RESEARCH

Studying Delayed Memories of Childhood Sexual Abuse

—by John Briere

Empirical investigation of the incidence and long-term effects of childhood sexual abuse spans less than 20 years. In that time, nevertheless, we have learned much about the many sequelae of sexual acts against children. With this greater knowledge have come new puzzles, however. One of these is reflected in the following scenario:

A 34-year-old woman presents to a psychotherapist with complaints of chronic depression, suicidal ideation, extensive drug abuse, episodes of self-mutilation, and, most recently, intrusive images and dreams of men engaging in sexual acts with a crying child. She describes multiple short-lived relationships with older men who are almost inevitably abusive, and states that she fears she drives them away by virtue of her "frigidity." The clinician recognizes these problems as among those commonly associated with childhood sexual abuse in the research literature, and asks about childhood trauma. The woman becomes very upset, and emphatically denies any history of sexual abuse.

The above example is not atypical: Many psychotherapists describe clients or patients whose difficulties are suggestive of a sexual abuse history but who report no memories of having been molested (see, e.g., Briere, 1989; Courtois, 1988; Gil, 1988; Goodwin, 1989; Meiselman, 1990). In the absence of definitive data, such clinicians are left with a limited number of possibilities: 1) If abuse isn't remembered it did not occur, or 2) Even though abuse isn't remembered, it might have occurred.

In the past, this dilemma was often resolved in favor of the former: The client was assumed to be suffering from other, nonabuse-related problems (e.g., "pre-Oedipal issues") or precipitants (e.g., maternal ambivalence or rejection). More recently, however, an increasing number of adult clients have come to report new recollections of childhood sexual abuse, often during intensive psychotherapy. At this juncture, a new set of possibilities arises: Either 1) There is a relatively common phenomenon, perhaps called amnesia, in which childhood traumas are "forgotten" until they are somehow restimulated at a later point in time, or 2) Some clients lie about (or are deluded into believing) childhood sexual abuse, perhaps as the result of a "False Memory Syndrome" (False Memory Syndrome Foundation, n.d.). In the former case, the recovery of childhood memories may be an important component of effective abuse-focused treatment. In the latter, deluded or mislead individuals should be disabused of their confusion lest they falsely accuse innocent people and/or waste precious time and resources on unnecessary treatment.

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To add to the potential confusion, we have at least two models from which to explain why someone abused as a child might "forget" such an event. The classic notion of repression, as presented by Freud (1966), suggested that sexual abuse memories might be blocked from conscious awareness by virtue of their potential to produce extreme psychical conflict. Thus, for example, a victim who experienced some level of enjoyment of his or her abuse, who for some reason desired the sexual contact, or who received bribes or special privileges for not disclosing, might actively repress his or her abuse memories in the interest of avoiding feelings of guilt or shame. In contrast, others refer to amnesia when describing absent sexual abuse memories, suggesting a dissociative defense against re-experiencing the anxiety and distress associated with recall of especially traumatic abuse. From this perspective, "Dissociation is adaptive: it allows relatively normal functioning for the duration of the traumatic event and leaves a large part of the personality unaffected by the trauma" (van der Kolk & Kadish, 1987, p. 195-186).

The Research

Obviously, the number of unknowns strongly supports vigorous research in this area. Thus far, two studies have been conducted to study possible delayed abuse memories: One by Judith Herman and Emily Schatzow, published in *Psychoanalytic Psychology* in 1987, and one by myself and Jon Conte (with assistance from Daniel Sexton), to be published in the *Journal of Traumatic Stress* early in 1993.

Herman and Schatzow (1987) studied 53 women with self-reported histories of childhood sexual abuse who were members of time-limited abuse-focused therapy groups. They found that 64% of these women reported incomplete or absent memories of their abuse at some time in the past. Memory impairment was associated with more violentt sexual abuse experiences and with abuse that occurred relatively earlier in life. The higher level of violence in the abuse histories of amnestic women suggested to the authors that these individuals were attempting to lessen internal distress by avoiding painful recollection — a process that would support a dissociative model of memory loss. Unfortunately, one cannot rule out the possibility that conflict, too, motivated absent memories, since this variable was not examined in Herman and Schatzow's research.

