

WHO NEEDS REPRESSION?

Normal Memory Processes Can Explain "Forgetting" of Childhood Sexual Abuse

Susan A. Clancy and Richard J. McNally
Harvard University

Twenty-seven adults reporting "recovered memories" of childhood sexual abuse (CSA) were interviewed to determine (1) whether they perceived their CSA to be traumatic (e.g., terrifying, life threatening) at the time it occurred, (2) why they believe they "forgot" their CSA memories, and (3) whether they report current psychological symptoms, negative life effects, or both related to their abuse. Only 7% of the group described the abuse as traumatic at the time it occurred. Eighty-nine percent endorsed ordinary forgetting mechanisms (e.g., avoidance, lack of rehearsal, retrieval failure) to explain why they had forgotten their abuse. Seven subjects met criteria for current CSA-related PTSD and all reported multiple negative life effects related to their abuse (i.e., difficulty trusting others, sexual problems, shame). Data are consistent with the hypothesis that (1) CSA that is "forgotten" and then "remembered" was not necessarily traumatic *at the time it occurred*, (2) CSA can be forgotten via normal forgetting mechanisms, and (3) it may be the retrospective interpretation of the event as traumatic, rather than the event itself, that mediates any subsequent impact.

INTRODUCTION

Some adults report recalling childhood sexual abuse experiences that they had not thought about for many years (colloquially, they "forgot" them). Many trauma theorists explain this forgetting by positing an involuntary, automatic mechanism that renders painful material inaccessible to consciousness (e.g., Briere & Conte, 1993; Elliot & Briere, 1995; Herman & Schatzow, 1987; Williams, 1995). Putative mechanisms include repression and dissociation (Brown, Schefflin, & Hammond, 1998, p. 647; Freyd, 1996; Terr, 1991). Such mechanisms are proposed because child sexual abuse is invariably understood as a traumatic stressor for the child—a painful or overwhelming event likely to produce strong adverse emotional responses—and such events are presumed unlikely to be forgotten in "ordinary" ways.

Other researchers disagree (e.g., Loftus, 1993). They believe that memories of CSA can slip from awareness in the same way that ordinary material can—due to normal memory processes (e.g., voluntary suppression,

insufficient retrieval cues, avoidance, lack of rehearsal, normal forgetting; McNally, Clancy, Barrett, & Parker, 2004; Schooler & Hyman, 1997). Further, they do not assume that the CSA memories were *inaccessible* during the period when the person did not think about them (e.g., Pope & Hudson, 1995). A failure to think about something is not the same as being *unable* to remember it (McNally, 2003a, p. 2).

Although trauma theorists are reluctant to invoke "ordinary forgetting" as an explanation for why people might not think about their CSA for long periods of time, survey data do indicate that victims may not think about their CSA for years (i.e., they "forget" it), either because they did not experience it as traumatic at the time it occurred (Finkelhor, 1979; Loftus, Polonsky, & Fullilove, 1994; Russell, 1986), because they did not understand it as sexual at the time (Epstein & Bottoms, 2002; Finkelhor, 1979; Joslyn, Carlin, & Loftus, 1997), or because they made conscious efforts to avoid thinking about it (Epstein & Bottoms, 2002; Melchert, 1999; Melchert & Parker, 1997). Furthermore, experimental data indicate that attempts to forget information—both neutral and emotional—can, in some cases, lead to its decreased accessibility on subsequent recall tests (Anderson & Green, 2001; Rassin, Merckelbach, & Muris, 2000).

To elucidate the phenomenology of "recovered memories" of CSA, we interviewed 27 adults who reported recalling CSA memories after long periods of

This research was supported by NIMH grant MH61268 awarded to the second author.

Correspondence concerning this article should be addressed to Susan A. Clancy, INCAE—Campus Francisco de Sola, Carretera Sur, Km. 15.5, Managua, Nicaragua; e-mail: Susan.Clancy@incae.edu.

having not thought about these experiences. A semi-structured questionnaire, the Childhood Sexual Abuse Interview (CSAI), was developed for this purpose. The interview covers characteristics of the abuse (e.g., single versus multiple episodes, identity of perpetrators, type of abuse), and how the victims understood or experienced the abuse at the time it occurred (e.g., Was it painful? Did you know what was happening? How traumatic was it?). In addition, subjects were asked why they believe they forgot the abuse and subsequently remembered it years later.

