

Recovery and Verification of Memories of Childhood Sexual Trauma

Judith Lewis Herman, M.D.,
and Emily Schatzow, M.Ed.
Women's Mental Health Collective

Fifty-three women outpatients participated in short-term therapy groups for incest survivors. This treatment modality proved to be a powerful stimulus for recovery of previously repressed traumatic memories. A relationship was observed between the age of onset, duration, and degree of violence of the abuse and the extent to which memory of the abuse had been repressed. Three out of four patients were able to validate their memories by obtaining corroborating evidence from other sources. The therapeutic function of recovering and validating traumatic memories is explored.

The connection between a history of childhood sexual trauma and psychological disturbance in adult life was first proposed by Freud almost a century ago (Freud, 1896). Freud soon disavowed what came to be known as his "seduction theory" because he found it impossible to believe that sexual abuse of children could be so prevalent as his theory would imply (Masson, 1985). More recently, however, a large body of evidence has been developed indicating that sexual abuse of children is indeed much more common than previously had been supposed. Large-scale surveys conducted with non-clinical populations yield estimates that for girls, the risk of a sexual assault prior to adolescence is approximately 1 in 4 (Kinsey, Pomeroy, Martin, & Gebhard, 1953; Russell, 1984), and for boys, approximately 1 in 10 (Finkelhor, 1979).

Because the great majority of these assaults are undetected at the time of occurrence, no long-term prospective study of their sequelae has ever been conducted. However, the preponderance of evidence from retrospective studies indicates that many child victims do experience persistent problems in

sexual, psychological, or social functioning. Long-term sequelae are found in a majority of victims who have been abused by fathers or stepfathers, or who have endured abuse that was violent, highly physically intrusive, or of long duration (Herman, Russell, & Trocki, 1986). Histories of childhood sexual abuse have been reported in a high percentage of female psychiatric inpatients (Carmen, Reiker, & Mills, 1984; Emslie & Rosenfeld, 1983; Jacobson & Richardson, 1985; Landis, 1940; Nelson, Miller, Bryer, & Krol, 1986) and outpatients (Briere, 1984; Herman, 1986; Rosenfeld, 1979). In a clinical study, Herman (1981) found that patients with histories of incest more frequently reported adolescent pregnancy, repeated victimization, suicide attempts, drug abuse, and negative identity formation, compared to patients who had not been victimized in childhood. Meiselman (1978), in a similar study, found that incestuously abused patients reported more sexual dysfunction, more disturbance in interpersonal relationships, more physical complaints, and more total symptoms than a comparable patient group. Gelinias (1983) described patients with incest histories as suffering from chronic depression combined with symptoms of a traumatic neurosis (confusion, recurrent nightmares, episodes of depersonalization, and impulsivity). Goodwin (1985) also described the sequelae of childhood incest as a chronic posttraumatic stress disorder than has become integrated into the victim's personality structure. Childhood sexual abuse has been implicated in the development of multiple (Sachs, Goodwin, & Braun, 1986) and borderline (Herman, 1986; Stone, 1981) personality disorders, and in the histories of women experiencing serious social difficulties including adolescent runaways (Densen-Gerber & Benward, 1976), prostitutes (James & Meyerding, 1977), and battered women (Walker, 1978).

Retrospective studies, however, depend on the reliability of informants' memories. In the absence of confirming evidence, such studies might conceivably be dismissed as seriously distorted at best, and at worst as the ever more elaborate documentation of women's fantasies by naive investigators. This study was undertaken with a group of patients who both reported memories of sexual trauma and had the opportunity to corroborate their memories from other sources. The purpose of the study was first, to investigate the link between traumatic childhood memories and symptom formation in adult life; second, to lay to rest, if possible, the concern that such recollections might be based upon fantasy; and third, to explore the therapeutic effect of recovery and validation of memories of early trauma.

DESCRIPTION OF THE PATIENT POPULATION

Fifty-three women were treated by the authors in time-limited (12-week) therapy groups for incest survivors at a clinic in the Boston area. All were in concurrent individual outpatient therapy and were referred for group

through therapists, agencies, self-help organizations, or friendship networks. Women who were actively drinking, drug dependent, or suicidal or who lacked major social supports were not selected for group treatment. A detailed description of the group selection process and treatment model may be found elsewhere (Herman & Schatzow, 1984).

