FACTORS ASSOCIATED WITH RECALL OF MEMORIES OF CHILDHOOD SEXUAL ABUSE

By

JILL MACKAY SCOTT

Bachelor of Arts
University of Southern Maine
Gorham, Maine
1987

Master of Science
Oklahoma State University
Stillwater, Oklahoma
1990

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
December, 1995

COPYRIGHT

BY

JILL MACKAY SCOTT

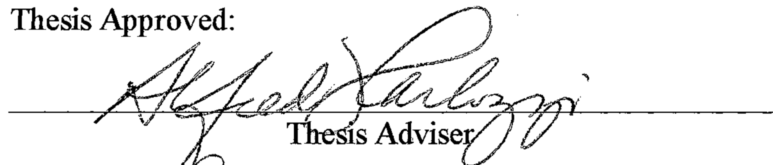
December 1995

FACTORS ASSOCIATED WITH RECALL OF

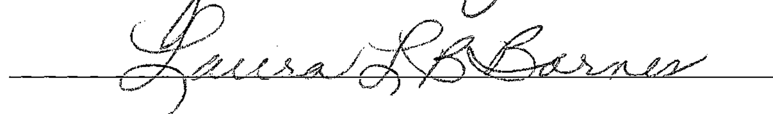
MEMORIES OF CHILDHOOD

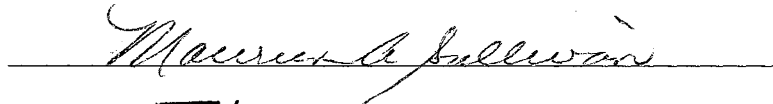
SEXUAL ABUSE

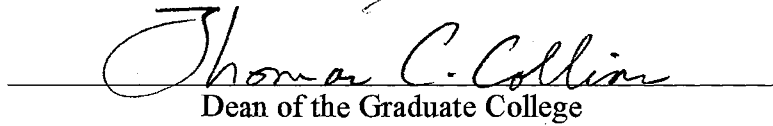
Thesis Approved:



Thesis Adviser







Dean of the Graduate College

ACKNOWLEDGMENTS

I wish to express my sincere appreciation to my major advisor, Dr. Alfred Carlozzi for his resourceful guidance and encouragement. My sincere appreciation extends to my committee members, Dr. Laura Barnes, Dr. John Romans, and Dr. Maureen Sullivan, whose insights provided exemplary mentoring. I express to Dr. Russell Koch much appreciation for his encouragement, support, and challenges during the pre-doctoral internship and data collection phase of this project.

I wish to acknowledge the sonorous support from my husband, Dr. Greg Scott, whose companionship has made the graduate school process fun. To our children, Wyn, Chris, and Molly Allen, Jeremy Scott, and Heather and Scott Linscheid, I extend thanks for sharing graduate school with me. I wish to express enthusiastic gratitude to my parents, Jean T. MacKay, and Mahlon E. and Geraldine T. Scott for their belief in my goals and their generous and nurturing support along the way. I dedicate this dissertation to the memory of the academic ideals of my father, Robert G. MacKay.

The participants must remain nameless, but their radiant contributions of stories, perceptions, ideas, and hopes has made this project possible. Thank you all!

TABLE OF CONTENTS

Chapter Page

I. INTRODUCTION 1

Background of the Problem 1
Statement of the Problem 5
Purpose of the Study 7
Research Questions 8
Significance of the Study 9
Definition of Terms 11
Limitations and Assumptions 12
Organization of the Study 13

II. REVIEW OF THE LITERATURE 14

Childhood Sexual Abuse 14
Memory 21
Factors Associated with Memory Recall 30
Summary 37

III. METHODS 39

Introduction 39
Participants 41
Instruments 43
Design 45
Procedure 46
Data Analysis 47

IV. RESULTS 48

Results related to the Research Questions 48
Research Question 1 54
Research Question 2 70
Research Question 3 71
Research Question 4 78
Research Question 5 80

Chapter | Page

Additional Research Findings 86

V. SUMMARY, DISCUSSION, AND RECOMMENDATIONS 90

Summary 90
Discussion 91
Recomendations 103

REFERENCES 109

APPENDIXES 123

APPENDIX A--FORMAT FOR THE MINIMALLY GUIDED INTERVIEW. 123

APPENDIX B--DEMOGRAPHIC QUESTIONNAIRE 125

APPENDIX C--MEMORY RECALL QUESTIONNAIRE 127

APPENDIX D--LETTER TO THE THERAPIST 130

APPENDIX E--SOLICITATION TO THE VOLUNTEER PARTICIPANTS.. 133

APPENDIX F--INFORMED CONSENT: OSU AND OU 135

LIST OF TABLES

Table Page

I. Data From Demographic Questionnaire 49

LIST OF FIGURES

Figure Page

1. Factors Identified In The Literature Which Correlate With Recall Of Memories Of Childhood Sexual Abuse 7

CHAPTER I

INTRODUCTION

Background of the Problem

Some adults, unaware of having been abused, recall memories of sexual abuse which occurred when they were children. Legal proceedings initiated in some cases in response to recall of abuse have generated controversy about the validity of the recalled memories. Despite this controversy in popular, professional, and legal literature, little is known about the manner in which repressed memories are recalled. The intent of this study was to identify factors associated with the recall of repressed memories. This study did not speak to the validity or accuracy of the recalled or reconstructed memories of childhood sexual abuse. It identified phenomena associated with the recall of memories of childhood sexual abuse by adults who were in psychotherapy at the time of the inquiry.

Each experience of memory recall occurred under one of three conditions: (1) prior to psychotherapy, (2) after initiation of therapy but not during the therapy hour, or (3) during therapy sessions. This study classified respondents according to these three conditions, known in this study respectively as Categories A, B, and C, as it identified their experiences, events, sensations, cognitions, emotions and other phenomena associated with the experience of recall of memories of childhood sexual abuse.

The purpose of this study was to generate new information about the conditions under which memories of childhood sexual abuse were recalled. Sexual abuse often involves the violation of trust between child and a caregiver on whom the child is sometimes totally dependent. By itself, the abuse constitutes a confusing, if not always violent, set of interactions between the child and the adult. The repression of memory of these events creates an even greater dimension of continuing psychological turmoil. Among victims of childhood sexual abuse as many as one in three women and one in five men are cognizant of past events (Browne & Finkelhor, 1986). The number of adults who have experienced sexual abuse and have no memory of it is not known. Figures on the prevalence of repressed memories in the general population vary from eighteen to fifty-nine percent in various studies. This wide range indicates the difficulty of assessing the size of the population which has experienced abuse and has no memory of it (Herman & Schatzow, 1987; Loftus, 1993; Loftus, Polonsky, & Fullilove, 1994; Williams, 1994).

For months or years abuse victims may fail to consciously recall either the abusive events or the emotional trauma associated with them. Some may experience the emergence of awareness of past sexual abuse in hazy recollections or shards of memories which build toward a whole recollection. For others, the recollection or flashback may occur all at once, triggered by external stimuli, internal stimuli, or a combination of both.

Reporting sexual abuse to authorities may create volatile interpersonal and legal situations. Parental divorce is not an uncommon result, and protection of the child as a ward of the state may be necessary. Additional chaos can result when children are placed in temporary foster care. The strongest legal battles are waged in the area of protective

custody, either by one parent or caregiver against the other parent, or by the parents in opposition to the state in response to charges of child sexual abuse (Gardner, 1992). Assessments by the therapeutic and legal communities conflict concerning the veracity of charges of sexual abuse. Gardner (1992) has suggested that a big percentage of charges by children or adolescents are false. Others challenge his research methods and data, and point instead to a small number of false accusations and evidence that these are most frequently made by adolescents caught in tough custody disputes (American Professional Society on the Abuse of Children, 1992; Berliner & Conte, 1990; Sgroi, 1992).

New legal and social implications are emerging as adults take action on recovered memories of formerly repressed sexual abuse. Adults' memories of childhood sexual abuse have called into question the justice of states' statutes of limitation that preclude bringing charges against suspected abusers. This raises an important question: if an adult recovers memories of sexual abuse experienced as a child, is the accused or suspected offender subject to criminal legal penalty? The answer to this question depends upon the state in which the legal action is sought. The answer is *yes* in nine states which have no statutes of limitation for any criminal offense or for any felony offense. The answer is *maybe* in twenty states which toll (a legal term meaning to render invalid) statutes of limitation for varying lengths of time. The answer is *no* in twenty-one states which impose statutes of limitation for childhood sexual abuse and have no statutory or common law provision for tolling the statutes (Mindlin, 1990; National Center for Prosecution of Child Abuse, 1992). Accused or suspected offenders in some states escape being charged with a crime or a felony when state law protects an accused or suspected offender from a "stale

claim" years after the actual abuse occurred (Clevenger, 1991-2). Sexual abuse is a crime in every state, yet there is no action that can be taken in some states if the victim fails to report the crime within the statutory period (Bharam, 1989; Mindlin, 1990). In *Tyson v. Tyson* (1986), the plaintiff used the discovery rule, commonly employed in medical malpractice cases, to file charges eight years after her eighteenth birthday, which was beyond the state's statute of limitation. She contended that the sexual abuse she had experienced from ages three to eleven had caused her such emotional trauma that she had repressed the memories for the events. The Washington State Supreme Court rejected her claim on the basis that evidence for repressed memories was not convincing. Other states, however, have made a variety of rulings in similar cases (Duffy, 1990; Nabors, 1990; Rodgers, 1992).

Not everyone supports the trend to toll statutes of limitation in cases of sexual abuse. *The False Memory Syndrome Foundation* was established in 1992 to investigate the spread of false accusations and to offer support to those who felt wrongly accused by people claiming to have recovered memories. *Issues in Child Abuse Accusations* is a publication that offers help for parents who feel wrongly accused of sexual abuse by their children. Both the organization and the publication have responded to the dozens of cases a year requiring litigation and the employment of expert testimony. In the setting of the courtroom, the paucity of knowledge about repression and memory is clearly evident (Goldstein, 1992; Loftus, 1993).

Loftus (1993) has suggested that there is little scientific, objective evidence to support the belief in the idea of repression. She cites studies in which false memories have

been implanted in people, creating a belief that an event happened when it did not. One study involved deliberately deceiving people, convincing them that they had been lost at age five, and then soliciting their detailed recollections of the event. Another study involved recalling details of a simulated automobile accident, which provided evidence of inaccuracies of memories (Loftus, 1975). Holmes (1990), in his review of research over the last sixty years, concludes that no "controlled laboratory evidence" supports the concept of repression (p.96).

The potential for a shifting public attitude about the validity of abuse claims, due to the rise in numbers of reportedly false claims, is a cause for genuine concern. Whereas veracity of the details is not *always* of central therapeutic concern in the treatment of adult survivors of sexual abuse, the truth of the act(s) of sexual abuse becomes extremely important in a court of law, and is certainly of great importance to the emotional well-being of those who may be falsely accused (Christianson, 1992; Christianson, Goodman & Loftus, 1992; Loftus, 1992).

Statement of the Problem

The problem is a lack of knowledge about phenomena associated with the recall of memories of childhood sexual abuse. Repression of memories sustains the negative effects of sexual abuse by impeding treatment or recovery of the client (Briere, 1992b; Gelinas, 1983; Herman & Schatzow, 1987; Kluft, 1991; Sgroi & Bunk, 1988). The experience of memory recall sometimes occurs prior to psychotherapy, sometimes after initiation but not during the therapy hour, and sometimes during therapy sessions. This study differentiated

and compared these three groups in regard to experiences, events, sensations, cognitions, emotions and other phenomena that are associated by therapy clients with the experience of memory recall of childhood sexual abuse. More knowledge about factors that help release the hold of repression might increase the ability of therapists to assist clients in recognizing and dealing with the effects of childhood sexual abuse. It is ethically and legally imperative that therapists gain better understanding of the recovery of memory of previous sexual abuse.

This study focused on the process of the recall experience, when an adult reported having experienced the lifting of previously repressed memories of childhood sexual abuse. This study looked specifically at the internal and external stimuli which were associated with the recall of memories, according to relevant professional literature, as well as in the reported experience of study participants with the recovery of those memories. It has been claimed that continued repression of past sexual abuse appears to preclude amelioration of symptoms which bring adult abuse survivors into therapy. Acting as a block to the real source of the symptomology, it has been argued that repression must be lifted if healing is to take place (Armsworth, 1989; Briere & Conte, 1989). Based upon clinical accounts, the characteristic signs and symptoms associated with a history of sexual abuse do not get better without awareness that the source of the symptom is past sexual abuse (Courtois, 1988; Herman & Schatzow, 1987; Kluft, 1991; Peters, 1988; Terr, 1991).

Factors identified in the literature that are associated with recall of childhood sexual abuse include items listed in Figure 1. Figure 1 is incomplete, and the relation of

these factors to memory retrieval is not well understood.

FIGURE 1

FACTORS IDENTIFIED IN THE LITERATURE WHICH CORRELATE WITH RECALL OF MEMORIES OF CHILDHOOD SEXUAL ABUSE

- televised public service announcements describing sexual abuse
- questions about inappropriate sexual touching
- sex education
- individual therapy
- group therapy
- recurrent dreams
- disclosure of sexual abuse by a sibling
- sexual abuse of a client's son or daughter
- developmental phenomena such as marriage, birth, death
- re-exposure to the environment of the original abuse
- particular sexual positions
- particular smells, sights, or sounds
- certain ways of being touched
- heavy breathing, associated with sexual arousal
- being alone
- anxiety or sleeplessness at a certain time of night
- newspaper accounts of own or others' sexual abuse
- medical records of own or others' sexual abuse
- participation in vacation, hospital stay, or social events such as family reunions
- graduate studies

Purpose of the Study

The purpose of this study was to identify factors which correlate with the retrieval of repressed memories of childhood sexual abuse. This study attempted to isolate and articulate conditions, experiences, events, and other phenomena which, according to study participants, occurred at the same time as or shortly prior to recall, and were experienced as being related to the recall of abuse.

As previously noted, there is no doubt that therapy clients have experienced sexual abuse during childhood and they do not remember the abusive events (Brothers, 1985; Courtois, 1988; Gelinas, 1983; Russell, 1983; Sgroi, 1988). Retrieval of repressed memories is considered by many to be beneficial in the therapy process (Alpert, 1991; Bass & Davis, 1988; Briere, 1992a; Goldwater & Duffy, 1990; Herman & Shatzow, 1987; Kendall-Tackett, 1991; Olio, 1989; Terr, 1991). Early intervention is critical to the healthy functioning of trauma victims. Because of threats and/or fears, victims often choose not to tell, or in the extreme, successfully repress the memory of the events. Therapist knowledge is vital in discerning signs and symptoms of earlier sexual abuse among the smoke screen of presenting concerns.

This study did not attempt to demonstrate a causal relationship between certain triggers and the moment of recall. It did not attempt to prove the accuracy or the inaccuracy of a recalled memory. Instead, it used the interview process as a research tool which may reveal patterns of correlation of certain life events, emotions, or thoughts with recall of previously repressed abuse. The results of this study added to the body of knowledge about how recall occurs. It contributed to researchers' and psychotherapists' understanding of how recall of memory may vary depending on the conditions under which it took place, and how those memories may be triggered.

Research Questions

There are events, conditions, and experiences in an adult's life which create an environment conducive to the emergence into consciousness of repressed memories of

childhood sexual abuse. A review of the literature suggested that certain events may be associated with the recall of such memories. The literature only partially identifies factors which correlate with the recall of abuse. This study, therefore, will provide information that will lead to answers to the following research questions:

(1) What factors are associated with the retrieval of repressed memories of childhood sexual abuse?

(2) How frequently do these factors occur in relation to memory retrieval?

(3) Do these factors occur in any patterns related to the three recall categories (A) recall prior to psychotherapy, (B) recall sometime after initiation of therapy but not during the therapy hour, and (C) recall during the therapy session)?

(4) Are there age or gender differences in the patterns of these factors?

(5) Are specific presenting concerns in psychotherapy more highly correlated with clients who have repressed memories than with clients who have had active memories all along?

Significance of the Study

A better understanding of how repressed memories of childhood sexual abuse may be retrieved by clients will assist therapists in understanding the healing process. In particular, comparing memory recall experiences that occurred prior to therapy, after initiation of therapy, and during the therapy hour may reveal characteristics of recalled memories that help in resolving current ethical and legal disputes within and outside of the profession. The False Memory Syndrome controversy, brought to public attention by

Elizabeth Loftus (1993) and others, has generated much discussion and a new aspect to the inquiry. This study, among other things, was an initial step in starting to acquire the data necessary to resolving these disputes. Differences found in the recall experiences of clients who recalled memories before, during, and after therapy, may eventually lead to discovery of factors related to how individuals become aware of how they recover their abuse histories.

This study contributed to the knowledge of the phenomenon of resilience among adults sexually abused as children. By exploring the positive adjustments of the participants, the information gathered added to the growing body of data about factors in participants' lives that were associated with positive outcomes.

The eventual applicability of this study is reduction of suffering for the portion of the population affected by repression of trauma from childhood sexual abuse. A better understanding of repression and the correlates related to its lifting has the potential to provide healing earlier in the life course. Further usefulness of this study occurs as practicing psychologists use this and similar information to make more cautious inquiry and better informed responses with clients who have the *appearance* of repressed sexual abuse histories. The information gathered in this study may eventually lead to better educational models for therapist training, with the potential of developing the treatment of sexual abuse as a field of specialization, including licensing or certification. The cost to human dignity and health is great, whether to those who are wrongly accused of sexual abuse or to those who's memory of childhood sexual abuse remains a secret.

Definition of Terms

Sexual Abuse

Child sexual abuse was defined as unwanted contact or interaction between a child and an adult when the child was used for the sexual gratification of an adult who was five or more years older than the child (Browne & Finkelhor, 1986; Kemp & Kemp, 1984; Seng, 1986; Wyatt, 1985). Contact or interaction included, but was not limited to, kissing, fondling, erotic over-stimulation, indecent exposure, seductive behaviors, oral-genital contact, intercourse (Berliner & Conte, 1990; Risin & McNamara, 1989), and being made to watch or participate in pornography, voyeurism, and lack of personal privacy in the bathroom or bedroom (Finkelhor, 1979; Gelinas, 1983; Maltz & Holman, 1987). The upper limit of childhood for this study was eighteen years of age.

Memory

Memory has been defined as "the processes by which information is encoded, stored, and retrieved" (Rathus, 1996), and as retaining information over the passage of time (Santrock & Yussen, 1992). Without memory, Gleitman (1987) suggested, our world would consist only of the present, providing little anchoring for a developing sense of self. Associative mechanisms of the memory process were important in the process of having the memory return to consciousness.

Repression

This study assumed the existence of the construct of repression which was defined by Freud (1957) as "...simply turning something away, and keeping it at a distance, from the conscious" (p.147). It is a defense mechanism which engages below the level of awareness and functions to reduce anxiety. For the purposes of this study, repression was operationally defined as having occurred for the participant if, at any point in the past, and for a period of time, the memory of childhood sexual abuse was not available to the participant's consciousness.

Factors of Recall

The factors of recall were various events and conditions gleaned from the literature, from interviews, and from the research tool, which have been thought to be responsible for providing context for the recall of heretofore repressed memories of past sexual abuse.

Limitations and Assumptions

The study was carried out with volunteer participants from selected agencies and private practices. The sample was non-random, limited in number, and ethnically homogeneous. The sample was self-selected due to the parameters of the study. The population of interest has higher representation in the clinic setting than in the general population. The participants were all currently in psychotherapy to ameliorate various distressing psychological and emotional symptoms. The participants in this study were

assumed to be honest and sincere in their responses. They were under no overt nor implied coercion to volunteer.

Another limitation of this study was that trained raters were not utilized in the process of analyzing and interpreting information derived from interviews and questionnaires. The researcher was the interviewer. Although every effort was made to insure objectivity through interpretation and analysis, there was greater potential for the introduction of subjectivity and bias when a single researcher is involved.

Results in this study may not be generalized to a larger population. The purpose of this kind of study is to gather information upon which to develop further directions for research.

Organization of the Study

Chapter I included the following: background of the problem, statement of the problem, purpose of the study, research questions, significance of the problem, limitations and assumptions of the study. In Chapter II related research was discussed. Chapter III presented an explanation of the methods used and described the characteristics of the participants, the research tool, and the research design. The results and discussion of the data analysis were presented in Chapter IV. Chapter V presented a summary of the research findings, conclusions, and recommendations for future research.

CHAPTER II

REVIEW OF THE LITERATURE

Current scholarly knowledge on the three subjects related to this dissertation are reviewed in this chapter. First, what is known about the impact on adult functioning of childhood sexual abuse is reviewed. Second, recent contributions to the literature on the constructs of memory, dissociation, reconstruction, and repression are summarized. Third, what is known about factors associated with memory recall by adults of childhood sexual abuse is examined. Although, as shall be demonstrated, the literature is adequate in a few basic areas related to these items, many serious gaps remain, and serious controversies have developed.

Childhood Sexual Abuse

Definition and Prevalence

The literature has not yet produced a cohesive, universally accepted definition of child sexual abuse. It does, however, reveal limited agreement. Most studies define child sexual abuse as unwanted contact or interaction between a child and an adult when the child is used for the sexual gratification of an adult who is five or more years older than the child (Browne & Finkelhor, 1986; Kemp & Kemp, 1984; Seng, 1986; Wyatt, 1985).

Contact or interaction includes, but is not limited to, indecent exposure, kissing, fondling, erotic stimulation, seductive behaviors, oral-genital contact, and intercourse (Berliner & Conte, 1990; Risin & McNamara, 1989). Some clinicians and researchers expand this definition to include lewd and sexualizing comments, lack of privacy in the bathroom or bedroom, voyeurism, and being made to watch or participate in pornography (Browne & Finkelhor, 1986; Finkelhor, 1979; Gelinas, 1983; Maltz & Holman, 1987). For the purposes of this study, child sexual abuse shall be defined broadly as unwanted contact or interaction by a person who is five years older and who seeks any form of sexual gratification from the younger person.