We had three main questions. First, Was the abuse experienced as traumatic (e.g., life threatening, overwhelming, terrifying) at the time it occurred? To date, in no study on people reporting forgetting and remembering of CSA have researchers actually asked subjects this question. Instead, any "forgetting" of CSA experiences reported by subjects (e.g., Briere & Conte, 1993; Elliot & Briere, 1995; Herman & Schatzow, 1987; Williams, 1995) is often adduced as support for repression (unconscious, involuntary forgetting) despite the lack of evidence that the memories were, in fact, inaccessible during the period of time when they never came to mind. Whether or not the "forgotten" childhood sexual experiences were experienced as traumatic when they occurred is an empirical question that remains untested.

Our second main question was, Why do the subjects believe that they "forgot" their abuse? Although research on qualitative differences in victims' perceptions of their forgetting is scarce, three studies show that victims seldom characterize their forgetting as unconscious and automatic (Epstein & Bottoms, 2002; Melchert, 1996; Melchert & Parker, 1997). Instead, most victims thought their forgetting resulted from ordinary mechanisms (e.g., lack of rehearsal, avoidance, and retrieval failure). If subjects retrospectively report that the abuse was experienced as nontraumatic (albeit uncomfortable, embarrassing, and shameful) at the time it occurred, and if subjects report consciously trying not to think about it, this provides support for the hypothesis that CSA may be forgotten and then remembered in the same way that other unpleasant experiences can be—due to ordinary memory processes.

Third, the CSAI asks subjects how they perceive the abuse today and how they believe it may have affected their lives (e.g., Was it traumatic? Do you think that it affected your life?). Related to this, we assessed for current symptoms of depression, dissociation, and posttraumatic stress disorder (PTSD). Even if subjects did not experience the CSA as traumatic *at the time of its occurrence*, they may retrospectively appraise it as a traumatic

stressor—one that they report had a negative impact on their lives and resulted in symptoms of PTSD. The potential of CSA to adversely affect some victims' emotional and behavioral development and adjustment has been demonstrated in the literature. However, research also indicates that CSA does not inevitably cause a specific profile of emotional responses (e.g., Kendall-Tackett, Williams, & Finkelhor, 1993; Rind, Tromovitch, & Bauserman, 1998). What factors mediate any link between CSA and outcome? Twenty years of research on objective characteristics of the abuse (e.g., severity, duration, identity of perpetrator) has yielded inconsistent results (e.g., Kendall-Tackett et al., 1993; Lauman, Gagnon, Michael, & Michaels, 1994; Rind et al., 1998). If victims do not report the abuse as "traumatic at the time it occurs" but still report social, psychological, and occupational dysfunction in the aftermath, this would suggest that factors other than objective characteristics of the abuse mediate the link between CSA and adjustment (e.g., Holman & Silver, 1996; Kolko, Brown, & Berliner, 2002).

METHOD

Recovered memory subjects were recruited through advertisements placed in newspapers that read:

Were you sexually abused as a child?
Do you think you might have been sexually abused?
Do you have no history of childhood sexual abuse?

Entry into the study was contingent upon the subjects (1) having experienced an episode of sexual abuse ranging from fondling to penetration (e.g., anal, oral, vaginal) prior to the age of 15 with a perpetrator who was at least 5 years older than the participant and (2) having a period of time in which they repressed, forgot, or otherwise were not aware of their abuse histories. Consistent with how forgetting has been assessed in previous studies (e.g., Briere & Conte, 1993; Elliot & Briere, 1995; Herman & Schatzow, 1987), subjects in the "recovered memory group" reported at least one autobiographical memory of CSA that came to mind after many years of having not thought about it. Again, in accordance with previous studies, we did not require that the abuse be traumatic (i.e., overwhelmingly terrifying or perceived as life threatening) at the time it occurred. Respondents received a phone screen (conducted by the first author) that determined their eligibility for the study. Subjects who met criteria were scheduled for an interview at our laboratory.