The patients were predominantly white, single, working women from a wide variety of social and ethnic backgrounds. The age range was 15 to 53, with the majority of women in their 20s and 30s; the mean age was 31.7. Almost two thirds (62%) were unmarried, 15% were currently married, and 23% were separated or divorced. Just over one third (34%) of the women had children. The majority were employed in traditional women's occupations, either in a professional capacity as teachers, nurses, or social workers (33%); as service workers in the educational, health, or mental health systems (25%); or as office workers (23%). Only a small minority were full-time homemakers (9%). Half (49%) of the women were raised in the Catholic religion, one third (32%) as Protestants, 13% as Jews. The educational level of the group was quite high: 41% had completed a college degree, an additional 17% had some postgraduate education, and an additional 11% had completed professional or technical training programs.

A striking characteristic of many of the patients was the contrast between the relatively high levels of competence and achievement evident in their working lives and the painfully constricted, isolated, or chaotic and self-destructive character of their intimate relationships. Moreover, though many functioned effectively in a caretaking role on the job or as parents, deficiencies in self-care were often remarkable. In Freud's time, these women would undoubtedly have been diagnosed as suffering from hysteria. They would readily have recognized their own afflictions in the anxiety attacks, the bodily disgust, the "mental sensitiveness" and hyperreactivity, the crying spells, the suicide attempts, and the "outbursts of despair" that Freud described in his hysterical patients almost a century ago (Freud, 1896). In present-day (*DSM-III*) nomenclature, the majority would be considered clinically depressed. Thirty (57%) met *DSM-III* criteria for dysthymic disorder, and 19 (19%) had had at least one major depressive episode. Fourteen (26%) had chronic severe anxiety symptoms. Eleven (21%) had a history of prior psychiatric hospitalization, 11 had made prior suicide attempts, and 9 (17%) had prior histories of alcoholism or drug dependency. Many patients would have earned a *DSM-III* personality disorder diagnosis, the most common being histrionic (10 patients), borderline (9 patients) and avoidant (7 patients) disorders.

PATIENTS' MEMORIES OF SEXUAL ABUSE

All the patients reported either that they had been sexually abused by a relative or that they strongly suspected that this was the case but could not re-

member clearly. The great majority (75%) named their fathers or stepfathers as the abusers. Brothers were named by 26%, uncles by 11%, and grandfathers by 6% of the patients. Two women named their mothers, one a sister, and one a cousin as perpetrators. Thirty percent of the patients had been abused by more than one person. The reported age of onset of abuse ranged from 2 to 19; the average age was 8. The reported duration ranged from single incidents to 18 years, the average being 5 years. The sexual experiences ranged from a few incidents in which no physical contact was reported (these tended to involve indecent exposure or propositions) to vaginal or anal rape. Genital fondling, masturbation, or oral/genital contact was reported in most cases.

The degree of violence associated with the sexual abuse was rated on a 3-point scale: 0 representing entirely nonviolent experiences, 1+ representing abuse that occurred in a climate of fear and coercion but without physical force during the sexual contact itself, and 2+ representing frankly violent abuse. A climate of fear and coercion was judged to be present when the patient reported that the perpetrator frequently beat other family members, threatened the patient or others with a weapon, or was known to have seriously harmed or murdered others. Overt violence included episodes described as rape, those in which the patient described infliction of pain, and those in which the patient described being held down, tied up, or otherwise forcibly immobilized.

Patients were judged to have full recall of their abuse experiences if they reported that they had always remembered the abuse in detail, and if in the course of group treatment no additional memories were recovered. Patients who had not been aware of major gaps in memory but who reported recent recall of new memories or who recovered some additional memories during group treatment were categorized as having mild to moderate memory deficits. Patients were categorized as having severe memory deficits if they could recall very little from childhood, if they reported recent eruption into consciousness of memories that had been entirely repressed, or if this kind of recall occurred during the course of group treatment.

