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ABSTRACT

Published empirical research on the repression of memories of childhood sexual abuse is limited at the present time, and the quality and usefulness of the research varies with the methodology, research design, statistical analyses, and researcher bias. This literature review discusses at length a 1987 study by J. H. Herman and E. Schatzow and 1994 studies by L. M. Williams; E. F. Loftus, S. Polonsky, and M. T. Fullilove; and discusses more briefly 5 other studies. The current research substantiates the prevailing clinical belief that a sizable minority of individuals who were abused sexually as children do forget this abuse for a period of time. Research also indicates that this "forgetting" is different from normal forgetting and is clinically tied to the theoretical concepts of repression and dissociation. Researchers agree that further research is needed and that this research must be contextually congruent with the broader foundations of research into human memory. Contains 77 references. (EAJ)

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REVIEW OF THE LITERATURE REGARDING THE REPRESSION OF MEMORIES OF CHILDHOOD SEXUAL ABUSE

by

Betsy A. Barber

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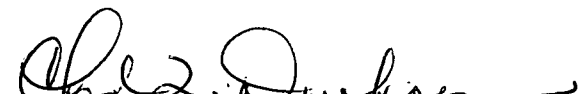

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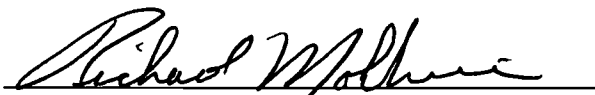

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REVIEW OF THE LITERATURE REGARDING THE REPRESSION OF MEMORIES OF CHILDHOOD SEXUAL ABUSE

A Doctoral Research Paper

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the Faculty of the Rosemead School of Psychology

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Doctor of Psychology

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by

Betsy A. Barber

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ABSTRACT

REVIEW OF THE LITERATURE REGARDING

THE REPRESSION OF MEMORIES OF

CHILDHOOD SEXUAL ABUSE

by

Betsy A. Barber

This paper is a literature review of the empirical research concerning the repression of memories of childhood sexual abuse. Though published research on this topic is limited at the present time, existing research indicates that 19 - 38% of the children who were sexually abused experience partial or total repression of the memory of this abuse at some time. Quality and usefulness of research on this topic varies with methodology, research design, statistical analyses, and researcher bias; studies are critically evaluated regarding these areas within this paper. Suggested clinical applications of these research findings as found in the literature is explicated. The need for further research is discussed and possible research directions are delineated.

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And to my clients and to my friends who were abused as children, for giving me the research question.

REVIEW OF LITERATURE REGARDING THE REPRESSION OF MEMORIES OF CHILDHOOD SEXUAL ABUSE

Introduction

The use of repression as a clinical reality was postulated by Freud in his 1896 explication of Seduction Theory. Here Freud hypothesized that traumatic events of a sexual nature occurring within childhood were experienced consciously by the child but then were sometimes not stored in the conscious memory but rather in the unconscious memory, out of volitional reach of the growing child or the grown adult. While forgotten, unrecalled, these distressing events nonetheless were manifested in the adult's character and experience as hysterical or histrionic behaviors. Freud said, "the essence of repression lies simply in turning something away, and keeping it at a distance from the conscious" ([1915] 1957, p. 147).

Freud's theorizing in such a manner was not well received by his fellow colleagues. In an effort to reconcile his work with the prevailing views of the time, Freud had bowed to his skeptical male critics and recanted of his hypotheses concerning the prevalence of sexual abuse and its long term clinical sequelae in children by 1897. The notion of repression as a defense

mechanism however, remained well-established and current in psychological parlance. While it is taught only as clinical theory, repression is commonly perceived as clinical fact.

Studies demonstrate clearly that the clinical results of child sexual abuse may result in dissociation (Elliot & Briere, 1992), as well as numerous other psychopathological responses (Briere & Runtz, 1990; Wyatt & Powell, 1988). Additionally, research indicates that well-reasoned and empirically supported clinical treatment of the sequelae of child sexual abuse involves careful exposure of the client to the traumatic memories as a means of disarming and integrating the trauma into the adult client's psyche (Foa, Tothbaum, Tiggs, & Murdock, 1991; Resick & Schnicke, 1992). Therefore the ethical treatment of repressed memories of childhood sexual abuse are of concern to clinical psychologists.

Pressed, however, by the growing presence of litigation upon the practice of psychology, therapists are increasingly called upon to support and defend their clinical practice with empirical facts which measurably establish the dynamic structures and strands with which they work (Caudill, 1995; Gutheil, 1993; Jarnoff, 1993; Watkins, 1993). Caudill, an attorney writing to clinical psychologists, reports that although the actual number of cases filed in October of 1995 regarding repressed memories was estimated to be between 120 and 800, nationwide, the number of estimates regarding potential lawsuits on this issue varies from a low of 1,000 to a high of 17,000. Caudill notes that

the most frequent type of lawsuit involving repressed memories occurs when the psychologist is sued by the individual accused by the client of abuse. Caudill predicts that future litigation brought by disgruntled families of clients may increase exponentially due to legislation at the state level called the "Mental Health Consumer Protection Act" which is being drafted and lobbied for by the False Memory Syndrome Foundation. This proposed legislation would allow third-party lawsuits accusing therapists of "negligent therapy". Such lawsuits could be brought by others over patient objections.

The body of empirical literature reviewed by this paper is notably sparse regarding the identification and treatment of adult victims of childhood sexual abuse (Beutler & Hill, 1992). This paper will examine the existing current body of empirical literature which addresses the existence of repression with an emphasis on the existence of repression of memories of childhood traumatic abuse. Relevant empirical research involving adult versus child memory will also be considered.

General Research Difficulties

The research question, concerning the repression of memories of child sexual abuse, has difficulties implicit to its nature. These difficulties are reflected unilaterally within the research under review in this paper. The problems in construction of sturdy research designs regarding the existence and extent of repression/forgetting of childhood abuse memories are typical

of those difficulties which plague much of the research on clinical topics. It is unethical and unlawful to set up blind studies in which half the population is abused and half the population is not abused, for example. Clinical research enacted on human subjects is bound to do no harm, therefore certain pragmatic constraints exist. Investigation of the particular subject of repression under scrutiny here, is further constrained by the very nature of the research question itself: what is being investigated is one's "memory" of "forgetting", a convoluted query indeed! As Yapko (1994a) states, "After all, repression cannot be studied directly, it can only be inferred. (One cannot ask someone, 'Are you repressing memories of abuse?' If he or she knows about it, then it is not repressed.)" (p. 164).

As one looks at the empirical studies, further weakness within the research present themselves. Most of the studies reported here did not practice random sampling practiced which leaves them open to criticisms regarding validity. The instruments used in the studies are in most cases constructed by the individual research teams and are not uniform across studies. There is no standard measure of reliability nor validity for these instruments. Consequent to this lack of standardization, there is a lack of a consistent definition of terms and items measured, therefore one study's definition of such terms as abuse, repression, forgetting, and violence, may differ from that of another study's definitions, making comparison and generalization between studies difficult. This lack of clear definition leads to

doubtful construct validity between these studies. In addition, due to the anonymity of some of the research and to the clinically sensitive nature of the topic, outside corroboration of the abuse was (in all cases but one) done by those subjectively involved in the victim's life, leaving corroborative data open to charges of nonobjectivity and skewing. The long statistical analyses done within these studies inevitably use too small an n for the number of correlates they run, leaving their results in more doubt than one would wish. Since this is a remarkably uniform problem within all studies reported on here, however, the results can be judged to be reliable relative to each other.

Further difficulties found generally within the research on repression of childhood abuse involve the lack of demographic consistency within the various studies. Since the research on this question is minimal, each study has its' own population and few of the populations overlap. This makes it difficult to draw general conclusions. In face of this lack of unifying population characteristics, the consistent research finding that 30 - 40% of all sample populations exhibit some forgetting of childhood abuse memories is noteworthy. If repression or forgetting of childhood abuse is prevalent to such a large degree within any sample, it seems likely that the numbers may yet be higher due to the fact that some of those abused have not yet remembered the abuse experiences.

Finally, researcher bias is a pervasive problem within this research. It appears that there are two well established camps regarding this question: (a)

those who believe that repression/dissociation/forgetting exists as a defense mechanism and (b) those who emphatically reject its' existence. Depending on their theoretical allegiance, authors' conclusions concerning similar data is wildly disparate, reflecting their bias. This trend will be further illustrated within the body of this literature review. Prone to litigation and strong statements, this research topic is increasingly in the public view. The long following quotes represent the two ends of the theoretical spectrum concerning the existence of repression of childhood sexual abuse memories and the included history of the authors indicates some of the heated controversy which creates researcher bias concerning this topic.

On one end of the spectrum there a small but vocal group of writers such as Wakefield and Underwager (1994) who state

> there are many survivors of childhood sexual abuse. The abuse may have always been remembered but never talked about. Sometimes, actual abuse may be forgotten in the way that other unpleasant, but not highly traumatic, events from childhood are forgotten. When the person is reminded somehow, the abuse is remembered. In such cases, attempts to postulate concepts of repression, dissociation, or traumatic amnesia are both unnecessary and in error... often a false memory appears to be have [sic] absolutely no basis in truth. (p. 340)

That Wakefield and Underwager are not unbiased mental health professionals concerning this area may be seen by reading their interview

with Geraci (1993). Wakefield and Underwager 's work is consistent with the views of the False Memory Syndrome Foundation (mentioned above), an organization led by Pamela Freyd, which is devoted to debunking the myth of repressed memories of childhood sexual abuse.

