were abused	YES NO
k) body work (e.g., massage)	YES NO
l) other: _____	YES NO

- 12) Below is a list of various events or experiences that, for some people, might trigger or bring on memories of abuse. (Such memories might come as body memories, flashbacks, emotions, thoughts, etc.) Please indicate whether, for your abuse by this perpetrator, you ever experienced any of these triggers, and if yes, indicate whether the trigger occurred before, during, or after you were in therapy. If you never received therapy, but a trigger occurred, check "before therapy."

TriggerAnswer

Developing an important relationship?

YES NO

If yes, when did this trigger a memory?

☐ before I entered therapy☐ while I was in therapy☐ after my therapy was completed

The birth of a child?

YES NO

If yes, when did this trigger a memory?

☐ before I entered therapy☐ while I was in therapy☐ after my therapy was completed

The death of perpetrator?

YES NO

If yes, when did this trigger a memory?

☐ before I entered therapy☐ while I was in therapy☐ after my therapy was completed

The death of other significant person?

YES NO

If yes, when did this trigger a memory?

☐ before I entered therapy☐ while I was in therapy☐ after my therapy was completed

Ending an important relationship? YES NO

If yes, when did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

During an illness? YES NO

If yes, when did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

After reading or seeing a film about abuse? YES NO

If yes, when did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

While parenting your own children? YES NO

If yes, when did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

Exposure to event(s) similar to the original abuse? YES NO

If yes, when did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

Participating in a sexual abuse support group YES NO

If yes, when did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

After stopping alcohol/drug abuse YES NO

If yes, when did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

During a creative process (e.g., drawing, writing) YES NO

When did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

Other: _____

When did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

Other: _____

When did this trigger a memory?

___ before I entered therapy

___ while I was in therapy

___ after my therapy was completed

13) Using the scale below please rate the extent to which your memories of your abuse by this perpetrator emerged via the following processes. Mark your response in the space provided to the left of each process.

1 = Never

4 = Often

2 = Rarely

5 = Almost always

3 = Occasionally

TO WHAT EXTENT DID YOUR MEMORIES RETURN:

Answer Process

_____ as flashbacks (as if you were reliving the event)

_____ as body memories (physical sensations)

_____ as other sensory processes (e.g., colours, sounds, tastes, odors)

_____ all at once, suddenly remembering the whole story

_____ in fragments, gradually overtime

_____ through dreams/nightmares

_____ images in my mind while awake

_____ sudden, intense emotional feelings

_____ through my drawings/paintings/sculpting

_____ through my writings

_____ through music

_____ through your behavior (e.g., aversions, avoidance behaviors, re-enactments). Describe briefly: _____

_____ other, describe: _____

_____ other, describe: _____

14) Please use the following scale to rate how clear and confident you are in your memories of the abuse by this perpetrator. Mark a number in the space to the left of each statement.

1 = Not at all 2 = A little 3 = Moderately
4 = Very 5 = Totally

a) How clear are your memories of:

- _____ the abuse in general?
- _____ who the abuser(s) was?
- _____ where the abuse took place?
- _____ when the abuse took place?
- _____ what the abuse involved?
- _____ your feelings at the time of the abuse?
- _____ your thoughts at the time of the abuse?
- _____ your bodily sensations at the time of the abuse?

b) How much confidence do you have in the accuracy of your memories of:

- _____ the abuse in general?
- _____ who the abuser(s) was?
- _____ where the abuse took place?
- _____ when the abuse took place?
- _____ what the abuse involved?
- _____ your feelings at the time of the abuse?
- _____ your thoughts at the time of the abuse?
- _____ your bodily sensations at the time of the abuse?

15) Have you ever thought your memories might be "all wrong" and that the abuse by this perpetrator never occurred?

(check one)

Never

 Rarely

 Occasionally

 Often

 All the time

16) Is there anything else you would like to tell us about your memories of your abuse by this perpetrator?

[illegible]

SECTION H: "FALSE MEMORY SYNDROME" DEBATE

There has been considerable debate concerning what some people call "False Memory Syndrome" (FMS). Some people are questioning the validity of survivors' previously forgotten, but recently recovered, memories of childhood abuse. That is, some people are questioning whether people can unintentionally receive well-intended suggestions from their therapists, friends, and families, or pick up ideas from books, television, and movies, and come to believe that they experienced abuse that never actually happened. Others argue that people cannot be made to recall sexual abuse that never happened, and that attempts to disprove such abuse are attempts to victimize those already violated.

1) How much have you been exposed to this debate?

(check one) ☐ Not at all; never heard of it.