The literature reveals substantial if not universal agreement with the proposition that approximately one in three females and one in six males have been sexually abused before the age of eighteen (Courtois, 1988; Finkelhor, 1979; Paxton, 1991). Finkelhor, Hotaling, Lewis, and Smith (1990) conducted the first national survey of adults designed to investigate the prevalence of childhood sexual abuse. Using the Los Angeles Times Poll of residential listed and unlisted telephone numbers in the U.S., a sample was randomly generated to conform to census demographics. The sample consisted of 1,145 males and 1,481 females questioned for a half hour on topics related to sexual abuse. Victimization was reported by 27% of the females and 16% of the males who responded. Part of the validity of this effort rested upon asking multiple questions rather than the characteristic one or two direct questions, e.g., "Were you sexually abused as a child?" This survey's results are more credible because, as its authors note, "...comparison among studies has shown that respondents disclose more experiences when they are given

multiple opportunities to disclose, and a variety of cues about the kinds of events researchers are interested in as opposed to a single screening question" (p. 20).

A minority view, however, claims that these estimates are not well founded (Beutler & Hill, 1992; Briere, 1992a; Haugaard & Emery, 1989; Persinger, 1992). Briere's study (1992) reports that the retrospective research upon which prevalence estimates have been made depend upon a subject's report of abuse, which may not reflect actual abuse histories. He maintains further that passage of time reduces the accuracy of abuse reports. Briere reports further (p. 197) that

> Russell [1983] found that older women report less molestation than do younger women, leading her to suggest that the incidence of sexual abuse may be increasing over the years. Although this is not an unreasonable hypothesis, it is also possible that the greater passage of time between childhood and interview for older subjects resulted in less complete memories for these subjects.

Coons, Bowman, Pellow, & Schneider (1989) reviewed the literature and found that the prevalence of childhood sexual abuse was specific to the population of interest. These studies also showed a rate of abuse for clinical populations (31%) to be higher than prevalence rates for non clinic populations (19%). Courtois (1988) suggested that the prevalence of sexual abuse among boys is presently underestimated by therapists. Reasons cited by other researchers for under-assessment include therapist attitudes about sexual abuse and lack of awareness of requirements of the law. Failure to report was found to be a significant problem even though mandated by law (Kalichman, Craig & Crowe, 1986). Some therapists found the system frustrating and wanted to avoid legal entanglement, in order to preserve the client/therapist trust (Frenken & Van Stolk, 1990; Hibbard & Zollinger, 1990). Mental health professionals may be reluctant to inquire about abuse

history for a variety of personal reasons (Wyatt, 1985). Clinicians are often unwilling to believe adolescents (Burgess, Groth, Holstrom, & Sgroi, 1978).

Psychological Consequences of Childhood Sexual Abuse

The credible academic literature demonstrates conclusively that sexual abuse in childhood has detrimental effects upon those who experience it. A link between a history of childhood sexual trauma and psychological disturbance in adult life was proposed by Freud almost a century ago (Herman & Schatzow, 1987). Although Freud was among the first researchers to recognize the prevalence of sexual trauma and its effects on memory, he retracted his initial findings, believing instead that his clients' reports of sexual abuse were actually fantasies. His retraction, affirmed by the professional therapeutic community, delayed for decades recognition of childhood sexual trauma.

Finkelhor, Hotaling, Lewis, and Smith (1989) present evidence that a childhood history of abuse was a risk factor for later adult problems. Their findings were based upon a nationally representative random sample of 2,626 adults. They found that people who had a history of childhood sexual abuse involving penetration were also more likely than the general population to report disrupted marriages and sexual dissatisfaction. Other researchers have linked childhood sexual abuse with symptoms of post traumatic stress disorder, low self-esteem, guilt, anxiety, depression (Lipovsky et al., 1989), somatization, dissociation, interpersonal dysfunction, eating disorders, sexual problems, substance abuse, suicidality (Briere, 1992b; Browne & Finkelhor, 1986), cutting and self-destructive behavior (Gelinas, 1983; Greenspan & Samuel, 1989), amnesia in response to abuse

(Alpert, 1991), and multiple personality disorder (Kluft, 1986, 1991; Putnam et al., 1986). These assessments were generally consistent with other studies looking at the long term effects of childhood sexual abuse and demonstrated the social dimensions of the problem and its psychological ramifications (Briere & Runtz, 1989; Browne & Finkelhor, 1986). Briere and Runtz (1989) reported that adults who were sexually abused as children had more anxiety and depression than the general population. Peters (1988) found higher rates of alcohol and drug abuse among sexual abuse victims. Russell (1986) reported that once victimized, the likelihood of additional victimizations was substantial. Kahr (1989) found that sexual abuse victims had a greater than average tendency toward suicidal and self-destructive behavior, heightened anxiety, confusion, promiscuity, prostitution, deep anger, sexualizing relationships, impaired emotional relationships and a predilection for abusing their own children. In addition, adults abused as children experienced a greater amount of somatic disturbance such as sleep disturbances, irritable bowel syndrome, chronic headaches, asthma, ulcers, and palpitations. Goldfarb (1987) reported that eating disorders sometimes developed concomitantly with sexual abuse and then reappeared at a later time of developmentally related stress.

People with abuse histories often entered therapy with depression, a history of assuming adult responsibilities as a child, self-abusive acts including self-mutilation and cutting, confusion, impulsive acts, addictions, and very low self-esteem. Many clients did not describe problems of unresolved sexual abuse more directly because as many as 50% of them do not remember the trauma (Maltz & Holman, 1987). Those who do may not consider it relevant to the behavior of concern. Often, these clients have not defined their

experiences as abuse (Gelinas, 1983).

Herman and Troki (1986) produced a leading study of the perceived effects of sexual abuse upon people's adult lives. They studied two groups of adult females with incest history, using a non-clinical sample, and an outpatient sample. Each woman was asked to subjectively estimate how upsetting the abuse had been. The study found that the younger the victim was at the time of the abuse, the more severe the abuse is likely to have been. Violent, prolonged, or intrusive abuse presents stressors beyond the adaptive capabilities of most children, resulting in long-lasting traumatic syndromes. Several variables affected the severity of the experienced effects of the abuse. More severe abuse effects were associated with (1) younger age at onset, (2) greater age difference between victim and perpetrator, (3) longer duration and greater frequency of abuse, (4) stronger violence or force, (5) experience of penetration, and (6) closeness of relationship. Sexual abuse affected females in their negative feelings toward males, sex, and themselves, and resulted in anxiety, distrust, and difficulties forming intimate relationships. In a review study, Browne and Finkelhor (1986) confirmed that depression was the symptom most commonly reported by adults molested as children.

In an overview of childhood traumas, Terr (1991) observed that for many victims "life must be endured, not savored" (p.14). Terr believed clients made admirable attempts to preserve the self and protect the psyche. Children and adults experienced not only pervasive denial, repression, and dissociation, but also self-anesthesia, self-hypnosis, identification with the aggressor, and aggression against the self. Terr defined childhood trauma "as a mental result of one sudden, external blow or a series of blows, rendering the

young person temporarily helpless and breaking past ordinary coping and defensive operations" (p.11). She identified several characteristics of traumas: thought suppression, sleep problems, exaggerated startle responses, developmental regressions, fears of the mundane, panic avoidances, and hypervigilance. She suggested that massive effort was needed to protect the psyche, which then resorted to denial, self-anesthesia, self-hypnosis, identification with the aggressor, and aggression turned against one's self. Terr (1994) asserted that visualizations were most often triggered by reminders of the traumatic event, but at times appeared entirely by surprise.

A parent/caretaker who behaves seductively toward a child may traumatize the child, yet the actions may not be recognized as sexual abuse. Children have no schema for adult sexual content and developmentally often cannot retrieve from memory a sexually traumatic event through direct inquiry (Piaget, 1979). For example, Love (1990) posits from her clinical experience that children often become a surrogate spouse for the opposite-sexed parent, or a confidant of a same-sexed parent. The emotional incest she described exists along a continuum. At one end is inappropriate, enmeshed boundaries where the child is treated as a special date. At the other end of the continuum is a situation where the child is a scapegoat, receiving a mix of abuse and favoritism. This sort of sexualizing is subtle and thereby confusing, leading to clinical symptoms which mimic sexual abuse without actual physical trauma or contact. Our culture is aware of these dynamics. In their extreme, they are manifest as "mama's boy" or "daddy's girl". This is an area of inquiry that needs to be explored in future research.

Memory

Definitions and Concepts of Memory

Memory has been defined as "the processes by which information is encoded, stored, and retrieved" (Rathus, 1996). During the encoding process, visual, auditory, and semantic codes are converted into formats that can be mentally represented. During the storage process, the task is to maintain the information over time. During the retrieval process, information is located and returned to consciousness. Memories are limited by selective attention and the inability to mentally capture all the details of an event.

Relevant research done on the subject of memory has focused upon "mood congruence" and "mood-state dependence." According to Blaney (1986), mood congruence is a concept that suggests that some potential memory material, by virtue of its affectively valenced content, is more likely to be stored and/or recalled when a person is in a particular mood, and the person's mood at exposure to the material and at the time of recall need not be congruent. Trewogt, Kremer, & Stegge (1991) add that "mood congruity means that stimuli whose affective valence matches the person's emotional state, will provoke greater attention, faster perception, and deeper processing, all of which results in better learning and remembering of these emotional stimuli" (p. 109).

Mood-state dependent memory is a process whereby memory for material is enhanced if the mood at the time of encoding the material and at the time of retrieval is the same (Dalgleish & Watts, 1990; Ucros, 1989). Ucros (1989) concluded that mood appears to have a moderate but significant facilitating effect on memory. The effect is not

as strong, however, as is sometimes portrayed in the psychological literature.

Revelle and Loftus (1990) use a cognitive approach to the study of memory, drawing on ideas of information processing. They found arousal, either naturally varying as a function of the stimulus materials, as a function of the situation, or as a characteristic of the subject, has an important effect upon information processing in general, and on memory in particular. They proposed, "that arousal, as an important component of emotional experience, has effects upon memory that are partly responsible for previously inconsistent findings in the mood and memory literature...the true relationship between mood and memory may be obscured by ignoring the interactive effects of arousal and retention interval" (p.210).

Memory as a reconstructive phenomenon explains how the individual's unique way of perceiving the world, their schema, helps to recreate the setting of the encoding of the original material. Memories as reconstructions may be stimulated by a variety of cues (Carmichael, Hogan, & Walter, 1932; Wells & Loftus, 1984). Loftus and Palmer (1974) demonstrated how verbal and visual cues presented to study participants can influence how they recall information about what they saw on a film.

Another area of memory research looks at "flashbulb memories," so named by Brown and Kulik (1977) to describe the capability memories have of preserving events in much detail. Flashbulb memories tend to occur under unusual or emotionally arousing circumstances. Autobiographical memory is another area of memory research that enhances understanding of what memory is and how it operates. Brewin, Andrews, & Gotlib (1993) suggest that personal events that are unique, or are a surprise, or are

emotionally powerful are relatively accurate when recalled (see also Terr, 1994) . It is easier to discriminate stimuli which are salient from neutral or ordinary stimuli (Thompson & Cowan, 1986). Barclay (1986) attributes a basic integrity to autobiographical memories even though the research methodology at this time is underdeveloped compared to laboratory memory research.

Concepts of Delayed Memory

There is substantial agreement in the literature on an important point: people sometimes remember things that they had forgotten for a long time. Beyond this point, however, agreement is hard to find. How, why, or how often memories are lost and regained are questions that generate substantial controversy.

The validity of recalled memories of is being challenged by researchers involved in the "delayed memory of childhood sexual abuse debate" (Yapko, 1993; Loftus, 1993; Loftus & Ketcham, 1991). Loftus and Loftus (1980) have demonstrated that many therapists hold beliefs that are not supported by research. These beliefs include the idea that all experiences are retained in memory, and that they may be retrieved by use of such devices as hypnosis. They assert further that therapy clients are influenced by authority figures, escpecially therapists, who may suggest that clients have experienced events which have not in fact occurred. Supporting this conclusion, Lindsay and Read (1994) assert that "individuals experience greater suggestibility when false information is provided by authoritative sources" (p. 209).

Although many descriptions of the processes of loss and regain of memories exist

in the literature, the most prominent ones are associated with one of the following categories: dissociation, reconstruction, and repression. This dissertation accepts its participants' reports of memory recall, and its results are not dependent upon acceptance of any particular conception of the recall process. However, for the purpose of helping readers better understand memory recall, a review of recent findings related to these three categories is presented here.

Dissociation

Dissociation is most clearly defined in the DSM-IV as, "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic" (American Psychiatric Association, 1994, p. 477). Recent research in the area of memory sometimes uses the terms dissociation and repression as one in the same (Herman, 1992; van de Kolk, & Greenberg, 1987). Davies and Frawley (1994) discuss dissociation as a split from consciousness of events that were too difficult to integrate with a person's sense of themselves. Kihlstrom and Hoyt (1990) conceptualize repression and dissociation as being able to function at the same time. They described dissociation as a vertical segmentation of consciousness into multiple segments which don't interact. A horizontal division, which they described as repression, separated the unconscious from the conscious events.

Maltz and Holman in their book *Incest and Sexuality,* (1987), suggest that the coping mechanisms for traumatic situations tended to be deeply ingrained, serving to

protect the client's sense of personal integrity. These adaptive skills functioned in an intrusive event to protect sanity or the will to live. In addition, those skills contributed to experiencing a measure of control over their experiences. Dissociation often resulted in the desire to separate self from the experience of abuse, which led to impairment of memory function generally, and to an inclination to not remember incest at all as an adult. Dissociation helped fulfill the deep wish that the abuse never really happened in the first place. In their observations, many males and females did not recall their sexually intrusive experiences until something triggered the memory in adulthood. These authors caution mental health professionals that only *after* the history is disclosed in the context of treatment can the professional confidently associate presenting symptoms with the sexual abuse experiences.

Reconstruction

The concept of reconstruction suggests that recalling the past is not simply scanning stored memory records but involves imagining and inferring what the past must have been like based on current beliefs and knowledge. In their study, Guenther and Frey (1990) used 69 students in psychology classes to complete the Marlowe-Crowne Social Desirability Scale and the Taylor Manifest Anxiety Scale. Forty-seven subjects were randomly assigned to a story on sexual abuse and 22 of them were randomly assigned to a neutral story. The story used in the study was about a woman who met her brother for lunch. The first group of subjects learned that the story was about a sister who had been sexually abused by her brother; the second group understood that the story was about a

sister having lunch with her brother. Both groups included repressors and non-repressors, determined by their scores on the Marlowe-Crowne Social Desirability and Taylor Manifest Anxiety scales. The subjects were tested on recall one week later, using a multiple choice memory test. The "repressor" respondents who were told that sexual abuse was a part of the story were less likely to report unpleasant aspects of the story. The idea of reconstruction was supported by this study in that the conclusion that the respondents' memories appeared to be reconstructions of events rather than remembered descriptions of them. Confirming this conclusion, other researchers have shown when a person's current knowledge (or beliefs) are systematically varied experimentally, the person's recollection about past events is predictably changed (Loftus, 1975; Snyder & Uranowitz, 1978).

Repression

In most simple terms, repression is the condition in which a person has had an important or traumatic experience which they do not remember. In the psychology literature, repression is a highly debated construct (Davis, 1990; Erdelyi, 1990; Hansen & Hansen, 1988). Freud (1957) first advanced it as a factor of the psyche, describing it as follows: "the essence of repression lies simply in turning something away, and keeping it at a distance, from the conscious" (p. 147). In a well known interpretation of Freud, Hall (1954) explained the concept of repression in the following terms: "...one may be unable to recall something because the cathexis [the urging force] of the memory trace is opposed by a resistance . . . . such memories are said to be repressed rather than forgotten" (p.51).

In order for the repressed memory to be recalled, psychic resistance must be weakened. Hall further suggested that memories were repressed for two reasons: (1) the memory itself was painful, or (2) the memory was associated with another painful memory. When attention was diverted elsewhere, resistance was weakened, and often the repressed memory came into consciousness. Further, at times the struggle for recall may have been conscious while at other times the person experienced only a feeling, or a tension. Repression drives a dangerous perception, idea, memory, or even a harmless associated memory out of consciousness. When the ego is strong enough to cope with danger rationally, the repression acts as an energy drain in the psyche (Hall, 1954). At this point, the defenses which allowed a person to function may become strained. Defense mechanisms which worked in the past are no longer adequate against the waning energy. As a person grows older and/or is better able to cope, lifting repression frees the psyche to more productive experiences. There is usually an intense outlet of energy when repression is broken.

Other researchers have described repression as a generalized inability to retrieve various unpleasant experiences or memories (Davis & Schwartz, 1987; Weinberger, Schwartz, & Davidson 1979). Repression was operationally defined by Davis and Schwartz (1987) as the strident tendency to forget fearful or unpleasant associations or events more than those of pleasant or neutral happenings. Their study described repression as a process of reduced access to negative affective memories. Kline (1987) operationally defined the unconscious as that which was that aspect of the psyche that is unable to be verbalized. Dollard and Miller (1950) suggested that there were two main

determinants of an unconscious process: (1) that certain cues to repressed memories are not available to our awareness because they are unlabeled, and (2) that cues may have been repressed because they were ineffective in preventing the distressing events from happening. Dollard and Miller (1950) concluded that when repression was lifted (identified and labeled for what it is), it lost its power to do intrapsychic harm.

In another effort to explore the phenomenon of repression, Hansen and Hansen (1988) identified repressors and non-repressors through the administration of the Taylor Manifest Anxiety Scale (Taylor, 1953) and the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1964). Repressors were subjects scoring as low-anxious on the Taylor Manifest Anxiety Scale and high in defensiveness on the Marlowe-Crowne Social Desirability Scale. The authors' intention was not to demonstrate the existence of repression, but to explore the mechanisms that leave emotionally tagged memories inaccessible, a framework they call "the architecture of repression" (p.811). They randomly assigned four hundred thirty-three undergraduates to one of four negative emotional conditions: angering, embarrassing, sad, or fearful. A 4x4 multivariate analysis of the data supported their predictions. Results implied that memories of repressors were more discrete than those of the non-repressors. They argued that repression "is fundamentally a phenomenon of the relatively impoverished structure of the repressor's memory linked to the less elaborate, more discrete emotional tags. . . ." (Hansen & Hansen, 1988, p.816). The authors surmised that repression was more than just inaccessibility of unpleasant memories. It appeared there was a fundamental difference in repressors' memories, rendering those memories less rich and blunted. Repressors took

longer to retrieve the memories than the non-repressors, and negative emotional memories were generally less accessible to repressors than to non-repressors. In this analog study, fear appeared to be the strongest motivating force for repression.

Those who support the concept of repression find it to be a highly significant coping mechanism. According to Herman and Schatzow (1987) repression may be the main defensive strategy available to the very young or to the violently abused. Repression is among the defenses which need to be unfolded slowly in order not to retraumatize the psychological system of the client (Briere, 1992b; Olio & Cornell, 1993; Schwartz, 1990).

The literature is quite varied in its estimates of prevalence of repression. Estimates of those who have repressed memories of sexual abuse range from 18% to 59% of sexual abuse victims (Herman & Schatzow, 1987; Loftus, Polonsky, & Fullilove, 1994). Williams (1994) found that 38% of the 129 female participants with documented histories of sexual abuse did not recall their abuse that had been reported to authorities 17 years prior to the study.

Holmes (1990) is among those who rejects the concept of repression. He maintains that "despite over sixty years of research involving numerous approaches by many thoughtful and clever investigators, at the present time there is no controlled laboratory evidence supporting the concept of repression" (p.96). However, Williams (1994) has directly contradicted Holmes' conclusion. Williams found that among her sample of women with documented histories of childhood sexual abuse, 38% had no memory of childhood sexual abuse. Ceci and Bruck (1993) have identified the most pertinent deficit in current research with regard to the validity of the concept of

repression. They conclude that much of the research on memory has been focused on laboratory induced stress, not on the phenomenon of memory for traumatic events.

Factors Associated with Memory Recall

The relevant literature provides no thorough or satisfactory identification of factors which lead to the recall of repressed or dissociated memories of childhood sexual abuse. Many in the helping professions are aware that ideas and events outside of clients' awareness can flood into their awareness at points along the therapeutic process. Paxton (1991), in her experience as a university professor, observed individuals' memories of abuse emerging into conscious awareness and noted that many different life circumstances "...can cause the defenses to crumble abruptly, triggering memory recall and symptom development" among adults molested as children (p. 53). These events may be so distressing that males and females doubt their sanity and/or regret they ever remembered. She notes some conditions under which repression has lifted. These include a lecture on growing up in alcoholic or otherwise dysfunctional families, defining child sexual abuse in class, a discussion about child abuse in general, or assigning reading on eating disorders.

Blake-White and Kline (1985) suggested that a plethora of situations may trigger vivid recollections, which could include the complete emotional context of the abuse, including visual and tactile memories. Sexual contact, being alone in bed at night, and hearing heavy breathing may revive memories of the incest. Being touched by another person can elicit an exaggerated startle response. Dissociative hysteria can occur when clients experienced a situation arousing grief, despair, or anxiety. They may have

responded by repressing totally memories of the abuse events, thereby experiencing some relief from painful the memories painful effects.

As therapy moved toward resolution of the presenting concern, often memories began to emerge (Herman & Schatzow, 1987). Vivid dreams were also worthy of inquiry (Agosta & Loring, 1988; Krug, 1989). Disclosure by a sibling of childhood sexual abuse often triggers the recall of one's own abuse. In like manner, females whose daughters or sons were abused often experienced the recovery of memories of their own childhood sexual abuse. A son or daughter, upon reaching the age at which the parent experienced abuse, may trigger a flood of anxiety or actual memories of the parent's own abuse at that age (Courtois, 1988).