At the other end of the spectrum is Jennifer J. Freyd, a professor of psychology and researcher at the University of Oregon who has accused her father of sexually abusing her during childhood. J. Freyd, writing in 1993, clearly represents the other end of the repressed/recovered memory spectrum when she suggests the Betrayal-Trauma theory as a way of explaining repression of childhood abuse memories.

> However, if the person who has betrayed us is someone we need to continue interacting with despite the betrayal, then it is not to our advantage to respond to the betrayal in the normal way... we essentially need to ignore the betrayal... Thus the trauma of child abuse by the very nature of it requires that information about the abuse be blocked from mental mechanisms that control attachment and attachment behavior. (p. 83)

Freyd's concluding comments include

> Betrayal-Trauma theory models the mental basis of response to Betrayal-Traumas using known cognitive phenomena and current cognitive science constructs. In particular, cognitive concepts such as mental modularity, parallel processing, selective attention, the

> dissociation between kinds of memory (such as implicit versus explicit), and the role of communication in mental coding and consciousness, can make sense of memory repression, dissociative states, and post-traumatic stress phenomena. (p. 89)

Given such differing views among mental health professionals, one turns to the research literature and asks: What is the empirical basis for repression of childhood sexual abuse?

Major Research

Within this presentation, major studies concerning the repression and recovery of memories of childhood sexual abuse are divided into two sections: the early studies and the recent studies. The recent studies are further broken down into (a) research done by those expecting to find repression of memories, and (b) research done by those expecting not to find repression of memories.

Early Research Studies

Herman and Schatzow (1987) were two of the earliest researchers into the topic of repression of child sexual abuse memories. Theirs is the seminal study, followed by Briere and Conte in 1993.

Herman and Schatzow's Study

Herman and Schatzow refer to Freud's 1896 seduction theory as their theoretical basis, expecting in their research to find a connection between

adult psychopathology and forgotten childhood sexual abuse. Freud had written that further research might demonstrate a relationship between preservation of recall of sexual trauma and other factors such as the age of the traumatized child and the nature of the trauma. In addition, Freud wrote of a connection between the severity of the trauma and the mechanism of repression and subsequent adult hysterical pathology. Herman and Schatzow set out to find such a connection supported by empirical data.

Herman and Schatzow (1987) refer to numerous clinical studies detailing the long-term sequelae found in adult patients who have been abused as children as the empirical basis for their theoretical predictions. They cite 2 studies which indicate that 1 in 4 pre-adolescent girls are sexually assaulted (Kinsey, Pomeroy, Martin, & Gebhard, 1953) and 1 in 10 pre-adolescent boys are sexually assaulted (Finkelhor, 1979).

Much of the symptomatology reported in these two early studies support diagnoses of chronic posttraumatic stress disorder in the adult victims of childhood sexual abuse; therefore, the authors postulate that such adults may display repression of abuse as a congruent symptom with this diagnosis. Herman and Schatzow (1987) note however, that retrospective studies of self-reported victimization must be interpreted in light of the reliability of the victim's memories. Therefore outside corroboration of these memories is desirable.

In their study therefore, Herman and Schatzow (1987) actively sought corroborating evidence from outside sources for remembered childhood sexual abuse since the reliability of retrospective studies is suspect if they rely solely upon the victim's memory. Herman and Schatzow had a three-fold purpose for their research:

> First, to investigate the link between traumatic childhood memories and symptom formation in adult life; second, to lay to rest, if possible, the concern that such recollections might be based upon fantasy; and third, to explore the therapeutic effect of recovery and validation of memories of early trauma. (p. 2)

Due to the clinical nature of this investigation, the lack of previous empirical studies, and the nonexistence of valid and reliable research instruments, the researchers stated no specific numeric expectations. They did, however, expect to find outside corroboration for some patient self-reported childhood sexual abuse.

Definitions. Herman and Schatzow (1987) defined sexual abuse in a similar manner to other authors in this field, therefore giving little cause for concern in the area of construct validity. Although a few of their sample reported sexual abuse involving no physical contact (indecent exposure or propositions), in most cases the sexual abuse measured involved genital fondling, masturbation, or genital/oral contact including vaginal or anal rape.

In this study, the authors considered as a variable, the degree of violence of the contact which accompanied the sexual abuse. Violence, for the purposes of this study, was defined and rated on a 3-point scale with 0 equalling nonviolence, 1+ equalling fear and coercion but no physical violence perpetrated (e.g., threats, observed past violent behavior), and 2+ equalling physically violent abuse involving pain, rape, or being forcibly immobilized.

Patient's memories of the childhood sexual abuse experience were also rated on a 3-point scale and were defined as follows: full recall indicated that the patient had always remembered the abuse in detail and had recovered no additional memories during the course of treatment; mild to moderate memory deficits indicated that the patient had come into treatment recognizing no memory gaps in their experience but had since recalled additional abuse data; severe memory deficits was the category for those patients who could recall little of their childhood or for those patients who reported sudden distressing recent memories of childhood sexual abuse.

Instruments. The instrument used to obtain the data of the study was a 12 week course of structured group therapy conducted by Herman and Schatzow (1987). The therapy began by having the participants set personal goals related to the sexual abuse for the therapy. Herman and Schatzow state that the three most commonly chosen goals were: (a) disclosure of the abuse to a family member (17 patients), (b) recovery of memories (16 patients), and

(c) confrontation of the perpetrator (10 patients). In the course of group therapy, the patients worked with the therapists to achieve these goals.

Samples. The sample consisted of 53 predominantly White, single, educated, working women aged 15 – 53 with a mean age of 31.7. The women were from a wide variety of social and ethnic backgrounds and all were living in the Boston metropolitan area. They were all concurrently being seen in individual outpatient therapy and were referred for this study through therapists, agencies, self-help organizations, or friendship networks. Active drug and alcohol abusers were eliminated from this study, as were actively suicidal patients or those lacking social support networks. The sample was therefore selected by referral, self-selection, and interview. Sixty-two percent of the women were unmarried, 15% were married, 23% were separated or divorced, and only 34% had children. The majority of the women were clinically depressed and also carried other secondary diagnoses. The authors state that during Freud's time, these women would have qualified for a diagnosis of hysteria, as indicated by dissociative and somatic preoccupations. All patients in the sample reported either that they had been sexually abused by a relative or that they strongly suspected this to be true.

Generalization from sample to population. In general, sudden recall of memories for which the patient was previously amnesiac has been critiqued by those who hold to a false memory approach. In particular, Herman and Schatzow's (1987) method of patient selection is problematic. Herman and

Schatzow selected for group treatment those patients who thought they had been abused but who could not remember the abuse. They then exposed these patients to other sexually abused patient's stories, and consequently accepted as valid the first group's suddenly recalled memories. This method is problematic since it is open to the criticism that such memories were suggested by the group's interactions and expectations. However, what makes Herman and Schatzow's research noteworthy, is that 74% of their sample were able to obtain outside confirmation of the remembered abuse. This outside corroboration ranges from evidence from the perpetrator, from family members, or from diaries/photographs (40%), to evidence from siblings that they too had been abused by the same perpetrator (34%). An additional 9% of the women in the sample stopped short of direct questioning, but did obtain nondefinitive (e.g., the supposed perpetrator was known to have sexually abused others) corroborating evidence of their abuse. A small percentage of the sample (3%) were unable to find the corroborating evidence for which they sought, and 11% of the sample did not seek such evidence.

A weakness in this method of research is that the patient's expectations were consciously set before commencing the study: the women used in the sample knew they were looking for validation of their childhood sexual abuse. A complementary weakness in this methodology is that the outside corroborating evidence was found and reported by the victim herself. This

would have been a stronger study if the patient did not come into the research knowing the purpose of the research and if more objective investigators were used to validate the remembered abuse incidents. Herman and Schatzow (1987) defend their methodology from a clinical standpoint, noting that having the patient do the investigation empowers her and also frequently stimulates the recall of more abuse memories. This weakness is a repeated problem in this area of research. It is a clinical reality that objectivity is difficult to come by in such studies because the events being measured are seldom observed by an objective reporter as they occur.

Because this is a self-selected clinical group, who knew what the research procedure was addressing, questions concerning internal validity and selection are raised. It is unclear how these statistics will generalize to a less specific clinical population. In addition, this sample has limited demographic variety, and therefore the cultural and gender limitations must be considered when attempting to generalize from this study. These validity concerns are somewhat ameliorated due to the statistical similarity of this study's results to William's (1994) study on repressed memories of childhood sexual abuse done with African-American females from a different socio-economic group. This raises the reliability rating and the generalizability of Herman and Schatzow's (1987) results. Because of the small number of participants in this study, only t tests and chi-square tests were used.

Repeating this research with a larger number of participants would render the results more clinically useful.