☐ Slightly

☐ Moderately

☐ A good deal

☐ A great deal

[If you answered "Not at all" above SKIP to the question 17, otherwise continue with the next question.]

2) When did you first learn about the "False Memory Syndrome" debate? month year

3) Where did you first learn about the "False Memory Syndrome" debate?

a) ☐ newspaper

e) ☐ therapist

b) ☐ magazine

f) ☐ friend

c) ☐ family member

g) ☐ television/radio

d) ☐ perpetrator

h) ☐ other:

- 4) In your own words, please describe your initial thoughts, feelings, and reactions when you first learned of the "False Memory Syndrome" debate.

- 5) In your own words, please describe your current thoughts, feelings and reactions to the "False Memory Syndrome" debate.

6) In your own words, please describe the impact the debate has had on your recovery process.

7) Please check the degree of impact the debate has had on your recovery process.

- ☐ Extremely detrimental
- ☐ Moderately detrimental
- ☐ Somewhat detrimental
- ☐ No effect
- ☐ Somewhat helpful
- ☐ Moderately helpful
- ☐ Extremely helpful

8) If you feel the "False Memory Syndrome" debate affected you, please describe any things, people, or activities that helped you cope with the impact of the "FMS" debate.

9) Are there any other types of support or resources that might have helped you cope with the impact of the "FMS" debate?

10) How confident are you in the accuracy of your memories?

- (Check one) ☐ Totally confident
☐ Very confident
☐ Moderately confident
☐ Slightly confident
☐ Not at all confident

11) Has anyone ever accused you of having false memories?

YES NO

If yes, who were these people (e.g., friends, family, therapist, etc.)?

12) Has the "FMS" debate affected the extent to which you talk to people about your abuse? (check one)

- ☐ I talk much less about it
☐ I talk moderately less about it
☐ I talk slightly less about it
☐ No change
☐ I talk slightly more about it
☐ I talk moderately more about it
☐ I talk much more about it

- 13) If you were in therapy when you learned about the "FMS" debate, please use the following scale to rate the extent to which the "False Memory Syndrome" debate affected the following aspects of your therapy. Mark a number in the space to the left of each statement.

1 = Not at all

2 = Slightly

3 = Moderately

4 = A good deal

5 = A great deal

- a) ____ negatively affected the relationship between yourself and your therapist
- b) ____ brought up problems of trust with your therapist
- c) ____ made you suspect that your therapist may doubt you
- d) ____ increased the distance between yourself and your therapist
- e) ____ made the therapy slow down
- f) ____ made more "roadblocks" surface during therapy
- g) ____ increased the feeling of a power imbalance between yourself and your therapist
- h) ____ made you limit or modify what you told your therapist
- i) ____ made you less likely to tell your therapist some things
- j) ____ made you doubt yourself in therapy
- k) ____ made you feel more scared in therapy
- l) ____ made you terminate therapy
- m) ____ made you change your therapist
- n) ____ other: _____

- o) ____ other: _____

14) Did learning about "False Memory Syndrome" affect your experience of any of the following? That is, after you heard about "FMS" did the following occur more often, less often, or was there no change? To answer, pick a number from the following scale and write it in the space to the left of each item.

- 3 = Occurred much less often
- 2 = Occurred moderately less often
- 1 = Occurred slightly less often
- 0 = No change
- +1 = Occurred slightly more often
- +2 = Occurred moderately more often
- +3 = Occurred much more often

Answer Item

- _____ Insomnia (trouble getting to sleep)
- _____ Restless sleep
- _____ Over sleeping
- _____ Nightmares
- _____ Waking up early in the morning and can't get back to sleep
- _____ Weight loss (without dieting)
- _____ Weight gain
- _____ Feeling isolated from others
- _____ Seeking isolation from others and withdrawing
- _____ Loneliness
- _____ Fear of others
- _____ Feeling unsafe
- _____ Fear of self
- _____ Intrusive, unwanted thoughts

[continued -->]

- 3 = Occurred much less often
 -2 = Occurred moderately less often
 -1 = Occurred slightly less often
 0 = No change
 +1 = Occurred slightly more often
 +2 = Occurred moderately more often
 +3 = Occurred much more often

Answer Item

- _____ Feeling generally confused
 _____ Low sex drive
 _____ Sadness
 _____ "Flashbacks" (sudden vivid distracting memories)
 _____ "Spacing out" (going away in your mind)
 _____ Headaches
 _____ Stomach problems
 _____ Uncontrollable crying
 _____ Anxiety Attacks
 _____ Trouble controlling temper
 _____ Trouble getting along with others
 _____ Dizziness
 _____ Passing out
 _____ Desire to physically hurt yourself
 _____ Desire to physically hurt others
 _____ Sexual problems
 _____ Sexual overactivity
 _____ Fear of men
 _____ Fear of women [continued -->]