Alexander's (1992) research described attachment theory as illuminating and predicting the developmental path of the formation of symptoms in adults molested as children. Memories of abuse were often "triggered" by crises of attachment concerns, i.e. marriage and birth of children (Bartholomew & Horowitz, 1991; Gelinas, 1983). Terr (1991, 1986) reported the case of a 40 year old male client having flashback images of a building. Returning to the early childhood home he left at age four, he found that the building in his flashbacks was actually located next door to his childhood home. This visit triggered the recollection of his early abuse by an attacker. Herman and Schatzow (1987) report that physical re-exposure to the environment where the abuse took place can precipitate retrieval of memories. Many such examples exist in the literature to provide evidence that gathering information about past events may lead to recall of previously repressed memories of childhood sexual abuse.

Men and women have recalled previously repressed memories of childhood sexual abuse by viewing on late night television a public service announcement which described symptoms possibly indicating abuse. Others have participated in in-service and conference presentations which educated them, allowing an enlarged schema into which to accommodate previously repressed information. If life at home was known and experienced as "normal," sex education might unlock memories and describe events in different language. Awareness can be triggered by the ability to label the memories (Dollard & Miller, 1950).

In an empirical study of 364 adults molested as children, undertaking therapy at a center for sexual abuse treatment, Kendall-Tackett (1991) asked why some adult victims of childhood sexual abuse sought treatment earlier than others. The subjects were 89% female and 11% male, ranging in age from 18-59, "...with a mean of 17 years between the end of the molestation and when treatment was first sought, with childhood sexual abuse as the presenting problem" (p.488). Eight were over 40 years in seeking treatment. A stepwise linear regression indicated four factors relating significantly to elapsed years before a victim sought treatment: (1) report to law enforcement, (2) age of onset, (3) duration, (4) and number of sexual acts. Characteristics of early presenters to therapy had: (1) late age of onset, (2) long duration of molestation, (3) reported to law enforcement (4) greater number of sexual acts. Late presenters had: (1) early age of onset, (2) short duration of molestation, (3) not reported to law enforcement, (4) fewer sexual acts. These findings are consistent with the studies of Briere and Conte (1989) and Herman and Schatzow (1987) on amnesia in adults molested as children, reviews of which

follow in this section. One explanation for the longer amount of time lapsed for early age of onset and treatment could be that many of the late presenters were amnesic until recently. Having a short duration and early onset, many late presenters may have experienced completed molestation before adolescence. Fewer acts point to the potential for greater severity later on (due to a lack of "grooming" and preparation of the victim by the perpetrator). Failure to report reflects possible lack of resources for telling; it also reduces the likelihood of being found out. Greater force and/or violence contributes to increased repression for the event. Late presenters, when they do come into treatment, often show serious symptoms and may require crisis intervention (Sgroi & Bunk, 1988).

Sexual abuse is highly correlated with a number of symptoms. There is copious literature of studies correlating eating disorders and a history of childhood sexual abuse (Button & Whitehouse, 1981; Cooper & Fairburn, 1986; Gelinas, 1983). Cutler and Nolen-Hoeksema, (1991) found unipolar depression to be nearly twice as prevalent among females as among males, and structured a study to account for that difference through systematically considering females' victimization experiences as a significant contributor to their higher risk for depression in adulthood.

There is copious literature correlating eating disorders and a history of childhood sexual abuse (Button & Whitehouse, 1981; Cooper & Fairburn, 1986; Gelinas, 1983). Losing weight below a certain safe threshold has triggered recall of repressed memories among some clients (Herman & Schatzow, 1987).

Clinicians who worked with sexual dysfunction were well acquainted with the intrusive nature of anxiety. Often clients experienced panic attacks during sexual

intercourse, or had intense anxiety associated with certain sexual positions, particular smells, or a way of being touched (Maltz & Holman, 1987).

Cutler and Nolen-Hoeksema, (1991) found unipolar depression to be nearly twice as prevalent among females as among males, and structured a study to account for that difference through systematically considering females' victimization experiences as a significant contributor to their higher risk for depression in adulthood. Of interest to the authors was why victimization affected males and females differently. Females appeared to experience more serious sexual abuse than males (Finkelhor, 1986) and seemed more apt to make internal attributions for the causes of negative events. In addition, females seemed to react to a depressed mood with self-focus and rumination about possible reasons for the mood (Cutler & Nolen-Hoeksema, 1991).

At times symptoms will become manifest at specific developmental stages of psychosexual maturity. A child who had been abused may not have a sense of self as a separate individual who can act in a way that allows more than simply surviving a crazy situation (Paxton, 1991). Effects of disclosure of childhood sexual abuse present challenges with which some clinicians are reluctant or unwilling to work (Cornell & Olio, 1991).

Herman and Schatzow (1987) attempted to explore the therapeutic value of recovering and validating traumatic memories, finding that clients with mild to moderate memory deficits are not always aware of these deficits before participation in group therapy. Some researchers and practitioners even advocated assertive interventions to identify and reveal repressed memories (Cornell & Olio, 1991). When trust was

established with the victim, these advocates believed, the clinician should slowly begin to uncover memories and abreactions, and work to reintegrate traumatic memories. They focused on the importance of integrating the content and affect of the trauma into the coherent experience of personal history and ego identity. Some methods for uncovering trauma may include the use of the patient's associations, dreams, fantasies, and hallucinations. A hazy memory may be helped therapeutically with old photographs, newspaper accounts, old medical records, and collateral interviews. Although the use of psychodynamic therapy was often cited as the treatment of choice, advocates of repression revelation also sometimes prescribe hypnosis, group therapy, and medication (Coons et al., 1989).

Other authors, are concerned, as has been stated earlier, that therapists may be too eager in this course of therapy and lead clients to reconstruct memories that did not occur. Still others ponder the therapeutic wisdom of interfering with a psychological defense when it is preserved into adult life, pointing out that the breakthrough of previously repressed traumatic memories often precipitates some ego disorganization. Still other researchers and practitioners advocated assertive interventions to identify and reveal repressed memories. Cornell and Olio (1991) focus on the importance of integrating the content and affect of the trauma into the coherent experience of personal history and ego identity.

Herman and Schatzow (1987) found that clients with mild to moderate memory deficits were not always aware of these deficits before participation in group therapy. However, the intense stimulation of hearing group members' stories often acted as a

catalyst for the recovery of additional memories. Clients with severe memory deficits, however, were different. They reported recurrent intrusive images associated with extreme anxiety. Sexual intimacy often "triggered flashback images of the abuser and panic states" (p.7). The authors reported that these females were plagued with indecision concerning whether the events were real or fantasized. They further reported:

> An additional group of females had had complete amnesia until a recent experience triggered sudden, dramatic recall of sexual trauma in childhood, at which point they developed acute symptoms of a full-blown Post Traumatic Stress Disorder. These patients described the return of repressed memories as extremely painful and disruptive to their established mode of functioning. They described themselves as reliving their childhood abuse experience as though they were occurring in the present. The reported experiences often included violence, sadism, or grotesque perversity. Recurrent images intruded both into sleep, in the form of nightmares and into waking life. . . [they experienced] derealization and terror and often expressed the fear that they were losing their minds (p.8).

Within this group setting, the most common individual goals chosen were disclosure, recovery of memories, and confrontation with the perpetrator. Seventy-four percent of the subjects were able to confirm the sexual abuse from another source, some from the perpetrator or from others who had also been abused by the same person(s). There was encouragement to soften the recall process so that "the breakthrough of previously repressed material could be experienced as active mastery rather than as repeated victimization" (p.8).

The Herman and Schatzow (1987) study contradicted assertions that most reports of childhood sexual abuse can be ascribed to fantasy. In their study, clients who were abused early in childhood and /or suffered violent abuse, seemed to use massive repression as the main defensive resource available to them. In his original thoughts on childhood sexual abuse, Freud (1896) proposed that repression maintains the fixation of the trauma

and impelled repetition. He further speculated that abuse occurring after about the age of eight would not be repressed in memory and therefore would not result in the formation of hysterical symptoms. Some contemporary categories for these symptoms might be Histrionic Personality Disorder, Dissociative Identity Disorder, Conversion Disorder, Somatization Disorder, in the Diagnostic and Statistical Manual IV (American Psychiatric Association, 1994). Females abused in latency and whose abuse was not particularly violent or sadistic did not seem to resort to massive repression. Partial repression, dissociation, and intellectualization seem a more common defense for this group.

Summary

In summary, the literature addressing childhood sexual abuse is adequate in its presentation of the most important fundamental facts about the effects of abuse, but certain methodological problems have produced some uncertainty about the accuracy of estimates of its prevalence. The literature has not yet produced a cohesive, universally accepted definition of child sexual abuse, but it is generally agreed that abuse consists of unwanted sexual contact between a child and someone who is at least five years older than the child. Approximately one in three females and one in six males have been sexually abused before the age of eighteen. The many detrimental effects of childhood sexual abuse include depression, dissociation, anxiety, and eating disorders.

The literature demonstrates that sexual abuse in childhood has detrimental effects upon those who experience it. People with abuse histories often entered therapy with depression, a history of assuming adult responsibilities as a child, self-abusive acts

including self-mutilation and cutting, confusion, impulsive acts, addictions, and low self-esteem.

Although many descriptions of the processes of loss and regain of memories exist in the literature, the most prominent ones are dissociation, reconstruction, and repression. The literature is inconsistent in its estimates of prevalence of repression. Those who support the concept of repression find it to be a highly significant coping mechanism. Although there is substantial agreement on the point that people sometimes remember things that they had forgotten for a long time, the questions of how, why, or how often memories are lost and regained are matters of great controversy. The validity of recalled memories of is being challenged by researchers involved in the "delayed memory of childhood sexual abuse debate."

Of paramount importance to this study is the fact that the relevant literature provides no thorough or satisfactory identification of factors which lead to the recall of repressed or dissociated memories of childhood sexual abuse. Sexual abuse is highly correlated with a number of symptoms, especially depression, anxiety and weight loss. Although the literature identifies a number of triggers to retrieval of lost memories of sexual abuse, no reliable patterns have yet been found. In this study, an attempt was made to elicit from participants what they claimed to have not previously remembered to ascertain what factors are associated with recall.

CHAPTER III

METHODS

Introduction

The theoretical framework of this research effort was phenomenological. The aim of phenomenologically informed studies is to articulate clearly certain aspects of the human experience and to understand the nature of experiences of people in an area about which little is known (Strauss & Corbin, 1990). Understanding a participant's point of view about the "...meaning of naturally occurring complex events . . . . in context", was a central goal of this project (Moon, Dillon & Sprenkle, 1990). According to Moon et al. (1990), "the phenomenological tradition is rooted in psychology" (p.359). Hoshmand (1989) asserts that phenomenological researchers focus upon subjects' beliefs and consciousness.

This study sought to identify factors which were associated with the recall of repressed memories of childhood sexual abuse. Due to the exploratory nature of this research project, a written, structured survey was inappropriate. The objective of this project could not have been met by seeking only answers to preformulated questions because other questions, not yet conceived, would likely arise during the research. The research interview informed the researcher of further, and appropriate questions to ask (Fowler & Mangione, 1990). The methodology was exploratory, regarding the participant

as both (1) the expert in the matter, and (2) the source of information sought to improve our understanding of the phenomenon of experiencing a return of memories.

Because the initial questions about the process of recall itself were drawn from what appears in the literature, this study extended the body of knowledge currently available through openness to what the participants had to say about their experiences. The subjects were male and female volunteers who had already recalled repressed memories of childhood sexual abuse and had revealed them to a psychologist or other mental health professional. The participants were volunteers who were willing to answer questions in the form of a personal interview conducted by the author.

The *Informed Consent Form*, Appendix F, covered the issue of consent, confidentiality, duration, and scope of the interview. Because of the nature of the inquiry and the potential to raise difficult issues, the consent form also addressed possible risks, remediation, and debriefing to ascertain the participants' level of comfort upon completion of the interview. Specific criteria for the inclusion and the exclusion of potential participants was clearly outlined in a *Letter to the Therapist* found in Appendix D.

This study attempted to isolate and to articulate internal and external conditions, experiences, events, and other phenomena which, according to study participants, occurred at the same time as or shortly prior to recall, and were experienced as being related to the recall of abuse. The interview process examined the participants' understanding, perceptions, and interpretations of their recall experiences.

Participants

Description of Participants

In the literature, phenomenologically based studies have a range of selected participants from three to three hundred twenty-five (Konig, 1979; Mruk, 1986; van Kaam, 1969). The number of participants in this study was chosen in accordance with two factors apparent in the literature, (1) a broad range of acceptability in the number of participants in a phenomenological study, and (2) the fact that there were few reliable estimates of the number of adults seeking psychotherapy who may have had repressed memories of childhood sexual abuse prior to starting psychotherapy or shortly thereafter. Fifteen survivors of childhood sexual abuse participated in this study. This number of participants has been shown to be adequate and appropriate for qualitative studies. The study focused upon generalizations to theory rather than upon generalizations to populations (Yin, 1989).

The participants in this study had the experience of recalling information which they report had been previously unavailable to them. There was no attempt to determine the "truth" of the awarenesses by corroborating stories, checking court records, or talking with family members. The fourteen women and one man in this study had recovered memories of childhood sexual abuse within the past five years and were in psychotherapy at the time of the interview.

The participants ranged in age from twenty-one to fifty-three, with an average age of forty. Each of the participants had at least fourteen years of education. Six had earned

MS or MA degrees, three had Ph.D. degrees, two had BA degrees, and three had two or three years of college beyond high school. Eleven participants were employed in various capacities in the helping professions such as nursing, social work, the clergy, and counseling. Of the remaining number, three were students and one a nutritionist. Several were combining parenting, employment, and other roles with continuing education at the time of the interviews.

Not all participants sought the services of a therapist prior to recalling memories. Of the twelve participants who did, the number of different therapist ranged from one to five prior to the recovery of memories, or an average of 3.25 helpers. Among the presenting concerns with the current therapists were the following: marital problems, rape, depression, concerns about family members, parenting problems, divorce adjustment, rage, sexual problems/acting out, and other relationship difficulties.

Selection of Participants

The volunteer participants were clients currently receiving psychological services in public agencies or private practices. The participants were located through referrals from psychologists and social workers practicing in the mid-west. Psychologists and social workers made appropriate identification of potential participants from clients on their caseloads (Appendix D, Letter to the Therapist). To control for agency or mental health professional bias, no more than two participants were selected from any one practice setting. The participants were invited to participate following determination of appropriateness from their therapist (Appendix E, Solicitation to Volunteer Participants).

Of the fifteen participants, six had the experience of memory recall prior to psychotherapy, six had the experience of recall after initiation of therapy but not during the therapy hour, and three had the experience of recall during the therapy hour.

Instruments

The Personal Interview

In phenomenological research, the researcher is the primary data collection instrument (Moon, Dillon, & Sprenkle, 1990). The interview process was structured according to standard practice for qualitative research as stated in current literature (Cook & Reichardt, 1979; Emerson, 1983; Lee, 1993; Lincoln & Guba, 1985; Polkinghorne, 1983; Strauss & Corbin, 1990).

The interviews conducted in this study followed the *Format for Minimally Guided Interview Process* (Appendix A). This format is semi-structured to assist the participants in simultaneously focusing upon the central issues and feeling free to explore any associations that may occur to them. The process followed the guidelines of Moon et al. (1990) which specify that "qualitative researchers attempt to approach their data without a priori assumptions, working to make 'the familiar strange,' to see events in a new way before interpreting what they see" (p.359-60).

The purpose of the interview was to gather information from participants. An opportunity for new information existed in the form of open response opportunities during the interview process. The process was intended to solicit the participant's perception of her or his experiences in recovering memories of past sexual abuse, life events and

experiences associated with memory recall, and the meaning those events held for the participant (Emerson, 1983; Fowler, 1993; Moon et al., 1990).

The interviews proceeded in a methodical and systematic way toward the goal of clearly and accurately articulating descriptions of the specific human experience of recalling repressed memories of childhood sexual abuse (Polkinghorne, in press; Stainback & Stainback, 1988). The focus of the interview was on gaining an increased understanding of the participants' beliefs, ideas, thoughts, feelings, and an increased awareness of the participants' social and cultural reality, in order to identify phenomena associated with the recall of repressed memories of sexual abuse (Lincoln & Guba, 1991; Yin, 1991).

The necessity of undertaking an information gathering approach in this study was indicated by the paucity of information on the subject of recall of repressed memories of childhood sexual abuse. In order to further explore this phenomenon, going to the source of information (the client who has experienced the recall of memory) by means of an interview appeared to be the most direct data collection method. The demographic questionnaire responses were organized to present the information gained. The interviews were coded by response category and analysis and data collection ran concurrently (Lofland & Lofland, 1984).

Demographic Questionnaire

The participants were asked to complete a Demographic Questionnaire (Appendix B) designed by the researcher. Age, date of recall, number of therapists seen prior to

recall were among the questions asked. This instrument was completed by all fifteen participants immediately following the interview.

Memory Recall Questionnaire

The Memory Recall Questionnaire (Appendix C) was designed by the researcher and included an inventory of items associated with the recall of repressed memories of childhood sexual abuse that had been identified in the relevant literature. Since there were few items found, most of them were included in the questionnaire.

Design

This study implemented a phenomenological, qualitative approach using the personal interview as the means of exploring and gathering data. The demographic questionnaire and the memory recall questionnaire provided data which enabled the principal investigator to describe factors of interest. The interview followed accepted principles of sound and rigorous phenomenological methods for collecting data (Hoshmand, 1989; Lincoln & Guba, 1985; Lofland & Lofland, 1984; Moon, et al., 1990; Strauss & Corbin, 1990). It has been suggested that "quantitative knowing must rely on qualitative understanding" (Stainback & Stainback, 1988, p.110). The qualitative approach provided the best known access to, and capacity for understanding the phenomenon of recovery of previously repressed sexual abuse, about which very little is known.

Procedure

Six Steps

This study proceeded in six steps. First, participants were identified through contacts with therapists. Second, tape recorded interviews (with participant permission, see Appendix F, *Consent Form*) were arranged and conducted with the participants. The interviews took place in a setting mutually agreeable to the author and the participant. Seven interviews took place in the author's office; six interviews occurred in the participant's homes, with the remaining two interviews occurring in participant's offices. The interviews were guided by the *Format for Minimally Guided Interview Process* (Appendix A). Third, following the interview, the researcher administered the *Demographic Questionnaire* (Appendix B) and the *Memory Recall Questionnaire* (Appendix C). Fourth, the tape recorded interviews were transcribed and the tapes destroyed. The transcriptions contained no names or other identifying information. Fifth, the transcriptions were analyzed according to data analysis procedures (described below). Finally, the results of the data analysis were compiled and reported in Chapter IV, and recommendations made in Chapter V.

Permission to Conduct Research

Permission to conduct the study was requested from the Institutional Review Boards for Research with Human Subjects at two universities. The applications were submitted under full board review status and granted full approval at both institutions.

Data Analysis

Moon et al. (1990) describe the qualitative data analysis process in the following terms:

> Data analysis in qualitative research is inductive and recursive. It generally occurs throughout the data collection phase of the research rather than at the end of it. Field notes and transcripts are usually copied, read, coded, and categorized. The goal of the analysis is not to support an hypothesis, but to generate rich descriptions of phenomena and discover theory (p.362).

This dissertation followed the above described process, common in qualitative research (Hoshmand, 1989; Lincoln & Guba, 1985; Lofland & Lofland, 1984; Moon, et al., 1990; Polkinghorne, 1989; Strauss & Corbin, 1990). Further, this dissertation's data analysis process followed the constant comparative method (Glaser & Strauss, 1967). The constant comparative method requires that the researcher undertake (1) inductive response-category coding and (2) comparison of observed phenomena. Inductive response-category coding means that the responses of the participants are coded according to categories that appear to have consistent internal relationships. Comparison of observed phenomena requires that assertions be made about relationships among responses and among categories of responses. Conducting inductive response-category coding and comparison of observed phenomena procedures required, therefore, careful and repeated review of responses, grouping responses into meaningful categories, and identifying relationships among categories.

The result of the data analysis process were a written summary of assertions, that is, observations about the relationships among responses revealed by the analysis process. In the qualitative data analysis process, the potential for bias is often mitigated by review.

CHAPTER IV

RESULTS

Results Related to the Research Questions

The purpose of this study was to identify factors associated with the recall of repressed memories of childhood sexual abuse. This study attempted to isolate and to articulate internal and external conditions, experiences, events, and other phenomena which, according to study participants, occurred at the same time as or shortly prior to recall, and were experienced as being related to the recall of abuse. The interview process proceeded in three parts: a demographic questionnaire, a memory recall questionnaire, and the interview. The Demographic Questionnaire (Appendix B) and the Memory Recall Questionnaire (Appendix C), discussed first in this chapter, were administered to participants after their interviews to avoid biasing the interviews.

The Demographic Questionnaire provided further information about the participants (Table 1). The participants were asked to comment on what action they had taken to manage the return of memories. Five of the participants joined a support group. Four participants did nothing in particular. One attended overeaters anonymous; one turned to academic and personal study; one became active in the child advocacy area; and two participants developed strong friendship networks.

TABLE I

DATA FROM DEMOGRAPHIC QUESTIONNAIRE

Pseudonym of Respondent	Age at time of interview	Sex	Number of therapists seen prior to memory recall	Age sexual abuse began	duration of sexual abuse	Age sexual abuse ended	Relation of offender to respondent	1-5 rating of violence or coercion of abuse: 5 is most violent or coercive
Rebecca	37	f	3	3/4	4 to 5 years	8	maternal grandfather	5
Kim	40	f	4	2/3	1 to 2 years	4 to 5	brother and father	2
Freda	50	f	3	birth	2 years	2 to 3	father	5
Susi	47	f	None	10	several months	10	grandfather	3
Lucy	30	f	1	18 mos.	9 years	10	father	5
Pam	52	f	3	7	about 1 month	7	father	3
Kip	21	f	2	2	"not long"	2 to 3	uncles	3
Kerby	53	f	1	6	9 years	14	step-father	3
Conrad	21	m	1	12	6 months	12	female family friend	4
Bev	32	f	3	5	6 years	11.5	brother, father, teacher, great uncle	4
Sally	44	f	1	4	5 years	9	father	5
Dora	48	f	None	more than 5	less than 1 year	6	father	5
Sarah	43	f	5	11	1 year	12	brother	3
Serena	43	f	None	6	3 years	10	family friend	5
Keri	37	F	3	5	3 years	8	father	5

Eight of the responses indicating the relationship of the alleged offender to the participant named biological fathers as offenders. Brothers, uncles, and grandfathers accounted for another four of the alleged offenders. Male and female family friends, and a step-father were named the offenders by the remaining three participants. The earliest abuse was reported to have occurred at six weeks old, with the oldest age of onset being twelve years old. The average duration of the abuse was three years, with a range of from one month to nine years.