Herman and Schatzow (1987), using one-tailed t tests, found that memory deficits were more severe when the abuse began early in childhood and ended before adolescence. Within this sample, 64% of the patients had some amnesia and 28% reported severe amnesia. Age of the victim when abused associated significantly with loss of memory of the abuse (non versus moderate amnesia, $t[39] = 2.10, p < .03$; moderate versus severe amnesia, $t[33] = 3.64, p < .0005$; moderate versus severe amnesia, $t[33] = 2.39, p < .02$). Additionally, Herman and Schatzow found that severity of abuse (violence or sadism involved) correlated positively with use of repression as a defense mechanism, 75% of the women who had recalled violent abuse had had no recall of these experiences for a prolonged period of time ($\chi^2[4, N = 53] = 19.72$, z score on normal approximation = 5.56, $p < .005$).

In their discussion of the results of their research, Herman and Schatzow (1987) draw the conclusion that since the majority of their patients who recalled memories of childhood sexual abuse were able to establish outside confirmation of this abuse, such abuse recall in therapy must be retrieved, validated, and clinically integrated by the patient. Such integration, they suggest, will include the task of grieving for a lost childhood, reintegrating as an adult various emotions and behaviors beyond the child's capacity to handle (hence the repression), and creating new meaning for life.

Another conclusion Herman and Schatzow propose, is that this study demonstrates Freud's 1896 theory that recall is related to the age of the child and the nature of the trauma. As Herman and Schatzow note, repression was most widespread and thorough among those patients who were abused earliest and most traumatically. Those patients abused less traumatically during latency used defense mechanisms such as partial repression, dissociation, and intellectualization. Those patients whose primary abuse occurred during adolescence did not repress the memory of their abuse.

Briere and Conte's Study

The second major research study specific to this topic was done by Briere and Conte in 1993. Using a more limited, less controlled research design than Herman and Schatzow's 1987 study, Briere and Conte nevertheless added significant data regarding the question of memories of child sexual abuse by having therapists ask their clients whether they had ever forgotten/repressed an experience of childhood sexual abuse.

In their results, Briere & Conte (1993) reported that 59% of the 450 men and women in their sample currently in treatment for sexual abuse stated that at some time before they were 18, they had forgotten their childhood sexual abuse. The sample consisted of 450 patients in either individual or group therapy. Of this sample, 93% were female and 90% were White. For the purposes of this study, violent abuse was defined similarly to Herman and Schatzow's 1987 study, as including either multiple perpetrators, a threat of

death if the victim disclosed the abuse, or physical injury during the course of the sexual abuse. The method used to obtain these results was to have the individual's therapists ask each individual a specific question concerning whether there had ever been a time between their first forced sexual experience and their 18th birthday when they could not remember the forced sexual experience.

Those who responded affirmatively (256 of the total 450 patients) and who also reported some incidence of childhood amnesia, were likely to display current adjustment difficulties. They were more likely to have experienced sexual abuse earlier rather than later in childhood, to have experienced abuse of a more violent nature, and to have a history of repeated abuse incidents as compared to the larger sample. This result is congruent with research on psychopathological responses in child sexual abuse victims (Briere & Runtz, 1990; Elliot & Briere, 1992; Wyatt & Powell, 1988).

This study, while important, can be criticized regarding its validity considerations. Because the research question was administered by the patient's therapist, a legitimate query is raised concerning external validity: was the researcher's bias communicated to the participant in previous therapy sessions? Had the clinician already talked to the client regarding the possibility their lack of recall of childhood sexual abuse? The generalizability of the study is also questionable since all the participants were already in therapy for sexual abuse and concommittant problems; moreover, the large

majority of those questioned were White and female. This last validity question is answered sufficiently when considered in conjunction with the African-American nonpatient population of William's (1994a) study.

Because of associations Briere and Conte (1993) found between lack of recall of childhood sexual abuse and violent trauma, and between lack of recall and experienced conflict (e.g., reported guilt, shame, and enjoyment), they postulate that the defense mechanism operating within their population may be dissociation rather than repression. Briere and Conte conclude their findings indicate that some sort of amnesiac defense mechanism is common among children who experience sexual abuse. Although Briere and Conte's research is not as extensive nor as statistically robust as William's (1994a) study, their findings add significant empirical support for the existence of periods wherein the patient forgets childhood sexual abuse.

Later Research Studies

Later research studies on repression of childhood sexual abuse are led by Williams in 1994 and by Loftus, Polonsky, and Fullilove in 1994. Further studies by Feldman-Summers and Pope (1994) and Nelson and Simpson (1994) also add to the pool of empirical knowledge concerning this topic.

William's Study

By far the strongest research concerning repression of childhood sexual abuse comes from William's 1994 study. This research study was strongly conceived and supported theoretically, impeccably designed, and well

implemented. The results, as represented by the data, are clear and the implications are enlightening.

Williams (1994a) begins her research report by discussing her conceptual hypothesis. Williams notes the diametrically oppositional views among psychologists regarding the possibility of the existence of such a phenomenon as recovered memories. She states these opposite views are due to the controversy over whether or not children of various ages could forget traumatic abusive events in the first place. Williams posits the question which she says is at the root of the debate, "How common is it to have no memory of child sexual abuse? Also, by what mechanism does such forgetting occur" (p. 1168)?

In her literature review, Williams (1994a) cites Briere and Conte (1993), Herman and Schatzow (1987), and Loftus, Polonsky, and Fullilove (1994), as support for recovered memories, since large percentages of these adult survivors of child sexual abuse reported times during which they did not recall the abuse. Data from these three studies suggest that the younger the victim and the more traumatic the abuse, the higher the likelihood that the adult will have not remembered the abuse at some point. Repression or dissociation are postulated to be used by the young child because of a lack of more mature, more functional defense mechanisms with which to deal with the trauma. Williams also appeals to Freud's argument for the theory of

repression based upon childhood sexual abuse to support her research question.

In her literature review, Williams (1994a) cites research concerning cognitive development, language acquisition, and memory in children which supports her expectation that some sexually abused young children would forget their abuse experiences. Some studies from experimental psychology suggest that adult memory of life events preceding 3 years of age are rare. This nonmemory is attributed to immature cognitive development and a still-developing central nervous system. Further studies have indicated that youngsters may remember events before age 3 if they are painful, if they fit adult cognitive schemas, or if the events were constructed verbally for the children (i.e., the painful events were talked about with the child in such a way as to lay the events down in the child's memory using linguistic rather than visual or sensory neural pathways) (Ceci & Bruck, 1993; Nelson, 1993; Pillemer & White, 1989; Usher & Neisser, 1993).

Williams (1994a) notes that a primary weakness in earlier studies (Briere & Conte, 1993; Herman & Schatzow, 1987) was that they were dependent upon the process of adults recovering memories of child sexual abuse in order to validate the possibility of forgetting such abuse. In Williams' study however, the sample was entirely made up from a group of adult females whose childhood sexual abuse was already established from hospital documents which had contemporaneously recorded both the report of the

abuse and the data concerning the sexual assault; these reports then were based upon both hospital medical records and upon interview with the child and/or the child's caregiver. Williams' study began with the abuse firmly established, but with the subject's memory of the event as yet unknown and not established.

Williams' 1994 study asked the following questions:

> (a) How common is forgetting of child sexual abuse? (b) Is forgetting associated only with young age at time of the abuse and suggestive of the operation of infantile amnesia, or are other factors, such as relationship to the perpetrator or severity of the trauma, associated with forgetting, independent of age at time of the abuse? (p. 1169)

In light of the sketchy research studies above, Williams' (1994a) expectation was that some of the adult sample interviewed would not remember this clearly documented child sexual abuse when given the clinical interview investigating this history.

In true investigatory manner, Williams (1994a) did not predict which factors would vary with the memory or forgetting of the abusive experience, though she did enumerate what she would be looking at (see research question above).

Statistical Hypothesis. Williams (1994a) wisely did not postulate a specific expected result here as she was careful to base her specific expectations upon the limited research results which predated her study. Because the pool

of empirical research in this area is small, Williams' hypothesis merely stated an expectation that some of the women interviewed would not remember as adults their medically recorded childhood abuse.

Definitions. In a manner similar to previous studies, Williams (1994a) defined sexual abuse in an operational range from sexual intercourse to touching and fondling. In 60% of the cases within this study, sexual abuse included a report of penetration, with some sort of physical assault (e.g., pushing, shoving, slapping, beating, or choking) being used by the perpetrator in 62% of the cases. For the sake of this study, childhood was defined as ages 10 months to 12 years.

Instruments. A face-to-face, 3 hour private interview was conducted by 2 female researchers in their 40s (one White and one African-American). The researchers asked the women subjects questions about their childhood and adult life experiences, in addition to assessing the women's social and psychological health using various (unspecified) measures. Questions included queries concerning childhood experiences with sex; these were 14 separate and detailed screening questions which covered topics such as sexual contact by force, with someone in a position of authority, with a family member, with someone who was 5 or more years older, or that took place against her wishes. In order to fully explore the topic, the women were also asked about the existence of any fabricated incidences of sexual abuse in their

history, and were asked whether anyone in their family had ever been in trouble for their sexual activities.

