Beliefs and Therapeutic Practices Related to Traumatic Memories among Italian Cognitive Behavioral Therapists and Trainees

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Abstract

A controversy exists on whether traumatic memories can be unconsciously repressed and then recovered during therapy. Here, we surveyed, using a questionnaire in Italian, certified Italian cognitive behavioral therapists ($n = 204$) and trainees ($n = 198$) about their beliefs concerning traumatic memories, and whether they discussed about the possibility of repressed memories with their patients. The majority of the participants held strong beliefs about many controversial aspects related to traumatic memory such as the mind being able to block out of consciousness memories of traumatic experiences (82.8%, $n = 333$). Also, half of them sometimes talked with patients about memories for traumatic events of which they may be unaware (50.0%, $n = 98$). Such practices could under some circumstances lead to false memories of abuse.

Keywords: Traumatic memories, repressed memories, EMDR, memory beliefs, memory wars, recovered memories, child sexual abuse.

Beliefs and Therapeutic Practices Related to Traumatic Memories among Italian Cognitive Behavioral Therapists and Trainees

A controversial issue in psychology is whether traumatic memories can be unconsciously repressed (e.g., McNally, 2005; Otgaar *et al*., 2019, Patihis *et al*., 2014). The question is whether overwhelming traumatic events can lead to a complete blockage of memories out of conscious awareness these memories are still available to be retrieved later, for example, during therapy. This debate, also termed "memory wars" (Crews, 1995), started in the 1990s following cases in which patients without any memory of trauma *before* therapy went on to recover traumatic memories *during* therapy. On one side of this debate, mainly clinicians asserted that these recovered memories were formerly repressed memories. On the other side, many memory researchers argued that the same memory reports could rather reflect instances of false memories, likely elicited during therapeutic interventions (e.g., Loftus, 1993; Otgaar *et al*., 2019). In the current study, we surveyed certified Italian cognitive behavioral therapists and trainees with respect to (i) their beliefs concerning traumatic memories, and (ii) whether therapists discussed about the possibility of repressed memories with their patients (see Loftus, 1993; Patihis *et al*., 2014). We now turn to the relevance of these issues.

Dissociation, Repression, and Traumatic Memories

Dissociation and repression are closely related to each other. The concept of dissociation has been defined by Janet (1889, 1886). According to Janet, there are two modes of mental functioning: One is the activity that preserves and reproduces past activities, the other is the activity oriented toward synthesis and creation (integration) (Janet, 1889). Janet defined dissociation as the narrowing of the field of consciousness occurring in hysterical patients thereby causing division or splitting of their minds and leading to the separation and isolation of certain psychological activities. These dissociated systems of

activities vary from a simple thought, image, or statement to the "personality states" of patients with dissociative identity disorder (van der Hart and Friedmann, 2019). In addition, Janet attributed a central role to trauma in the genesis of the phenomenon of dissociation suggesting that the intense emotional experiences of traumatic events can become dissociated, meaning that they are excluded from personal consciousness thereby resulting in traumatic memory loss. According to Janet, the treatment of psychological trauma involved an attempt to fully recover and integrate the memories of the trauma into the patient's personal identity (van der Hart *et al*., 2019).

In psychoanalytic theory, the importance of the concept of repression is summarized by Freud as follows, "theory of repression is the cornerstone on which the whole structure of psycho-analysis rests" (Freud, 1914, p.16). In the first formulation of repression theory, repression was seen as a defensive mechanism, a means to withdraw from painful stimuli following trauma (Boag, 2018, p.75). According to Freud, the 'repressed' material continues to affect the person's ongoing experience, thought and action implicitly, outside of awareness. Finally, repressed memories can be recovered by applying certain therapeutic interventions.

However, the idea of repressed memory stands in contrast with a plethora of research showing that memories for trauma are typically easily retrievable (e.g., McNally, 2005). Also, according to the critics, claims of traumatic memory loss can be explained by other, more plausible explanations such as lack of initial encoding of the traumatic event, normal forgetting, and failures to disclose or remember previous discussions concerning the traumatic experience (McNally, 2003; Otgaar *et al*., 2022b; see also Mangiulli *et al*., 2021; Mangiulli *et al*., 2022).