The recovered memory group consisted of 27 adults

(17 female, 10 male). The average age of the subjects was 41.1, and the average years of education completed was 14.9.

During the subjects' visit to our laboratory, the first author fully explained the study and obtained written informed consent before administering the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 1995). Current Axis I diagnoses included major depression ($n=1$), dysthymia ($n=2$), bipolar disorder ($n=1$), specific phobia ($n=1$), and generalized anxiety disorder ($n=1$). Following completion of the SCID, subjects were administered the Post-traumatic Stress Symptoms Inventory (PSS; Foa, Riggs, Dancu, & Rothbaum, 1993). Nine subjects met criteria for PTSD: 7 related to their CSA and 2 related to other traumatic events.

Subjects then received the CSAI. Interviews were audiotaped and transcribed. For those that requested it ($n=5$), treatment options were discussed.

To characterize our subjects further, we asked them to complete the Dissociative Experiences Scale (Bernstein & Putnam, 1986) a measure of dissociative symptoms (e.g., "spacing out," memory lapses), the Absorption Scale (Tellegen & Atkinson, 1974) a measure of proneness to become engaged in imaginative experiences—a correlate of fantasy proneness, and the Beck Depression Inventory (Beck & Steer, 1987) a measure of depressive symptoms. Mean scores and standard deviations on these instruments were 6.7 (10.4), 20.1 (6.4), and 11.7 (7.4), respectively.

RESULTS

The mean number of abuse episodes reported by subjects was 1.7. Thirteen subjects reported that they were abused multiple times, but were unsure of the exact number. The average age at which victims were abused was 7.7 years.

In every case the victim knew the perpetrator ($n=27$). Perpetrators included: family friend ($n=4$), brother ($n=4$), stepfather ($n=4$), father ($n=3$), uncle ($n=2$), cousin ($n=2$), camp counselor ($n=2$), priest ($n=2$), grandfather ($n=2$), mother ($n=1$), aunt ($n=1$), and teacher ($n=1$). Only one person (female) reported more than one perpetrator (mother and father). In all but two cases the alleged perpetrators were male.

The type of abuse reported ranged from fondling of the genitals ($n=15$) to oral sex ($n=8$) to vaginal penetration ($n=2$) and anal penetration ($n=2$, both male). Six subjects reported more than one type of abuse. Two

reported both fondling and penetration and were placed in the penetration group. Four reported both fondling and oral sex and were placed in the oral sex group.

On average, subjects were 29 years old when they recovered their memories and the mean number of years between the CSA and memory recovery was 21.5. Recall reminders were being asked ($n=3$), overhearing a father tell his daughter to get into bed with him ($n=1$), getting aroused by girls during puberty ($n=1$), moving out of the house for the first time ($n=1$), TV movie about anorexia ($n=1$), high school class on recovered memories ($n=1$), being in Alcoholics Anonymous ($n=3$), reading about someone else's abuse experience ($n=1$), reflecting on childhood ($n=2$), friend's disclosure ($n=2$), similar abuse situation occurring ($n=1$), significant other's disclosure of abuse ($n=3$), being in therapy ($n=2$), a traumatic event ($n=2$), and getting sober ($n=1$). Two people reported having no idea why they remembered their abuse histories; "it just popped in," they said.

Twenty-one out of 27 subjects (78%) reported seeking therapy at some point in their lives. Reasons for therapy were as follows: depression, anger, eating disorders, alcohol/drugs, sexual problems, relationship problems, life issues, and career requirement (psychoanalytic training). Three people reported seeking therapy *after* they recovered their memories to assist them in the coping process. Only one person sought therapy (breath work) *in order to recover* CSA memories believed to be repressed.

Three people were undergoing therapy during the period of time in which they recovered their memories; only one was actually in the therapist's office when she recovered her memories.

Subjects were confident about the accuracy of their memories. On a 10-point confidence scale (10 = extremely confident, 1 = not confident at all) the average confidence rating was 9.4.