In response to the question, "How violent or coercive was the sexual abuse experience?" the following was found. On a Likert type scale of 1-5, one being least coercive or violent, and 5 being the most coercive or violent, seven of the participants rated the experience a 5, two rated it a 4, five rated it a 3, and one rated it a 2. Of the eight participants who reported childhood sexual abuse by a biological father, five of them rated the experience a "5", the most coercive or violent. Three of the four participants who named family members other than the father as the offender, rated the experience a "3" on the scale of 1 to 5. The three participants who reported the offenders as not related to them, rated the experience an average of 4.

The childhood sexual abuse experience of the fifteen participants ranged in duration from about one month to nine years, with an average duration of three years. For eight participants, the sexual abuse experience began at age five or younger. For the other seven, the onset of the abuse experience ranged from ages six to twelve.

The second element of the interview process was the Memory Recall Questionnaire (Appendix C). Results from the Memory Recall Questionnaire are as

follows. Four items on the questionnaire are highly significant because they were identified by more than half of the participants as being associated with their memory recall experience:

- depression
- receiving individual therapy
- difficulty falling or staying asleep
- feeling of detachment or alienation from someone else or others

Fourteen items were also important because they were checked by at least five but not more than seven participants:

- gaining or losing excessive weight
- having a particular dream
- inability to recall an event or an aspect of an event
- feeling uncomfortable with certain ways of being touched
- having a recurrent dream
- having a recurrent recollection of an event
- having a sense of a foreshortened future
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- fear of losing your mind
- feeling uncomfortable or anxious when being alone in bed at night
- feeling uncomfortable or anxious at certain times of night

- difficulty in relating to a male or female in a role of authority

The following twenty-three items were associated with the memory recall experience by at least one but not more than four respondents:

- health problem or illness
- having an aversion to or feeling anxious about particular smells
- feeling uncomfortable with particular sexual positions
- feeling uncomfortable when hearing heavy breathing
- experiencing intense distress at an event such as an anniversary of a trauma
- family reunion
- seeing old letters or family memorabilia
- having a distressing recollection of an event
- divorce
- birth of a child
- death of relative
- seeing educational announcements about sexual abuse on t.v.
- being a member of a support group (not group therapy)
- my therapist suggested I may have been sexually abused
- disclosure of sexual abuse by a sibling
- death of a parent
- death of the perpetrator of sexual abuse
- going on vacation
- experiencing a hospital stay

- receiving sex education
- being asked a question: have you been sexually abused?
- participating in group therapy
- sexual abuse of your own son or daughter

Six items were not selected by any of the participants:

- class reunion
- marriage
- death of brother or sister
- seeing newspaper accounts
- seeing old medical records
- being asked a question about inappropriate sexual touching

Data from the Memory Recall Questionnaire and accounts gathered during the interviews provided answers to the five research questions. The results of the questionnaires and the interviews are presented here one research question at a time. The answers to each of five research questions are organized according to three categories of respondents: those who experienced memory recall

- prior to psychotherapy (Category A)
- after initiation of therapy but not during the therapy hour (Category B), and
- during the therapy session (Category C)

Brief summaries follow each of these three categories. The reader is reminded that the names of the participants have been changed to ensure their anonymity.

Research Question 1

Research Question 1 is: What factors are associated with the retrieval of repressed memories of childhood sexual abuse. Interview Question 1, asked in order to answer Research Question 1 is: What do you remember about the experience of recalling the memory of sexual abuse? Did the memory return all at once, or in fragments over time?

Category A: Recall Prior to Psychotherapy

Conrad was the only male participant in this study. He became animated, raising his arms and the volume of voice as he attempted to answer this question. He was not sure he remembered it all and contradicted himself. He first stated that his girlfriend confronted him with incidences of his unfaithfulness to their relationship. Conrad tried to explain himself, but his girlfriend insisted she did not understand what he was saying. In exasperation, Conrad blurted out, "I was molested as a child!" It was the first time he had verbalized this admission. "I was almost uncontrollable at that point, just broke down in tears! God!" He described the event as "earth-moving." For Conrad, the memory or awareness came all at once. Like other people cited in the literature, Conrad's first memory of the abuse event seemed almost pre-conscious. Upon the memory being triggered into awareness, he "knew" for the first time the event actually happened.

Susi prefaces her description of the recall of past abuse by saying, "This might sound crazy to you, but I think it plays very strongly into my recall. I have always felt I am an intuitive person and in touch with other people." The actual event of the recall occurred in a dream at night, which was unusual, since she had never previously been able

to recall dreams. "I just suddenly woke up in the midst of a dream of recalling some of the events, and felt taken aback by the fact that the recall occurred." Her response was to stay up and think about the dream for awhile. The memory of this particular abuse event came, for Susi, all at once. The experience of becoming aware of the sexual abuse information was abrupt and startled the consciousness of both Conrad and Susi. The memories of abuse experiences emerged more slowly for the other thirteen participants in the study.

Bev, student and single parent in her early thirties, experienced a more concrete and steady progression of events and feelings that eventually led to a flood of memories. Bev had experienced anxiety whenever her sense of control in relationship with a man would change. She became preoccupied with her feelings and nightmares about monsters. After these nightmares and other disconcerting dreams, Bev experienced flashbacks of vague images of her brother at Christmas time and of her father, which produced unusual feelings. She was aware that her father's anger and "squirreliness" triggered intense feelings. These events preceded more concrete memories. A TV news program triggered her first tangible recall, that of a teacher touching her breasts. Another recollection occurred "like a flash--poof!" when she observed her young daughter climbing into the lap of a young man. These events were isolated and disturbing, but were only fragments which made no sense and had no meaning until Bev learned of her three-year-old daughter's sexual abuse, the recognition of which triggered a rush of memories, emotions and dissociation. Foreshadowing hints in the form of fragments of memories and their attendant feelings built up over a period of several years before the spate of memories that

followed that moment. Bev's own assessment was that when the daughter's abuse became apparent, memories and nightmares came "flooding" forth. "It is like you tune into that part of you, that still sensitive side of you, and that alone brings back the emotions and triggers the memories." As she encountered her daughter's abuse, she felt the anger, the violation, as if her own abuse was taking place all over again. Bev went on to describe "...that yucky feeling... I pull back ... it's like a disgust...too much emotion, too much fear and disgust."

For Serena, the process of recall began about three years prior to the interview. Similar to Conrad, Serena reported she "knew," in some indescribable way, that she had been sexually abused, but had no memories of the abuse until she went into a depression, at which time the memories started coming back. The trigger for her depression and the recall was a betrayal of trust by a man who had convinced her to trust him. This betrayal triggered flashbacks and nightmares. The flashbacks always occurred at work, where she had a panic attack while walking past a cellar door leading to the boiler-room. Another trigger for panic attacks and "getting the shakes", was the smell of sweat from the men on the treadmill she monitored as part of her nursing job. She surmised the jell used for the patches in combination with the sweat smelled like semen. She did not connect her reactions to events from childhood at this time. Until the depression became too painful and suicidal thoughts were constant, Serena experienced these flashbacks with no emotion and with successful dissociation, actually experiencing the nightmares or flashbacks as happening to someone else. Serena's actual memories returned dramatically, when her mother asked her if a particular man from her childhood neighborhood had

molested her as he had abused both of her other sisters. Serena accounts, "I think after my mother knew, I had permission to remember; it wasn't anything that was going to be a secret any more." Conrad recalled similar permission to remember after he disclosed his abuse.

Freda's memories of childhood sexual abuse were pieced together in a more circular fashion. As she talked to relatives about their concerns of common childhood experiences, she reflected about her own understanding of childhood events in a new light. Freda reported she wasn't aware or even curious about her childhood until after her father died eight years ago. While talking about a cousin's recently recalled childhood sexual abuse, Freda began thinking about her own and her family's behavioral idiosyncrasies. After a suicidal depression, she was curious why her sister had been a prostitute, had screamed in the night, "daddy, something scary about daddy." She wondered why his coughs scared her. Freda began to recall her father would watch her pee and take baths. She wondered for the first time why she and her sister always had to dress in the living room, or why her father always dressed out in the hallway. These returning memories brought Freda relief as they put to rest the "weirdness" she experienced about herself in her childhood and in her adult life. She now is relieved that the non-sensible events from childhood have new meaning. Freda, in her analytical and intellectually crisp manner, assessed the process of recalling memories as additive, much like figuring out a puzzle.

Dora, student and widow, said her body has always told her things, but without any clarity or meaning. Her back ached and she was depressed much of the time. She wondered why she could not recall her childhood before age six. Meditating to find

answers led to more confusion. She had suspected for years that she had been sexually abused and wanted to confirm or disprove these nagging thoughts. While on a trip to visit her family, she mentioned to a half-sister that she had always been afraid of her step-father. The half-sister replied that she had also been afraid. Inadvertently, and while traveling home, Dora discovered that the step-father had gone to jail "for years and years and years" for some sexual impropriety against the half-sister. She exclaimed, "I was just flabbergasted when I heard that because I had always had these suspicions about myself." Dora attempted to clarify her suspicions by asking her mother, long divorced from the step-father. The mother had previously made only vague mention of an incident in which the family had to move out of a relative's house because the step-father had been accused of something.

Dora had not been able to understand some of her physical sensations. In a dream she asked if she had been sexually abused as a child, and an "Oz-like" answer came, "Well, my child, your father has left his mark on you." For Dora, this affirmed that something had affected her, but was not sure it was sexual abuse.

To summarize the results of this category (recall of abuse memories prior to psychotherapy), we may say that for Conrad and Susi, the return of memory occurred all at once, with little related build-up. A single event revealed to them what they considered a relatively complete memory of the childhood sexual abuse experience. Neither of them had had prior psychotherapy. Bev, Serena, Freda, and Dora experienced recall as a cumulative progression toward a memory that opened a flood of awarenesses and other memories. Those with cumulative recall patterns each experienced feelings, body

sensations, anxiety symptoms and depression prior to conscious awareness. For Bev, Serena, Freda, and Dora there had been therapy experience in the distant past, but these experiences were unrelated to the recall. It is interesting to note that Conrad, Serena, and Keri named *having permission* to remember from an important person as triggering memories.

Category B: Recall After Initiation of Therapy but Not During the Therapy Hour

Kip, a student, was the youngest participant. At the time of the interview she had few supportive resources outside the therapy hour. Problems associated with a rape two years previously brought Kip into counseling. She couldn't study but did not realize the rape was what was bothering her. Telling her therapist about the rape made it easier for her to study. It was during a year of irregular counseling sessions that Kip confirmed what she had "known" all along. Kip said of the sexual abuse, which had taken place at about age three, "I think what is hard for people to understand is that it just happened. It's like the first thing I remember, it's always been there." Her memory was confirmed when she and a friend returned to the neighborhood where she had lived at age three. Upon seeing the house with a path leading next door, what she "knew" was validated. When asked what it felt like to her when she "knew," she replied: "I think it was like I had a bad dream. I was upset about it because I finally knew I wasn't crazy or just dreaming stuff. Now that I had proof I had to face it." It became clear that Kip had repressed the *meaning* of these events more than the memories of them.

Pam was a graduate student and a single parent of three children at the time of the

interview. She had previously been in therapy for the rage and pain she experienced around irregularities in her mother's behavior. After many years and childhood concerns had been settled regarding mother, Pam went back into therapy feeling "actually probably stronger than I had ever been in my life." Pam had divorced her husband and was living on her own for the first time in eighteen years when one night she awoke crying. She had remembered a fragment of what had happened with her father and felt terrified. The next week she had a dream of her father being naked and standing in front of her bed. "It was clear to me that that was a memory and it was much more complete." Upon thinking about the dream, Pam described, "it was sort of anticlimactic, it was like 'Oh' that makes sense!"

In retrospect, she linked this dream with a Posttraumatic Stress Disorder-like response she had had several months before the dream. It was triggered by being aroused from a quasi-sleep state by her husband's arm touching her chest. Her heart raced and she was terrified, thinking she was back in her room as a child. As her panic began to abate, "it was literally like ice cream melting" as she returned to the present and out of the dream state. She says she has no desire to know more about her abuse although it is clear to her that more remains to be uncovered. She describes her memories as "clear negatives of a shot . . . . frozen frames of behavior." Pam recounted that a picture triggered a recent dream of her father. About this experience, she declared, "I can almost feel that there is something about it that I'm not ready to deal with."

Rebecca is married, has two children and a full time career. For Rebecca, memories began coming during a period of time when she was under great stress, as little

disconnected pieces of information from the past. She did not see the meaning in the pieces. Comments from other people about how much her older daughter looked like her triggered the recall. "This was breaking me up!" Flashbacks, desperation, and rage overcame her, and she started therapy. During her first visit, her psychiatrist asked, "have you been sexually abused in the past?" to which she answered "no." Rebecca began taking Prozac and for the first time in twenty-five years she felt great, "a week of pure heaven, feeling wonderful." Then, the first identifiable memory occurred, recreating a sense of terror. The recalled event was confirmed and explained by her sister-in-law. Subsequent recalls came while at work. The memory started with a feeling of having been assaulted, which evolved in her awareness "like a flashback, like a video." During this first episode, she identified her grandfather's face accompanied with the words screaming through her head, 'you dirty, filthy bastard! She described a life long sense of feeling dirty, and recognized that certain smells triggered those feelings. Rebecca then had memories of leaving her body:

> I would be up on the ceiling watching what was happening. That just blew my mind. I'd say to the counselor, 'I know that's me, but where am I?', and she explained that it was really more of an escape. One thing I remember was my grandfather. He wore those God-awful coveralls and he had the zipper undone and he had himself exposed. I would freeze and he'd look so funny and I'd be up on the ceiling watching myself. And so the memory was not remembering what happened; it was back being a little child, being terrified.

In subsequent memories, Rebecca recognized herself going up to the ceiling during assaults from her grandfather. Rebecca described that before she had the "awake memories" she "knew" something was coming that had to do with the dark, and the dread was terrible enough to become suicidal. "I wanted no more memories." Through therapy,

group support, and flashbacks, the experience of recall has been grievous. "Looking back now, I think forgetting was the best thing I could have done."

When confronted with her memories, Rebecca's family denied them and suggested that the psychiatrist put the ideas in her head. Rebecca states, "I will say that my psychiatrist was very good in helping me with memories. She would say, 'tell me' and I would just take off. She never said, 'you must have been abused'; she never said 'well, your father must have been in on this too', or anything along that line." Like many others in this study, fragments of memories accumulated over time. The moment of recall however, gave new meaning to the isolated fragments.

Kerby, the next participant, had been abused by her step-father. In Kerby's words: "I was in the master's program when I realized that I had been molested; prior to then I knew I had been touched by my stepfather, but that was among other memories and feelings about him. Classes about sexual abuse caught my interest. Before recall I wondered about my own fascination with subject. Also, the subject of abusers prompted feelings which were confusing. I was in therapy, which helped me explore feelings which were intense at times." Her ambivalent feelings towards her step father were a mix of anger and physical attraction, which she characterized as "he messed with me." When her seven-year-old child was molested, Kerby had a very strong reaction. The child's molestation triggered powerful feelings, feelings she thought were directed toward her child's situation. Kerby felt depressed and flooded with a sense of "going crazy." During a subsequent time of relative stability she became fascinated with the study of sexual abuse. It was unnerving, abhorrent, and made her feel "creepy-crawly." She had no

awareness that she needed knowledge for self. She thought that she needed to know more only to help others. A step toward conscious awareness came when trusted colleagues suggested she explore her apparent strong transference around sexual abuse issues. These feelings arose during work with a particular offender, who prompted feelings of revulsion and attraction similar to those she experienced with her step father. While reading a definition of sexual abuse, it became clear to Kerby that what had happened to her was sexual abuse. The awareness came all at once as she remembered thinking, "Oh, my gosh!" Isolated thoughts and uncomfortable and disturbing feelings preceded the recollection. The memory returned all at once, giving new meaning to these isolated thoughts and feelings. After that, other memories were triggered by client concerns. The process of having fragments of thoughts and feelings was extended before the moment of recall gave clarity and new meaning to them.

Among all the participants in this study, Sally had the most recent experience of recall. The entire picture of the recalled memory emerged over three distinct episodes, each one of which was like re-experiencing the sexual abuse. The first trigger of recall was a panic response to the sound of a van idling beside her at an intersection. The anxiety subsided, but she mentioned it to her therapist. In Sally's own words:

> After that first event of panic, I drew a picture of the van but had no awareness of its significance. A few days later I had what I would call a flash-back, and all of sudden became very emotionally distraught. I was hugging an animal, just walking---totally emotional, and that was when the memory surfaced.

Sally's feelings of anxiety built throughout the day toward "tremendous emotional agony." As the memory was recalled in a flashback, Sally felt very young and vulnerable. The memory of being in the van and being vaginally penetrated by her father and then

passing out was the first episode of recall. The extreme pain was reduced after an emergency call to her therapist. The second segment of the recall happened while driving. She "got physical manifestations of pleasure and could picture some child standing in the van naked." Again, the anxiety built throughout the day, and in the evening, Sally called her therapist for support. The third part of the recall was triggered, she thought, by coming awake out of a deep sleep, and feeling extreme fear.

Sally had been in therapy for marital and sexual problems. She wondered if a renewed commitment to her life-long marriage partner, and their engagement had allowed more memories to surface. For example, just putting on her watch one day created much anxiety. By the evening, memories of her abusive brother tying her up and putting a noose around her neck flooded back. Another trigger was a car pulling up close to her as she stood on the sidewalk. The memory she recalled was an incident of sexual abuse by her father when he picked her up from school. "Pretty much every time there was some physical stimulus when I got my memory." Hearing a Christmas carol triggered sexual abuse memories of her father dressed up like Santa Clause. The meaning of the words of the carol changed dramatically after that recall. That was her last memory.

Keri, like others in this category, had memories return in shards. After one memory unlocked the meaning of a forgotten experience, all the other fragments and shards acquired meaning. Keri's step-son's anger and depression created in Keri feelings of terror and lack of control, and she sought psychotherapy to deal with his problem. Keri was aware that her step-son had suffered some form of abuse in his other family and also knew her own father was a violent alcoholic. She knew her father had stopped hitting her

after fifth grade because she had scoliosis.

During a session, the psychologist suggested that Keri start writing about her childhood. Keri began an emotionally draining experience of writing about what she thought she had missed as a child. Pent-up feelings became intense. "I was on the outside of myself, looking in." The tension spread to other relationships. As general childhood memories came back, Keri had feelings of "unsafeness", of feeling different, as if something were wrong with her. "What I am trying to say," she spoke, "is that I felt that at some point I had been sexually abused. It was a feeling."

While talking about their family with her sisters, mention was made of her father and Keri physically startled. "It was like I was right there. That scared me. It was like I *was* a child. I withdrew, I shrunk away. I started crying." Her therapist suggested she and her sister read together Healing Your Sexual Self. "I was brought down to my knees", she recalls of reading it. She experienced images and feelings, and was very angry. She felt like she was going to fall apart. Conscious, identifiable memories came after eleven months of therapy. Her recall experiences have been partially corroborated by a sister. She confronted her mother, wrote her father a letter and has effectively cut herself off from communicating with her family of origin.

Summarizing results from this category (recall sometime after initiation of therapy but not during the therapy hour), it is important to note that memories of abuse were presaged by feelings, sensations, and odd recollections which at first had no context or meaning to the participants. Kerby, Rebecca, and Keri expressed feelings such as "yucky", "creepy-crawly" and "fear" as descriptors of the offenders before having

concrete memories about them. At the point described as recollection, the previous disconnected feelings, images, or fragments were given meaning. Sally had the unique experience of recalling one event in three discreet episodes. This group had been in therapy from one month to one year at the time of recall.

Category C: Recall During the Therapy Session

Sarah was seeing her fifth therapist when her memory returned. She told the psychologist about something that had happened to her as a child and the therapist said, "Well, that sound like sexual abuse!" Another item she believed triggered her desire to pursue this problem, and which set the stage for awareness, was the fear that her oldest son was being abusive to her daughter. Once aware that she had been abused, Sarah noted that "I just couldn't stop crying! I mean I cried night and day, just night and day." In addition to being depressed and tearful, Sarah also felt very relieved to finally have a "reason to feel awful." Sarah says of herself, "I think I was relieved to be a victim for a while, to actually embrace my victimness and to feel sorry for myself."

Isolated events returned to memory for Kim over time. The first event occurred during a Neurolinguistic Programming session for weight loss, when she "accessed some real vague memories, and kind of minimized them." During some regression work later on, Kim had another recall experience.

> It was really vague, but it felt really traumatic to recall my brother having sexually molested me. It scared me. My mother came into the bathroom, and asked if my brother had touched me. I was scared to death. Seems like the feelings, physical sensations were easy for me to recall. The queasy feeling in my stomach, the scared feeling I had when it was happening, the scared feeling I had when my mother was asking me, the fear of punishment, the shame, all those things came up. I am kind of kinesthetic anyway. That was my first recollection.

With another therapist who did more regression work, Kim had a different kind of recall experience. Her memories progressed, "from being there, to watching it, to watching myself watch it. It was terrifying." While describing these experiences, Kim slowed down and said, "I'm having trouble tracking. I'm getting kind of dissociative. I don't feel distressed, but I feel like I'm leaving." During another therapy session, Kim began to think her abuse memories were related to her father. "I would get glimpses of my father's face. I was having feelings, emotions, and body memories; feeling hair around my face and pressure in the back of my throat, pressure on my chest. I can't call them flashbacks, it was just a repulsed feeling and it would come all of a sudden." Kim thought all of these events paved the way for the most recent recall, which occurred when she went to see a psychic:

> I had regression with him and at that time I recalled an incident with my father. I recalled a room, the place, started having feelings, body memories. Recalling my father taking me to the upstairs of our garage. Being very little . . . . I remember those sounds, I remember him saying 'I'll buy you a pretty', I remember sensations.