Furthermore, research has shown that suggestive pressure can lead to the creation of autobiographical false memories (Loftus and Pickrell, 1995; Loftus, 2005). This means that

if suggestive practices are used during therapy, they may elicit false memories of trauma. If therapists believe in the concept of repressed memory and succeed in helping people to recover memories for traumatic events for which patients never had memory before, they may assume such memories to be accurate. However, in case such recovered memories are false, they could be harmful and lead to social and legal consequences even including false accusations for serious criminal offences.

Belief in Repressed Memory

Several studies have been conducted to survey different professional groups (psychologists, clinical or academic, as well as social workers and medical doctors) on issues related to the reliability of testimony and the existence of repressed memories. For example, a quarter century ago, Yapko (1994a) collected data from over 869 U.S. therapists about their beliefs and practices regarding some aspects of their patients who did and did not report a background of sexual abuse. He found that nearly half (47%, n = 407) of respondents agreed to at least some extent with the item "Psychotherapists can have greater faith in details of a traumatic event when obtained hypnotically than otherwise", and 31% (n = 269) with the item "When someone has a memory of a trauma while in hypnosis, it objectively must actually have occurred.". Given that the Yapko survey was done early on in the memory wars, one might wonder whether these views continue in recent times.

The debate on repressed memory is still ongoing (Patihis *et al*., 2014; Otgaar *et al*., 2019). For example, research has shown that many groups (e.g., therapists, students, legal professionals) continue to endorse the idea of repressed memory. Also, research has shown that a significant minority of respondents from the general population indicate that their therapist discussed the possibility of repressed memories during treatment (e.g., Dodier *et al*., 2019; Patihis and Pendergrast, 2019).

More recent work confirms that the belief in repressed memory is endemic. Patihis *et al*. (2014) surveyed 1,376 participants including psychotherapists, research psychologists, alternative therapists, undergraduate students, and individuals from the general population. They explored changes in beliefs at the time of the survey (2011-2012) with past beliefs by including questions used in previous studies (Golding *et al*., 1996; Gore-Felton *et al*., 2000; Yapko, 1994a, 1994b). They found than less than 30% of experimental psychologists agreed that "traumatic memories are often repressed" whereas at least 60% of members of all other participant groups agreed with this statement. Similarly, less than 25% of experimental psychologists agreed with the statement "repressed memories can be retrieved accurately in therapy" whereas the other groups reported at least 43% agreement.

Otgaar and colleagues (2019) reviewed all survey studies regarding beliefs in repressed memory. Strikingly, they found that in the 1990s, 61% (n = 719) of surveyed clinical psychologists endorsed the concept of repressed memory and this percentage increased to 76% (n = 1,586) from 2010 onward. The authors argued that this increase reflects the debate on unconscious repressed memory raging on. Taken together, survey studies show that many therapists continue to believe in repressed memory. A telling sign of the relevance of the scientific debate comes from Dodier (2019). The author examined the volume of publications and citations regarding repressed and/or recovered memories during the years 2001–2018, and a control sample of articles related to the same issues published during the 1990s and found that the mean number of citations per article was not statistically different between the articles published in the 21st century and those published during the 1990s. Different stances in the debate (i.e., sympathy, skepticism, and neutrality) are equally cited. In sum, the memory wars are still ongoing (see Otgaar *et al*., 2019 and Otgaar *et al*., 2021 for a comprehensive overview of the issue).

A quarter century ago, the situation of the memory wars was summarized by the American Psychological Association (APA, 1995) in this way: “Many clinicians who work with trauma victims believe that this dissociation is a person's way of sheltering himself or herself from the pain of the memory. Many researchers argue, however, that there is little or no empirical support for such a theory. (…). The mechanism(s) by which both of these phenomena happen are not well understood and, at this point it is impossible, without other corroborative evidence, to distinguish a true memory from a false one.”.