Only two subjects reported experiencing their abuse as terrifying, life threatening, or overwhelming (i.e., as traumatic) at the time it occurred. In one case the memories were so bizarre that we question their authenticity ("My mother was twisting my nipples and yanking my pubic hair . . . it would go on for hours . . ."). In the other case, the subject reported, "My grandfather raped me. He was on top of me, moving . . . pain . . . there was blood on my sheet." In all other cases ($n=25$, 93%) the CSA was described as unpleasant or distressing, but not traumatic. Terms such as "confusing," "weird," and "uncomfortable" were consistently used by these subjects to describe their experience.

Subjects' abuse descriptions included the following:

- "He didn't hurt me and I was too young to think of it as sexual . . . the experience just didn't fit into my notions of right and wrong" (a victim of oral sex).
- "I had no idea what was going on. . . . I knew he was an authority figure so I figured he must know what he's doing. . . . I didn't like it, knew it was wrong, but it didn't really hurt, it felt good. If anything I was embarrassed" (a male victim of oral sex).
- "I went from confused to bewildered to scared . . . it culminated in me feeling somewhat angry and betrayed" (a female victim of genital fondling).
- "Man, I knew it was wrong, but not why. . . . I started to think maybe I was doing something wrong" (a male victim of oral sex).
- "It was weird, I kind of liked the attention" (a female victim of genital fondling).
- "I remember thinking this person would like me more if I did it . . . but I knew something didn't seem right about it . . ." (a male victim of oral sex).
- "I didn't know what was going on. I didn't know, but I knew something was wrong" (a female victim of genital fondling).
- "I didn't think of it as sex, I just thought of it as disgusting . . ." (a female victim of oral sex).
- "Like the earliest things I remember were it like being pleasurable you know and that being like just what we did on Grandpa's lap when we watched TV . . ." (a female victim of genital fondling).
- "It hurt."
- "It felt wrong."
- "I was just confused and definitely feeling dirty, especially when I was forced to perform oral sex, I mean I couldn't breathe, I was like dying to get out of there. . . ."
- "First I felt confused, then I was shocked at what was happening, and I think I was afraid, there was a lot of weirdness, insecurity, a lot of anger."
- "I was not comfortable with what he was doing."
- "I knew it was wrong, but I didn't know what to do. I started to think I was doing something wrong."
- "I only knew it was wrong because he told me not to tell my mother and he would be real quiet, he'd tell me not to make any noise."
- "At the time I knew I shouldn't be doing it . . . you know like . . . there's something that doesn't seem right. . . ."
- "We were hiding it so I knew it wasn't right."
- "I don't remember what I thought was going on but I knew it was wrong. . . . I thought it was my fault."
- "He was acting remorseful afterwards."

Subjects were asked to rate their CSA on a 10-point scale (10 = extremely traumatic, 1 = not traumatic at all). Although only 2 subjects reported abuse descriptions consistent with the definition of a traumatic event, the average trauma rating was 7.5.

All 27 subjects (100%) reported multiple adverse effects from the abuse. Five (19%) said that it undermined their trust in other people. Seven (30%) reported difficulties in relationships. Five (19%) reported sexual problems. Two men who identified themselves as gay linked their sexual orientation to the experience (e.g., "This is how I learned about sex . . . it's why I'm gay"). Four (15%) reported self-esteem problems (i.e., "I decided at the age of 9 not that God didn't exist, but that he certainly didn't love me . . . it was devastating . . . I felt like I was nobody"). Three (11%) reported mental health problems (i.e., "It explains why I'm so screwed up"). Four (15%) related it to their history of drug and alcohol abuse. Six (22%) reported that the abuse affected all aspects of their lives (i.e., "It created a whole bunch of issues for me surrounding trust, intimacy, control and food, and other people. It's affected all my life. There's nothing untouched"). Five (19%) reported feeling cut off from others or alienated because of the abuse (i.e., "I had to live in secrecy for so long that I was like not there . . . I always felt separate, different"; "It's an erasure of self"). Three (11%) reported a loss of innocence (i.e., "I never had a childhood, never knew innocence"; "There's an innocence taken from you").