Ratings of degree of violence and of amnesia were made independently by the two authors. Interrater agreement was 92% on memory ratings and 98% violence ratings. Cases of disagreement ($n = 5$) were resolved in favor of the lower rating.

The majority of patients (64%) did not have full recall of the sexual abuse but reported at least some degree of amnesia (see Table 1). Just over one quarter of the women (28%) reported severe memory deficits. A strong association was observed between the degree of reported amnesia and the age of onset and duration of the sexual abuse. Women who reported no memory deficits were generally those whose abuse had begun or continued well into adolescence. Mild to moderate memory deficits were usually associated with

TABLE 1
Memory of Sexual Abuse Related to Age of Onset and Duration

<i>Abuse History</i>	<i>Degree of Amnesia</i>		
	<i>None (N = 20)</i>	<i>Moderate (N = 19)</i>	<i>Severe (N = 14)</i>
Age onset (years)			
mean	10.6	8.2*	4.9**
<i>sd</i>	4.5	2.8	2.4
Duration (years)			
mean	5.9	5.5***	2.5****
<i>sd</i>	3.7	4.3	2.9

*none versus moderate amnesia: $t = 2.01$ (one-tailed test), $df = 39$, $p < .03$.

**moderate versus severe amnesia: $t = 3.64$, $df = 33$, $p < .0005$.

***none versus moderate amnesia: no significant difference.

****moderate versus severe amnesia: $t = 2.39$, $df = 33$, $p < .02$.

abuse that began in latency and ended by early adolescence. Marked memory deficits were usually associated with abuse that began early in childhood, often in the preschool years, and ended before adolescence.

In addition, a relationship was observed between frankly violent or sadistic abuse experiences and the resort to massive repression as a defense. Nine of the 12 women who suffered overtly violent abuse reported that they had been amnesic for these experiences for a prolonged period of time. Of the women categorized as having severe memory deficits, the majority (60%) eventually recalled experiences of violent abuse (see Table 2).

Characteristic differences were also observed in the adaptive styles and symptoms of patients with no memory deficits, those with mild to moderate deficits, and those with severe amnesia. Patients who reported full recall often commented that they wished they could repress their memories. Lacking this defensive option, they tended to depend heavily on dissociation and isolation of affect to protect themselves from the overwhelming feelings associ-

TABLE 2
Memory of Sexual Abuse Related to Degree of Violence

<i>Degree of Amnesia</i>	<i>Degree of Violence</i>		
	<i>0</i>	<i>1+</i>	<i>2+</i>
0	13	6	1
1+	8	9	2
2+	1	5	8
Total	22 (41%)	20 (38%)	11 (21%)

Note. Chi square = 19.72, $df = 4$, z-score on normal approximation = 5.56, $p < 0.005$.

ated with the abuse. They often described themselves as “numb,” “frozen,” “in a fog,” or “behind a glass wall.” At times, some of the patients who could not repress their memories also lost the capacity for dissociation. When this resource failed, patients resorted to more maladaptive coping strategies, including somatization (conversion reactions, hypochondriasis), impulsive risk-taking, drug abuse, and transient psychotic episodes. In the group treatment setting, patients will full recall of their abuse experiences often formulated goals that required them to tolerate and share the feelings associated with their memories, and thereby to emerge from their chronic feeling of numbness and isolation.

CASE EXAMPLE ONE¹

Since graduating from an Ivy League college, Andrea, now 22, has been working intermittently as a waitress and living with her 38-year-old boyfriend, who is on parole after serving a prison term for bank robbery. Andrea’s stepfather, the vice president of a large commercial bank, has disinherited her, and the family has severed all ties with her. She entered treatment in distress about her relationship with her boyfriend, who was becoming increasingly abusive to her.

Andrea gave a history of a sexual relationship with her stepfather beginning soon after her mother’s remarriage when she was age 11 and ending when she left home for college at age 17. The sexual contacts consisted of masturbation and thigh intercourse. She has clear recall of the details, especially the expression on her stepfather’s face as he entered her room at night, the sound and smell of his breathing, and the sight of semen “like mashed potatoes.” She would attempt to dissociate during the sexual encounters by chanting to herself, “There’s nobody here.” Her most distressing memories are of the times that her stepfather spoke to her and required her to answer (“You like this don’t you? I know you like it”), as this interfered with her dissociation and made her feel additionally violated.