Because many of the women interviewed recalled more than one incidence of child sexual abuse, 2 additional investigators (the chief researcher and research assistant) assessed whether any of the reported incidences matched the index abuse (that recorded by the hospital documentation) before recording the abuse as remembered or not remembered by the victim. This was conservatively done, with the abuse incident being recorded as remembered even if the victim had mis-remembered her age, or had not remembered the specific incident but had reported other sexual abuse by the original offender.

Samples. The potential sample consisted of 206 young females (aged 10 months to 12 years at the time of abuse), reported as sexual abuse victims, who were brought to a large northeastern inner-city hospital emergency room between 1973 and 1975 for treatment and the collection of forensic evidence. Extensive documentation is available on these females because they were examined as part of a National Institute of Mental Health study on the consequences of sexual assault on victims of various ages. From this original group of 206, during 1990 and 1991, Williams and her associates (1994a) located 153 of these women. Williams' actual sample is 129 of these women who agreed to be interviewed, came in for the interview, and who were not disqualified during the interview process. (Williams actually interviewed 136

women, but 4 interviews were dropped because initial report did not prove sexual contact, 3 additional cases were dropped because the women involved reported that the original reports of child sexual abuse had been fabricated.) At time of reinterview, the sample ranged in age from 18 - 31.

Generalization from sample to population. External validity questions are minimal in this study. The research was constructed elegantly, thus the construction rules out most external validity distortions. Even Williams' (1994a) harshest critics can find no fault with her method (Loftus, Garry, & Feldman, 1994). Williams and her associates were not the researchers who participated in the original National Institute of Mental Health study, therefore they rate well as independent follow-up researchers. The sampling techniques of this study are particularly strong, as they potentially include the entire population. Williams and associates located 72% of the population for their study and succeeded in obtaining data from 63% of the total population to use in their study. This is statistically impressive data and lays to rest most external validity concerns. Such a complete sample establishes this as a strong study.

However, one potential external validity question left unanswered is, since the majority of the sample were poor, inner-city dwelling African-American women, can this be generalized to the larger, more homogenous American culture? Williams (1994a) addresses this validity question by citing a study by Wyatt (1990) which indicates few ethnic differences between racial

groups regarding the impact of sexual abuse. However, Williams also notes that one other study (Russell, Schurman, & Trocki, 1988) indicates African-American women are more likely than White women to exhibit the negative impact of sexual abuse. This question needs more research as William's study leaves it unclarified.

This study specifically examines those women whose abuse as a young child was reported and was extensive enough as to require medical intervention in a hospital emergency room. It would be difficult to structure a similar study of women whose abuse as children went unreported. This study therefore, documents in a conservative manner the extent of forgotten childhood abuse experiences, since it examines only those abuse experiences that were reported to authorities. The study indicates that those victims who were younger and who were closer to their abuser at the time of abuse were more likely to deny abuse as adults and to therefore be undetected in studies of childhood abuse which depend upon self-report. Indeed, 16% of this study's sample who did remember their index abuse, reported that there had been a time when they did not remember this event (Williams, 1993). The current findings do suggest that nonreporting of childhood abuse or a period of forgetting childhood abuse cannot be regarded as conclusive evidence that such abuse did not occur.

The primary published criticism of Williams' (1994a) research concerns neither her methods nor her results; rather, her critics concern themselves

primarily with semantic quibbling and over-extension of Williams' findings in the publications of other authors. The invited critique of Williams' study published by the Journal of Consulting and Clinical Psychology was written by Loftus, Garry, and Feldman (1994). They applaud Williams' study, stating that it is well-done. They applaud Williams' conclusions, noting that she was careful in her application. They then argue at length over whether or not the lack of memory in Williams' sample is any different from regular forgetting. For example, Loftus, et al. compare the forgetting of memories of childhood sexual abuse to forgetting to buy aspirin when that is the item for which one went to the store.

Williams' reply to them is thoughtful (1994b). Williams addresses their stated concerns carefully, citing other research which indicates the long-term sequelae of child sexual abuse (Bagley, 1990; Briere & Runtz, 1987; Browne & Finkelhor, 1986; Saunders et al., 1992), the likelihood of fabrication of abuse reports (Everson & Boat, 1989), the studies which indicate the distinctive memory problems related to trauma, and the clinical ramifications of her study (Briere, 1992; Briere & Conte, 1993; Gold, Hughes, & Hohnecker, 1994; Herman, 1992; Waltz & Berliner, 1994). Williams concludes her rebuttal by noting that 22 years ago, in 1972, the researchers in the field of sexual abuse began their studies thinking they were dealing solely with the abuse of adult females (McCahill, Meyer & Fischman, 1979) but that recent studies show 62% of all rape victims are children (Kilpatrick et al., 1992). With this in mind,

Williams' study of these child victims and their survival mechanisms promises to be the beginning, not the end, of a new set of research questions: How many children repress their abuse, what are the effects of this, and what is the appropriate therapeutic response to these grown-up children?

Statistical Results. Williams' (1994a) study found that of the 129 women questioned, over one third (38%) did not report the child sexual abuse for which they were treated (the index abuse documented by hospital records) nor did they report any other sexual abuse by the same perpetrator. In reporting the results of her study, Williams addressed several validity concerns regarding the sample and her response to these concerns:

1. Is it likely that the women were embarrassed or just did not want to talk about such personal matters? Sixty-eight percent (68%) of the women who did not report the abuse which brought them into the hospital ER reported other incidents of child sexual abuse; 35% of the women who did not report the abuse reported other sexual abuse perpetrated by family members; and, 51 of the women questioned reported other potentially embarrassing personal matters (abortion, prostitution, or having a sexually transmitted disease). These women (61%) were no more likely to recall the index abuse than were those women who reported no such history (63%), χ^2 (1, $\underline{N}$ = 129) = .0023, $\underline{p}$ = .9621 (Williams, 1994a).

2. Were the women so traumatized by negative life events or affected by substance abuse problems that the child sexual abuse was insignificant or

easily forgotten? Thirty-seven percent (37%) of the women in the sample had experienced other very traumatic life events such as having a close friend or family member killed violently. These women were no more likely than others of the sample to have no recall of child sexual abuse, χ^2 (1, $\underline{N}$ = 129) = .7242, $\underline{p}$ = .948. Those women reporting substance abuse experiences (38%) were no more likely than those not reporting current substance abuse (39%) to have forgotten child sexual abuse, χ^2 (1, $\underline{N}$ = 128) = .0114, $\underline{p}$ = .9150. (Williams, 1994a).

3. Is it possible that some women did not recall the abuse because the abuse never occurred, not withstanding the documentation in the records? This seems unlikely, as current research reports that between 4 - 8% of present child sexual abuse reports are fictitious. The hospital reports used in Williams' (1994a) study are from the 1970s, when reporting child sexual abuse was much less socially acceptable than it is today. Additionally, none of the victims were involved in a child custody hearing as is common today. In order to err on the side of false negatives rather than false positives however, Williams and associates constructed an even more conservative estimate of percentage recalling abuse by restricting the sample to those women who had recorded medical evidence of genital trauma when treated in the hospital ER and whose accounts had high credibility ratings in the 1970s (based upon a 4-point, subjective, interviewer rating). Of these women (23 of the 129 in the sample), 52% did not recall the index abuse when reinterviewed in 1990 -

1991. This suggests that the 38% non-recall rate is not attributable to lack of abuse occurrences.

4. Is the high proportion of women who do not recall attributable to the young age of the children at the time of abuse? The data collected by Williams (1994a) indicates not. While 55% of the women who were 3 years or younger at the time of abuse had no recall of the event, even more women (62%) aged 4 - 6 years at the time of abuse had no recall of the abuse event. This data suggests that forgetting the trauma cannot be solely linked to factors such as cognitive formation and language acquisition. Over 31% of the women who were 7 -10 years at the age of victimization reported no adult recall of the abuse and over 26% of the women who were abused when aged 11 - 12 reported no memory of the trauma, χ^2 (3, $\underline{N}$ = 149) = 12.65, $\underline{p}$ < .006 (Williams, 1994a). (A further research question suggested by this data is: could the age of the women at reinterview be a factor in recall, since those women who were younger at the time of abuse were also younger [in their 20s] at the time of reinterview? This question is presently unanswered. It could be illuminated by further longitudinal study of this population.)

5. What accounts for recall besides age? Molestation by strangers was more readily remembered than molestation by those known to the women. Women who experienced genital trauma were more likely to have no recall of the event. In general, those women who were subjected to more force were less likely to recall the events of abuse. When age was combined with the

above factors, those who were younger at the time of abuse and who had a close relationship (close relationship was measured by kinship titles and nominal categories rather than on emotional closeness) with the perpetrator were most prone to forget the abuse, $\underline{N} = 129$, and logrithmic likelihood = 171.309; χ^2 (124, $\underline{N} = 129$) = 129.283, $\underline{p} = .354$ (Williams, 1994a). This finding differs from research done with adult survivors of sexual abuse (Briere & Conte, 1993; Herman & Schatzow, 1987) which indicates that sexual penetration and physical force are associated with remembering the abuse.