Of the four victims who reported penetration, two (both female) reported descriptions that were consistent with trauma (reported above). The two men, while reporting that the anal rape was painful, did not describe it as traumatic. In the words of one of the victims, "He would always say if you love me you'll do it. It hurt, and after a while I knew it was wrong, but not at the beginning." The other victim of penetration reported, "I didn't like it—I knew it was wrong—but it was better than having to go back to DYS [Department of Youth Services custody]."

Although subjects were asked to describe their abuse experiences in their own words, they were also specifically asked whether the experience was painful, whether they understood it as sexual, and whether they knew, at the time, that it was wrong. Three out of 27 (11%) reported that it was painful. Only 2 out of 27 (7%) were aware that the experience was sexual, and 16 out of 27 knew it was wrong (59%). As most were unaware that it was sexual, these subjects inferred it was wrong based on the following types of responses:

Finally, subjects were asked why they believe that they forgot their abuse. Fourteen of 27 (52%) reported that it was because they *actively tried not to think about it*. Sample answers included:

- "You don't want to think about it so you stuff it."
- "I'm able to suppress things that are uncomfortable."
- "Well, I guess it was because it was so confusing or upsetting that I just kind of mentally put it aside for a day when I could deal with it."
- "I think I intellectually made myself forget because I didn't want to deal with the consequences."
- "I just didn't want to think about it . . . it just didn't feel right and you want to wash it out of your head."
- "Well, it was clear to me that it was nothing I could ever tell my mother . . . you never really knew how she was going to react . . . and obviously my father wasn't going to ask me any more about it and he never did. So how was I going to handle that? I decided to forget about it."

Seven out of 27 (30%) reported that they just forgot about it, but did not actively try to forget it. Three of these 7 (43%) say it was because there were no reminders (i.e., "It never happened again and then the other Spanish kid that was with me, he lived in the neighborhood and we weren't really friends . . . I'd see the kid around the neighborhood but we never talked about it, never discussed it, I never told anyone. Basically I just forgot about it"). Four offered no explanation for why they forgot (i.e., "I had just plumb forgot about it").

Three out of 27 (11%) endorsed some sort of unconscious, automatic defensive mechanism (i.e., "I didn't have the coping skills to deal with it and my body just kind of shut down"). All three had been in therapy to discuss their sexual abuse histories; one had been in recovered memory therapy (breath work).

Three out of the 27 (11%) were unable to answer the question (i.e., "I just really have no idea").¹

DISCUSSION

The results of this study are threefold. First, most of the recovered memory subjects (93%) report that their

CSA experiences were unpleasant, distressing, or confusing, but not traumatic (e.g., terrifying) at the time they occurred. This is consistent with the research on both children's recall of their experiences (e.g., Finkelhor, 1979; Kendall-Tackett et al., 1993) and adults' retrospective recall of their abuse experiences as children (Finkelhor, 1979; Long & Jackson, 1993; Nash & West, 1985; Okami, 1991; Russell, 1986). Second, consistent with the three previous studies on this topic (Melchert, 1996; Melchert & Parker, 1997; Epstein & Bottoms, 2002) more than half of the subjects report that they *actively* tried to forget their experiences after they happened. These findings are consistent with the hypothesis that CSA experiences may be forgotten due to normal memory processes, such as voluntary suppression and absent retrieval cues. One need not posit any automatic, unconscious repression or dissociation mechanism to explain why some subjects do not think about their abuse for many years.

Trauma theorists who postulate dissociative mechanisms to explain why CSA victims might not think of their abuse for many years presuppose that overwhelming terror activated the defensive mechanism. But if the abuse were not experienced as traumatic at the time it occurred, then the motive for repression or dissociation would not be present. The subjects themselves were quite explicit in stating that they, as children, did not understand the abuse to be sexual; that the perpetrators were in most cases known and trusted; and that the actual abuse (usually genital fondling) was not painful at the time—all findings strikingly consistent with both survey data (e.g., Finkelhor, 1979; Russell, 1986) and national epidemiologic research on CSA (e.g., Laumann et al., 1994).

Pinker (2005) has lamented that certain topics of vital social relevance have become taboo, frightening scientists away from studying them. Indeed, the emotions provoked by controversial issues such as CSA can lead to misunderstanding about what the research says or does not say. In the spirit of preventing misunderstandings, we address several possible criticisms of our study.