In Briere and Conte's study (in press), a large clinical sample of adults who reported forced sexual contact at age 16 or younger by a person five or more years older was recruited by their therapists. Ultimately, 450 women and men completed an extensive questionnaire examining current symptomatology (via the SCL-90), characteristics of the abuse and perpetrator behaviors, victims' reaction to the abuse (e.g., enjoyment, fear, guilt), and — among a number of the variables — response to the following question: "During the period of time between when the forced sexual experience happened and your eighteenth birthday was their ever a time when you could not remember the forced sexual experience?"

Of the 450 subjects, 267 (59.3%) reported amne-

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sia for sexual abuse at some point before age 18. Relative to the nonamnestic group, these subjects reported molestation at an earlier age (at 5.8 years versus 7.3 year), abuse over a longer period of time (11.5 years versus 9.3 years), victimization by more individuals (2.5 versus 2.1), a greater likelihood of having been physically injured as a result of the sexual abuse (35% versus 19%), a greater fear that they would die if they ever reported the abuse (34% versus 21%), and, as adults, higher scores on the General Symptom Index of the SCL-90. Not associated with abuse-related amnesia, however, were any potential indicators of intrapsychic conflict, such as physical or emotional enjoyment of the abuse, whether the victim struggled with the abuser, presence of bribes or extra privileges, guilt about the abuse or about not disclosing it to others, or extent of shame regarding the abuse experience.

Potential Limitations of the Research

There are several problems inherent in both Herman and Schatzow's study and our own, however, that constrain each's interpretability. Both used data derived from retrospective self-report, a limitation of most "abuse effects" research (Briere, 1992). As a result, we cannot rule out the possibility that subjects' recall of abuse-related events and/or their reactions to said events, or even their recall of their remembering was not affected by other variables such as passage of time, continuing memory impairment, current psychological distress or dysfunction, etc. Similarly, as reflected by a relatively recent discussion in the *American Journal of Psychiatry* (Briere & Zaidi, 1989; Rich, 1990), such research cannot rule out entirely the possibility that subjects lied or otherwise confabulated their abuse, as per concerns about a False Memory Syndrome. The large (and relatively equal) percentage of subjects reporting some level of amnesia in each study, however, appears to suggest either that abuse-related amnesia is a common, "real" phenomenon, or that an unknown phenomenon of major proportion caused more than half of 500+ women and men to misrepresent their childhood histories.

Potential Implications

If the self reports of subjects in these two studies are more or less accurate, several tentative conclusions may be made:

1. Amnesia for childhood sexual abuse (partial or otherwise) may be a relatively common phenomenon, at least among adults in clinical populations;
2. Abuse-specific amnesia may be associated more with violence than with internal conflict, suggesting that the motivation for amnesia may be dissociative avoidance of abuse-related distress;
3. Earlier abuse may promote amnesia more than abuse at a later age; and
4. Previous amnesia for childhood sexual abuse may be associated with greater current psychological symptomatology, even when subjects report that amnesia has since lifted.

Conclusions

In both of the above studies the authors speculate further on why violence might stimulate dissociative avoidance of memories, and why early abuse might be more likely to be repressed. Briere and Conte suggest that avoidant defenses may be a risk factor for poorer psychological health, much as initially suggested by Freud (1954) in his model of the etiology of hysteria. More relevant to the present discussion, however, is the fact that the available data do not support definitive statements about the incidence, form, or function of abuse-related amnesia. Short of longitudinal research on the content and accuracy of abuse-related memories over time, or some other method of independently validating the veracity of recalled abuse (Briere, 1992), our knowledge of delayed memories will be, at best, incomplete.

Despite the preliminary quality of the information presently available, these data do suggest that some type of defensive memory disruption occurs in some adults who were severely abused as children. To the extent that this is true, it logically follows that memory recovery will be an important component of abuse-focused therapy for some individuals. Ultimately, of course, only further research on trauma, memory, and recall will provide the clarity so obviously needed in this controversial area.

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