- 3 = Occurred much less often
 -2 = Occurred moderately less often
 -1 = Occurred slightly less often
 0 = No change
 +1 = Occurred slightly more often
 +2 = Occurred moderately more often
 +3 = Occurred much more often

Answer Item

- ___ Feelings of inferiority
 ___ Feelings of guilt/shame
 ___ Feelings that things are "unreal"
 ___ Memory problems
 ___ Feelings that you are not always in your body
 ___ Feeling tense all the time
 ___ Having trouble breathing
 ___ Not feeling rested in the morning
 ___ Waking up in the middle of the night
 ___ Not feeling satisfied with your sex life
 ___ Having sex that you didn't enjoy
 ___ Bad thoughts or feelings during sex
 ___ Being confused about your sexual feelings
 ___ Sexual feelings when you believe you shouldn't have them
 ___ Suicidal thoughts
 ___ Suicidal attempt
 ___ Trying to physically hurt yourself, other than a suicide attempt [continued --->]

- 3 = Occurred much less often
- 2 = Occurred moderately less often
- 1 = Occurred slightly less often
- 0 = No change
- +1 = Occurred slightly more often
- +2 = Occurred moderately more often
- +3 = Occurred much more often

Answer Item

- _____ Phobias (extreme fear of something)
- _____ Promiscuity
- _____ Prostitution
- _____ Celibacy
- _____ Alcohol use
- _____ Prescription drug use
- _____ Street-drug abuse
- _____ Running away from home
- _____ Difficulties concentrating
- _____ Strong feelings of not being able to trust others
- _____ Strong feelings of not wanting to be touched by anybody
- _____ Thinking the same thoughts repeatedly
- _____ Generalized aches and pains
- _____ Startled reaction when you are touched
- _____ Binging and purging
- _____ Other problems with food
- _____ Irritability [continued ---->]

- 3 = Occurred much less often
- 2 = Occurred moderately less often
- 1 = Occurred slightly less often
- 0 = No change
- +1 = Occurred slightly more often
- +2 = Occurred moderately more often
- +3 = Occurred much more often

<u>Answer</u>	<u>Item</u>
_____	Anger
_____	Depression
_____	Bad thoughts or feelings about yourself
_____	Being confused about who you are
_____	Unnecessary or over-frequent washing
_____	Feeling helpless
_____	Feeling like everyone or the world is against me
_____	Other (specify) _____
_____	Other (specify) _____
_____	Other (specify) _____

15) Please use the scale below to rate the following items.
Mark a number in the space provided to the left of each
statement.

-3 = Much less confident

-2 = Moderately less confident

-1 = Slightly less confident

0 = No change

+1 = Slightly more confident

+2 = Moderately more confident

+3 = Much more confident

For any of your abuse experiences, to what extent did the
"False Memory Syndrome" debate affect your confidence in the
accuracy of your memories of:

_____ the abuse in general?

_____ who the abuser(s) was?

_____ where the abuse took place?

_____ when the abuse took place?

_____ what the abuse involved?

_____ your feelings at the time of the abuse?

_____ your thoughts at the time of the abuse?

_____ your bodily sensations at the time of the abuse?

16) Is there anything else you would like to tell us about the
"FMS" debate and its impact on you?

17) How familiar are you, or how much exposure have you had, with child sexual abuse and the issues surrounding it?

- (check one) ☐ Not at all familiar
 ☐ Slightly familiar
 ☐ Moderately familiar
 ☐ Very familiar
 ☐ Extremely familiar

18) If you have not always remembered your abuse, how familiar were you with child sexual abuse and the issues surrounding it before you recovered your memories?

- (check one) ☐ Not at all familiar
 ☐ Slightly familiar
 ☐ Moderately familiar
 ☐ Very familiar
 ☐ Extremely familiar

Table 22

Mean Impact of Debate on Therapy for Participants in Therapy When They Learned of the Debate

Therapy item ^a	<u>M</u>	<u>SD</u>	<u>t</u>
Doubting self	2.00	1.10	7.42***
Creation of roadblocks	1.91	1.23	5.89***
Slowed pace	1.86	1.14	6.07***
Increased fear	1.76	1.16	5.29***
Suspicion of doubt	1.56	.99	4.58***
Decreased likelihood to tell certain things	1.53	1.02	4.15***
Limitation/modification of what is said	1.45	.89	4.07***
Problems of trust	1.42	.77	4.50***
Increased distance	1.40	.79	4.10***
Increased power imbalance	1.37	.82	3.63***
Negative impact on client- therapist relationship	1.27	.54	4.09***
Change of therapist	1.20	.81	1.98*
Termination of therapy	1.20	.64	5.21**

Note. N = 64 - 66.

