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Self-Reported Amnesia for Abuse in Adults Molested as Children[1]

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A sample of 450 adult clinical subjects reporting sexual abuse histories were studied regarding their repression of sexual abuse incidents. A total of 267 subjects (59.3%) identified some period in their lives, before age 18, when they had no memory of their abuse. Variables most predictive of abuse-related amnesia were greater current psychological symptoms, molestation at an early age, extended abuse, and variables reflecting especially violent abuse (e.g., victimization by multiple perpetrators, having been physically injured as a result of the abuse, victim fears of death if she or he disclosed the abuse to others). In contrast, abuse characteristics more likely to produce psychological conflict (e.g., enjoyment of the abuse, acceptance of bribes, feelings of guilt or shame) were not associated with abuse-related amnesia. The results of this study are interpreted as supporting Freud's initial "seduction hypothesis," as well as more recent theories of post-traumatic dissociation.

KEY WORDS: amnesia; dissociation/ sexual abuse; survivors.

INTRODUCTION

The empirical study of childhood sexual abuse and its longterm psychological effects is less than 20 years old, despite a considerably longer

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period of speculation in this area. As noted by several recent authors (e.g., Lerman, 1986; Masson, 1984; Rush, 1980), Freud posited as early as 1896 that children who had been "seduced" by adults were prone to the development of hysteria in adulthood, especially if the molestation transpired early in life and was subsequently repressed from consciousness (Freud, 1954). Later, of course, Freud reversed his position vis à vis the role of sexual abuse, stating in 1933 that "I was driven to recognize in the end that these reports were untrue and so came to understand that the hysterical symptoms are derived from phantasies and not from real occurrences" (Freud, 1966, p. 584).

Despite Freud's ultimate rejection of the role of childhood sexual trauma in the development of later symptomatology, recent research has, in fact, validated much of his early speculation. It is now generally accepted that childhood sexual abuse is quite common in our society (Finkelhor, 1979; Russell, 1983; Wyatt, 1985), and that incidence rates in outpatient clinical populations may parallel those first reported by Freud in his clinical practice (Briere and Runtz, 1987). Such victimization has been associated with a variety of long-term impacts, including depression and anxiety (Courtois, 1979; Elliott and Briere, 1992; Herman, 1981; Peters, 1988), sexual problems (Jehu *et al.*, 1984-1985; Maltz and Holman, 1987), suicide attempts (Briere *et al.*, 1988; Briere and Zaidi, 1989), substance abuse (Densen-Gerber and Benward, 1976; Herman, 1981), somatization (Briere and Runtz, 1988; Walker *et al.*, 1986), and dissociation (Briere and Runtz, 1988, 1990; Putnam, 1989); many of which would have been subsumed under Freud's original conceptualization of hysteria.

Further support for portions of Freud's "seduction hypothesis" comes from Herman and Schatzow's (1987) study on repression and sexual abuse. These authors studied 53 female outpatients with sexual abuse histories, and found that 64% had been at least partially amnestic at some point regarding their abuse and that, as Freud hypothesized, abuse at an especially early age was more likely to be repressed. Also found was a relationship between repression and especially violent abuse experiences. In light of such data, Herman and Schatzow suggest that "it would seem warranted to return to the insights offered by Freud's original statement of the etiology of hysteria, and to resume a line of investigation that the mental health professions prematurely abandoned 90 years ago" (p. 11).

Beyond its relevance to our theoretical understanding of reactions to trauma, the study of abuse-related amnesia has substantial clinical implications. Many psychotherapists, for example, describe individuals whose clinical presentations are highly suggestive of a sexual abuse history, but who do not recall having been molested (Briere, 1992; Courtois, 1988; Gil, 1988; Goodwin, 1989). In the absence of definitive data, such clinicians are forced

to either (a) conclude that sexual abuse must not be present if the client cannot recall it, or (b) hypothesize, based on theoretical notions, that characteristic symptomatology in certain clients arises from repressed sexual abuse trauma. Research in this area, beyond the single study by Herman and Schatzow (1987), might assist clinicians faced with such concerns by providing information on the likelihood and potential etiology of abuse-related amnesia.

In light of the above issues, the current authors sought to examine empirically the role of repression in sexual abuse trauma. Utilizing a large database of clinical "sexual abuse survivors" (adults molested as children), we addressed four questions: (1) Is repression a common characteristic of childhood sexual abuse trauma; (2) If so, does such repression arise as a defense against "psychical conflict" (Freud, 1896) inherent in certain aspects of sexual abuse, such as concurrent feelings of pleasure, feelings of guilt, or perceptions of complicity, or is this defense primarily invoked to avoid the painful affect caused by memories of especially violent abuse; (3) does early age at onset of abuse especially increase the likelihood of repression, as hypothesized by Freud and reported by Herman and Schatzow; and (4) is repression of abuse associated with greater symptomatology, as Freud suggests when he notes that "hysterical symptoms are derivatives of memories which are operating unconsciously" (cited in Masson, 1984, p. 272).