6. Are older girls who were sexually penetrated, had high credibility ratings, and have no current drug or alcohol problems less likely to have forgotten the child sexual abuse? When such rigorous specifications are applied to the sample (i.e., age at trauma over 6-years-old, extensive sexual abuse, no drug or alcohol problems), the sample size is reduced to $\underline{n} = 10$. The resulting conclusions therefore are not statistically significant when seen in the context of the whole sample. However, it is noteworthy that even within this rigidly defined group, 40% of the women did not recall the abuse. When the age limit is lowered to include women who were abuse at age 4 or above, 54% of the women did not recall the abuse. This data bears further investigation as it may rule out some of the skeptic's criticism of this study.

7. Do these findings apply only to memories of single occurrences of sexual abuse rather than a history of repeated abuse? Would recall of repeated abuse be more likely? Due to the research questions asked in the 1973 - 1975

study, it is unclear whether the women had been repeatedly abused by the same perpetrator. The follow-up finding, that women who had been abused by someone in close relationship to them were more likely to forget the incident leads to speculation that repeated abuse may be associated with no recall. The only empirical data known, however, is that 30% of the women in the study had been sexually abused previously to the index abuse incident of the study. These previously abused women were as likely to forget the index abuse as were those in the study who had been previously nonabused, χ^2 (1, $\underline{N}$ = 110) = .1871, $\underline{p}$ = .665 (Williams, 1994a).

Conclusion. Clinical realities make this a difficult area to access for sturdy research designs. Therefore, the elegance and sturdiness of William's 1994 study make it the preeminent work currently in the field. Because of the nature of what is being studied (i.e., abuse and trauma and its effect upon the victim's memory) no planned primary research can be set up surrounding the event. All research must occur after the life events have occurred. Because of these ethical restraints, most of the existing literature concerning the repression of childhood abuse memories is nonempirical, speculative, and less than ideal in nature. Williams' study therefore is a hallmark for following research efforts which illuminate the dark landscape of forgotten childhood abuse.

Loftus, Polonsky, and Fullilove's Study

In a study contemporary to Williams' 1994 work, Loftus, Polonsky, and Fullilove (1994) examined a related research question with a different population. While their statistical results are similar to Williams' results, Loftus, Polonsky, and Fullilove draw a very different conclusion.

Conceptual Hypothesis. Loftus, Polonsky, and Fullilove (1994) begin their research in a unique way. In their literature review section, they hypothesized that other researchers who have investigated the question of childhood sexual abuse brought such sloppy skills to their work and such overcommittment to the theory of repression to their work, that the validity of their work is called into question. These authors therefore set out to investigate the question of the possibility of repression of child sexual abuse from a skeptical theoretical stance. Their perception was: though the literature seems to indicate the existence of vast repression of child sexual abuse, the clinical literature can be disregarded because it is unscientific and the research literature on this topic is skewed by the theories of the researchers, therefore we will investigate this subject from a more neutral, critical position.

Operational Hypothesis. Loftus, Polonsky, and Fullilove (1994) do not question that child sexual abuse occurs, but they do question that repression of these events occurs. When discussing the construction of their study, they state, "Normal forgetting of all sorts of events is a fact of life, but is not

thought to involve some special repression mechanism" (p. 73). So they began their study expecting to find forgetting, not repressing.

Definitions. Loftus, Polonsky, and Fullilove (1994) properly point out the importance of how one defines child sexual abuse. The authors spend some effort to make the point that the empirical measurement of the frequency of childhood sexual abuse depends upon how the experience is defined by the researcher. For example, in one prominent study, sexual abuse before age 18 involving physical contact gives "prevalence rates of 27% - 51% for narrowly defined childhood sexual abuse by an older perpetrator and 31% - 67% if noncontact experiences are included" (Pope & Hudson, 1992, p. 460). For the purposes of their study, Loftus, Polonsky, and Fullilove defined sexual abuse as indecent exposure, as a variety of sexual touching including intercourse, and as using the child for the purposes of pornography. They also defined incest as abuse by any family member. Violent sexual abuse involved vaginal intercourse, anal intercourse, and oral sex. All other physical sexual contacts were classified as nonviolent sexual abuse.

Loftus, Polonsky and Fullilove (1994) take issue with behaviors that are commonly called repression. In general, they report that repression is defined as

> a warding off of any conscious experience of a frightening memory, wish, or fantasy, or of unwanted emotions. When discussed in the context of child sexual abuse, the extent of banishment from

> consciousness assumed in some definitions of repression is virtually total. (p. 68).

Results. These authors invest six pages of their research report to critique and to call into question the research findings of the other studies on this topic. Discussing their own research results, Loftus, Polonsky, and Fullilove (1994) expend sustained effort to explain away their own empirical results which indicate that 19% of their sample repressed memories of childhood sexual abuse. They suggested that their figure of 19% may be an overestimate due to their sample participants not understanding the language used in questioning; they suggested that since these women had all been substance abusers, the reported repression may be related to possible blackouts suffered because of substance abuse; and finally, the authors postulated a theory that robust repression does not exist at all. Loftus, Polonsky, and Fullilove proposed that what psychologists have been observing as repression for one hundred years is really "normal processes of forgetting" (p. 80). With these statements, the authors swept away years of theoretical, clinical, and research work concerning the subject of repression of childhood sexual abuse. This is markedly biased behavior when by their own report

> using the very liberal definition of repression to include anyone who does not claim they remembered the abuse their whole lives, the percentage in our sample was 31%. One might, then, conclude that a

sizable minority of our sample showed at least partial repression (Loftus, Polonsky, & Fullilove, 1994, p. 80).

However, this is not the conclusion that Loftus, Polonsky, and Fullilove (1994) make in their summation. Rather, they conclude that their analysis suggests there is no absolute answer available, and that there are few possible ways of getting at the question of repression of childhood memories of sexual abuse because in essence one is asking the subject to have a memory of forgetting a memory. It is most peculiar to see the authors of a well-designed, well-executed study failing to uphold the data which they generated.

Instruments. Loftus, Polonsky, and Fullilove (1994) recruited 105 women for a study concerning the effects of stressful events in the lives of women who had used drugs. These women were all outpatients at the Lincoln Medical and Mental Health Center Substance Abuse Division. Of the 105 participants, 46% were between the ages of 20 and 30, the remaining 54% were between 31 and 53 years old. Most of the women (96%) had children, though 67% of the sample had never married. Most of the women (80%) were African-American, 16% were Hispanic; most of the women (81%) had not gone beyond grade 12 in school. Coming from a variety of addictions, 69% of the sample were participating in the program under court order and all were free of drugs at the time of the interview and 85% had been so for at least one

week. The authors do not report how the women were recruited or selected for the study.

Statistical Results. Procedurally, the women were interviewed for 3/4 to 3 hours by trained professionals using a clinical interview formatted by the authors of the study. Women's responses concerning their history of abuse and their memory of this history were recorded on a variety of Lichert scales. When asked whether they had experienced childhood sexual abuse, 57 of the 105 subjects responded affirmatively. Of these 57, 52 of the women also responded to the question about the persistence of remembering this abuse. Using SPSS, a one-way analysis of variance procedure was performed on the data to compare those who always remembered with those who had forgotten or repressed this memory. Thirty-six of the 52 women (Group I = 69%) reported always remembering the abuse, 6 of the women (Group II = 12%) claimed to have remembered parts of the abuse (e.g., pictures, smells, touch, sounds, emotions) but not all of the abuse experience, while 10 of the women (Group III = 19%) reported complete forgetfulness (robust repression) of the event with later retrieval of the memory. On the variables of memory measured, Groups I and II did not differ significantly from each other, however Group III (complete loss of memory for a time) differed from Group I on clarity ($p < .01$), on intensity of feelings ($p < .001$), and on overall memory ($p < .01$). Group III also differed significantly from Group II (partial repression) on the intensity of feelings at the time of abuse ($p < .01$). Closeness of

relationship to the perpetrator, violence involved in the abuse, number of perpetrators, or frequency of abuse were not found to be significant discriminators across the three groups.

Discussion. Loftus, Polonsky, and Fullilove (1994) have done a good job operationalizing the constructs within their study. They have measured what they set out to measure. Due to lack of reported method, selection remains a validity question regarding their population. It is unclear whether or not these women were self-selected or if this interview was part of their court-remanded treatment. This would have been a stronger study if random selection methods were employed. Additionally, the results are open to question since all of the women involved had severe substance abuse problems and this could have skewed their memory processes in either direction being tested by the research.

It is unclear how generalizable these results are to the population at large due to the cultural and socioeconomic demographics of this group. However, the findings do line up with other studies of this nature, so this external validity concern is mitigated. Since the authors chose not to speculate about any alternate explanations for the variance which they observed and their hypothesis, attribution questions concerning internal validity are not a problem for this study. However, the authors' reluctance to work with their data in this way is troublesome and reveals their bias toward explaining away the trend toward repression which their data demonstrates.

This study then is remarkable because it demonstrates the likely existence of the theoretical phenomena which its researchers set out to disprove.