One possible criticism of this data is that our subjects are not representative of the populations of victims of CSA who recovered their memories. Indeed, without corroboration we cannot even be certain that our subjects *are* abuse survivors. By assuming they were abused, we can only say that they might be representative of those willing to volunteer for studies on this topic. Furthermore, we did not draw subjects from clinical settings, and so they may be less impaired than many abuse survivors. However, there is no reason to believe that

1. Because we conducted the memory interview with each participant only once, we did not obtain an estimate of the reliability of participants' beliefs regarding why they believed they had not thought about their abuse in years. It is possible that some participants might have given different responses if they had been reinterviewed on a second occasion. Because of the length of the memory interview, we opted not to administer it twice in an effort to gauge reliability of their responses.

those seeking treatment are more representative of the population of abuse survivors than ours, who were at least recruited from the general population.

Another possible criticism of this study is that the abuse experienced by our subjects was less traumatic than the abuse experienced by those in clinical CSA populations of people reporting recovered memories. This seems unlikely for a number of reasons. First, most of our subjects report that *today* they view the abuse as a traumatic event—one that resulted in multiple symptoms of psychosocial distress. Second, many of our subjects do report current symptoms of PTSD and depression. Third, although recruited from the community, 94% sought therapy for their problems at various points in their lives. In short, our subjects resemble other CSA survivors (i.e., they perceive the abuse today as traumatic; they report numerous symptoms of psychological distress; they believe their lives have been seriously negatively affected). Had we not specifically asked how their abuse was retrospectively perceived, there would be no reason to suspect that the abuse was not traumatic at the time it occurred.

Another possible criticism of our data is that the reason subjects did not report the abuse as being traumatic at the time it occurred is due to “defenses of denial and repression.” Although, theoretically possible, a more probable and parsimonious account for the data is that the subjects are “telling the truth” and that the abuse was not particularly traumatic (painful, terrifying) at the time it occurred.

The notion that the mind protects itself by sealing off memories of the most terrifying events comes partly from survey data showing periods of forgetting of CSA (forgetting that, as discussed earlier, could be the result of normal memory process), data showing memory deficits after trauma (memory deficits are not the same as total amnesia), studies on brain-damaged victims (e.g., Dollinger, 1985), and uncorroborated reports of bizarre trauma (e.g., memories of having cannibalized babies in a satanic cult or being raped by aliens). For corroborated traumatic events, reviews indicate that the more terrifying the event, the more likely it is to be remembered (e.g., Holocaust trauma; Pope, Oliva, & Hudson, 1999, for a review, see McNally, 2003a). That being said, even traumatic events are not recalled completely or flawlessly—memory does not operate like a videotape machine. But the essence of a truly horrific event is seldom, if ever, inaccessible to recall.

A fourth possible criticism of our data is that, in general, retrospective accounts are not reliable. A limitation to our research is that it relies on victims’ self-reports of

the severity of the abuse at the time it occurred. This presupposes that people can accurately and objectively recall their stressful experiences. Self-reports of adverse events that happened long ago can be unreliable (Southwick, Morgan, Nicolaou, & Charney, 1997). However, research indicates that subjects’ clinical state strongly predicts the degree and direction of memory distortion (Harvey & Bryant, 2000; Schwarz, Kowalski, & McNally, 1993). All of our subjects (1) had either symptoms or diagnoses of PTSD and (2) reported negative life effects from the abuse. Therefore, *if* memory for the CSA were being distorted, it should be in the direction of remembering the event as *more* traumatic than it was, not less traumatic.

Asking participants to speculate about why they believe they had not thought about their abuse in years has the additional complication, underscored by Nisbett and Wilson (1977), that people often do not have access to the cognitive mechanisms underlying conscious mentation, but that they nevertheless often generate seemingly plausible explanations based on available “folk psychology” accounts (e.g., “I repressed the memory”).