This recall gave meaning to isolated memories and feelings and brought resolution to her sense of bewilderment.

Lucy, like Sally and Kim, recalled memories of sexual abuse during a therapy hour. Initial recoveries paved the way for memories to return in other settings such as the hospital and at home. Lucy had flashbacks. When she talked about the abuse it caused intense anxiety. She would know a flashback was coming from the body memory first.

> I would get this anxious I-don't-want-to-know-what's-coming kind of feeling. I would get a body memory first and my body would start to feel funny and then I would try to deny or repress that, I did not want to know what my body was trying

to tell me. At first they would come back as little memories, little bitty things, little body things that, uh, my arm would go to sleep.

The first memory of the violent abuse came as a result of being in a safe place with a psychologist she had been seeing for awhile through a divorce. The psychologist suggested she write down the earliest memory, and when Lucy tried, she vomited! Over time, Lucy drew pictures that had objects and places in them that triggered more curiosity than actual awareness. "I could say to you I was sexually abused as a kid. What I had always remembered all of my life, Daddy would come into my bed and I would jack him off." She had always said to herself "but he never hit, this is just how my daddy loves me. He never hit me, he was never physically violent. But that's not true."

While in the hospital for severe depression, the most significant memory returned. It revealed violent abuse by her father and by his friends. The memories of the violent sexual abuse "blew me [Lucy] out of the water." Lucy said she had flashbacks for more than a year, but they have now ceased. She described going to a psychiatrist in the past who hypnotized her, "putting a band-aide on my brain so that my memories would quit leaking out. What he did was put a message that said you're not going to have the flashbacks come until you're in a safe enough place to experience them." Not until she and the current psychologist had established a trusting relationship, was it safe enough for the recall to occur.

To summarize the results from Category C (recall during the therapy hour), it is important to note that for Sally and Kim, the memories came during the therapy hour directly, one in group therapy and one in session with a psychic. For Lucy, the recall took place in the hospital while she was in a group therapy setting. The trigger for Sally was

the statement, "Well, that sounds like sexual abuse!" This statement was made by Sally's fifth psychotherapist. For Kim who was in therapy with her fourth psychotherapist, a one-time experience of regression with a visiting psychic released the memory which gave meaning to the feelings and images previously without context. Lucy cited that the safety of the setting allowed the violent memories to become available to her.

Summary of Results from Research Question 1

Research Question 1 is "What factors are associated with the retrieval of repressed memories of childhood sexual abuse." For each participant, there was a point in time of "knowing" something they had not known before that recall experience. The effects of that new information for Pam and Freda brought resolution and relief. For these two participants, prior self reflection and time in therapy had largely resolved other issues, allowing them to experience the new memory as the last piece of a puzzle. Other participants seemed to need more time in the process of accessing the memory. They seemed to be looking for an insight or a clue which would put the last piece into the puzzle of their abuse history. It appears significant that there were few notable differences among the participants in the factors or process of recall.

The uniqueness of each individual's experience was also apparent. A variety of images, body sensations, and vignettes of past experiences were recalled which were troubling the individual because they lacked meaning to them. These phenomena, which were troublesome, included quirky behavior, weirdness, unexplained reactions to smells or environmental stimuli, queasy or "yucky" feelings, sudden frights and many more. The

factors participants associated with recall seem to not only crystallize the presaging emotions, images, and vignettes into meaning, but also allow a "missing piece" to be identified.

Research Question 2

Research Question 2 is: How frequently do these factors of recall occur in relation to memory retrieval? The exact enumeration of the frequency of these factors has been previously provided in this chapter. It is important to reiterate that the four most frequently endorsed factors on the Memory Recall Questionnaire were depression, receiving individual therapy, difficulty falling or staying asleep, and feeling of detachment or alienation from someone else or others. Anxiety and depression may provide a base of emotional agitation from which memories may be retrieved, and therefore, they may act more as facilitating conditions of the environment than as actual triggers. Dreams were identified by seven participants and discussed in the interviews. The dreams in two cases were direct recall experiences in which the content of the dreams revealed the abuse event and the identity of the offender.

On the Memory Recall Questionnaire, five items were not endorsed by any participant. They were class reunion, marriage, death of brother or sister, seeing old medical records, and being asked a question about inappropriate sexual touching.

Five of the participants wrote in a total of six additional factors not found on the list, which they associated with the retrieval of repressed memories. They were as follows:

- "Became engaged to my husband"
- "An increase in alcohol and marijuana use and a new and different type of relationship with a man"
- "An intimate experience with a woman"
- "bad break-up experience with a long-term girl friend. I had trouble letting go of the relationship"
- "problems in my marriage, feeling controlled which was an ongoing problem in my relationships with men"
- "found a picture of family in an album: my father and the man in the dreams were one in the same. It shocked me."

Advanced statistical analysis of this research question is inappropriate for the design of this study because determining significant statistical frequency requires a greater number of participants. The question itself, however, yielded responses which may suggest additional research questions more directly related to the phenomenological experience of recall.

Research Question 3

Research Question 3 is: Do any of the factors which have been associated with recall of memories of abuse occur in patterns related to specific recall conditions? Patterns from the Memory Recall Questionnaire seem to cluster around items associated with depression and anxiety based on DSM-IV criteria (American Psychiatric Association, 1994). For example, depression was marked by n=10; gaining or losing excessive weight

was marked by n=7; sleeplessness, by n=7; inability to recall an event or an aspect of an event, by n=7; difficulty falling or staying asleep, by n=8; having a recurrent dream, by n=6; having a distressing recollection, by n=6.

The interviews provided more insight about the participants understanding of how these and other events related to the recall. The responses to the third interview question, which was directed towards the third research question, were organized by the three recall categories. The third interview question is: How do you account for the return of memories at this time?

Category A: Recall Prior to Psychotherapy

Conrad wrote in response to this interview question, "confrontation by my girlfriend to explain unfaithful behavior." Conrad accounts for the awareness by saying that "I suddenly realized that I kind of had it in the back of my mind...but I never said it aloud to myself...I never thought of it [the sexual abuse] as that [sexual abuse]." Conrad explained that he had been researching the psychiatry literature and realized that his pattern of sexual promiscuity was typical of people who had been affected by inappropriate sexual contact as children. He thought, "Hey! That was just like me." He had always conceptualized that he was not the promiscuous person, that the promiscuous person was someone else. At 21, Conrad had found a relationship that was very important to him, important enough to risk "...being shunned" if he told her.

Susi accounted for the timing of these memories with the multiple life changes which brought emotions closer to the surface and "opened some doors that have been

there for a long time." Susi had suffered some permanent injuries in a car wreck and her husband had been diagnosed with a very serious heart condition. As Susi put it, "...there was no more room in that back closet to store stuff, or to push stuff." Susi continued, "the timing was uncanny. The night of my dream, and away in another town, the boys who had been raping X were caught. Intuitively, I knew that something had been going on, that may sound crazy to other people, but knowing me, I know that was part of it [the memory returning in a dream]."

Bev accounted for the memories returning when they did because she and her daughter were molested at the same age. She said, "I watch my kid and I can see her confusion now. That triggers not a lot of the actual abuse, but the feelings I had as a kid." Although many incidences related in research question 1 contributed to recall, her daughter's molestation was the key event in Bev's perception.

Serena said "the man I was seeing betrayed my trust after a long time of my trusting no one, and I felt that the whole system of abuse began again." This event seemed to push beyond her developed ability to control thoughts and feelings, often by just saying to herself, "Just stop!" With the man friend, she felt used, "and I think that's when the memories and the transition took place." She became very depressed, when, as an adult, she was unable to repress the memories as she had as a child. Serena showed the journal entry written at the time the awareness emerged. She wrote: "He hurt me, he killed me. I'm tired of his running my life from the grave....I'm still a victim . . . . I need help, someone to talk to. I need to cry and to scream. Help me!!" Only after reading what

she had written, did she have clear awareness of the events and the identity of the offender. Serena joined group therapy.

Freda wrote clearly, "Through helping my female cousin to figure out, and finally recall, memories of sexual abuse by our uncle, and through vague fears and memories of my younger sister regarding our father, I was able to piece together bits of events in my own life, and ways I had of reacting to certain things, which led me to believe that I had been sexually abused as an infant by my own father."

Dora accounts for the return of memories when her husband died. Her life fell completely apart. She felt betrayed by him, by the loss of their house, and by not having friends in the new community.

Summarizing results from Category A (recall prior to therapy), it may be said that participants had unique accounts of the timing for the recall. For example, one participant judged the timing "uncanny" as she had no more psychological room to "push stuff." Another participant recognized he was about to lose an important intimate relationship. One participant felt used and betrayed by a man, which she believes motivated her put a stop to the abuse cycle.

Category B: Recall After Initiation of Therapy but Not During the Therapy Hour

Kip did not anchor the return of the memories to preceding events, and therefore had limited awareness of what led up to recall. Pam remarked:

> The death of my father gave me permission to look at past issues. My therapist named distressing experiences as incestuous by my mother. After integrating that, I began to dream about my father coming in my room. I was only dealing in therapy with my mother-issues. In another dream that I never disclosed in therapy for about a year.

Pam's life at the time of recall of father's abuse was stable enough to allow the return of the "father-piece" of the past history. Rebecca tracks the pieces of memory as occurring in isolation and conceptualized as odd thoughts by her. Only in hind sight did they make a clear picture of the abuse. These pieces or "vignettes" began at a time of challenge and stress in her career and challenges with her children. People began to remark about how much her oldest daughter looked like her, which caused her to be despondent because she recognized similarities between herself and her own mother. She dreaded to go to sleep because of flashbacks and nightmares.

Kerby was in a master's degree program when she realized that she had been molested. She knew she had been "messed with" by her step-father, but she also had other memories and feelings for him. Classes about sexual abuse fascinated her, but she had confusing feelings about abusers. She recalled her sexual abuse upon reading a definition of it, long after she became well acquainted with the subject. Kerby accounts for the timing of her recall of sexual abuse by noting that she felt relatively stable and settled at the time of the awareness.

Sally wrote, "the first experience was triggered by the engine sounds of a van next to me at a stop light. After hearing the sound, I looked over and saw the van and suffered a mild panic attack. This happened twice and led to my first memory of childhood sexual abuse. All of my memories have been triggered by an environmental stimulus which led first to extreme anxiety and afterward to regain the memory." As with Kerby, stability was the factor Sally credited with the timing of the memory. She was falling in love with

her husband after years of strain in the marriage, finishing graduate school, and feeling relaxed after a life time of hypervigilance.

Keri explained, "the process of dealing with my step-son's problems led to dealing with my intense anger at my father." This paved the way for memories. Unlike Sally, Keri remained agitated and anxious until after the memory returned. She did experience security and trust in her marriage, which she credited with being able to have the recall experience when she did.

Summarizing results of Category B (recall sometime after initiation of therapy but not during the therapy hour), it may be affirmed that each participant in this section accounted for the timing of the return of the key memory by describing circumstances they believed allowed the memory to return. Four participants attributed recall to stability, which allowed absorption of the impact of traumatic information. Rebecca's experience did not conform to the pattern of the other four. Her memories returned in a time of turmoil. Kip's awareness of factors leading to recall was limited at the time of the interview. With hindsight illuminated by the recall, participants could make new interpretations of past dreams, thoughts, feelings. The recall experience was always dramatic. They considered it a breakthrough or a turning point in therapy and in their healing process. They were all in therapy at the time of recall, but not for sexual abuse issues. Memories returned outside the therapy sessions. Two experiences were environmentally stimulated, one through a dream, one in a flashback, and two through reading a definition of or information about sexual abuse.

Category C: Recall During the Therapy Session

In response to the interview question, Sally speculated that she had thought that she had reached the end of her problems. She believes the stage was set for the recall she had during a group session by the time spent in individual therapy. Kim described events, which, in retrospect, were leading to awareness. She attributed the timing of recall to children living with her after a period of absence, and things going well with career and relationships. By chance, a friend referred her to a psychic who was in town. It was while in session with the psychic that the memory returned. On the tape recording of the regression, she described her voice as sounding much like that of a little girl. Lucy accounted for the timing of the recall by finally feeling safe enough with the therapist she had been seeing for some time. She described "body memories were alerting her to something" but events did not become clear until the recovery of her most violent memories.

Summarizing the results of this category (recall during the therapy session), it is important to note that among the three participants in this category, a subjective sense of safety was foundational to the recall experience. In addition it is significant that Kim had seen four therapists and Sally had seen five therapists before the recall. While Lucy had had only one therapist, she was more than ten years younger than the other two in this category and had had the most violent abuse history. For Sally and Kim, the forms of recall were hearing and experiencing. Lucy, while in the safety of the hospital setting, had violent visual images in the form of flashbacks.

Summary of the Results of Research Question 3

There appeared to be one substantive difference in emotional experiences leading to recall among the three categories, (1) recall prior to psychotherapy, (2) recall sometime after initiation of therapy but not during the therapy hour, and (3) recall during the therapy session). Of significance was the uniformity of the subjective report of anxiety and unrest among those participants in Category A. Each participant, Conrad, Susi, Dora, Bev, Serena, and Freda, experienced some significant distress, turmoil, and agitation in his or her life when the memory returned. All sought individual or group therapy to deal with the difficult memory and the changes and challenges the new information evoked.

Across the other two categories, the conditions were not so distinct. A subjective sense of general stability and calm accounted for the timing of recall for half the number in Category B, Pam, Kerby, and Sally, and Kim in Category C. However, three people in Category B (Keri, Kip, and Rebecca), and two people in Category C (Sarah and Lucy) used the words "agitation," "anxiety," and "unrest" to describe the conditions of recall.

Research Question 4

Research Question 4 is: Are there age or gender differences in the patterns of the factors of recall? The study included one male, so gender differences were not addressed. From the Memory Recall Questionnaire data, age has little apparent significance in the patterns of factors of recall. Being in a similar age range did not seem to reflect patterns of similar factors which influenced recall of memories. The age range of the participants was twenty-one to fifty-three. The youngest participants were both twenty-one, one male

and one female. Both were single and students at a university in the mid-west. Neither one has sought particular support other than individual therapy. On the Memory Recall Questionnaire the only item endorsed in common was #18, feeling uncomfortable or anxious when being alone in bed at night.

There were four participants in the thirty to forty year old age group. The only item shared by all four participants in this group was item #44, fear of losing your mind. The remaining twelve items checked by three of the four people in this age group were items that reflected symptoms of depression and anxiety and have not been cited in the literature as a trigger for recall of memories, but often are interpreted by clinicians as symptoms of childhood sexual abuse. This group was more homogeneous and might reflect the developmental issues of this decade of life. Each had from zero to three children, and most were attending school.

In the forty to fifty year old age range, the strongest agreement among this group of seven was #12, depression, endorsed by five of the seven participants. Item #13, gaining or losing excessive weight, and item #45, feeling detached, characterized more than half of this age group.

In summary, in the thirty to forty year old age group, all endorsed item #44, "fear of losing your mind." This age group's responses were distributed across the three recall categories. Three out of four in this age group endorsed twelve other items in common, pointing to some commonality of concern, generally having to do with anxiety or depression. These four people exhibited a high degree of energy.

In the forty to fifty year old group, depression, #12, was the most common item. Four of the seven women in this group had experienced recall prior to seeking therapy.

Research Question 5

Research Question 5 is: Are specific presenting concerns in psychotherapy more highly correlated with clients who have repressed memories than with clients who have had active memories all along? There were similar presenting concerns between this population and clients seeking therapy who have had memories of childhood sexual abuse all along. Among those similar concerns were: rage, depression, relationship issues, marriage and sexual problems, parent/child problems, and eating concerns. Due to similarities in presenting concerns for psychotherapy, psychotherapists should guard against making assumptions of repressed memories.

An interview question 5, related to research question 5, was asked during the interview which gave the participants an opportunity to describe more about themselves as they adjusted to their specific sexual abuse memory and the recall process. Interview question 5 is: In what ways did your life or relationships change after recalling the sexual abuse experience?

Category A: Recall Prior to Psychotherapy

For Conrad, the biggest change since recall was that he does not have to explain as much about himself anymore. This interview included his girlfriend who had the following to say about the changes she observed in Conrad "...he is more willing to face up to

things, to understand what it [the sexual abuse] has made him do, and helped him avoid those situations [sexual infidelity]." Conrad added that couple therapy was addressing concerns in how they were relating, but "I really feel like individual therapy is 'mine'." He was amazed that his girlfriend supported his efforts. Conrad acknowledged he just hadn't stopped having 'those desires and impulses' but understands he is able to stop and think now. He realized he let the sexual abuse episodes control what he did, which made him angry when he realized the effects of events over the past ten years. He realized that if he really could just stop his "bad" behavior, he would have done it. He is now more expressive of his feelings, is able to cry when he feels sad, and is emotionally available to the current relationship.

Susi recounted that the new memories "have affected my sexuality and my responsiveness. I'm much less comfortable with touching and affection, and I want to be in control all the time." Susi experienced a heightened sensitivity to her feelings. She had feelings of not knowing who she was as she tried to integrate the new memory into her established sense of herself. She ruminated about past events in trying to make sense of the anger and guilt she felt toward her caretakers more than toward the offender. She felt vulnerable in a new way which motivated her energies toward child advocacy work.

Dora reported that after memories returned she was frightened about how she had changed from the person she was before. She began to see that she had been in a victim pattern most of her life. She was trying to learn from her dreams and from the constant pain she experienced.

Bev recounted rather poignantly, "it's like discovering yourself up to a certain

point, finally having a whole picture. I had no sense of existing as a child." She couldn't remember having a "self" as a child. With the new information from the memory, she started to realize what her character was before she became angry, before she became scared. She describes the change precipitated by memory recall as "like seeing the other side of the shadows." She thinks it has "balanced" her in that some of her better characteristics or qualities are coming forth since she has regained a sense of herself as a child.

Serena found herself experiencing two identities, where one had existed before the memory came back. "I was the logical one while 'the little girl' was like having another child to care for." These two aspects of herself both now struggle with the relationship with the mistrusted man. Serena used to be gregarious and outgoing, while now she finds things to do by herself. She was able to mask her fears by being overly busy, and now, that strategy no longer works. Group therapy experience has taught her to set boundaries, and to not "let things fly in and out." The most healing change is integration within herself. "The child and I have come to an understanding in which we trust each other to be honest."

For Freda, the most pervasive change that has resulted from figuring out the memories concerned sexuality. For the duration of her first marriage, she did not enjoy sex at all. After divorce, sex was more interesting but power was too big a factor. Over the past three years with her new husband, sex is not a power thing, "...but just fun, exciting. This is new for me." Recalling memories has answered questions and solved mysteries

about her "weirdness" growing up. Before the recall experience, someone else was always defining for her what she should be doing and what she should be feeling.

Summarizing results from Category A, recall prior to therapy, it may be said first that Conrad is emotionally available now and does not think he has to explain his behavior any longer. His strongest experience of change since the memory recall is to allow himself to have individual therapy. For Susi, the new memories have reduced her comfort with touching and sexuality while Dora felt fear at the changes she experienced in herself. For Bev, the sexual abuse recall let her have a whole picture of herself. Serena has found that as she integrates compartmentalized aspects of herself she feels healed. Freda cited greatest change occurred for her when she figured out that her memories concerned sexuality.

Category B: Recall After Initiation of Therapy but Not During the Therapy Hour

Kip did not think she was any different now than before she had her memory confirmed by the visual experience of seeing the childhood sexual abuse location again. The recall experience confirmed in her mind that the event had taken place as she had feared. Pam believes her recall experience has helped free her children from bearing some parenting patterns similar to the ones she abhorred in her family of origin. For example, without thinking she would demand a kiss from her sons as they left for school. She became much more cognizant of boundaries and respect, which has continued to enrich her relationships with others throughout the healing process.

Rebecca experienced trouble with intimacy after the memories returned and spent much time in tears. As she became healthier, she recognized what a good and capable person she was. "My life has just blossomed." I am a very strong and determined person, sometimes "block-headed." Rebecca suggested it had been a lot easier, though, not to feel.

Kerby found most of the changes came in working with people whose concerns acted as triggers to her own history. Her boundaries with other's concerns became much clearer to her. Sally reported that after some of the early of sexual abuse emerged, she gained self esteem through being successful in school and in graduate school. She gained more independence while living alone for a year in her husband's absence. She knew she was seriously distressed after the most recent and most devastating recall, and asked for time out from studies. The healing has brought smiles, as she marveled at the child in herself. "Instead of grieving over what was done to me, I could rejoice over what I had done, what I had accomplished, so there had been a total change." Keri has found friends she can trust. She was stubbornly self-sufficient and now can accept help when she needs it. For the first time, she has been able to feel attractive. "I've got a lot more confidence in myself." While she has good and bad days, much anxiety remains.

To summarize this category, it is possible to say that Kip's life had not changed since recall of memory of childhood sexual abuse. Her recall served to confirm her worst fears, that the sexual abuse had really taken place. Pam has confidence in her new awarenesses to be able to break away from family patterns of limited respect for others. Rebecca feels her life has blossomed. Keri, Kerby, and Sally share increased self esteem and confidence.

Category C: Recall During the Therapy Session

Sarah wanted a better relationship with her daughter. “And its like I don’t accept myself, therefore I don’t accept my daughter.” It was still hard for her to recognize when she was being undermined by her husband and stand up for herself. Now she is very committed to staying in the marriage, and to rebuilding relationship.

Even though Lucy has not been sexual with her husband since recovering memories of violent abuse, she and her husband are both committed to making the marriage work. Kim detached from her family by choice after the recall of sexual abuse in childhood and she is no longer self destructive through eating abuse.