During her adolescence, Andrea had several arrests for drunken and reckless driving and for joyriding in stolen cars. she also had several emergency room visits for drug ingestions and for seizures judged to be hysterical in origin. These events confirmed the family view of Andrea as a troublemaker. She received no psychiatric attention, and the incest was not disclosed on any of these occasions.

In group, Andrea defined her goal as telling her story with the appropriate affect. Group support enabled her to tolerate intense feelings of grief and rage without resorting to dissociation or impulsive activity. Following this, she was

¹In the interest of protecting patient anonymity, all examples cited are composites of several cases.

better able to direct her anger toward her stepfather rather than toward herself. Because she no longer needed someone to punish herself or her family, she found it possible to extricate herself from her destructive relationship with her boyfriend.

Patients with mild to moderate memory deficits were often not aware of these deficits prior to participation in group. However, in response to the intense stimulation of hearing other groups members' stories, these patients reported recovery of additional memories. These new memories often disrupted an existing defensive adaptation that involved partial repression and minimization of the abuse history. Patients in this category suffered some increased anxiety in the process of recovering new memories, but were usually able to integrate them without prolonged distress, and generally reported that the new memories enabled them to form a more realistic picture of their families and a less critical estimate of themselves.

CASE EXAMPLE 2

Bernadette is a 26-year-old legal secretary, the single mother of a 10-year-old girl. The oldest of five children, she still maintains close ties to her family of origin, and has often relied on her parents or sisters for babysitting. Her father is a judge in superior court. She sought therapy, complaining of chronic depression, low self-confidence, and fears of men. She had become increasingly worried that any boyfriend she brought home might molest her daughter. On entering therapy, she recalled a few sexual approaches by her father when she was 14. She found this an inexplicable aberration on her father's part, as he is highly esteemed in the family and the community. She was preoccupied with the idea that she might have been provocative and cited her out-of-wedlock pregnancy as evidence of her immoral character. In the course of the group, Bernadette recovered new memories of earlier incidents with her father beginning at about the age of 9. She also realized that the abuse had persisted until she escaped by acquiring a boyfriend and becoming pregnant at the age of 15. As she came to terms with these new memories, she stated sadly, "I really can't make excuses for my father anymore." Although she grieved for the loss of her idealized image of her father, she expressed relief at her revised, less shameful estimation of herself. She was also able to identify the true source of her anxiety about her daughter's safety, and began to take more realistic action to protect her.

Patients with severe memory deficits presented quite differently in group. Often they described almost complete amnesia for childhood experiences but reported recurrent intrusive images associated with extreme anxiety. Attempts at sexual intimacy often triggered flashback images of the abuser and panic states. These women were preoccupied with obsessive doubt over

whether their victimization had been fantasized or real. Some had previously sought treatment with hypnosis or sodium amytal. An additional group of women 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 posttraumatic 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 experiences 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. Patients experienced derealization and terror and often expressed the fear that they were losing their minds.

Participation in group proved to be a powerful stimulus for recovery of memory in patients with severe amnesia. Almost all of the women who entered the group complaining of major memory deficits and who defined a goal of recovering childhood memories were able to retrieve previously repressed memories during group treatment. Active intervention of the group leaders was sometimes required to slow the process, in order to allow time for some measure of defensive reintegration. Patients were encouraged to retain as much voluntary control as possible over the process; for example, by seeking or limiting exposure to sources of information that might stimulate memory, so that the breakthrough of previously repressed material could be experienced as active mastery rather than as repeated victimization.

CASE EXAMPLE 3

Claudia is a 30-year-old, single emergency room nurse. Although she has been highly successful in her career, she has been socially isolated for as long as she can remember, a fact she always attributed to her severe obesity. Three years prior to entering group therapy, Claudia was hospitalized in a controlled environment for weight reduction, losing over 100 lb. When her weight fell below 200 lb, she began to have intrusive flashback memories of sexual abuse by her brother, who is 10 years older than she.