^aScores could range from 1 (not at all) to 5 (a great deal).

*p < .05. **p < .01. ***p < .001, two-tailed.

Appendix D

Tables for

Part II: The Impact of the Debate on Survivors

Table 16

Descriptive Statistics for Quantitative Sample
Characteristics

	Range	<u>M</u>	<u>SD</u>
Age	18 - 57	34.21	(8.25)
Family income	1 - 8	3.43	(2.22)
Number of children	1 - 5	2.27	(1.11)
Number of abusers	1 - 22	3.41	(3.73)

Note. N = 105 - 107 for all variables except for number of children where N = 49.

Table 17

Frequencies for Qualitative Sample Characteristic

	Cases	Valid %
Education:		
High school	81	72.3
Non-university cert./diploma	66	59.0
Bachelor's degree	34	30.4
Master's degree	8	7.1
MD / DDS / DMD / DVM /OD	1	.9
Ph.D.	1	.9
Other	19	17.0
Employment:		
Full time paid	45	40.5
Homemaker	36	32.4
Part time paid	29	26.1
Student - full time	25	22.5
Student - part time	19	17.1
Unemployed	18	16.2
Volunteer	15	13.5
Disability	15	13.5
Sexual Orientation:		
Heterosexual	73	65.8
Lesbian	20	18.0
Celibate	12	10.8
Bisexual	10	9.0
Undecided	4	3.6
Relationship status:		
Living with life partner	41	36.9
None	25	22.5
No current sign. involvement	23	20.7
Current sign. involvement	15	13.5
Living with current partner	7	6.3
Had therapy	102	91.9

Table 18

Descriptive Information for Variables Potentially Moderating
the Impact of the Debate

Mediator	Possible Range	<u>M</u>	<u>SD</u>	<u>N</u>
Extent of memory loss	1 - 3	1.94	.88	246
Stage of recovery:				
Overall	1 - 5	3.32	.73	112
Safety	1 - 5	3.64	.80	111
Remembering and mourning	1 - 5	2.96	.94	112
Reconnecting	1 - 5	3.22	.96	112
Exposure to debate	0 - 5	2.30	1.14	110

Table 19

Pattern Matrix for Stage of Recovery Items

Aspect of recovery process	Factor 1
<hr/>	
Experiencing safety issues	.623
Abusing substances	.115
Trusting self	.724
Trusting others	.501
Recovering memories	.552
Mourning childhood losses	.602
Time out to deal with issues	.702
Time out to feel safe and comfortable	.762
Allowed to "live again"	.756

Table 20

Participants' Responses to the Recovered Memory Debate

Response	First reactions ^a	Current thoughts ^b
Emotional response	88 (85.4%)	35 (37.6%)
Backlash/social denial	50 (48.5%)	70 (97.7%)
Negative impact on self	37 (35.9%)	31 (33.3%)
Recovered memories are possible	22 (21.4%)	47 (50.5%)
False memories are possible	17 (16.5%)	27 (29.0%)
Increased awareness/cautiousness	13 (12.5%)	19 (20.4%)
Worried about impact on others	6 (5.8%)	17 (18.3%)
'Not me'	4 (3.9%)	4 (4.3%)
Tried to ignore it	1 (1.0%)	1 (1.1%)
Determined to fight back		11 (11.8%)

^aN = 103. ^bN = 93.

Table 21

Factor Loadings for Impact of Debate on the Confidence in
Accuracy of Memory for the Abuse Items

Accuracy of memory for:	Factor 1	Factor 2
Abuse in general	.776	.440
Who abuser was	.870	.186
Where abuse took place	.864	.247
When abuse took place	.767	.488
What the abuse involved	.775	.397
Feelings at time of abuse	.329	.933
Thoughts at time of abuse	.344	.915
Bodily sensations at time of abuse	.322	.935

Table 22

Mean Impact of Debate on Therapy for Participants in Therapy When They Learned of the Debate

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Creation of roadblocks	1.91	1.23	5.89***
Slowed pace	1.86	1.14	6.07***
Increased fear	1.76	1.16	5.29***
Suspicion of doubt	1.56	.99	4.58***
Decreased likelihood to tell certain things	1.53	1.02	4.15***
Limitation/modification of what is said	1.45	.89	4.07***
Problems of trust	1.42	.77	4.50***
Increased distance	1.40	.79	4.10***
Increased power imbalance	1.37	.82	3.63***
Negative impact on client- therapist relationship	1.27	.54	4.09***
Change of therapist	1.20	.81	1.98*
Termination of therapy	1.20	.64	5.21**

Note. N = 64 - 66.