METHOD

Subjects

Subjects for the present study were recruited by their therapists, who were part of an informal, nationwide sexual abuse treatment referral network organized by Childhelp, U.S.A. Clinicians were asked to distribute a questionnaire to their individual or group clients who reported histories of childhood sexual abuse and who were willing to participate in this study. A total of 633 women and men returned questionnaires, although 183 were eliminated from further analysis due to missing data or because their sexual abuse experiences failed to meet the relatively narrow research criterion of the present study: psychologically or physically forced sexual contact between a child 16 years of age or younger and a person 5 or more years older.

The resultant sample consisted of 420 females and 30 males who had a mean age of 34.6 years, reported a modal income of $10,000-$19,000, were primarily Caucasian (90%), and had an average of 1-3 years of college

education. Sexual abuse began, on average, at age 6.4 years, lasted 10.57 years, involved a mean of 2.3 perpetrators, included vaginal or anal intercourse in 53.8% of cases, and involved at least one incident of incest for 89.8% of subjects. The average abuser was 25.8 years older than his or her victim in this sample.

Materials

Subjects were administered an "Adult Survivor Questionnaire" that inquired about various aspects of sexual abuse and included the 90 items of the Symptom Checklist (SCL-90; Derogatis *et al.,* 1973). Among questions asked were (a) parameters of the abuse (e.g., age at time of first victimization, number of incidents [log-transformed in this study to ameliorate non-normality], number of perpetrators, whether the abuse was intrafamilial or extrafamilial); (b) victim responses to the abuse (e.g., extent of psychological and/or physical enjoyment, struggle against the abuser, fears regarding disclosure); (c) abuser behaviors (e.g., promises, threats); and (d) extent of coexisting physical abuse, assessed by subjects' responses to the Conflict Tactics Scale (Straus, 1979) applied to parent-child violence.

Abuse-specific amnesia was assessed by the question "During the period of time between when the first forced sexual experience happened and your eighteenth birthday was there ever a time when you could not remember the forced sexual experience?"

Analysis

Discriminant function analysis (simultaneous entry method) and post-hoc ANOVAs were performed on the data, using the above noted abuse variables to predict subjects' self-reported history of amnesia for their abuse.

RESULTS

A total of 267 of 450 subjects (59.3%) reported not having remembered their abuse at some point after it occurred but before their 18th birthday. Discriminant function analysis revealed a significant multivariate relationship between abuse characteristics and history of amnesia regarding one's abuse, $Rc = .349$, $\chi^2(28) = 56.35$, $p < .0012$. As presented in Table I, post-hoc univariate ANOVAs and the discriminant structure coefficients both indicated that subjects with an amnesia history had been molested at

Table I. Discriminant Analysis of Amnesia Versus No Amnesia History Among Former Sexual Abuse Victims

Variable	No Amnesia (n = 183) $\bar{x}$	Amnesia (n = 267) $\bar{x}$	$F(1,448)$	$p<$	DFA[a]
Subject sex (0 = male, 1 = female)	0.94	0.93	0.01	ns	.01
Subject age (years)	34.90	34.43	0.01	ns	.07
Subject education level (1 = less than junior high school, 7 = Master's degree or beyond)	4.77	4.94	2.01	ns	–.18
Subject race (0 = Non-white, 1 = White)	0.91	0.90	0.03	ns	.02
Age at first abuse incident (years)	7.26	5.84	20.19	.0001	*.57*
Duration of abuse (years)	9.26	11.46	6.99	.009	*–.34*
Log of number of incidents	1.33	1.34	0.04	ns	–.03
Number of abusers	2.10	2.45	9.05	.003	*–.38*
Victim injured as result of abuse (0 = no, 1 = yes)	0.19	0.35	15.18	.0001	–.49
Extent of physical abuse by parents	11.94	12.21	0.41	ns	–.08
Incest (0 = no, 1 = yes)	0.87	0.91	1.85	ns	–.17
Victim enjoyed abuse physically (1 = enjoyable, 5 = unenjoyable)	0.29	0.26	0.53	ns	.09
Victim enjoyed abuse emotionally (1 = enjoyable, 5 = unenjoyable)	0.11	0.09	0.74	ns	.11
Victim fought with abuser during abuse (0 = never, 4 = very often)	2.00	1.88	0.78	ns	.11
Victim tried to enjoy abuse (0 = never, 4 = very often)	0.76	0.76	0.00	ns	.00
Abuser promised special things (0 = no, 1 = yes)	0.38	0.31	2.77	ns	.21
Abuser threatened to take privileges away (0 = no, 1 = yes)	0.22	0.21	0.02	ns	.02
Victim fears redisclosure: Thought no one would believe me (0 = no, 1 = yes)	0.57	0.63	1.90	ns	–.17
Victim fears redisclosure: Thought I would get in trouble (0 = no, 1 = yes)	0.72	0.64	3.23	ns	.23
Victim fears redisclosure: Thought abuser would hurt someone else (0 = no, 1 = yes)	0.19	0.19	0.01	ns	.01
Victim fears redisclosure: Thought abuser would hurt me (0 = no, 1 = yes)	0.44	0.44	0.01	ns	–.02
Victim fears redisclosure: Thought I would die (0 = no, 1 = yes)	0.21	0.34	9.08	.003	*–.38*
Victim felt guilty about abuse (0 = not at all, 4 = a great deal)	3.64	3.55	1.84	ns	.17
Victim felt guilty about not disclosing (0 = not at all, 4 = a great deal)	2.75	2.65	0.75	ns	.11
Victim felt ashamed about abuse (0 = not at all, 4 = a great deal)	3.77	3.76	0.02	ns	.02
General Symptom Index (SCL-90)	1.17	1.37	9.05	.003	*–.38*