Recent surveys with mental health clinicians have found that a significant number of them believe in the possibility that traumatic memories could be repressed (e.g., Patihis *et al*., 2014; Ost *et al*., 2017; Erens *et al*., 2020). Simultaneously, other surveys have questioned patients regarding whether their therapists discussed repressed memories with them. For example, Patihis and Pendergrast (2019) surveyed an age-representative sample of 2,326 adults in the United States and found that of the 1,082 who had received therapy, 20.1% (n = 217) reported that their therapist discussed the possibility that they might have been abused during childhood but had repressed the memories. Similarly, in a French survey of 1,312 participants, Dodier *et al*. (2019) found that among those who had received therapy (n = 551), 10.5% (n = 58) reported that their therapist suggested them the possibility that they had repressed memories of child abuse. Recently, Patihis *et al*., (2022), surveyed a sample of 576 undergraduates, and found that among the 188 participants who had received therapy or counseling, 16.5% (n = 31) reported that their therapist mentioned the possibility that they might have been abused during their childhood but had repressed the memories.

One way to examine whether the memory wars continue is to examine whether therapists themselves report discussing the concept of repressed memory with their patients. Specifically, Poole *et al*. (1995) surveyed several psychotherapists and psychologists and 71% reported using suggestive techniques (e.g., hypnosis) during therapeutic practices. This

work was conducted during the 1990s (Poole *et al*., 1995). No recent data regarding such therapeutic practices are available. This was the impetus of the present study.

The Present Study

Many surveys so far have examined whether therapists belonging to different psychotherapeutic orientations believe that traumatic memories can be repressed. Yet to our knowledge, no study has investigated therapeutic practices in relation to alleged traumatic experiences and whether they are linked with therapists' beliefs about various aspects of traumatic memory. In the current study, we surveyed Italian cognitive behavioral therapists (CB therapists) and trainees (CB trainees). In general, concepts of repression and the unconscious are absent in the philosophical and theoretical foundations of CBT (Dozois *et al*., 2019). However, even CB therapists and trainees are exposed to the concepts of repression and dissociation in Italy. To begin with, they learn about these issues during their basic education. In Italy, the majority of bachelor and master programs in psychology have at least one course about psychodynamic psychology. Furthermore, CB therapists, as well as other clinical psychology professionals, are required to periodically obtain training credits from accredited providers. As part of this training, trauma-oriented seminars and webinars have been proliferating in recent years. For example, a survey of the events advertised, between 2010 and 2020, in newsletters coming from companies that organize training courses for psychologists and psychotherapists, about 30% pertained to topics like trauma and dissociation.

Therefore, we surveyed a sample of Italian CB therapists and trainees regarding their beliefs concerning traumatic memories. In line with previous research (e.g., Dodier *et al*., 2019; Patihis and Pendergrast, 2019), we expected many participants to embrace various controversial aspects of traumatic memory (e.g., unconscious blockage of traumatic memories) and that such beliefs would be linked with their practices with their patients.

Method

Participants

A total of 402 participants completed the survey, approximately equally divided between CB therapists and trainees [CB therapists: 50.7% (*n* = 204); CB trainees: 49.3% (*n* = 198)]. The average age of the participants was 33.8 [range: 24-73; *SD* = 8.79; 84.6% (*n* = 340) female]. CB therapists had an average of 7.5 years of experience as therapists (*SD* = 9.59). Of them, 44.6% (*n* = 91) reported having had fewer than 50 patients during their career, 21.6% (*n* = 44) had between 50 and 100 patients, 8.8% (*n* = 18) had had between 101 and 200 patients, 22.5% (*n* = 46) had had more than 200 patients and 2.5% (*n* = 5) reported to not having had any patients.

Before conducting the survey, we wrote a document specifying the objectives, scientific relevance, methodology, and procedures employed to conduct the research. To this document was attached to the final version of the questionnaire and sent to the Ethics Committee of XXX. The Ethics Committee refers to national, EU and international legal, deontological and ethical frameworks, and is inspired in particular by the principles of the current version of the Declaration of Helsinki (World Medical Association, 2013).

Materials

Participants received a questionnaire (in Italian), consisting of two parts, and built upon previous research (Magnussen and Melinder, 2012; Ost *et al*., 2017; Patihis *et al*., 2014; Otgaar *et al*., 2019). The first part contained the informed consent, demographic information and two questions about participants' clinical experience (i.e., number of patients treated and years of experience). The second part contained several questions. Specifically, five items referred to (Items 1 – 5) general beliefs about traumatic memories, three items (Items 6 – 8) to beliefs on the reliability of traumatic memories and their recoverability, one item (Item 9) to what type of therapy was deemed useful for recovering

memories for traumatic experiences, and finally three items (Items 10 – 12) to the way traumatic memories were discussed with patients during clinical practice (see Table 1).