For three decades, CSA has been seen through the lens of a traumatogenic framework—perceived of as an almost invariably traumatic event that causes negative psychosocial outcomes. Although PTSD has served as a focal point for the analysis of sexual abuse trauma (in part because it is a well-developed generalized theory of traumatic processes) some theorists (Finkelhor, 1986; McNally, 2004) have raised questions about how well the model accounts for CSA experiences. PTSD is described as resulting from experiences that are objectively traumatic (ones that result in overwhelming fear and horror)—and much sexual abuse lacks these components (e.g., Laumann et al., 1994). Clinical and nonclinical data consistently indicate that most abuse consists of touching, does not involve force, and is perpetrated by those known to the victims, and the modal victim is prepubescent. Thus, it is likely that, beyond a sense of shamefulness or “wrongfulness,” many victims do not understand that what is happening to them is sexual or wrong at the time it occurs.

Life threat was integral to the original concept of PTSD. The point was to demarcate traumatic stressors from severe, but more mundane stressors. Yet ever since DSM-IV, the concept of traumatic stressor has undergone a kind of bracket creep where stressors that are not life threatening are certified as qualifying as traumatic (McNally, 2003b). Recollecting having been fondled by one’s stepfather is now bracketed with rape, combat, confinement to a concentration camp, and so forth as stressors deemed sufficient to produce PTSD. Nearly a third of our subjects did qualify for PTSD. This raises

the issue of whether individuals who affirm enough symptoms to qualify for PTSD from stressors as diverse as fondling to the Holocaust are, in fact, experiencing and suffering from the same illness. Hence, although many adult victims of CSA may suffer symptoms that appear to be *explained* by the PTSD model (i.e., cognitive avoidance, reexperiencing, hyperarousal), the mechanisms underlying them are unclear.

Due to the morally reprehensible nature of CSA, there is an understandable tendency to project our adult fears, repulsion, and horror onto child victims, who, in many cases, may simply not understand the nature of what is happening to them until years later. However, researchers and clinicians are dealing with children's sexual experience, not adults', and we may need a framework other than the trauma paradigm to understand them (e.g., Browning & Laumann, 1997; Burkhardt & Rotatori, 1995). As far back as 1979, a pioneer in the field decried the adult-centric focus of much of the reason on the topic of CSA. "Kids have only a dim sense of adult sexuality. The child, as a newcomer to the vocabulary of sexual gestures, is likely to fail to recognize sexual action and intention on the part of others or to interpret them as something else (Finkelhor, 1979, p. 47). What may seem like a horrible violation of social taboos from an adult perspective may not be so to a child (p. 31).

This is the first study concerning retrospective perceptions of trauma in people reporting recovered memories of sexual abuse and only the third to examine why subjects report they forgot their abuse. The data are consistent with the hypothesis that (1) CSA is not necessarily traumatic at the time it occurs, (2) CSA can be forgotten via normal forgetting mechanisms, and (3) it may be the retrospective interpretation of the event, rather than the event itself, that mediates its subsequent impact.

These findings have the potential to begin to quell some of the controversy surrounding temporarily forgotten and recovered memory, most of which is fueled by those who do and do not accept the mechanism of repression. Can people forget their CSA abuse histories? The answer appears to be "yes." Is this forgetting unconscious and involuntary (due to repression or dissociation)? To date, no research convincingly supports this hypothesis. Instead, a growing body of data shows that such forgetting is most likely the consequence of either normal forgetting mechanisms or subjects experiencing a time when they failed to understand the experience (e.g., Epstein & Bottoms, 2002; Finkelhor, 1979).

Future research needs to explore further (1) the mechanisms underlying "forgetting and remembering" of CSA and (2) the cognitive and social characteristics of

the types of abuse that do report getting forgotten. The lack of attention to retrospectively reported assessments of the CSA abuse experience is unfortunate. How children understand abuse at the time it occurs is one cognitive factor likely related to future symptoms (e.g., Burkhardt & Rotatori, 1995; Finkelhor, 1979; Holman & Silver, 1996; Kolko et al., 2002).

In conclusion, regardless of whether a subject experienced the abuse as traumatic, the sexual exploitation of children remains morally reprehensible. Sexual abuse calls for condemnation regardless of whether a victim experienced it as traumatic, and regardless of whether a victim develops psychiatric disease as a consequence.

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