^aScores could range from 1 (not at all) to 5 (a great deal).

*p < .05. **p < .01. ***p < .001, two-tailed.

Table 23

Mean Impact of Debate on Trauma Symptoms

TSC-40 subscale	<u>M</u>	<u>SD</u>	<u>t</u>
Dissociation	.38	.68	5.43*
Post Sexual Abuse Trauma	.36	.64	5.50*
Depression	.36	.58	6.20*
Sleep disturbance	.34	.65	5.18*
Anxiety	.27	.53	5.14*
Sexual problems	.22	.50	4.36*

Note. N = 95 - 98. Scores could range from -3 (occurred much less often) to +3 (occurred much more often).

* $p < .05$, two-tailed.

Table 24

Correlations of Moderating Variables with General Impact Items

Impact item	Exposure to debate ^a	$\bar{M}$ extent of memory loss ^b	Stage of recovery ^c		
			Safety	Remembering and mourning	Overall
Recovery process	-.116	-.297**	.157	.044	.308***
Talking to others	.027	-.027	.016	-.015	.219*
Confidence in accuracy of:					
Explicit memories	.023	-.105	.086	-.097	.040
Implicit memories	.033	-.007	.177*	-.096	.076

^a $\bar{n} = 94$ - 97. ^b $\bar{n} = 92$ - 95. ^c $\bar{n} = 83$ - 97.* $p < .05$. ** $p < .01$. *** $p < .001$, one-tailed.

Table 25

Correlations of Moderating Variables with the Impact of the Debate on Therapy Items

Therapy item	Exposure to debate ^a	M extent of memory loss ^b	Stage of recovery ^c			Overall
			Safety	Remembering and mourning	Reconnecting	
Doubting self	.143	.228*	-.047	-.016	-.057	-.040
Creation of roadblocks	.008	.137	-.169	-.039	-.105	-.123
Slowed pace	.095	.144	-.276*	-.148	-.224*	-.255*
Increased distance	.036	.037	-.120	-.062	-.088	-.103
Suspicion of doubt	.154	.115	-.146	-.101	-.023	-.102
Decreased likelihood to tell	.230*	.102	-.026	-.156	-.056	-.077
Limit what is said	.122	.119	-.107	-.185	-.180	-.176
Problems of trust	.096	.074	-.089	-.156	-.068	-.112
Increased fear	.081	.053	.069	.013	.117	.105
Increased power imbalance	.090	.049	-.182	-.328**	-.152	-.237*
Neg. impact on relationship	.090	.189	-.208*	-.096	-.203*	-.211*
Change of the apist	.258*	.043	-.251*	-.068	-.107	.183
Termination of therapy	.106	-.041	-.088	-.156	-.145	-.157

^a $\eta^2 = .64 - .66$. ^b $\eta^2 = .64 - .66$. ^c $\eta^2 = .64 - .66$.* $p < .05$. ** $p < .01$, one-tailed.

Table 26

Correlations of Moderating Variables with the Impact of the Debate on Trauma Symptoms

TSC-40 Subscale	Exposure to debate ^a	M extent of memory loss ^b	Stage of recovery ^c		
			Safety	Remembering and mourning	Reconnecting Overall
Dissociation	.028	.227**	-.114	-.281**	-.278**
Anxiety	.003	.212*	-.058	-.249**	-.248**
Depression	.043	.232**	-.115	-.213**	-.271**
Post Sexual Abuse Trauma	.074	.111	-.123	-.240**	-.233**
Sleep disturbance	.119	.195*	-.051	-.230**	-.168*
Sexual problems	.126	.056	-.157	-.184**	-.152

^a $\eta^2 = .95 - .98$. ^b $\eta^2 = .93 - .96$. ^c $\eta^2 = .83 - .98$.* $p < .05$. ** $p < .01$, one-tailed.

Table 27

What Helped and What Might Have Helped Participants Cope
with the Debate

Suggestions	What helped ^a	What would have helped ^b
Education/awareness raising	39 (59.1%)	40 (74.1%)
Good therapy	18 (27.3%)	7 (13.0%)
Support from friends/family	15 (22.7%)	26 (48.2%)
Hearing similar stories to own	15 (22.7%)	5 (9.3%)
Self-support	19 (19.7%)	5 (9.3%)
Nothing	8 (12.1%)	9 (16.7%)
Corroboration	5 (7.6%)	-
Avoidance	1 (1.5%)	-

^aN = 66. ^bN = 54.

END

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FIN