Participants were asked to rate their beliefs on a 6-point Likert scale, ranging from 1 ("Strongly Agree") to 6 ("Strongly Disagree") (Items 1 – Item 8) and on a 4-point Likert scale ranging from 2 ("False") to 5 ("True") (Item 7, Item 8). For items 10 – 12 (i.e., practice during therapy), participants were given the following options: "Yes, always", "Yes, sometimes", and "Never".

Procedure

The participants were recruited between the March 2020 and October 2021 through mailing lists of the XXXXX. The recruitment email contained general information about the research, and an internet link to direct participants to the survey. After providing their informed consent and filling in demographic information, participants completed the survey consisting of 12 items. The survey took approximately 5 minutes, and participants were thanked after completing it.

Statistical Analyses

Besides frequencies, we computed Pearson correlations between beliefs and practices on one hand and work experience and beliefs on the other hand. No adjustments were made for multiple testing.

Results

General Beliefs about Traumatic Memories (Items 1 – 5).

Participants' responses to questions concerning their general beliefs are shown in Table l. In line with consensus in the field regarding the etiology of psychopathology, the majority of participants agreed with the idea that in the development of psychopathology, trauma has great importance (93.5% strongly agree or agree, n = 376). However, the

majority of them (78.4% strongly agree or agree, n = 315) also believed that traumatic memories are often not accessible to the consciousness, and that traumatic memories often become inaccessible due to their painful content (83.1% strongly agree or agree, n = 334). Furthermore, the majority of participants agreed that traumatic memories can remain inaccessible to the consciousness for years and then are suddenly remembered (77.9% strongly agree or agree, n = 313), and that the mind is able to unconsciously block the memories of traumatic experiences (82.8% strongly agree or agree, n = 333) (see Table 1).

INSERT TABLE 1 ABOUT HERE

Beliefs about the Recoverability and Reliability of Traumatic Memories (Item 6 - 8)

Concerning the recovery of memories, almost all participants agreed that traumatic memories can be recovered through psychotherapy (92.6% strongly agree or agree, n = 372), and the majority of the participants agreed that such memories are reliable (77.8% answered true or mostly true, n = 313). A similar percentage of participants agreed with the idea that when adults, during psychotherapy, recall being sexually abused in childhood, and they previously had no recollection of events, such memories are reliable (71.1% answered true or mostly true, n = 286) (see Table 2).

INSERT TABLE 2 ABOUT HERE

Therapy Deemed Useful for Recovering Memories (Item 9)

When participants were asked what type of practices can be useful for recovering memories for traumatic experiences, the majority responded that Eye Movement Desensitization and Reprocessing (EMDR) is useful (78.6%, n = 316) with a minority indicating that EMDR is the only therapeutic option (14.2%, n = 57). Also, nearly one in four believed that hypnosis is a useful technique for recovering memories for traumatic experiences (23.6%, n = 95). Similarly, nearly one out of ten participants reported that psychoanalysis is useful (9.2%, n = 37) (see Table 3).

INSERT TABLE 3 ABOUT HERE

Experiences and Practices during therapy

Focusing only on CB therapists (i.e., CBTs trainees were not included, and one therapist was excluded because they stated that they had not had any patients), we found that more than half (64.3%, *n* = 126) reported that they sometimes had patients who recovered traumatic memories that they did not have before therapy. Moreover, half of the participants (50.0%, *n* = 98) sometimes discussed with their patients about the potential existence of traumatic memories of which the patients were unaware of. Less than half (41.8%, *n* = 82) always discussed with their patients the importance of traumatic events in the genesis of the patient's psychological problems (see Table 4).