Though the data from the two studies are similar, it is worth noting that the Loftus, Polonsky, and Fullilove's (1994) summary is very different from the Feldman-Summers and Pope's (1994) summary. Feldman-Summers and Pope, when faced with a sample in which 23.9% reported childhood abuse and 40% of those reported some period of forgetting of this abuse, conclude that "empirical findings such as those presented here make it clear that reported forgetting and recall of past trauma are common phenomena [italics added] that demand our attention as clinicians and social scientists" (p. 639). Of Loftus, Polonsky, and Fullilove's sample, 54% had experienced childhood sexual abuse and 31% of these subjects reported at least some forgetting of these events at some point in their lives; however, Loftus, Polonsky, and Fullilove, in stark contrast to Feldman-Summers and Pope, conclude that their data suggests no absolute answers can be found to measure this occurrence and that research is hindered by the very question to be asked. Researcher bias is demonstrated by such conflicting conclusions. The False Memory Syndrome Foundation lists Loftus as a member of their Professional Advisory Board, thus suggesting Loftus' theoretical allegiance. Loftus, Polonsky, and Fullilove stand alone and apart from other clinical researchers in their unwillingness to attribute their empirical findings on

forgetting childhood abuse to some sort of repression/dissociation defense mechanism.

Other Studies

Two other studies, one by Feldman-Summers and Pope and one by Nelson and Simpson, comprise additional recent research into the topic of repression of childhood sexual abuse.

Feldman-Summers and Pope's Study. From the beginning of their report, Feldman-Summers and Pope (1994) state their professional interest in seeing an empirical exploration of the theoretical subject of repression of childhood abuse memories. Based upon their literature review, the authors expected to find some forgetting of childhood abuse memories within their sample. Their research study was "designed to extend our knowledge of the conditions under which childhood trauma may be forgotten" (p. 636). Feldman-Summers and Pope asked four research questions of their data: (a) To what extent are childhood memories of abuse being forgotten?, (b) What are the triggers which lead to recall of the abuse?, (c) Is corroboration of the abusive experience available for those who report forgetting childhood abuse?, and (d) Is this phenomena of forgetting related to the age or sex of the abuse victim or to the duration or severity of the abuse?

A strength of Feldman-Summers and Pope's study is that they recruited participants from 7 divisions of the American Psychological Association (APA) to form the sample for their research via random selection

procedures. A self-report questionnaire and stamped, addressed envelope were sent to 250 men and 250 women randomly selected from the APA Membership Register. The initial question asked whether or not the respondents had experienced childhood physical abuse (either sexual or nonsexual abuse before their 18th birthday), for those who answered 'yes', the questionnaire then went on to investigate this experience, corroboration of this experience, and the respondent's memory of this experience. The words repression or repressed memory were not used in the questionnaire.

For the purpose of this study by Feldman-Summers and Pope (1994), it appears from the article that the terms "physical abuse, sexual abuse, and nonsexual abuse" were left to the definition of the respondent. This may be defensible and nontroublesome since all respondents were members of APA and therefore may be assumed to have a common working definition of these terms, still, having clear definitions of terms of abuse would have made the study stronger.

Three hundred and thirty of the questionnaires were filled out and returned by 145 men and 185 women. Of the respondents, 40% were under 45 years old and 56% were female. This gives a good external validity ratio indicating generalizable results when compared with the US population over 25, where 50.9% are under 45 and 51.25% are female. For the educated population within the US, results of this research have generalization capabilities.

Of the 330 participants, childhood abuse was reported by 28.6% of the female respondents and 17.9% of the male respondents. Childhood sexual abuse was reported by 25.9% of the women and by 16.5% of the men. Of the 79 participants who reported childhood abuse, 32 (40.5%) reported that they had forgotten the abuse for some period. When compared, periods of forgetting abuse by a relative vs. forgetting abuse by a nonrelative were nonsignificant, χ^2 (2, $\underline{N}$ = 97) = 0.5, $\underline{p}$ < .0001. Fifty-six respondents reported that the process of therapy was related to their remembering the abuse, while 25% reported the media as a trigger, and 28.1% reported another event as a trigger. Nearly half (46.9%) of those reporting forgotten abuse also reported having corroboration of the abuse. Those who had experienced more than one type of childhood abuse were more likely to report forgotten abuse than were those who had experienced only one type of abuse, χ^2 (1, $\underline{N}$ = 79) = 13.82, $\underline{p}$ < .0001.

From these statistical results, Feldman-Summers and Pope (1994) concluded that their findings "lend support to the growing body of empirical evidence that a substantial proportion of adults reporting childhood sexual abuse have experienced a period of forgetting with regard to all or some of the abuse" (p. 638). New information from this study indicates that men who report childhood sexual abuse are as likely to report a period of forgetting as are women similarly abused. This study found no difference in reporting forgetting of abuse experiences based upon current age of the respondent. Support was found within this study for Briere and Conte (1993) and Herman

and Schatzow's (1987) findings that severity of abuse enhances the likelihood of repression, as those who were multiply abused were more apt to have forgotten the events.

Given the clinical realities of this research question discussed earlier and the design of this particular study which protects the anonymity of the participants, outside corroboration of the results are impossible. Additionally, this study is open to criticism for its nonelaboration of the kinds of forgetting involved and its apparent lack of standard definitions of abuse. Still this was a well-designed study based upon random selection which gave similar statistical results to other studies on this question. This study therefore, stands in contrast to Nelson and Simpson's 1994 study.

Nelson and Simpson's Study. Faulty in the conceptual hypothesis, Nelson and Simpson (1994) begin their report on their research by a narrow review of the literature surrounding repressed memories, pseudomemories, and the therapeutic interventions which are reported as being useful in the recovery of memories. The authors' incomplete literature review, which does not mention any studies representing opposing views, makes it clear that their bias is to distrust repressed/recovered memories, as does the publication of their study in the journal, Issues in Child Abuse Accusations, edited by Underwager, and their use of the False Memory Syndrome Foundation offices to distribute their questionnaire and to recruit their sample.

Given this stance, the authors stated their intent to explore the growing number of people who are rejecting their previous claims of recovered memories of childhood abuse, "to gather some initial demographic information, as well as identify characteristics of the common experiences of a sample of these persons" (Nelson & Simpson, 1994, p. 124). From the literature quoted in their beginning sections, the authors expected to find that various therapeutic techniques were involved in the retrieval of repressed childhood abuse memories. The authors also suggest that these intervention techniques create the visualizations (Nelson and Simpson's preferred term for repressed memories) of past abuse rather than recover the memories.

Since Nelson and Simpson (1994) come to their research convinced that recovered memories of childhood sexual abuse are actually false memories or visualizations (pseudomemories), their definitions are substantially different than other researchers. Nelson and Simpson urge that remembered abuse should be called "visualizations until such time as they are confirmed as historical memories, disconfirmed as fantasy, or are found to be a combination of the two" (p. 129). While other researchers speak positively of various therapeutic interventions such as group therapy or bibliotherapy, Nelson and Simpson refer to group therapy as a source of "the operation of contagion [and bibliotherapy as] media distortion effect" (p. 128).

Nelson and Simpson (1994) did their investigation in two stages: (a) an initial pilot study using a questionnaire was mailed to persons who had

contacted the False Memory Syndrome Foundation (FMSF) stating they had falsely claimed to have repressed memories of abuse, and (b) using these subjects and other individuals whom they had suggested to the researchers, a phone survey was conducted. Most of the participants in this study knew each other, some had the same therapist. For the main section of the study, 20 subjects were used, 19 females and 1 male, ages 18 - 48. Eighty percent of the subjects had some college education. Nineteen of the subjects reported that they recovered abuse memories while in therapy, one subject recovered memories while reading the book The Courage to Heal by Bass and Davis (1988). Nelson and Simpson found that 90% of their sample had initially used one or more trance induction techniques to recover their now disavowed memory. These techniques included hypnosis, regression, trance writing, sodium amytal, relaxation/imagery work, and dream work. Other techniques used to recover abuse memories were group or therapist suggestion/pressure, reading recovery books on abuse, sharing of flashbacks in groups, use of nonprint media related to abuse, medication, and empty chair work. The participants reported that their memory recovery took place in both group and individual therapy sessions.

Notably absent from this descriptive report is any mention of how the 20 participants came to disbelieve their previously avowed recovered memory, though the authors do say that 8 of the 20 subjects are suing their former therapists.

Given their stated research bias and their self-selected, small pool of subjects, Nelson and Simpson (1994) wisely restrict their research conclusions to descriptive generalizations, noting that "this study has limited application. The data collected is anecdotal in nature. A comparison group was not considered. The findings may not generalize to the entire population of people who have experienced recovered memory therapy" (p. 128). This study, in fact, generalizes only to those who come forward on their own claiming that their therapists led them astray, reporting that they (the subjects) in fact fabricated false stories concerning childhood abuse experiences. In order to clearly understand this phenomena, outside corroboration or noncorroboration of these subject's histories needs to be found. It appears that the primary finding of this small study may be the establishment of the existence of this group of doubly abused people.