[a]Discriminant structure coefficient, considered meaningful if $c \geq .30$.

an earlier age, were abused for a longer period of time, had been victimized by more perpetrators, were more likely to have been physically injured as a result of the sexual abuse, more often reported having feared they would die if they told others about the abuse, and, as adults, scored higher on the General Symptom Index of the SCL-90.

DISCUSSION

The current data offer information with regard to each of the four questions introduced earlier: (1) amnesia for abuse (partial or otherwise) appears to be a common phenomenon among clinical sexual abuse survivors—59% of abused subjects in the present study reported some time period before age 18 when they could not recall their first molestation experience, (2) abuse-specific amnesia was associated with violent abuse (e.g., involving physical injury, multiple perpetrators, fears of death if the abuse was disclosed), as opposed to abuse that might be expected to increase psychological conflict (e.g., psychological or physical enjoyment of the abuse experience, receipt of bribes, feelings of guilt or shame), (3) early molestation onset (i.e., at a mean of 5.8 years in this study) and longer abuse duration were both related to an increased likelihood of amnesia, and (4) amnesia about sexual abuse experiences was associated with greater current symptomatology on the SCL-90.

The apparent commonness of sexual abuse-related repression in the current study has clinical, research, and forensic implications. With regard to the first, it is likely that some significant proportion of psychotherapy clients who deny a history of childhood sexual victimization are, nevertheless, suffering from sexual abuse trauma. Such amnesia may be relatively refractory to treatment—as van der Kolk and Kadish (1987) note, "After intense efforts to ward off reliving the trauma, a therapist cannot expect that the resistances to remember will suddenly melt away" (p. 187). Thus, the clinician who has some reason to believe that his or her client was molested as a child (e.g., in terms of his or her current clinical presentation) may be well advised to continue to entertain that hypothesis during treatment, even in the absence of specific abuse memories. In the authors' clinical experience, and as noted by Herman and Schatzow (1987), such amnesia may partially or totally remit as therapy continues, especially if the structure and pace of treatment communicate safety and encourage exploration, and the therapist remains open to the possibility that sexual abuse occurred (Briere, 1992).

The effects of abuse-specific amnesia on clinical research primarily relate to the membership of "control" or comparison groups in investiga-

tions into the psychological impacts of sexual abuse. If the repressing sexual abuse survivor is included in such research, he or she must, by definition, be placed in the "no history of abuse" category—an outcome that can underestimate the observed effects of molestation, since self-reported sexual abuse survivors are thereby compared to a group which includes (potentially more symptomatic) repressing survivors rather than to a group of truly abuse-free individuals.

The impact of repressed abuse history in the forensic domain resides in the potentially decreased credibility of abuse survivors who charge their perpetrators with sexual abuse, and the possible unavailability of civil remedies for the former victim who wishes to bring suit against her abuser. In the first case, the client's "spotty" or absent memory regarding when abuse did or did not occur may cause her to appear a poor witness and may, in fact, engender doubts in judge or jury as to whether said victimization actually ever took place. In the second instance, state statutes of limitation regarding civil actions may prevent the abuse survivor from suing her abuser if, for example, her amnesia did not resolve within a certain number of years after the abuse and thus her "discovery" of her injury was delayed beyond the maximum time period legally allowed for litigation.