INSERT TABLE 4 ABOUT HERE

Correlations between Beliefs and Practices and Beliefs and Work experience

Pearson correlation coefficients were computed to assess the relationship between beliefs and practices (see Table 5). We found several statistically significant positive correlations between beliefs that endorse repressed unconscious memories (Item 2 – 6) and the practice of discussing with patients about the existence of memories for traumatic events of which they may be unaware (Item 11). Therapists reporting to have beliefs that endorse repressed unconscious memories (Item 2 – 6) were more likely to tell their patients that they may have memories that they do not recall (Item 11).

We also found statistically significant positive correlations between beliefs that endorse repressed unconscious memories (Item 1, 6, 7) and the practice of discussing with patients about the importance of traumatic events in the genesis of their disease (Item 12).

We also found correlations between beliefs in the reliability of recovered memories, during psychotherapy (Item 7, 8) and the practice of discussing with patients about the existence of memories of traumatic events of which they may be unaware (Item 11) and

discussing with patient about the importance of traumatic events in the genesis of their disease (Item 12).

We also found a correlation, $r(196) = .414$, $p < .001$, between the practice of discussing with patients about the importance of traumatic events in the genesis of their disease (Item 12) and discussing whether they have unconscious traumatic memories (Item 11). Also, the more therapists believed that memories of childhood sexual abuse recovered in therapy are reliable (Item 8), the more they discussed the importance of trauma with patients (Item 12), $r(196) = -.226$, $p = .001$.

Furthermore, we observed significant correlations between therapists' career characteristics, in terms of patients treated and years of experience, with the practice of discussing the importance of trauma with patients (Item 12). Specifically, the more patients the CB therapists reported to have treated, $r(196) = -.274$, $p < .001$, and the more years of experience they had, $r(181) = -.210$, $p = .005$, the more they talked to patients about the importance of trauma.

Significant correlations were also found between having patients who in therapy recovered traumatic experiences (Item 10) and the practice of discussing with patients about the existence of memories of traumatic events of which they may be unaware (Item 11), $r(196) = .392$, $p < .001$, and having patients who in therapy recovered from traumatic experiences and the practice of discussing with patient about the importance of traumatic events in the genesis of their disease, $r(196) = .284$, $p < .001$.

INSERT TABLE 5 ABOUT HERE

Discussion

We surveyed therapists about their treatment practices and beliefs to explore their views regarding repressed memories, using an Italian sample of certified cognitive behavioral therapists and trainees. Specifically, we looked at their beliefs concerning

traumatic memories, and whether they discussed about the possibility of repressed memories with their patients.

Our findings showed that high levels of agreement with beliefs in (unconscious) repressed memories and the reliability of such recovered memories in psychotherapy were present in a sample of CB therapists and trainees. We anticipated these results because repression- and dissociation-related concepts continue to be popular within training programs, seminars, and webinars provided to Italian psychologists, including CB therapists. However, given that the CBT perspective does not particularly embrace the concept of repression, we were surprised to find that so many clinicians held these views. The founding fathers of cognitive therapy, Beck (1970) and Ellis (1970), did not specifically consider the patients' personal history of trauma in treating their symptomatology. Actually, early work in the area of CBT (e.g., Beck, 1967; Ellis, 1973, 1979) tended to reject psychoanalytic ideas focusing, for example, on unconscious processes (Dozois *et al*., 2019). Furthermore, also more recent CBT approaches do not emphasize such ideas (e.g., unconsciousness, repression) (see Masuda and Rizvi, 2020; Carona, 2022).

One particularly novel finding relates to the evidence that CB therapists reported that they had discussed with patients the importance of traumatic events in the genesis of their illness and frequently noted that they talked about the possibility of repressed memories with them. Discussing with patients about the importance of traumatic events in the etiology of psychopathology is of course not problematic in and of itself given that there is a consensus in the field that traumatic events are important factors contributing to psychological problems (McLaughlin *et al*., 2012; Suliman *et al*., 2009). However, the results of the present study suggest that these discussions were often related to simultaneous belief in and endorsement of repressed memories which suggests that such discussions may also be problematic. In fact, we found a positive correlation between these practices and their beliefs

in (unconscious) repressed memories. The length of the therapist's career, both in terms of number of patients treated and years of experience as a therapist, was likewise significantly positively correlated with these practices. In other words, the more experienced the therapist, the more likely he or she was to discuss the above issues with their patients. This correlation could be due to either older psychotherapists being more likely to have a psychoanalytic background, and confirmation bias impacting them over time (wherein believing in a hidden memory for traumatic experiences leads therapists to actively look for them, reinforcing this belief), or a combination of the two. Such therapeutic practices might induce patients to search for traumatic events in their autobiographical memory that might explain why they have psychological distress.