Related Research

The research reported on above represents the beginning of a wave of research concerning the existence of repression as a defense mechanism in both adults and children, research concerning therapist's beliefs and practices regarding recovery of memories of child sexual abuse, and research regarding whether or not children's memories can be systematically tampered with in order to create mistaken memories. Many such studies are still in progress. Some research however, has been completed and published.

Poole, Lindsay, Memon, and Bull's Study

Poole, Lindsay, Memon, and Bull (1995) bring some empirical data to bear upon the debate concerning therapists' part in the recovery process of repressed memories of childhood sexual abuse. As noted earlier, there is a tendency toward polarization on the part of repressed memory researchers. One end of the spectrum suggests that practitioners are responsible for suggesting childhood sexual abuse to their clients, and that this may even cause false memories of such abuse (Loftus, Polonsky, & Fullilove, 1994; Nelson & Simpson, 1994). The other end of the spectrum claims that this is not the case (Freyd, 1993), and some outliers make expansive claims about the likelihood of the existence of repression of memories of childhood abuse whether or not the client ever remembers such an experience (Bass & Davis, 1988).

While the survey conducted by Pool, et al. (1995) yields only descriptive data, it solicited the opinions, practices, and experiences of 202 randomly selected doctoral-level psychotherapists in the United States and Britain regarding the childhood sexual abuse of their female clients. While this survey defined sexual abuse similarly to other researchers, they limited "childhood" to age 16 and under. This limitation differs significantly from the majority of other research on childhood sexual abuse where the standard upper age limit is 18 years of age. This more narrow definition of childhood would limit the sexual abuse reported in this study, however even with this

definition, 67% of the clinicians sampled reported having clients who reported childhood sexual abuse within the past year.

Poole, Lindsay, Memon, and Bull (1995) asked their respondents four questions about the existence of and the importance of the recovery of repressed childhood sexual abuse memories. When asked to estimate whether clients who initially denied childhood sexual abuse had in fact been abused, of those clinicians who responded, 75% said that at least some of their clients fit this category. A minority of these clinicians 17 - 20% felt that they could determine this about a client after the initial session. When asked to list symptoms which led the clinician to suspect childhood sexual abuse, participants came up with a wide variety of symptoms, agreeing primarily (14%) that adult sexual dysfunction was such an indicator. Of the respondents, 60% felt it important to remember childhood sexual abuse in order to therapeutically deal with the symptoms generated by the abuse.

When queried about the use of memory retrieval techniques (e.g., hypnosis, age regression, dream interpretation, guided imagery, interpreting physical symptoms), 71% of the 195 useable responses indicated use of at least one such technique. Respondents did not however agree which of the memory recovery techniques were appropriate, for example 25% of the US sample stated that hypnosis was nonappropriate to recover repressed memories while 25% of the US sample indicated that hypnosis was an

appropriate therapeutic technique. Theoretical orientation did not predict which clinicians would engage in what memory retrieval techniques.

Poole et al. (1995) have then shown us that a minority of doctoral-level clinicians engage regularly in some memory recovery work with their clients. This study also demonstrates the variability in symptoms seen by clinicians as indicative of childhood sexual abuse and the variety of therapeutic responses. The research also indicates that most clinicians are concerned that their clients are not led into false memories of childhood sexual response and that they practice therapy with this caution in mind. This survey shows the need for further study and education of clinicians concerning recovery of childhood abuse memories.

Yapko's Study

Another survey of therapists done by Yapko (1994a) investigated attitudes and beliefs about the use of hypnosis in recovering repressed memories. This is an important piece of research because hypnosis is one of the primary memory recovery tools in the therapeutic arsenal. Yapko gave his Hypnosis Attitude Questionnaire to 1,000 attendees at various mental health conferences and workshops during 1992. He received 869 useable questionnaires back. The average respondent in Yapko's sample was 44 years old, had a Master's level education, and had been in clinical practice for 11 years. Of those responding, 43% indicated formal training in hypnosis, however 53% indicated that they used hypnosis in their clinical work.

Yapko (1994a) investigated therapist's beliefs about hypnosis and found the following: 97% regard hypnosis as a useful therapy tool, 18 % believe that an individual cannot lie under hypnosis (this is false), 47% felt details gained under hypnosis were more likely to be true than those gained without (also false), 31% believed that memories regained under hypnosis were objectively true (false), 54% agreed to the principle that hypnosis could retrieve memories back to birth (most research casts doubt on this), 28% felt hypnosis could recover memories of past lives (?), 79% knew that untrue suggestions could be made under hypnosis which could be incorporated by the patient as true memories (this is true), and 19% reported that they knew of cases in which a therapist had suggested to a client that they had been traumatized. This data demonstrates the widespread faith of Master's level therapists in hypnosis, including some fallacies believed by a sizable minority of such therapists. Further education of therapists regarding hypnosis as a means of repressed memory retrieval is indicated by this study.

There are possible criticisms concerning Yapko's (1994a) work. What is not clear from Yapko's study is how closely therapist's beliefs about hypnotism influence their practice with clients. Poole, Lindsay, Memon, and Bull's (1995) data gives more concrete evidence of this. Since Yapko tabulated slightly agree and slightly disagree in the same categories as strongly agree and strongly disagree, he skewed the responses in his data. Additionally, the questions asked may be interpreted ambiguously. Yapko does not offer

psychometric data concerning the construction of his questionnaire nor concerning his interpretation of the data. This leaves the reader unsure as to the sturdiness of his research. Lynn, Myers, & Sivec (1994) also critique Yapko by noting that his sample are only trained at a Master's degree levels and in various disciplines; they hypothesize that this training factor may render the sample genuinely ignorant of hypnosis and its' uses. Yapko (1994b) responds that, like it or not, these respondents were legally practicing mental health professionals who should have known better.

Research concerning childhood memories of painful events

The empirical research studies explored above are investigating the fundamental question of whether or not the phenomena of repression of childhood memories of sexual abuse even occurs. And further, if it does occur, under what conditions? This debate over the veracity of memories of child sexual abuse does not limit itself to either strictly empirical data nor to well-done, carefully defined research. Much of the debate involves a flurry of semi-theoretical articles which have, in some cases, a barely concealed tone of: "Did not!", "Did too!" (Berliner & Williams, 1994; Ceci & Loftus, 1994; Freyd, 1993; Lindsay & Read, 1994; Loftus, 1993; Morton, 1991; Morton, 1994; Morton, Hammersley, & Bekerian, 1985; Pezdek, 1994; Read & Lindsay, 1994; Sales, Shuman, & O'Connor, 1994; Williams, 1994).

For example, some of the research is quoted with confidence by one polar end of the spectrum in order to demonstrate that false memories can be

easily introduced into a person's mind (Loftus, 1993; Read & Lindsay, 1994). In the two studies so confidently cited, the n = 1. In both, skilled interviewers were able to demonstrate the introduction of false memories to highly vulnerable subjects (Loftus, 1993; Ofshe, 1992) about traumatically tinged life experiences (being lost as a child and being a perpetrator of satanic ritual abuse). While interesting, such reports do not constitute research, and should not be quoted as standards of reference, nor employed to validate a theoretical point. Unfortunately, they are so used by psychologists who should know better (Loftus, 1993; Read & Lindsay, 1994) and are published in prestigious journals (American Psychologist & Applied Cognitive Psychology).

On the other end of the spectrum, we find psychologists downplaying well-done, applicable research which demonstrates that children's memories can be systematically re-written regarding details of painful events (Berliner & Williams, 1994). The study which Berliner and Williams seek to diminish was done by Bruck, Ceci, Francoeur, and Barr (1995). In this study, Bruck et al. studied 75 five year olds who were given shots at their pediatrician's office. Immediately following the shot and over the course of the next year, the 5 year olds were systematically either given neutral feedback concerning the shot, "the shot is over", or misleading information concerning the shot, "the shot didn't hurt" (p. 195). The children were similarly reinforced or misled concerning who had given them the shot, the pediatrician (who had given the shot) or the research assistant (who had comforted them afterwards).

Those children receiving erroneous feedback did not challenge the feedback. Of those given false information regarding who had administered the shot, 32% agreed to the misinformation after a year of being misled, whereas those receiving neutral feedback were unlikely to make this mistake (χ^2 [3, $\underline{N}$ = 75] = 13.41, $\underline{p}$ < .003). Over one year of time, the children who had been told that the shot didn't hurt reported significantly less "hurt" than did those who had received neutral feedback (F [1, 61] = 35.32, $\underline{p}$ < .001).

This study by Bruck et al. (1995) is especially interesting when compared to a similarly constructed study done in 1993 by Baker-Ward, Gordon, Ornstein, Larus, and Clubb on children's long-term retention of pediatric exams. Baker-Ward et al. found that 5 year olds retention of the events of the pediatric exam, compared over time with the memory retention of 3 year olds and 7 year olds, displayed forgetting of factual events after merely 3 and 6 weeks ($\underline{ts}$ [16] ≥ 2.66, $\underline{ps}$ < .05). Therefore, compared to Baker-Ward et al.'s study, Bruck et al.'s study also demonstrates that rehearsal of a pediatric exam, whether conducted with misleading or reality-based information, seems to insure a higher degree of remembering overall. This highlights previously shown research that rehearsal heightens memory in children (Ceci & Bruck, 1993), an interesting trend in light of the secrecy surrounding child sexual abuse.