To summarize results of this category it may be said that for the three participants in this group, self awareness, boundaries, and self-care were part of a new basis of relating after recall of the abuse memories.

Summary of the Results of Research Question 5

All participants in categories B and C sought the help of a psychotherapist due to relationship concerns. The accompanying interview questions asked about changes in life or relationships as a result of the recall. The responses reflect individual perceptions of their personal changes and strategies for adjusting to change. Self-awareness underscores the creative energy the participants have to effect change in their lives. The strongest pattern was that relationship problems brought most participants into therapy, and therapy has provided the setting for personal growth and healing for each.

Additional Research Findings

To pursue further understanding of participants' resilience, interview question 4 was asked during the interviews: How did you cope with the return of these memories?

a. recall prior to therapy

Conrad wanted to understand his actions and sought therapy when recall occurred. He was curious. He wanted information and was eager to talk about himself, something quite uncharacteristic for him. He made a decision to allow himself to talk about his new awarenesses. He could no longer restrain his need to express his thoughts and feelings. He attributes his resilience to his self described strength of will. When challenged with the possibility of losing his girl friend, his determination to maintain the relationship gave strength to the setting for recall to occur. Seeking therapy was his way of coping.

Susi thought she could manage the emotions accompanying the return of her memory with her husband's help, but sought therapy when that strategy failed. Susi described her resilience as knowing that she needed a "holding vessel" and found trusted people to be with through the early phases of recall. She could not think through the experience without becoming over-anxious. Therapy helped her feel at peace with the recall and talk about it.

Dora saw herself as a victim and as alone during the early stages of recall, at which point she decided to return to school. She changed her name and joined a support group, although she feels support from neither her group nor from anyone else. Feeling unresolved, she has made understanding the connection between her present turmoil and past abuse her life work.

Bev coped at first by drug and alcohol use. After starting therapy she learned not to react so strongly to the fear she felt at the strength of her emotions. "It became more of a living-it-out instead of thinking about it." She felt the anger and dissociated more often. "It was like I was living in two different states of being." The trust she developed for her therapist allowed her to reduce harmful behavior even though making changes was painful and awkward. Bev draws upon an internal hopefulness of getting through the awkwardness of the memories returning and finds the hopeful quality keeps her "pushing forward."

Serena coped by writing about how she was feeling. She used a technique wherein after writing she changed writing hands and answered herself as if she were a different person. As the returning memories became harder to dissociate she became more depressed and suicidal but had no idea about the source of her pain. "So I think it was a process of accepting that there was a part of me that I didn't even know existed, and allowing myself to know that person." Joining a group of people who understood how she felt in addition to starting an antidepressant medication, was life saving.

Freda reported:

> I was helped by having had counseling three or so years prior because of suicidal feelings and plans. The counselor explored with me my relationship with my mother, which ultimately resulted in my feeling strong and able to deal with life's slings and arrows. I have never returned to the depression which had plagued my life from childhood on, due to whatever this counselor did. Consequently, when I developed my belief that I'd been sexually abused, I was able to draw on my strength and sense of self worth to deal with this information evenly!

For a while after the realization of her history of sexual abuse, Kip felt upset, and thought about the abuse a lot. "I guess I was putting pieces together." She has found

individual therapy helpful. Kip expressed confusion about her feelings and ideas about the childhood memories. At this point, as a way of coping, Kip has decided not to let the memories bother her. This strategy is consistent with how Kip approaches management of other problems and is most likely helpful to her at this time.

Pam wrote: "I recalled 90% of my childhood experiences. My children kept me going when I got worn out; workshops with Ellen Bass gave me a good model. Got permission to be angry, experience rage in appropriate ways, not forgive and not make forgiveness my work. I wrote poetry and published it myself, then did readings."

Rebecca continued individual therapy, joined a group for support, and started marriage counseling. She arranged help with her children, who both required special services. The resilient strengths which guide Rebecca's actions are her self described determination to work out problems and her hopefulness that she would feel better.

Kerby coped with individual therapy and being able to talk about the abuse with trusted people. Her home life was relatively stable and thereby supportive, for the first time in a while. Resilient qualities of self reliant strength, feeling loved, and feeling loving have guided her transition from not knowing to her experience of knowing about her sexual abuse history.

Sally stayed in close touch with her therapist when the panic and anxiety occurred. She learned to get out of the house to decrease anxiety. Sally drew upon her capacity to compartmentalize and to dissociate to cope with the flood of memories.

Keri credited her management of stress to personal strength, self-sufficiency, and writing which helped her to get rid of the pain and anger. She had a strong desire to live a

better, more relaxed life. She coped with disclosing to a female friend, with medication, riding lessons, and by burying herself in work.

Sarah coped by becoming either withdrawn or very aggressive in interactions with her mother and her brother. She has used the new skill of recognizing and setting boundaries to manage the turmoil after the recall experience. Kim credited her attitude, ("I see the sunshine in the rain; a very functional approach") as her coping strength. Lucy created a safe place for self, had friends for first time, and practiced better basic hygiene.

CHAPTER V

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Summary

Relevant literature acknowledges a lack of knowledge about phenomena associated with the recall of repressed memories of childhood sexual abuse. The purpose of this study was to identify factors associated with the recall of these memories. In achieving this purpose, this study isolated and articulated internal and external conditions, experiences, events, and other phenomena which, according to study participants, occurred at the same time as or shortly prior to recall, and were experienced as being related to the recall of abuse. This study has accepted the claims of participants about their experiences of recalled memories and has not attempted to validate those claims.

This study implemented a phenomenological, qualitative approach using the personal interview as the means of exploring and gathering data. A demographic questionnaire and a memory recall questionnaire provided descriptive data. The data collection process proceeded in three parts. The first part was the personal interview, conducted in homes of the participants or in the principal investigator's office. After completion of the sixty minute interview (Appendix A), the second and third parts of the

process were completed by the participant: the Demographic Questionnaire (Appendix B) and the Memory Recall Questionnaire (Appendix C).

The five research questions were as follows:

1) What factors are associated with the retrieval of repressed memories of childhood sexual abuse?
2) How frequently do these factors occur in relation to memory retrieval?
3) Do these factors occur in any patterns related to the three recall categories: (A) recall prior to psychotherapy, (B) recall sometime after initiation of therapy but not during the therapy hour, and (C) recall during the therapy session?
4) Are there age or gender differences in the patterns of these factors?
5) Are specific presenting concerns in psychotherapy more highly correlated with clients who have repressed memories than with clients who have had active memories all along?

Discussion

Research Question 1

Research Question 1 is "What factors are associated with the retrieval of repressed memories of childhood sexual abuse?" The data indicates that, in terms of recall experience, each individual is unique, and no individual's recall experience contains the exact same set of factors experienced in the same sequence. However, five specific factors in different sequences, manifestations, and combinations, were highly important to all of the participants. These five factors, explained in the paragraphs which follow, are:

1. non-specific anxiety
2. emotional security
3. attribution of meaning
4. abuse-related internal stimuli
5. abuse-related external stimuli

Non-specific Anxiety. All six participants categorized in Category A (recall prior to psychotherapy), three of the six participants in Category B (recall sometime after initiation of therapy but not during the therapy hour), and two of the three participants in Category C (recall during the therapy session) reported generalized anxiety, depression, and unrest leading up to the recall experience. Participants were aware that something was bothering them, but unable to associate any particular meaning or experience with the distress. The anxiety and the depression which the participants experienced took the forms of body sensitivities, inability to concentrate, acting out behavior, and desire for drug use. The desire on the part of the participants to find the cause of the distress helped to set the stage for the recall of memories.

The significance of this finding, that non-specific anxiety is a leading factor associated with the recall of memories of abuse, is that it suggests that the experience of abuse has the effect of shattering the link, in the victim's mind, between the physical experience of abuse and the anxiety that the victim associated with that experience. It can be argued that the experience of sexual abuse, at the time it happened, caused anxiety. After the abuse event, the victim lost the memory of the event but retained a sense of anxiety, the origin of which was not known. The existence of non-specific anxiety, then,

suggests the strong possibility of the existence of repressed memory of sexual abuse events as a means of coping with the trauma of sexual abuse.

Emotional Security. Having established that non-specific anxiety is a common experience of sexual abuse victims, it is no surprise that emotional security was the most significant "trigger" of recall of repressed memories. This is because when victims of sexual abuse experience non-specific anxiety, and then begin to experience a sense of security in a relationship, such as the therapeutic relationship, they begin to develop a new sense of security that allows them to explore or experience anxiety or anxiety-related feelings which they were too afraid to explore previously. While not a "trigger" in the sense that it is an active agent of recall initiation, emotional security creates the conditions under which the other factors mentioned in this report could operate. Seven of the participants cited being emotionally stable and relatively secure as a factor leading to recall. For each individual, the important elements of stability revolved around family and careers, or relationships in general. Three participants mentioned that emotional security, in the form of having subtle permission from mothers or other loved ones, enabled them to recall the abuse. This emotional security had more to do with an internal state of being rather than with a particular setting of safety or security. While it may be important for men and women who are experiencing recall of memories of childhood sexual abuse to secure a refuge or a place of safety, the internal emotional security of the participants appeared to be the important dynamic for the return of repressed memories.

This research finding strongly suggests that emotional security deserves more attention in future research and treatment of sexual abuse. Emotional security depends

upon developing trust, perhaps most importantly in relationships with other people. Sexual abuse is the experience of violation, not only of a person's physical boundaries, but of emotional boundaries as well. Because sexual abuse in childhood is perpetrated by people who are older than the victim, the victim's trust is often shattered in the experience. The perpetrator may be a parent, in which case the victim loses trust in someone who is supposed to be the source of protection and love. Even if the perpetrator is an adult who is not a parent, the victim loses trust in adults as individuals responsible to at least warn them of hazards, if not be directly concerned with their welfare and safety. This means, then, that healing for sexual abuse victims is not only a result of regaining a capacity to develop trust, but that healing is the very process of having trust restored, at least in intimate relationships.

The research results of this study confirm these observations. The participants in this study fell into two categories with respect to their progress in developing emotional security. The first category included seven participants who mentioned being emotionally stable as a factor leading to the recall of their memories of abuse. They had been able to establish trust in therapeutic and other relationships and declared that the resultant emotional security led to recall of memories of abuse. The other eight participants who were experiencing non-specific anxiety at the time of memory of recall, were attempting to trust others in therapeutic or other significant relationships. It is important to note then, that both the establishment of trust and the attempt to establish trust are vitally important factors in the process of the recall of memories of childhood sexual abuse.

Attribution of Meaning. A prominent finding of this research was the observation that memories of abuse were recalled when the participants were able to attribute meaning to the shards of memories which they had not previously been able to link with any concrete experience. For all the participants there was a point in time when they did not have awareness of the memory of childhood sexual abuse, but had shards of memories in the form of dreams or fragments of recollections of events that were later understood to be in some way associated with abuse events. For all participants, including all three recall categories, there was a point in time of "knowing" something they had not known before that recall experience. This "knowing" took the form of associating sexual abuse with a fragment of memory with which no abuse had previously been associated. There was variation in the number of years it takes to reach the point of "knowing." For the oldest participant, who was fifty-three, many more years were invested in getting to the memory which put the last piece into the puzzle, than for those two participants in their twenties.

This research finding is significant because it provides one explanation of the process of memory recall. According to the research findings described in this study, non-specific anxiety is at least partly the result of trauma, specifically the violation of trust. For the victim of sexual abuse the meaning of the abuse event (the violation of trust) gets separated in the victim's consciousness from the memory of the abuse event itself. The abuse event, too painful to bear, is transformed, within the victim's emotional make-up, into non-specific anxiety. This non-specific anxiety has no apparent meaning to the victim. Once the victim attributes meaning to the shards of memories of the abuse event, the recall of the event becomes complete. At this point the victim faces the full significance of her

or his abuse experience, and healing is a result. Further, the search for meaning is itself an important part of the healing process. As the participants in this study approached the recall of the abuse experience, their non-specific anxiety escalated, in some cases to the level of the original trauma. They then started to grope for the meaning of the anxiety that they were experiencing, in an attempt to cope with it.

The new knowledge gained from the return of previously unavailable memories provided impetus for positive personal change for most of the participants. For most of them, new meaning perceived about decades of unexplained feelings, thoughts, and behaviors was powerful and liberating, and resulted in subsequent educational and professional success and a sense of relative contentment. The implication of the attribution of meaning, therefore, are virtually limitless because they include all the attributes of emotional health. Participants specifically mentioned numerous indications of emotional health, including gaining a sense of confidence, enjoying "normal" sexuality, and restoring a sense of contentment and balance in relationships.

Abuse-associated Internal Stimuli. Internal stimuli related to abuse were phenomena that originated from within the consciousness of the participants, such as emotions, dreams, or shards of memories. One participant, for example, was unaware of ever thinking or suspecting she had experienced sexual abuse in childhood. She became aware of the abuse through a dream in which the sexual abuse and the identity of the offender were clear. With the awareness came profound new information. This one memory led to clarification of all of the other memories, and gave meaning to them. Other participants described recurrent dreams of odd or distressing content which disturbed their

sleep. For others still, memories of abuse were presaged by feelings, sensations, images, or odd recollections which, at the time they occurred, had no context or meaning. Flashbacks, by participant description, were experienced as visual images of places and people contributing to recall. What did stand out was the uniqueness of each individual's internal stimuli. From this non-random sample, it was common to have images, body sensations, and incomplete vignettes of past experiences. Factors which were troublesome included self-described quirky behavior, weirdness, unexplained reactions to smells, queasy or "yucky" feelings, sudden frights and many more. The factors participants associated with recall seem to not only crystallize the presaging emotions, images, and vignettes into meaning, but also allow a "missing piece" to be identified. Although the recall process normally extended over months or even years, the moment of recall, when a clear picture of the abuse formed in the participants mind, was often dramatic and was considered a turning point in therapy and in their healing process.

The meaning of the research findings related to internal stimuli is that internal stimuli are like signposts. They are indications that trauma has occurred. They are pieces of the puzzle that the victim of abuse has to sort out in order to put at rest a growing anxiety. Sexual abuse breaks through personal boundaries and destroys trust. Internal stimuli are the broken pieces of these internal boundaries, the shards of broken trust. Internal stimuli are the most prominent signals of sexual abuse, and provide the best cues as to the source of a therapy client's distress, and to the direction in which to look for healing.

Abuse-associated External Stimuli. External stimuli are phenomena that occur in the victim's environment during the time that the victim is attempting to understand her or his non-specific anxiety or suspicions that something from the past has not been understood. Ten of the participants experienced external stimuli as contributing to the recall of memory. The range of experiences included a visit to the environment where the abuse had occurred eighteen years ago. Engine sounds, being asked a question about sexual abuse, reading a descriptive passage about sexual abuse, were among other events associated with recall. Reading a definition of or about sexual abuse led to previously unencountered awareness of abuse for two participants. For some of the participants in this study, certain smells caused anxiety, and certain sounds caused panic. For one participant the experience of regression with a psychic released the memory which gave meaning to the feelings and images which were previously without context. Therapy was the most significant external stimulus. Each participant in Categories B and C sought psychotherapy for some variety of relationship concerns. Of the six in the Category A, only two sought help directly for the resolution of the new awarenesses brought about by the recall; the others sought help for depression. For one participant, the recall occurred in response to the statement, "Well, that sounds like sexual abuse!" which was made by the participant's fifth psychotherapist.

As in the case of internal stimuli, attributing meaning was the link between an external stimulus and the memory of sexual abuse. The attribution of meaning to external stimuli occurred as trust in a relationship, most often with a psychotherapist, developed. In fact, relationships challenged participants to trust. Relationships with therapists placed

participants in situations wherein they were challenged to trust that their feelings could be explored. Relationships with spouses or other sexual relationships put participants in sexual situations which recreated some aspects of the original abuse, situations which challenged the abuse victim to trust an intimate partner. Relationship concerns often led participants to inquire about their problems, which in turn set the stage for recall of memories of abuse.

Another significant implication of this research is that triggers of recall of memories fall into two qualitatively different categories: internal and external. These categories are different because internal stimuli originate within the victim and external stimuli originate from outside the victim. For internal stimuli, a perception or emotion that was previously unexplained, is attributable to sexual abuse experiences that are now recalled. For external stimuli, an event (a sound, smell, or sight of something familiar) is connected with an actual abuse event. Therefore, it may be concluded that while internal stimuli connect perceptions to meaning, external stimuli connect similar actual events (the abuse event and a current event) together.

Research Question 2

Research Question 2 is "How frequently do these factors occur in relation to memory retrieval?" Four items on the questionnaire were highly significant because they were identified by more than half of the participants as being associated with their memory recall experience: depression, receiving individual therapy, difficulty falling or staying asleep, and feeling of detachment or alienation from someone else or others. Fourteen

items were somewhat significant because they were checked by at least five but not more than seven participants. These fourteen were gaining or losing excessive weight, sleeplessness, having a particular dream, inability to recall an event or an aspect of an event, feeling uncomfortable with certain ways of being touched, having a recurrent dream, having a recurrent recollection of an event, having a sense of a foreshortened future, irritability or outbursts of anger, difficulty concentrating, hypervigilance, fear of losing your mind, feeling uncomfortable or anxious when being alone in bed at night, feeling uncomfortable or anxious at certain times of the night, and difficulty in relating to a male or female in a role of authority. Another twenty-three items, described in Chapter IV, were potentially significant because they were associated with the memory recall experience by at least one but not more than four respondents. These research findings are significant for two reasons. First, they confirm the conclusions of previous research because most of the phenomena that were identified as being associated with recall in previous research were also identified by at least some of the participants in this study. Second, the phenomena identified as important "triggers" of recall in this study provide a wealth of opportunities for further research, and priorities for further research are established because the most commonly cited "triggers" of memory recall are likely to reveal more clues about the nature of the memory recall process. The four most important items for further research, therefore, are: depression, receiving individual therapy, difficulty falling or staying asleep, and feeling of detachment or alienation from someone else or others.

Also of significance, paradoxically, is that the four most commonly experienced attributes of people who have experienced sexual abuse are also among the most commonly mentioned problems of all people who seek therapy. What is important to note, however, is that therapy clients with *all four* of these symptoms may have a greater chance of being sexual abuse victims than clients who exhibit only one or two of these complaints. This means that therapists should be aware that clients who are depressed, have sleeping problems, and express feeling detached from important relationships are more than likely than other clients to be abuse victims. The implications of this finding for further research and therapy are explained in detail in the sections of this chapter entitled "Recommendations for Future Research," and "Recommendations for Intervention in Therapy."

Research Question 3

Research Question 3 is "Do these factors occur in any patterns related to the three recall categories (A) recall prior to psychotherapy, (B) recall sometime after initiation of therapy but not during the therapy hour, and (C) recall during the therapy session?" With one exception, there appeared to be no discernible pattern of factors across the three recall categories. The factors which led to recovery of memory for therapy clients during the therapy session were basically the same as those that led to recovery of memories for clients who experienced recall outside of therapy sessions, and for those who were not receiving therapy. The one substantive difference in emotional experiences leading to recall among the three categories was the subjective reports of anxiety, agitation, and

unrest among those participants in Category A, which was greater than those expressed by participants in Categories B and C. All the participants in group A sought individual or group therapy subsequent to memory recall to deal with the difficult memories, changes, and challenges the new information had evoked. Across the other two categories, conditions of anxiety were not so readily apparent. A subjective sense of general stability and calm accounted for the timing of recall for the remaining participants .

Research Question 4

Research Question 4 is "Are there age or gender differences in the patterns of these factors?" Younger participants, those in the thirty to forty year old age range, were more likely than older participants to be, during the six months leading up to memory recall, fearful of "losing their minds." Three out of four participants in this age group endorsed twelve other items on the Memory Recall Questionnaire in common. These endorsements point to a greater concern with anxiety than was the case in the other age groups. Older participants (in the forty to fifty year old group) were less likely to be fearful or anxious just prior to recall, but more likely to be depressed. Four of the seven women in this group had recall prior to seeking therapy.

Perhaps the differences in the responses of these ages groups may be attributed to the possibility that the younger participants were closer in time to the actual abuse event. Their anxiety may indicate fear of a repetition of the event itself. Their response, that they were "fearful of losing their minds," may indicate that they are closer in time to an event or series of events which were so traumatic that they felt incapable of coping with them.

The older respondents, on the other hand, may not be so fearful of a repetition of the abuse. Having had more negative experiences in life, and having experienced more difficult situations that they had successfully overcome, the older participants may feel more able to face the trauma of the abuse experience. They may therefore be less fearful and more depressed than their younger counterparts about the fact that the abuse occurred. All of these possibilities need to be tested by further research.

Research Question 5

Research Question 5 is "Are specific presenting concerns in psychotherapy more highly correlated with clients who have repressed memories than with clients who have had active memories all along?" Findings of this study did not reveal any patterns that were significant in relation to this question except that all participants in Categories B and C presented relationship problems to their therapists. Further research could determine if relationship problems are presented more frequently in cases of repressed sexual abuse than in therapy population who has had active memories of childhood sexual abuse.

Recommendations

Recommendations for Future Research

In view of the findings of this study, the following seven categories of recommendations are made for future research. First, several recommendations revolve around the problem of the destruction of trust involved in the abuse experience, and the re-establishment of trust for both recalling memories and regaining emotional health.

Although much is already known about how therapists can develop trust in the therapeutic relationship, more research could focus on how trust can be established specifically in cases which have a history of sexual abuse. More specifically, research could focus on the ways the abuse victims develop trust, the conditions acceptable to abuse victims for emotional security, and the way the personalities or other characteristics of specific clients and therapists interact to increase or inhibit trust. In addition, more information on (1) the ways in which emotional security is linked to memory recall (2) the types of emotional security that are most likely to lead to recall, and (3) the extent to which different types of emotional security lead to memory recall in different age and gender groups. In regard to the clients other intimate relationships, research could focus on two questions. First, are certain types of relationship concerns more indicative of sexual abuse than other types of relationship concerns? Second, can a list of relationship concerns be produced that form a profile of abuse victims?.