The association between reports of violent abuse and subsequent amnesia highlights the immediately adaptive aspects of unconsciously dissociating oneself from one's traumatic memories. As noted by van der Kolk and Kadish (1987), "it allows relatively normal functioning for the duration of the traumatic event and leaves a large part of the personality unaffected by the trauma" (p. 186). This defense may persist into adulthood as a result of avoidance learning—continued psychological inhibition of violent abuse memories may be reinforced because such activity reduces or circumvents the anxiety and dysphoria associated with abuse-related recollections, and permits superficially higher levels of psychosocial functioning in the absence of such painful distractions. Whether this unconscious solution is ultimately effective is unclear, however, since a history of amnesia for sexual abuse was also associated with greater current psychological symptoms on the SCL-90.

Although the notion of amnesia as an active, defensive process is supportive of Freud's general concept of repression, its association with trauma—not conflict —in the present instance is more problematic for his theory. Memory loss after psychological trauma is, however, quite consistent with Janet's (1889) formulation of dissociation, and fits well with modern understandings of the dissociative process (Putnam, 1985; van der Kolk and Kadish, 1987). As DSMIII-R perhaps overstates, "Several studies indicate that in nearly all cases, the [dissociative] disorder has been preceded by abuse (often sexual) or another form of severe emotional

trauma in childhood" (American Psychiatric Association, 1987, p. 271). Similarly, several studies report that a significant proportion of veterans are partially or completely amnestic for their combat experiences (Archibald and Tuddenham, 1965; Henderson and Moore, 1944), with greater dissociation being present for more violent or stressful experiences (Henderson and Moore, 1944; Putnam, 1989). Ultimately, the relationship between repression, dissociation, and amnesia is far from clear (Frankel, 1990; Nemiah, 1989), and awaits further empirical and theoretical analysis.

The current data support the findings of Herman and Schatzow regarding age of abuse onset and abuse-related amnesia, since loss of memories was greatest when sexual abuse occurred at an earlier age. This connection is unlikely to reflect mere forgetfulness as a result of the greater passage of time for amnestic subjects—the difference between amnestic and nonamnestic subjects' abuse onset was less than 2 years, and the abuse later recalled by amnestic subjects was significantly more violent than that of nonamnestic subjects; a characteristic that would seemingly *increase* its memorability. Possible explanations for this relationship include (a) the likelihood that early abuse is more likely to be experienced as violent than later abuse (especially if intercourse was attempted or took place), thereby motivating its repression or dissociation; (b) Herman and Schatzow's (1987) implication that younger children, being less cognitively complex, have fewer psychological defenses available to them other than the primitive recourse of simply not recalling threatening material; and (c) the possibility that the memory acquisition systems of (on average) 5.8-year-old children are less efficient or capable than those of 7.3 year olds. The latter explanation, however, is to some extent contradicted by the fact that these memories were eventually retrieved by formerly amnestic subjects.

Although the data reported here are relatively straightforward regarding self-reported abuse-related amnesia, the methodology of this study was insufficient to resolve certain issues in this area. First, abuse-amnestic subjects were identified on the basis of a single yes-no item, as opposed to a series of focused, detailed questions. As a result, what is likely to be a continuum of repressive or avoidant responses was artificially constrained into a simple dichotomy. Future research in this area might expand on the present findings by investigating the timing, quality, and precipitants of recovered memories, as well as the possibility that different abuse memories may appear at different times. Also relevant in this regard would be the role of therapy in the recall of formerly repressed events.

A potential limitation of this study is in the area of sample recruitment. Subjects of this study were those who (a) had therapists willing to solicit their clients' involvement in this study, and (b) were, themselves, willing to participate upon being asked. As a result of this selection

process, it is unclear to what extent the incidence of abuse-related amnesia reported in this study can be generalized to other clinical or nonclinical groups.

A last issue concerns the validity or accuracy of subjects' abuse reports. As has been discussed elsewhere (see, for example, Briere and Zaidi, 1989, and the subsequent discussion in the *American Journal of Psychiatry* (Briere, 1990; Rich, 1990)), objective corroboration of subjects' abuse disclosures is, at best, difficult. In the absence of such supportive data in the present study, one cannot rule out the possibility that some subset of subjects misrepresented their childhood histories and/or amnesia experiences. Although clinical experience leads the present authors to doubt that abuse confabulation is a major problem in abuse research, only further study and empirical data in this area will resolve this question.

In summary, the results reported here document the frequency of self-reported amnesia for abuse-related events in at least one large clinical sample of sexual abuse survivors, and suggest that such memory disturbance may arise from cognitive mechanisms invoked in order to avoid the painful affects associated with recall of especially violent abuse episodes. Interestingly, in agreement with Freud's earliest thinking, amnesia was also related to greater subsequent symptomatology—despite the immediately adaptive aspects of such behavior. In general, these data appear to further support Freud's initial conceptualization—as opposed to his later theories—regarding childhood sexual abuse, symptomatology, and memory. Whether such amnesia is due to "repression" or "dissociation" is unclear, although the current data are more congruent with a model stressing post-traumatic dissociative processes.

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