This study does, therefore, seem to indicate that over time, some 5 year olds can be convinced that normal though painful, bodily events were done

differently than what factually happened. This is data worth knowing. However, it seems a large leap in rationale to say therefore, either that all children's painful memories can be easily misled (and therefore we can discount recovered memories of child sexual abuse) or that children's painful memories can usually be relied upon (and therefore we can believe them all). Both ends of the spectrum on the repression of child sexual abuse question rightly would exercise caution when interpreting such data.

Studies which examine repression of adult memories are of interest when considering the topic of repression of child sexual abuse because these studies seem to indicate that repression is an experience common to some people. However, care must be taken not to over-generalize studies done on adult repression by applying them to childhood repression since the two mechanisms appear to be separate (Freyd, 1993; Share, 1994; Szajnberg, 1993; van der Kolk & van der Hart, 1991).

Additional studies involving empirical data which give insight into the repressed/recovered memory debate are not numerous, but a few do exist. One such study is research done by Femina, Yeager, and Lewis (1990) which examines discrepancies between adolescent reports of physical abuse and reports given by those same subjects as adults. Femina, Yeager, and Lewis followed up 69 incarcerated youths who had been physically abused. Of those 69 subjects, 26 gave discrepant reports of abuse when interviewed as adults. Eleven of the subjects consented to extensive follow-up interviews in order to

clarify the discrepant abuse accounts. Outside corroboration indicated that all 11 subjects had been, in fact, physically abused during childhood. However, 8 of the 11 denied in adulthood the abuse which they had claimed during adolescence; 3 of the 11 reported abuse as adults which they had not reported as adolescents.

When questioned further, a variety of reasons for the disparity in reporting were given by the subjects. None of the subjects reported a repression of memory, though some stated that they had consciously tried to forget the abuse or to put it out of their minds. Other motivations for reporting/nonreporting included "embarrassment, a wish to protect parents, a sense of having deserved the abuse, a conscious wish to forget the past, and a lack of rapport with the interviewer" (Femina, Yeager, & Lewis, 1990, p. 229). The authors note that errors by the subjects always occurred in the direction of under-reporting of childhood abuse rather than over-reporting. This study demonstrates that unreported childhood sexual abuse exists in nonrepressed memory as well as in repressed memory.

Another study of interest measures the correlation between childhood sexual and physical abuse and the tendency/ability to dissociate in 312 college undergraduates. The findings of this study indicate that abused individuals were more likely to have dissociation as a psychological mechanism than were nonabused individuals. DiTomasso and Routh (1993) found significant correlations between the Sexual Abuse Scale and the Dissociative Experiences

Scale: $R = .21$, $F(1, 310) = 14.64$, $p < .001$. Since dissociation and repression are related defense mechanisms, this study supports the theory that repression or dissociation may be used by children to deal with abuse. This is a particularly useful study because it uses a large enough sample to support the research questions asked. It also uses well-known, reasonably reliable and valid instruments to measure dissociation and abuse: The Physical Abuse Scale of the Assessing Environments III (PAS) (Berger & Knutson, 1984), The Harvard Group Scale of Hypnotic Susceptibility (Shor & Orne, 1962), Tellegen Absorption Scale (Tellegen, 1982), Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986), and a sexual abuse instrument crafted by the authors which had good internal consistency (Cronbach's $\alpha = .93$). Basing research results upon the validity and reliability of the DES and PAS alone would be troublesome, as research gives conflicting reports concerning their vulnerability to malingering (Draijer & Boon, 1993; Gilbertson, Torem, Cohen, Newan, Radojicic, & Patel, 1992), therefore the multiple instrumentality used by DiTomasso and Routh better supports their data.

Research concerning repression as a defense mechanism

Research on adult repression has made it clear that emotional events are remembered differently than neutral or ordinary events (Christianson, 1992); that emotional moods are tied to state dependent memory in adults, with activation of the emotional state affecting memory retrieval (Bower, 1981); that unconscious, nonremembered events do affect conscious abilities

and attentions (Jacoby, 1983; Jacoby, Lindsay, & Toth, 1992); that people who repress, use emotional memory differently than nonrepressors (Hansen & Hansen, 1988); and, that repression is a defense which impairs the memory by protecting the individual from highly distressing emotions which accompany the traumatic events which are thought to form the etiology of postraumatic stress disorder (Kolb, 1988).

A further group of research studies are of interest because they give data on repression of childhood memories by studying a group of adults who use repression as a common defense mechanism (Davis, 1987, 1990; Davis & Schwartz, 1987; Davis, Singer, Bonanno, & Schwartz, 1988). This series of seven research studies were performed at Yale, using psychology students. The numbers of subjects in the studies is sufficient to support the statistical analyses done. The subjects were selected for the studies based upon their scores on two widely used measures, the Repression-Sensitization Scale and the Manifest Anxiety Scale; these tests were used in selection because low anxiety combined with high defensiveness was the operationalized definition of repression in this research (Byrne, Barry, & Nelson, 1963; Taylor, 1953).

In well constructed tests using physiological measures, self-report measures, and structured interviews, it was clearly demonstrated that individuals who are repressors have difficulty recalling negative and unpleasant life events, and that they do not experience the emotion related to recalled events even when physiological data indicates physical arousal

responses (Davis, 1987; Davis, 1990; Davis & Schwartz, 1987; Davis, Singer, Bonanno, & Schwartz, 1988).

Additionally, repressors showed a greater difference than nonrepressors between physiological responses on the two sides of the body during recall of negative affective memories. This lateralization is thought to indicate some underlying biological mechanism of repression which serves to disconnect the right and left cerebral hemispheres. Individuals identified as repressors had difficulty gaining access to emotional material from their past as measured in relation to nonrepressors. For example, the mean number of primes that failed to elicit a memory in Low Anxious subjects on the topic of fear was 1.83, in High Anxious it was 1.80, for defensive High Anxious it was 2.19, but for the Repressor category, it was 2.85.

To sum up, this well-constructed research (Davis, 1987, 1990; Davis & Schwartz, 1987; Davis, Singer, Bonanno, & Schwartz, 1988) indicates that adults who typically repress as a defense mechanism have difficulty recalling negative, unpleasant experiences from their childhood and later life. This series of studies on repression in adults supports the findings cited earlier in this paper concerning the existence of repression of negative childhood events, specifically the possibility of repression of childhood sexual abuse (Briere & Conte, 1993; Herman & Schatzow, 1987; Loftus, Polonsky, & Fullilove, 1994; Williams, 1994).

Future Research Directions

Much research remains to be done. Several researchers reported on in this paper suggest further directions for study. A standard procedure or instrument for confirming or disconfirming reported abuse would be helpful (Nelson & Simpson, 1994). Poole et al. (1995) recommend further clinical research to demonstrate the effectiveness of dealing with these memories, to clarify methods of distinguishing between etiological causes of symptomatology, and to assess the validity and usefulness of various memory retrieval techniques with clients of varying diagnoses. Berliner and Williams (1994) appeal to cognitive researchers to investigate and clarify how a complete lack of recall of trauma may occur, van der Kolk and van der Hart (1991) concur with this need for research into the differences between adult memory and child memory regarding cognitive encoding, storage, and retrieval processes.

Yapko (1994a) generates a list of clinically relevant queries regarding the occurrences, the predisposing factors, and the clinical indicators of repressed memories. Loftus, Polonsky, and Fullilove (1994) recommend more research into prevalence of repressed memories of childhood sexual abuse. Williams (1994b) also calls for better ways to document the process of repression of abuse memories, recommending as well further study into why partial forgetting versus full forgetting occurs, what causes the varying length of forgetfulness, why do some people never remember the abuse, how does

forgetting child sexual abuse compare to forgetting other violent childhood traumas, and what is the association between forgetting childhood trauma and various adult social and psychological functioning. Freyd (1993) points to future research which would tie together the basic cognitive mechanisms underlying dissociative experiences, and which would trace the psychological aspects of abuse with the psychological symptoms.

Research into the cognitive processes of child memory versus adult memory, into the conditions affecting recall of the memories of child sexual abuse, and into the effective clinical treatment of such memories and their resultant sequelae would be especially helpful to clarify the issues. Due to the emotionally laden nature of the question of reference, researchers must take extra care to validate each assumption, to seek outside corroboration for clinical observations.

Conclusion

This paper has illustrated that current research substantiates the prevailing clinical belief that a sizable minority of the individuals who were abused sexually as children do forget this abuse for some period of time. Research indicates that this "forgetting" is different from normal forgetting and is clinically tied to the theoretical concepts of repression and dissociation. The researchers, clinicians, and theorists examined in this paper generally agree that childhood sexual abuse occurs and that its effect is felt in the adult

life of the abuse victim. All of these psychologists, no matter what their bias or stance, also agree that further research is needed into this clinical reality. And, as Hedges (1993) elucidates, this research, regarding repression of memories of childhood sexual abuse, must be contextually congruent with the broader foundations of research into human memory.

Telling the truth about childhood sexual abuse memories, whether this truth proves the memories to be false or true, will ultimately provide therapeutic benefit to the individuals involved.

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