Our results showed that a sizable minority considered imaginative techniques and hypnosis as useful techniques to recover memories. It has been shown that these techniques may create false memories (Lilienfeld, 2007; Lynn *et al*., 2003). Equally interesting was the observation that especially EMDR was heralded as an effective method to recover traumatic memories. EMDR is currently highly popular, but concerns have been raised with respect to potential false memory effects of EMDR (Houben *et al*., 2020; Leer and Engelhard, 2020). Houben *et al*. (2020) investigating the susceptibility to spontaneous false memories after performing eye movements, found an increase of both correct memories and spontaneous false memories due to eye movements when memories were retrieved after a time delay (i.e., 48 h later; van Schie and Leer, 2019).

In light of our findings, legitimate concerns can be raised about the elicitation of false memories by CB therapists in Italy. This concern is based on the following issues. First, our data and those of others as well (e.g., Otgaar *et al*., 2019, Ost *et al*., 2017; Patihis *et al*., 2014; Yapko, 1994a) show that therapists hold controversial beliefs concerning memory and trauma such as that traumatic memories become inaccessible due to their

painful content. Second, our data show -for the first time- that CB therapists may suggest their patients that they might be unaware of their traumatic memories. Such discussions might pave the way for the production of false recovered memories of abuse. This latter finding is especially interesting because it extends and is aligned with previous studies showing that patients stated that their therapists discussed the possibility of repressed memories (e.g., Dodier *et al*., 2019; Patihis and Pendergrast, 2019).

Our results suggest several recommendations. First, it is clear that there is a discrepancy between the beliefs of memory and practices of Italian CB therapists and what science tells us about these (Patihis *et al*., 2014). Hence, it is our opinion that the science of memory and the danger of suggestion should be standard teaching materials in training programs for mental health professionals. Such training programs might have the potential to make therapists more critical towards controversial topics such as repressed memory (Otgaar *et al*., 2022b; Sauerland and Otgaar, 2022).

Second, although research shows that EMDR may be an effective treatment for PTSD (e.g., Cuijpers *et al*., 2020), it can be problematic when EMDR techniques are used to look for memories or images that the patient is unaware of. This being problematic becomes clear when looking at a recent Italian case in which a therapist inappropriately applied EMDR techniques by using suggestive questions in therapy thereby implanting false memories of abuse in a young woman (Otgaar *et al*., 2022a).

Taken together, our results warn about the possibility that CB therapists' beliefs about traumatic memories and their practices with their patients could involuntarily fabricate memories of traumatic experiences in individuals (see Kanter *et al*., 2002). All of this could have forensic implications. Specifically, criminal investigations and trials often rely on memory-related statements. Thus, it is important to question whether these statements elicited during the course of therapy might actually reflect a false, rather than a true,

experience (Bernstein and Loftus, 2009). Therefore, if a false memory of sexual abuse recovered during therapy leads to the initiation of a criminal investigation, judges should be aware that external corroboration is needed (APA, 1995). However, this external corroboration cannot come from the expert opinion of a clinician who believes in possibility that repressed memory for traumatic experiences can accurately be retrieved in psychotherapy. If no external corroboration is available, memory experts should be consulted to assist in the evaluation of the validity of testimonies. Such evaluations might help to decide whether a statement was the product of suggestion or might refer to an authentic experience. In the end, such evaluations might prevent false memories doing immense damage in legal proceedings and might prevent the occurrence of wrongful convictions.

Some limitations of the current study need to be addressed. First, it would be good to assess the presence of similar beliefs in Italian clinicians with other theoretical orientations, given the strong historical prevalence of psychoanalytic practices. Second, it should be noted that we did not provide participants with a choice to respond “I do not know” to our statements. Perhaps, in future studies, a more nuanced approach to participants’ responses (e.g., “Agree”, “Disagree”, “I do not know”), could more accurately reflect what participants believe.