In group, she recounted for the first time vivid memories of being handcuffed, burned with cigarettes, forced to perform fellatio, and having objects introduced into her rectum and vagina. She had especially clear memories of the wallpaper in the room. Reconstructing from this and other details, she estimated that she was 4 years old when the abuse began. The abuse could not have continued past the age of 7, since at that time her brother left home to enlist in the military.

Prior to the group session in which she planned to tell her story, Claudia became extremely agitated. She was unable to sleep and could not tolerate being alone

in her apartment at night. For several days she did not return home after work, but spent the night at the hospital. She expressed the fear that when she told her story she would become her 4-year-old self and would not be able to return to adult functioning. During the narration she did indeed appear age-regressed: She trembled, sobbed, and spoke in a high, child-like voice. At the end of the narration, however, she was able to accept comfort from other group members and resume her ordinary adult persona. Following this session, she reported being able for the first time in many years to sleep at home in her bed without a night-light.

CASE EXAMPLE 4

Doris is a 37-year-old housewife and mother of four children. She sought treatment because of panic attacks during sexual intercourse with her husband. She had always feared and disliked sex, but in the previous 2 years her anxiety had become so intolerable that the couple had ceased sexual relations altogether. Doris was extremely ashamed of this failure of what she considered her marital obligation and feared her husband might leave her in spite of his assurances to the contrary. A couple therapist, suspecting sexual abuse, referred her to group.

In group, Doris initially reported almost complete amnesia for her childhood. She spoke little until the sixth session, when she began to moan, whimper, and wring her hands. In a childlike voice she cried "The door is opening! The door is opening!" She was instructed to tell her memories to go away and not to come back until she was ready to have them. This she did, first in a whisper, and then in a loud voice. Her anxiety then subsided to bearable levels.

In the 3 weeks following this session, Doris was flooded with memories which included being raped by her father and being forced to service a group of her father's friends while he watched. The sexual abuse began at about the age of 6 and continued until the age of 12, when she was impregnated by her father and taken to an underground abortionist. During the time that she was retrieving memories, Doris required several emergency psychotherapy sessions and antianxiety medication. At the end of this period, her panic subsided and she experienced considerable relief. At 6-months follow-up, she reported feeling better about herself and was able to tolerate more intimacy with her husband.

VALIDATION OF TRAUMATIC MEMORIES

Participation in group therapy offered an opportunity for many patients to gather corroborating evidence of abuse. The groups were structured around the definition and achievement of a personal goal related to the sexual abuse. The three most commonly chosen goals were disclosure of the abuse to a fam-

ily member (17 patients), recovery of memories (16 patients), and confrontation with the perpetrator (10 patients). Patients who defined a goal of recovering memories were encouraged to interview family members or others who might be able to contribute pertinent information. Thus the majority of patients defined a goal that included the potential for gathering evidence from a source other than the patient's memory.

The majority of patients (74%) were able to obtain confirmation of the sexual abuse from another source. Twenty-one women (40%) obtained corroborating evidence either from the perpetrator himself, from other family members, or from physical evidence such as diaries or photographs. Another 18 women (34%) discovered that another child, usually a sibling, had been abused by the same perpetrator. An additional 5 women (9%) reported statements from other family members indicating a strong likelihood that they had also been abused, but did not confirm their suspicions by direct questioning. The following three case examples illustrate corroboration of the incest histories by, respectively, admission of the perpetrator, testimony of other family members, and physical evidence.

Andrea (Case Example 1) wrote a letter to her stepfather confronting him about the sexual abuse and demanding an apology. Her stepfather responded by phone. He acknowledged "fooling around" with her but refused to apologize, stating that he knew she "wanted it as much as he did." He did not believe the abuse had been harmful because vaginal intercourse had not occurred, and added resentfully that he had respected her virginity, only to have her "throw it away on a bum." He concluded the conversation by exhorting her to stop blaming the family for the troubles she had brought upon herself.

Bernadette (Case Example 2) disclosed the sexual abuse to her mother, who burst into tears and cried, "Oh no! Not you too!" She then told Bernadette that after she left home, her younger sisters had complained that their father tried to molest them.