Further research questions are also apparent in relation to emotional security and trust. Since a violation of trust is involved in sexual abuse cases, how do varying personality types deal with violations of trust? Do some types bury the violation more deeply than other personality types?

A second group of possibilities for future research revolve around an issue directly related to the establishment of trust: fear and anxiety. Generalized anxiety is reported by many sexual abuse victims. More research is needed, therefore, on the perennial question of how generalized anxiety can be dealt with in therapy. Perhaps much more can be learned, especially in determining if new therapeutic methods can be developed to help

clients specify their generalized anxiety. A highly important area of future research in this connection would center upon the manner in which anxiety that comes from sexual abuse be sorted out from anxiety that comes from other sources. If the results of this research allow therapists to both more easily identify and treat sexual abuse, many people will be relieved of much of the difficulty they experience in the healing process.

Also important in this connection is the distinction between fear and depression as factors that must be overcome in order to recall memories. Further research could attempt to find answers to several questions. How does fear impede the recall of memories? How does depression impede the recall of memories? Do fear and depression have the same or different effects on memory recall? Why do younger respondents seem to express more fear, and older respondents more depression?

A third general area of concern for future research suggested by the findings of this study relates to the concept of meaning. What is the mental process through which meaning is attached to events? How can this process be facilitated? Why do some people search for the meaning of their experience more than other people? Why does this need to search for meaning come to some sooner in life, and others later? Can new techniques be devised that help people to attribute meaning to non-specific anxiety?

Research on the attribution of meaning could investigate the connection between meaning and memory retrieval with specific reference to memories of sexual abuse. At the time of the abuse victims sometimes dissociate or split the meaning of the event from the event itself. The research findings of this study suggest that when the memory is recalled, the meaning of the event is attributed to the event. This possibility should be verified with

further research. More research is also needed on how the dissociating process occurs, and how this process may be reversed so that an event and its meaning may be rejoined. In addition, research is needed on the meaning that is attributed by victims to the loss of trust they have experienced. The following questions are pertinent in this regard. What meaning do people attach to the experience when their bodies are penetrated, especially unwanted penetrations? What sense do people have of the integrity of their bodies, and what does it mean to individuals when this sense of integrity is violated? Also, does this meaning vary from one cultural setting to another?

A fourth group of possible research questions evolves from the possibility of personality differences in the ways in which people respond to both the experience and the treatment of sexual abuse. What personality factors are involved with the manner in which different people deal with sexual abuse? Which personality types have characteristics which tend to impede the course of memory recall? How can some personality factors be mitigated and others be enhanced?

A fifth group of potential future research questions revolves around the differences between internal and external stimuli. What is the significance of the difference between internal and external stimuli? How can the effects of both internal and external stimuli be determined? Research on abuse-related internal stimuli could quantify the occurrence of dreams, emotions, and sensory experiences, and investigate patterns that develop among these stimuli. Research on abuse-related external stimuli could center on quantifying types of external stimuli. Further, investigators could explore the ways in which therapists

introduce stimuli that lead to recall of sexual abuse experiences, a subject of much controversy in the field today.

Recommendations for Intervention in Therapy

The results of this research suggest that therapists treating clients who have been or may have been sexually abused should consider the following recommendations.

First, therapists should be aware that sexual abuse clients are individually unique in the manner in which the respond to abuse and in the series of events that lead to memory recall. No set pattern is the same for everyone. Second, therapists should be aware that their most important task is to help the client build trust in intimate relationships. To this end, therapists should try to help clients identify specific details about the client's generalized anxiety. Therapy is probably the most important setting for the rebuilding of emotional security. To this end, therapists should try to determine the extent of trust in the therapeutic relationship and in other relationships, and to remedy any defects in either area. Relationship concerns have brought many abuse victims to therapy, and therefore therapists should thoroughly explore relationship concerns with their clients. Since emotional security is the major factor in the return of abuse memories, it is also important to help the client find liberation from any current danger or abuse situation.

Uncovering the hidden meaning in shards of memories or dreams is also vital to the recall of memories. The biggest help to abuse clients is their own desire to locate the source of their distress, and so the desire for understanding should be encouraged. The

therapist can help the client to explore the meaning of distressing events and to explore the missing "pieces of the puzzle."

As clients identify important stimuli in their environments, therapists may help them find links, if there are any, with abuse experiences. The same techniques could be applied to internal stimuli important to clients. A focus on the construct of resilience may provide insight into what internal and external elements guide a person with an abuse history toward healthy behavior. Further, the development of resilience in general in clients may be found to help them to recall memories of abuse. By identifying what resilient qualities enhance adjustment to adult life in individuals with sexual abuse histories, therapists may be better equipped to provide focused treatment.

Finally, therapists should be aware of individual strengths and weaknesses, and cultural differences especially as they are related to the capacity to develop trust. A therapist who is sensitive to the specific concerns of different personalities or members of different cultural groups will be more able to help the client find the sense of emotional security so necessary to the recall of memories of abuse, and the healing that accompanies it. Effective and ethical psychotherapy includes an unbiased appraisal of clients' concerns, expressing a tendency to either dismiss claims of abuse, or a tendency to accept those claims in the absence of any exploration. By itself recalling memories which had been claimed to have been forgotten, does not bring healing. The goals of therapy need to include establishing resilient qualities, developing a sense of wholeness and well-being, and defining effective and meaningful relationships with others.

REFERENCES

Agosta , C . , & Loring , M . (1988) . Understanding and treating the adult retrospective victim of child sexual abuse. In S . M . Sgroi (Ed .) , Vulnerable Populations Volume I (pp. 115-135) . New York : Lexington Books.

Alexander , P . C . (1992) . Application of attachment theory to the study of sexual abuse . Journal of Consulting and Clinical Psychology , 60 , 185-195 .

Alpert , J . L . (1991) . Retrospective treatment of incest victims: suggested analytic attitudes . Psychoanalytic Review , 78 , 425-435 .

American Psychiatric Association . (1994) . Diagnostic and statistical manual of mental disorders (4th ed.) . Washington, DC : Author .

Armsworth , M . W . (1989) . Therapy of incest survivors : abuse or support? Child Abuse & Neglect , 13 , 549-562 .

Barclay , C . R . (1986) . Schematization of autobiographical memory . In D . C . Rubin (Ed.) , Autobiographical memory (pp 82-99) . New York: Cambridge University Press .

Bartholomew, K . , & Horowitz , L . M . (1991) . Attachment styles among young adults : A test of a four-category model . Journal of Personality and Social Psychology , 61 , 226-244 .

Bass , E . & Davis , L . (1988) . The Courage to Heal . New York : Harper & Row.

Bendig , A . W . (1956) . The development of a short form of the manifest anxiety scale. Journal of Consulting Psychology , 20 , 384 .

Berliner , L . & Conte , J . R . (1990) . The process of victimization : The victim's perspective . Child Abuse & Neglect , 14 , 29-40 .

Beutler , L . E . & Hill , C . E . (1992) . Process and outcome research in the treatment of adult victims of childhood sexual abuse : Methodological issues . Journal of Consulting and Clinical Psychology , 60 , 204-212 .

Bharam , D . M . (1989) . Statute of limitations for child sexual abuse offenses : A time for reform utilizing the discovery rule. Journal of Criminal Law & Criminology , 80 , 842-865 .

Blake-White , J . , & Kline , C . M . (1985) . Treating the dissociative process in adult victims of childhood incest . Social Casework : The Journal of Contemporary Social Work , Sept. , 394-410 .

Blaney , P . H . (1986) . Affect and memory: A review . Psychological Bulletin , 99 , 229-246 .

Brewin , C . R . , Andrews , B . , & Gotlib , I . H . (1993) . Psychopathology and early experience : A reappraisal of retrospective reports . Psychological Bulletin , 113 , 82-98 .

Briere , J . (1992a) . Methodological issues in the study of sexual abuse effects . Journal of Consulting and Clinical Psychology , 60 , 196-203 .

Briere , J . (1992b) . Child abuse trauma: Theory and treatment of lasting effects. Newbury Park: Sage Publications.

Briere , J . & Conte , J . (1989) . Amnesia in adults molested as children : Testing theories of repression . Paper presented at the annual meeting of the American Psychological Association, New Orleans, LA .

Briere , J . , & Runtz , M . (1989) . The trauma symptom checklist (TSC-33) : Early data on a new scale. Journal of Interpersonal Violence , 4 , 151-163 .

Brooks , B . (1985) . Sexually abused children and adolescent identity development . American Journal of Psychotherapy , 39 , 401-410 .

Brothers, B. J., (1985). Incest 1964 : Confusion and terror 1984. New York : Haworth Press.

Brown, R., & Kulik, J. (1977). Flashbulb memories. Cognition, 5, 73-99.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse : A review of the research. Psychological Bulletin, 99, 66-77.

Burgess, A. W., Groth, A. N., Holmstrom, L. L., & Sgroi, S. M. (1978). Sexual assault of children and adolescents. Lexington, MA : Lexington.

Button, E. J., & Whitehouse, A. (1981). Subclinical anorexia nervosa. Psychological Medicine, 11, 509-516.

Carmichael, L. L., Hogan, H. P., & Walter, A. A. (1932). An experimental study of the effects of language on the reproduction of visually perceived form. Journal of Experimental Psychology, 15, 73-86.

Ceci, S. J., & Bruck, M. (1993). Suggestibility of child witness : A historical review and synthesis. Psychological Bulletin, 113(3), 403-439.

Christianson, S. (1992). Remembering emotional events : Potential mechanisms. In Sven-Ake Christianson (Ed.) The handbook of emotion and memory : Research and theory (pp. 307-340). Hillsdale, NJ : Lawrence Erlbaum Associates.

Christianson, S., Goodman, J. & Loftus, E. F. (1992). Eyewitness memory for stressful events: Methodological quandaries and ethical dilemmas. In Sven-Ake Christianson (Ed.) The handbook of emotion and memory: Research and theory (pp. 217-241). Hillsdale, NJ: Lawrence Erlbaum Associates.

Clevenger, N. (1991-2). Statute of limitations : Childhood victims of sexual abuse bringing civil actions against their perpetrators after attaining the age of majority. Journal of Family Law, 30, 447-469.

Cook, T. D. & Reichardt, C. S. (Eds.) (1979). Qualitative and quantitative methods in evaluation research. Beverly Hills : Sage Publications.

Coons, P. M., Bowman, E. S., Pellow, T. A., & Schneider, P. (1989). Post-traumatic aspects of the treatment of victims of sexual abuse and incest. Psychiatric Clinics of North America, 12, 325-335.

Cooper, P. J., & Fairburn, C. G. (1986). The depressive symptoms of bulimia nervosa. British Journal of Psychiatry, 148, 268-274.

Cornell, W. F., & Olio, M. A. (1991). Integrating affect in treatment with adult survivors of physical and sexual abuse. American Orthopsychiatric Association, Inc.

Courtois, C. (1988). Healing the incest wound/adult survivors in therapy. New York: Norton.

Crowne, D. P. & Marlowe, D. (1964). The approval motive: studies in evaluative dependence. New York: Wiley.

Cutler, S. E., & Nolen-Hoeksema, S. (1991). Accounting for sex differences in depression through female victimization: Childhood sexual abuse. Sex Roles, 24, 425-438.

Dalgleish, T., Watts, F. N. (1990). Biases of attention and memory in disorders of anxiety and depression. Clinical Psychology Review, 10, 589-604.

Davies, J. M., & Frawley, M. G. (1994). Treating the adult survivor of childhood sexual abuse: A psycholanalytic perspective. New York: Basic Books.

Davis, P. J. (1990). Repression and inaccessibility of emotional memories. In J. L. Singer (Ed.), Repression and dissociation (pp 387-403). Chicago: University of Chicago Press.

Davis, P. J., & Schwartz, G. E. (1987). Repression and inaccessibility of affective memories. Journal of Personality and Social Psychology, 52, 155-162.

Dollard, J., & Miller, N. (1950). Personality and psychotherapy: An analysis in terms of learning, thinking, and culture. New York: McGraw-Hill.

Duffy , C . J . (1990) . Use of the discovery rule in cases of alleged child sexual abuse: Does the statute of limitations ever run? Duquesne Law Review , 28 , 777-783 .

Edwards , P . W . , & Donaldson , M . A . (1989) . Assessment of symptoms in adult survivors of incest: A factor analytic study of the responses to childhood incest questionnaire . Child Abuse and Neglect , 13 , 101-110 .

Emerson , R . M . (Ed.) (1983) . Contemporary field research . Prospect Heights, IL: Waveland Press.

Enns , C . Z . , McNeilly , C . L . , Corkery , J . M . , & Gilbert , M . S . (1995) . The debate about delayed memories of child sexual abuse . The Counseling Psychologist , 23 , 181-279 .

Erdelyi , M . H . (1990) . Repression, reconstruction, and defense : History and integration of the psychoanalytic and experimental frameworks . In J . L . Singer (Ed.) , Repression and dissociation (pp.1-32) . Chicago: University of Chicago Press.

Erikson , E . H . (1963) . Childhood and society . New York: Norton .

Finkelhor , D . (1979) . Sexually victimized children . New York : Free Press .

Finkelhor , D . (1986) . A sourcebook on child sexual abuse . Beverly Hills , CA : Sage .

Finkelhor , D . , Hotaling , G . T . , Lewis , I . A . , & Smith , C . (1989) . Sexual abuse and its relationship to later sexual satisfaction, marital status, religion, and attitudes . Journal of Interpersonal Violence , 4 , 379-399 .

Finkelhor , D . Hotaling , G . , Lewis , I . , & Smith , C . (1990) . Sexual abuse in a national survey of adult men and women: prevalence, characteristics and risk factors . Child Abuse and Neglect , 14 , 19-28 .

Fowler , F . J . (1993) . Survey research methods . London: Sage .

Fowler , F . J . & Mangione , T . W . (1990) . Standardized survey interviewing: Minimizing interviewer-related error . Newbury Park: Sage .

Frawley , M . G . (1990) . From secrecy to self-disclosure. In G . Stricker , & M . Fisher (Eds.) , Self-disclosure in the therapeutic relationship . New York: Plenum , 247-250 .

Frenken , J . , & Van Stolk , B . (1990) . Incest victims: Inadequate help by professionals . Child Abuse and Neglect , 14 , 253-263 .

Freud , S . (1957) Repression . In J . Strachey (Ed. and Trans.) The standard edition of the complete psychological works of Sigmund Freud , 3 , (pp. 187-222) . London : Hogarth .

Freud , S . (1896) . The aetiology of hysteria . In J . Strachey , A . Freud , A . Strachey, and A . Tyson (Eds . and Trans .) . The standard edition of the complete psychological works of Sigmund Freud . London : Hogarth Press .

Gardner , R . A . (1992) . True and false accusations of child sex abuse . Cresskill, NJ: Creative Therapeutics .

Gary , M . , & Loftus , E . (1994) . Repressed memories of childhood trauma: Could some of them be suggested? USA Today, January, 1994 .

Gelinas , D . J . (1983) . The persisting negative effects of incest . Psychiatry , 46 , 312-332 .

Gleitman , H . (1987) . Basic Psychology . New York: Norton .

Goldfarb , L . A . (1987) . Sexual abuse antecedent to anorexia nervosa, bulimia, and compulsive overeating: Three case reports . International Journal of Eating Disorders, 6 , 675-680 .

Goldstein , E . (1992) . Confabulations: Creating false memories, destroying families . Boca Raton: SIRS Books.

Goldwater , L . , & Duffy , J . F . (1990) . Use of the MMPI to uncover histories of childhood abuse in adult female psychiatric patients . Journal of Clinical Psychology , 46 , 392-399 .

Greenspan , G . S . , & Samuel , S . E . (1989) . Self-cutting after rape . American Journal of Psychiatry , 146 , 789-791 .

Groth , A . N . (1979) . Men who rape: the psychology of the offender . New York : Plenum .

Guenther , R . K . , & Frey , C . (1990) . Recollecting events associated with victimization . Psychological Reports , 67 , 207-217 .

Hall , C . S . (1954) . A primer of Freudian psychology . New York: Mentor .

Hansen , R . D . , & Hansen , C . H . (1988) . Repression of emotionally tagged memories : The architecture of less complex emotions . Journal of Personality and Social Psychology , 55 , 811-818 .

Hartman , M . , Finn , S . E . , & Leon , G . R . (1987) . Comparisons of familial and nonfamilial abuse . Psychotherapy , 24 , 154-159 .

Haugaard , J . J . , & Emery , R . E . (1989) . Methodological issues in child sexual abuse research . Child Abuse and Neglect , 13 , 89-100 .

Herman , J . L . , & Shatzow , E . (1987) . Recovery and verification of memories of childhood sexual trauma . Psychoanalytical Psychology , 4 , 1-14 .

Herman , J . L . (1992) . Trauma and recovery . New York : Basic Books .

Herman , J . & Troki , K . (1986) . Long-term effects of incestuous abuse in childhood . American Journal of Psychiatry , 143 , 1293-1296.

Hibbard , R . , & Zollinger , Terrell . (1990) . Patterns of child sexual abuse knowledge among professionals . Child Abuse & Neglect , 14 , 347-355 .

Holmes , D . S . (1990) . The evidence for repression: an examination of sixty years of research. In J . L . Singer (Ed.) , Repression and dissociation (pp. 85-102). Chicago: University of Chicago Press.

Hoshmand , L . L . S. T . (1989) . Alternate research paradigms: A review and teaching proposal. The Counseling Psychologist , 17: (1) , 3-79.

Kahr , B . (1991) . The sexual molestation of children: Historical perspectives . The Journal of Psychohistory , 19 , 191-214 .

Kahr , B . (1989) . The sexual molestation of children: historical perspectives . The Journal of Psychohistory , 2 , 192-211 .

Kalichman , S . C . , Craig , M . E . , & Crowe , C . M . (1986) . Incestuous abuse: Licensed and non-licensed clinicians' attitudes and reporting . Paper presented at the 94th meeting of the American Psychological Association, August, 1986 , Washington: D. C.

Kemp , R . & Kemp , H . (1984) . The common secret . New York: W . H . Freeman .

Kendall-Tackett , K . A . (1991) . Characteristics of abuse that influence when adults molested as children seek treatment . Journal of Interpersonal Violence , 6 , 486-493 .

Kihlstrom , J . F . , & Hoyt , I . P . (1990) . Repression, dissociation, and hypnosis . In J . L . Singer (Ed.) , Repression and dissociation (pp. 181-208) . Chicago : University of Chicago Press .

Kline , P . (1987) . The experiential study of the psychoanalytic unconscious . Personality and Social Psychology Bulletin , 13 , 363-378 .

Kluft , R . P . (1986) . High-functioning multiple personality patients . The Journal of Nervous and Mental Disease , 174 , 722-726 .

Kluft , R . P . (1991) . Clinical presentations of multiple personality disorder . Multiple Personality Disorder , 14 , 605-629 .

Konig, A. J. J. de (1979). The qualitative method of research in the phenomenology of suspicion. In A. Giorgi, R. Knowles, & D. L. Smith (Eds.), Duquesne studies in phenomenological psychology, 3, 122-134. Pittsburgh: Duquesne University Press.

Krug, R. S. (1989). Adult male report of childhood sexual abuse by mothers: Case descriptions, motivations and long-term consequences. Child Abuse and Neglect, 13, 111-119.

Lincoln, Y. S., & Guba, E. G. (1991). Naturalistic inquiry. London: Sage.

Lindsay, D. S., & Read, J. D. (1994). Psychotherapy and memories of childhood sexual abuse: A cognitive perspective. Applied Cognitive Psychology, 8, 281-338

Lipovsky, J. A., Saunders, B. E., & Murphy, S. M. (1989). Depression, anxiety, and behavior problems among victims of father-child sexual assault and nonabused siblings. Journal of Interpersonal Violence, 4, 452-468.

Lofland, J., & Lofland, L. H. (1984). Analyzing social settings: A guide to qualitative observation and analysis. Belmont, CA: Wadsworth.

Loftus, E. F. (1975). Leading questions and the eyewitness report. Cognitive Psychology, 7, 560-572.

Loftus, E. F. (1979). Eyewitness testimony. Cambridge, MA: Harvard University Press.

Loftus, E. F. (1992). The reality of repressed memories. Paper presented at the annual meeting of the American Psychological Association, Washington, D. C.

Loftus, E. F. (1993). The reality of repressed memories. American Psychologist, 48, 518-537.

Loftus, E. F., & Ketcham, K. (1991). Witness for the defense. New York: St. Martin's Press.

Loftus , E . F . , & Loftus , G . R . (1980) . On the permanence of stored information in the human brain . American Psychologist , 35 , 409-420 .

Loftus , E . F . , & Palmer , J . C . (1974) . Reconstruction of automobile destruction : An example of interaction between language and memory . Journal of Verbal Learning and Verbal Behavior , 13 , 585-589 .

Loftus , E . F . , Polonsky , S . , & Fullilove , M . T . (1994) . Memories of childhood sexual abuse: Remembering and repressing. Psychology of Women Quarterly , 18 , 67-84.

Love , P . (1990) . The emotional incest syndrome . New York: Bantam .

Maltz , W . , & Holman , B . (1987) . Incest and sexuality . Lexington, MA : Heath.

Mindlin , J . E . (1990) . Child sexual abuse and criminal statutes of limitation: A model for reform . Washington Law Review , 65:171 , 189-207 .

Moon , S . M . , Dillon , D . R . , & Sprenkle , D . H . (1990) . Family therapy and qualitative research . Journal of Marital and Family Therapy , 16 , 357-373 .

Mruk , C . J . (1986) . Toward a phenomenology of self-esteem . In A . Giorgi , A . Barton, & C . Maes (Eds.) , Duquesne studies in phenomenological psychology : 4 , 137-149 . Pittsburgh : Duquesne University Press .

Nabors , K . L . (1990) . The statute of limitations: A procedural stumbling block in civil incestuous abuse suits . Law and Psychology Review , 14:153 , 153-166 .

National Center for Prosecution of Child Abuse , (1992) . Draft legislation extending or removing the statutes of limitations for offenses against children . Alexandria: Author.