Conclusion

The debate about whether memories for traumatic experiences are repressed and whether they can be recovered during psychotherapy remains heated and without a definitive conclusion. Knowing psychotherapists' beliefs about traumatic memories and how these beliefs affect their clinical practice is imperative because this has important clinical and legal implications (with reference to the legal context, due to the subjective nature of traumatic experiences and symptoms, this disorder is susceptible to fabrication by those

seeking secondary gain. See Peace and Richards (2020) on how context for malingering and the provision of incentives influence malingered symptom profiles of post-traumatic stress disorder). In line with other studies (Dodier *et al*., 2019; Patihis and Pendergrast, 2019), our survey on a sample of Italian cognitive behavioral therapists and trainees showed that the majority of the respondent endorsed the idea of repressed memories and their recovery in therapy. Our results also showed that about half of the therapists reported that they sometimes discuss with their patients the importance of traumatic events in the genesis of their illness which may also be problematic given that such discussions were associated with belief in repressed memories. Almost half had spoken with their patients about the existence of memories for traumatic events previously unknown to them. In turn, patients may be induced to recall traumatic experiences from their lives, thereby producing false memories which may tear families apart and could even lead to wrongful convictions.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Table 1

General Beliefs about Traumatic Memories (N = 402)

Item	Statement	Scale					
		Strongly Agree	Agree	Slightly Agree	Slightly disagree	Disagree	Strongly disagree
		%	%	%	%	%	%
1	In the development of a psychopathology, trauma has a great importance.	37.8 (*n* = 152)	55.7 (*n* = 224)	3.7 (*n* = 15)	.7 (*n* = 3)	1.5 (*n* = 6)	.5 (*n* = 2)
2	Memories of traumatic experiences are often not accessible to consciousness.	18.2 (*n* = 73)	60.2 (*n* = 242)	15.7 (*n* = 63)	2.7 (*n* = 11)	2.5 (*n* = 10)	.7 (*n* = 3)

3	Memories of traumatic experiences often become inaccessible to consciousnesses due to their painful content.	24.1 (*n* = 97)	59.0 (*n* = 237)	10.2 (n = 41)	2.7 (*n* = 11)	3.0 (*n* = 12)	1.0 (*n* = 4)
4	Memories of traumatic experiences can remain inaccessible to consciousness for years and then suddenly be remembered.	17.7 (*n* = 71)	60.2 (*n* = 242)	17.9 (*n* = 72)	2.2 (*n* = 9)	2.0 (*n* = 8)	.0 -
5	The mind is able to unconsciously block the memories of traumatic experiences.	21.1 (*n* = 85)	61.7 (*n* = 248)	9.2 (*n* = 37)	2.2 (*n* = 9)	4.5 (*n* = 18)	1.2 (*n* = 5)

Table 2

Beliefs about the Recoverability and Reliability of Traumatic Memories (N = 402)

Item	Statement	Scale					
		Strongly Agree %	Agree %	Little Agree %	Little Disagree %	Disagree %	Strongly Disagree %
6	Memories of traumatic experiences can be recovered through psychotherapy.	28.9 (*n* = 116)	63.7 (*n* = 256)	5.2 (*n* = 21)	.7 (*n* = 3)	1.2 (*n* = 5)	.2 (*n* = 1)
		True %	Mostly true %	Mostly false %	False %	Don't know %	

7	Sometimes adults, during psychotherapy, recall experienced traumatic events during childhood. Of these events they previously had no recollection. Do you think such memoirs are true or false?	7.7 (*n* = 31)	70.1 (*n* = 282)	5.7 (*n* = 23)	.2 (*n* = 1)	16.2 (*n* = 65)
8	Sometimes adults, during psychotherapy, recall being sexually abused in childhood. Of these events they previously had no recollection. Do you think such memoirs are true or false?	8.2 (*n* = 33)	62.9 (*n* = 253)	7.7 (*n* = 31)	.2 (*n* = 1)	20.9 (*n* = 84)

Table 3

Therapy Practices Deemed Useful to Recovered Memories for Traumatic Experiences (N = 402)

Therapy/Technique	*n*
EMDR	316
Sensorimotor Psychotherapy	176
Guided methods	114
Hypnosis	95
Schema Therapy	92
Emotion focused therapy	72

EMDR exclusively	57
Mindfulness	54
Compassion Focused therapy	40
Psychoanalysis	37
Acceptance and Commitment Therapy	34
Psychodynamic	32
None in particular	43

Note. For this item, participants could choose more than one answer.

Table 4

CB Therapists' Practices during Therapy (N = 196)

Item	Statement	Scale		
		Yes, always %	Yes, sometimes %	Never %
10	During your clinical practice, have you ever had patients tell you that they remembered traumatic experiences that they didn't think they had?	2.0 (*n* = 4)	64.3 (*n* = 126)	33.7 (*n* = 66)
11	In your clinical practice, have you ever discussed with patients about the existence of memories of traumatic events of which they may be unaware?	11.7 (*n* = 23)	50.0 (*n* = 98)	38.3 (*n* = 75)

12	In your clinical practice, do you discuss with patient about the importance of traumatic events in the genesis of their disease?	41.8 (*n* = 82)	53.6 (*n* = 105)	4.6 (*n* = 9)

NOTE: CB Therapist who reported "*I have not yet begun clinical work with patients"* or "*No patients*" were not included)

Table 5

Correlations between Beliefs and Practices and Beliefs and Work Experience (N = 196)

Item	Beliefs	Practices		Work experience		
		[c] In your clinical practice, have you ever discussed with patients about the existence of memories of traumatic events of which they may be unaware? (Item 11)	[c] In your clinical practice, do you discuss with patient about the importance of traumatic events in the genesis of their disease? (Item 12)	[d] Number of patients in career	Years of work as therapist	[c] During your clinical practice, have you ever had patients tell you that they remembered traumatic experiences they didn't think they had? (Item 10)
1	[a] In the development of a psychopathology, trauma has a great importance.	.128	.280**	-.088	-.018	.140
2	[a] Memories of traumatic experiences are often not accessible to consciousness.	.180*	.070	-.070	-.128	.189**
3	[a] Memories of traumatic experiences often become inaccessible to consciousnesses due to their painful content.	.275**	.055	-.040	-.036	.210**
4	[a] Memories of traumatic experiences can remain inaccessible to consciousness for years and then suddenly be remembered.	.232**	.066	-.002	-.120	.177*
5	[a] The mind is able to unconsciously block the memories of traumatic experiences.	.200**	.059	.056	-.081	.121
6	[a] Memories of traumatic experiences can be recovered through psychotherapy.	.324**	.171*	.073	.063	.156*

7	[b] Sometimes adults, during psychotherapy, recall experiencing traumatic events during childhood. Of these events they previously had no recollection. Do you think such memories are true or false?	-.233**	-.232**	.019	.150*	-.188**
8	[b] Sometimes adults, during psychotherapy, recall being sexually abused in childhood. Of these events they previously had no recollection. Do you think such memories are true or false?	-.242**	-.226*	.022	.104	-.087
11	[c] In your clinical practice, have you ever discussed with patients about the existence of memories of traumatic events of which they may be unaware?	-	.414**	-.132	-.118	.392**
12	[c] In your clinical practice, do you discuss with the patients about the importance of traumatic events in the genesis of their disease?	.414**	-	-.274**	-.210**	.284**

** Correlation is significant at the .01 level (2-tailed)

* Correlation is significant at the .05 level (2-tailed)

[a] 6-point Likert-type scale, ranging from 1 = *Strongly agree, 2 = Agree, 3 = Little agree, 4 = Little disagree, 5 = Disagree,* 6 = *Strongly disagree.*

[b] 4-point Likert-type scale, ranging from 2 = *False, 3 = Mostly false, 4 = Mostly true,* 5 = *True* (1 = *Don't know* cases were not included in the analysis).

[c] 1= *Yes, always*; 2 = *Yes, sometimes*; 3 = *Never; (4 =I have not yet begun clinical work with patients* cases were not included in the analysis).

[d] 1 = *less than 50*; 2 = *50 – 100*; 3 = *101 – 200*; 4 = *more than 200* (One participant was not included because reported "*No patients*")