Olio , K . (1989) . Memory retrieval in the treatment of adult survivors of sexual abuse. Transactional Analysis Journal ; 19 , 93-100 .

Olio , K . A . , & Cornell , W . F . (1993) . The therapeutic relationship as the foundation for treatment with adult survivors of sexual abuse . Psychotherapy , 30 , 512-523 .

Paxton , C . (1991) . A bridge to healing: Responding to disclosures of childhood sexual abuse . Health Values , 15 , 49-56 .

Persinger , M . A . (1992) . Neuropsychological profiles of adults who report "sudden remembering" of early childhood memories: Implications for claims of sex abuse and alien visitation/abduction experiences . Perceptual and Motor Skills , _ , 259-266 .

Peters , S . D . (1988) . Child sexual abuse and later psychological problems . In G . E . Wyatt , & G . J . Powell , (Eds.) . Lasting effects of child sexual abuse (pp. 110-117) . Newbury Park, CA : Sage .

Piaget , J . (1979) . The child & reality: problems of genetic psychology . New York . Penguin Books .

Polkinghorne , D . (1989) . Phenomenological research methods . In R . S . Valle and S . Steen , (Eds.) . Existential-phenomenological perspectives in psychology : Exploring the breadth of human experience (pp. 41-60) . New York : Plenum .

Putnam , F . W . , Guroff , J . J . , Silberman , E . K . et al (1986) . The clinical phenomenology of multiple personality disorder: Review of 100 recent cases . Journal of Clinical Psychiatry , 47 , 285-293 .

Rathus , S . A . (1996) . Psychology in the new millennium , 6th ed. . New York : Harcourt Brace .

Revelle , W . , Loftus , D . (1990) . Individual differences and arousal : Implications for the study of mood and memory . Cognition and Emotion , 4 , 209-237 .

Risin , L . I . & McNamara , J . R . (1989) . Validation of child sexual abuse: the psychologist's role . Journal of Clinical Psychology , 45 , 175-184.

Rodgers , K . E . (1992) . Childhood sexual abuse: Perceptions on tolling the statute of limitations . Journal of Contemporary Health Law and Policy , 8 , 309-334 .

Russell , D . E . H . (1983) . The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children . Child Abuse and Neglect , 7 , 133-146.

Russell , D . E . H . (1984) . Sexual exploitation . Beverly Hills, CA : Sage .

Russell , D . E . H . (1986) . The secret trauma: Incest in the lives of girls and women . New York : Basic Books .

Santrock , J . W . & Yussen , S . R . (1992) . Child development: an introduction . Dubuque : Wm . C . Brown .

Sardella , S . (1994) . Child-protection system needs overhaul, says panel. The APA Monitor , February, p.34.

Scheff, T . J . (1979) . Cartharsis in healing ritual and drama . Berkeley : University of California .

Schwartz , G . (1990) . Psychobiology of repression and health : A systems approach. in J . L . singer (Ed.) , Repression and dissociation (pp. 405-433) . Chicago : University of Chicago Press .

Seng , M . J . (1986) . Sexual behavior between adults and children: some issues of definition . Journal of Offender Counseling, Services, & Rehabilitation , 11 , 47-61 .

Sgroi , S . M . (1988) . Vulnerable populations: Evaluation and treatment of sexually abused children and adult survivors . New York : Lexington Books .

Sgroi , S . M . (1992) . Child sexual abuse intervention: A look at what really works . Northwest Area Health Education Center seminar . Enid, Oklahoma .

Sgroi , S . M . & Bunk , B . S . (1988) . A clinical approach to adult survivors of child sexual abuse . In S. M. Sgroi (Ed.) , Vulnerable populations , 1 , 137-186 . Lexington, MA : Lexington Books .

Snyder , M . & Uranowitz , S . W . (1978) . Reconstructing the past: Some cognitive consequences of person perception . Journal of Personality and Social Psychology , 36 , 941-950 .

Stainback , S . , & Stainback , W . (1988) . Understanding and conducting qualitative research . Dubuque: Kendall/Hunt .

Strauss , A ., & Corbin , J . (1990) . Basics of qualitative research: Grounded theory procedures and techniques . Newbury Park: Sage .

Taylor , J . A . (1953) . A personality scale of manifest anxiety . Journal of Abnormal and Social Pschyology , 48 , 285-290 .

Terr , L . C . (1986) . What happens to early memories of trauma? A study of twenty children under age five at the time of documented traumatic events . A paper presented at the 1986 annual meeting of the American Psychiatric Association, Washington, D. C.

Terr , L . C . (1991) . Childhood traumas: An outline and overview . American Journal of Psychiatry , 148 , 10-19 .

Terr , L . C . (1994) . Unchained memories: True stories of traumatic memories, lost and found. New York: Basic Books .

Terwogt , M . M . , Kremer , H . H . , Stegge , H . (1991) . Effects of children's emotional state on their reactions to emotional expressions: A search for congruency effects . Cognition and Emotion , 5 , 109-121 .

Thompson , C . P . , & Cowan , T . (1986) . The neurobiology of learning and memory . Science , 233 , 941-947 .

Ucros , C . G . (1989) . Mood state-dependent memory : A meta-analysis . Cognition and Emotion , 3 , 139-167 .

van der Kolk , B . A . , & Greenberg , M . S . (1987) . The psychobiology of the trauma response: Hyperarousal, constriction, and addiction to traumatic reexposure . In B. A . van der Kolk (Ed.) , Psychological trauma (pp. 63-87) . Washington, DC: American Psychiatric Press .

van Kaam , A . (1969) . Existential foundation of psychology . New York : Image Books .

Weinberger , D . A . Schwartz , G . E . & Davidson , R . L . (1979) . Low-anxious, high-anxious, and repressive coping strategies: psychometric patterns and behavioral and physiological responses to stress . Journal of Abnormal Psychology , 88 , 369-380 .

Weiner , L . J . (1988) . Issues in sex therapy with survivors of intrafamily sexual abuse. Haworth Press .

Wells , G . L . & Loftus , E . F . (1984) . Eyewitness testimony: Psychological perspectives . Cambridge: Cambridge University Press.

Wilk , R . J . , & McCarthy , C . R . (1986) . Intervention in child sexual abuse: A survey of attitudes . Social Casework: The Journal of Contemporary Social Work , January , 20-26 .

Williams , L . (1994) . Recall of childhood trauma : A prospective study of women's memories of child sexual abuse. In press , Journal of Consulting and Clinical Psychology .

Wolf , A . & Alpert , J . L . (1991) . Psychoanalysis and child abuse . Psychoanalytic Psychology , 8 , 305-327 .

Wyatt , G . E . (1985) . The sexual abuse of Afro-American and White-American women in childhood . Child Abuse and Neglect , 9 , 507-519 .

Wylie , M . S . (1993) . The shadow of a doubt . Networker . September/October, 18-73 .

Yapko , M . (1993) . The seductions of memory . Networker . September/October , 31-37 .

Yin , R . K . (1991) . Case study research: Design and methods . London: Sage .

Yin , R . K . (1989) . Case study research: Design and methods (2nd. ed.) . Beverly Hills, CA: Sage .

APPENDIX A

FORMAT FOR THE GUIDED INTERVIEW

Format for Minimally Guided Interview Process

- What do you remember about the experience of recalling the memory of sexual abuse?
- When you did remember, what effect did it have on you?
- In what ways did your life or relationships change after recalling the sexual abuse experience?
- How did you cope with these memories and these changes?
- Where were you when you retrieved memories?
- What of interest was happening in your life at the time of recall?
- Did the memory return all at once, or in fragments, or gradually over time?

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Your identity will remain confidential. Please provide the following information about yourself:

Age:___________________
Sex: ____ Female ____ Male
Date at which your memory of sexual abuse was recalled.______________________
Were you in therapy at the time that the memory was recalled? ___ Yes ___ No?

If so, what type of therapy? ____ Individual ____ Group.

The therapist you were seeing at the time of the recall of memory was ____ Male ____ Female.

This therapist was of approximately what age? ______

How many different therapists, altogether, had you seen before the memory of sexual abuse was recovered? ____

What brought you to the therapy you are currently receiving?

____

Have you taken other actions to deal with the abuse, such a joining a support group? What have you done in this regard?_____________________________________

How old were you when the sexual abuse began? ____
How long did the abuse last? ____________________
How old were you when the sexual abuse ended? ___

What was the relationship of the perpetrator(s) to you?__________________________

How violent or coercive was the sexual abuse experience? Rate the violence and coercion on a scale from 1 to 5. 1 is the least coercive or violent, and 5 is the most coercive or violent. Circle one:

1 2 3 4 5

Memory Recall Questionnaire

During the six months prior to the moment when you recalled a memory of childhood sexual abuse, which of the following did you experience? Please mark (x) in the box next to all items that apply.

- ❑ class reunion
- ❑ family reunion
- ❑ marriage
- ❑ divorce
- ❑ birth of a child. Your age at their birth was___Child's birth order ___.Your birth order___
- ❑ death of a parent. Parent's age____
- ❑ death of the perpetrator of sexual abuse. His/her age at death____.
- ❑ death of brother or sister. Age of the brother or sister at death_________
- ❑ death of relative. Relationship_____ Age at death ____
- ❑ a renewed exposure to the environment where abuse occurred.
- ❑ health problem or illness. Describe: ________________________
- ❑ depression
- ❑ gaining or losing excessive weight
- ❑ having an aversion to or feeling anxious about particular smells
- ❑ feeling uncomfortable with certain ways of being touched
- ❑ feeling uncomfortable with particular sexual positions
- ❑ feeling uncomfortable when hearing heavy breathing
- ❑ feeling uncomfortable or anxious when being alone in bed at night.
- ❑ feeling uncomfortable or anxious at certain times of night
- ❑ sleeplessness.
- ❑ seeing newspaper accounts
- ❑ seeing old letters or family memorabilia
- ❑ seeing old medical records
- ❑ going on vacation.
- ❑ experiencing a hospital stay.
- ❑ seeing educational announcements about sexual abuse on t.v.
- ❑ receiving sex education.
- ❑ being asked a question about inappropriate sexual touching
- ❑ being asked a question: have you been sexually abused?
- ❑ being a member of a support group (not group therapy)
- ❑ participating in group therapy
- ❑ receiving individual therapy
- ❑ having a particular dream
- ❑ having a recurrent dream.
- ❑ having a recurrent recollection of an event
- ❑ having a distressing recollection of an event
- ❑ experiencing intense distress at an event such as an anniversary of a trauma
- ❑ inability to recall an event or an aspect of an event
- ❑ having a sense of a foreshortened future
- ❑ difficulty falling or staying asleep
- ❑ irritability or outbursts of anger
- ❑ difficulty concentrating
- ❑ hypervigilance
- ❑ fear of losing your mind.
- ❑ feeling of detachment or alienation from someone else or others
- ❑ difficulty in relating to a male or female in a role of authority.
- ❑ my therapist suggested I may have been sexually abused
- ❑ disclosure of sexual abuse by a sibling.
- ❑ sexual abuse of your own son or daughter

Please write in any experience that you believe led to recall of a memory of your childhood sexual abuse:

Please write in any experience that is not on the above list that happened in the six months prior to the moment when you recalled the sexual abuse. Write in as many such experiences as occur to you:

Please describe how you dealt with your feelings after recalling memories. What inner resources and strengths do you credit with helping you cope with and integrate these new awarenesses? What external support helped you deal with these experiences?

APPENDIX D
LETTER TO THERAPIST

Letter to the Therapist

Dear Therapist,

I am seeking a sample of adult men and women who have within the past five years recovered previously repressed memories of childhood sexual abuse. I will be asking respondents to participate in a taped, personal interview, and to complete a Demographic Questionnaire and a Memory Recall Questionnaire. The approximate time for the personal interview is fifty minutes, for the demographic questionnaire, ten minutes, and for the recall questionnaire, twenty minutes.

I am seeking clients who have recalled memories for childhood sexual abuse under any one of the following three conditions: recall of memories prior to psychotherapy, after initiation of therapy but not during the therapy hour, and during the therapy session. I will limit the number of participants to no more than two per agency or therapist. It is of interest to the researcher what might be learned from the comparison of these three groups about the process of recall of repressed memories of childhood sexual abuse.

The purpose of this study is to explore the process of recall of repressed memories of childhood sexual abuse. The principal investigators are not interested in the details of the past sexual abuse itself and will not seek that information. Since there is much controversy regarding not only the validity of the idea of repression but also the accuracy of recovered memories, therapists' knowledge of the recall process desperately needs to be expanded. This research will contribute to the understanding in this area, which at present is scant.

The appropriate participant will demonstrate the following:

A. Inclusion criteria

1. Will have had the experience of recalling a repressed or delayed memory within the past five years.
2. Be able to clearly describe the experience of recalling the sexual abuse memories.
3. Be emotionally able to participate.

The inappropriate participant will have any one of the following:

B. Exclusion criteria

1. Any suicide attempts in the past five years.
2. A history of psychotic episodes requiring hospitalization.
3. Chronic dissociative patterns.
4. Major depression
5. Be actively engaged in litigation relating to sexual abuse.
6. Be actively considering litigation relating to sexual abuse.

The researcher will be vigilant throughout the interview for signs of increasing anxiety, depression, or other distress evident in the participant. An evaluation of the participant at the end of the session will ascertain if any debriefing will be necessary. To accomplish this the interviewer will use her clinical skills and best judgment to determine if additional time should be spent in remediating any distress. The current therapist will be informed if any distress as a function of the interview requires therapeutic follow-up.

Yours truly,

Jill M. Scott, M.S.

APPENDIX E
SOLICITATION TO PARTICIPANTS

Solicitation to Volunteer Participants

Dear Participant,

I am seeking to interview adult men and women who have recalled, within the past five years, repressed memories of childhood sexual abuse. I will ask permission to tape record the personal interview during which you will describe to me the conditions under which memories of childhood sexual abuse returned. It is the experience of recall which is of interest to this project. You will not be asked to describe or give details of the past sexual abuse experience itself. I am interested in your understanding of the experiences that you believe led to your recall of sexual abuse. I will also be asking volunteer participants to complete a demographic questionnaire and a Memory Recall Questionnaire which will take about twenty minutes.

Discussing former sexual abuse may be unpleasant. At any point in the interview process that you experience distress or anxiety, you may stop the interview without penalty. We will take the time necessary to remediate any distress as a function of the interview.

Yours truly,

Jill M. Scott, M.S.

APPENDIX F
INFORMED CONSENTS

Informed Consent Form
for participation in a research investigation
conducted under the auspices of the University of Oklahoma,
Norman Campus.

This study is entitled **Factors Associated with Recall of Repressed Memories of Childhood Sexual Abuse**. The principal investigator is Jill M. Scott and the Sponsor is Russell Koch, Ph.D.

I, ______________________________________, hereby authorize or direct Jill M. Scott to perform the following interview and to administer questionnaires:

This study will explore the adult experience of recall of repressed memories of childhood sexual abuse. It will gather information about and identify phenomena which are associated with the recall of repressed memories of childhood sexual abuse. The purpose of this research is to add to current understanding factors associated with the recall process. At present, there is very little known about the experience and how it can instruct therapists to be more effective in the helping process in response to adult men and women who have recalled memories.

The procedure will involve a minimally structured interview of approximately one hour in duration, which will be tape recorded. The Demographic Questionnaire will take approximately ten minutes, and the Memory Recall Questionnaire will take about twenty minutes to complete. Both of these will be administered after the interview.

The interviewer will not refer to the interviewee by name and the tape recording and/or the interview may be interrupted or stopped at any time without penalty. Transcription made from the tape recording of the interview will not include names and the audio tape recording will be destroyed upon completion of the transcription. The transcript will remain with the interviewer. Confidentiality is assured in this procedure and will be maintained. I understand that if I disclose intent to harm myself or others, the researcher may report that intent to the current therapist and, when appropriate, to the proper authorities. I understand that if I disclose knowledge of current sexual abuse, physical abuse, or neglect of a child under the age of eighteen, the researcher is required to report that information to the Department of Human Services. The Demographic Questionnaire and the Memory Recall Questionnaire will be attached to the transcription.

This study represents minimal risk to participants. Possible discomforts would be those arising from the discussion of a potentially sensitive issue and it is possible that you may experience distress as you discuss these issues during the interview or sometime later. The interviewer will use her clinical skills and best judgment to determine if additional time should be spent in remediating any distress. Your current therapist will be notified if further debriefing is needed.

Potential benefits to society include (1) informing the helping profession of factors associated with recall of repressed memories of childhood sexual abuse, (2) informing our current understanding of the experience of recall of memories of childhood sexual abuse, (3) contributing to vitally needed models for educational training for those therapists involved with the treatment of childhood sexual abuse. The eventual application of the new knowledge may help shorten the elapsed time between the onset of repression and the lifting of repression, as well as reduce the amount of time in therapy and number of therapists seen before recovery of the repressed memories.

I understand that participation is voluntary, that there is no tangible reward for participating, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty.

For answers to pertinent questions about research subjects' rights I may contact Jill M. Scott at telephone number (405) 325-2700 or (405) 359-8982, or Ms. Stepheni Griffin, (405) 325-4511, of Office of Research Administration, 1000 Asp Avenue, Room 314, Norman, OK 73019-0430.

I have read and fully understand the consent from. I sign it freely and voluntarily. A copy has been given to me.

Date: _________________ Time: __________________

Signed: ____

(signature of participant)

I certify that I have personally explained all elements of this form to the subject before requesting the participant to sign it.

Signed: ____

(signature of graduate student researcher)

Consent Form

I, ____, hereby authorize or direct Jill M. Scott to perform the following interview and to administer questionnaires:

This study will explore the adult experience of recall of repressed memories of childhood sexual abuse. It will gather information about and identify phenomena which are associated with the recall of repressed memories of childhood sexual abuse. The purpose of this research is to add to current understanding factors associated with the recall process. At present, there is very little known about the experience and how it can instruct therapists to be more effective in the helping process in response to adult men and women who have recalled memories.

The procedure will involve a minimally structured interview of approximately one hour in duration, which will be tape recorded. The Demographic Questionnaire will take approximately ten minutes, and the Memory Recall Questionnaire will take about twenty minutes to complete. Both of these will be administered after the interview.

The interviewer will not refer to the interviewee by name and the tape recording and/or the interview may be interrupted or stopped at any time without penalty. Transcription made from the tape recording of the interview will not include names and the audio tape recording will be destroyed upon completion of the transcription. The transcript will remain with the interviewer. Confidentiality is assured in this procedure and will be maintained. The Demographic Questionnaire and the Memory Recall Questionnaire will be attached to the transcription.

This study represents minimal risk to participants. Possible discomforts would be those arising from the discussion of a potentially sensitive issue and it is possible that you may experience distress as you discuss these issues during the interview or sometime later. The interviewer will use her clinical skills and best judgment to determine if additional time should be spent in remediating any distress. Your current therapist will provide services if further debriefing is necessary.

Potential benefits to society include (1) informing the helping profession of factors associated with recall of repressed memories of childhood sexual abuse, (2) informing our current understanding of the experience of recall of memories of childhood sexual abuse, (3) contributing to vitally needed models for educational training for those therapists involved with the treatment of childhood sexual abuse. The eventual application of the new knowledge may help shorten the elapsed time between the onset of repression and the lifting of repression, as well as reduce the amount of time in therapy and number of therapists seen before recovery of the repressed memories.

This is done as part of an investigation entitled Factors Associated with Recall of Repressed Memories of Childhood Sexual Abuse.

I understand that participation is voluntary, that there is no tangible reward for participating, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty.

For answers to pertinent questions about research subjects' rights I may contact Jill M. Scott at telephone number (405) 744-6036 or (405) 359-8982, or Ms. Jennifer Moore, (405) 744-5700, of University Research Services, 001 Life Science East, Oklahoma State University, Stillwater, OK 74078.

In summary:
1. I give my permission for tape recording the interview.
2. I understand I am free to withdraw from the interview and/or the questionnaires at any time without penalty.
3. I understand that if I disclose intent to harm myself or others, the researcher is obligated to report that intent to the current therapist and/or to the appropriate authorities.
4. I understand that if I disclose knowledge of current sexual abuse, physical abuse, or neglect of a child under the age of eighteen, the researcher is required to report that information to the Department of Human Services.

I have read and fully understand the consent from. I sign it freely and voluntarily. A copy has been given to me.
Date: __________________ Time: ____________________
Signed: ____
(signature of participant)
I certify that I have personally explained all elements of this form to the subject before requesting the participant to sign it.
Signed: ____
(signature of graduate student researcher)

2

VITA

Jill MacKay Scott

Candidate for the Degree of

Doctor of Philosophy

Thesis: FACTORS ASSOCIATED WITH THE RECALL OF MEMORIES OF CHILDHOOD SEXUAL ABUSE

Major Field: Applied Behavioral Studies

Biographical:

Personal Data: Born in Millinocket, Maine, November 2, 1947, the daughter of Robert G. MacKay and Jean T. MacKay.

Education: Graduated from Stearns High School, Millinocket, Maine, June 1966; received Bachelor of Arts Degree in Geography/Anthropology from University of Southern Maine in January 1987; received Master of Science Degree in Applied Behavioral Studies from Oklahoma State University in December 1990. Completed the requirements for the Doctor of Philosophy Degree at Oklahoma State University in December 1995.

Experience: Family & Children's Services, Inc., Tulsa, OK., 8/90-7/91, provided therapy and sexual abuse education to individuals and families; Doctoral Practica: Edwin Fair Community Mental Health Center, Stillwater, OK., 8/91-8/92, provided therapy; University Counseling Services, Oklahoma State University, Stillwater, OK., 8/92-5/93, provided therapy and community outreach; Oklahoma State University, Stillwater, OK., 8/91-5/94, taught 8 courses and assisted with 4 courses. Oklahoma Health Consortium Residency in Clinical Psychology, American Psychological Association approved pre-doctoral internship 8/94-8/95. Adjunct teacher, Tulsa Junior College, 1991; Rose State College, 1995.

Professional Memberships: American Psychological Association, Oklahoma Psychological Association