After a heroic military service career, Claudia's brother (Case Example 3) was killed in combat in Vietnam. Her parents continued to make pilgrimages to his grave, and had transformed their home into a shrine dedicated to his memory. His room with all his belongings, had been left untouched. During a visit to her parents' home, Claudia conducted a search of her brother's room. In a closet she found an extensive pornography collection, handcuffs, and a diary in which he planned and recorded his sexual "experiments" with his sister in minute detail.

A fourth example illustrates a situation in which abuse of another family member by the same perpetrator was suspected but not confirmed.

Doris (Case Example 4) reported that at Thanksgiving 2 years previously, her younger sister had contrived to speak to her alone and asked her, "Did Daddy

ever try anything funny with you?" Doris replied, "I don't know what you're talking about," and fled from the room. Her panic attacks began after this incident. Doris now suspected that her sister had also been sexually abused, but was afraid to ask her directly.

Six patients (11%) made no attempt to obtain corroborating evidence from other sources. An additional 3 patients (6%) were unable to obtain any corroboration in spite of active attempts to do so. These three women confronted families who united in absolute denial of the abuse. This situation proved extremely distressing to the patients, who felt obliged to choose between their own perception of reality and any sense of connection to their families. The most dramatic resolution of this conflict occurred in one case in which the patient severed all ties with her family, changed her name, and consciously mobilized alternative social supports for family occasions such as birthdays and holidays.

DISCUSSION

The presumption that most patients' reports of childhood sexual abuse can be ascribed to fantasy no longer appears tenable. In this study, the large majority of patients who recalled experiences of sexual abuse in childhood were able to validate their memories from other information sources. The majority of patients who did not obtain corroborating evidence of abuse were those who made no attempt to do so. No positive evidence was adduced that would indicate that any of the patients' reports of sexual abuse were fantasized. In the light of these findings, 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.

In his original statement of the seduction theory, Freud (1896) speculated that further research might demonstrate a relationship between the preservation of conscious recall of sexual trauma and such factors as the nature of the trauma and the child's age at the time of its occurrence. Such a relationship is borne out by the data in this study. Massive repression appeared to be the main defensive resource available to patients who were abused early in childhood and/or who suffered violent abuse. The 15 patients who presented with severe memory deficits were those who most closely resembled Freud's classic hysterics, both in their symptomatology and in their cathartic responses to the breakthrough of previously repressed memories. Women whose predominant experience of abuse was in latency and whose abuse was not particularly violent or sadistic rarely resorted to massive repression; instead, they seemed to employ a combination of defenses including partial repression,

dissociation, and intellectualization. Freud further speculated that abuse occurring after a certain age would not be repressed in memory and therefore would not result in the formation of hysterical symptoms. The age he proposed as a dividing line was 8. In this study, a dividing line of sorts was observed, but much later in development, at puberty. Those women whose predominant experiences of abuse occurred on adolescence generally did preserve conscious memory and did present with a different constellation of defenses from those who had been abused in early childhood. However, the preservation of memory of the abuse apparently did not prevent the formation of classic hysterical symptoms, such as Andrea's psychogenic seizures (Case Example 1).

Because massive repression appears to be one of the few adaptive resources available to young children to deal with overwhelming trauma, and one of the more adaptive responses in the repertoire of older children, the question arises whether it is therapeutically wise to attempt to interfere with this defense when it has been preserved into adult life. The breakthrough of previously repressed traumatic memories is accompanied by powerful affect and marked, though temporary, ego disorganization. Patients may become extremely symptomatic during this process, with severe anxiety, feelings of despair, and impulses toward self-destructive behavior. Often patients approach the task of recovering repressed memories with the fantasy that a single overwhelming and cathartic experience will result either in total annihilation or total cure. The danger then arises that the breakthrough of repressed memories will be experienced merely as a reenactment of abuse, with the therapist in the role of the tormentor.

It is our impression, however, that the retrieval and validation of repressed memories has an important role in the recovery process. With the return of memory, the patient has an opportunity as an adult to integrate an experience that was beyond her capacity to endure as a child. The purpose of reliving the experience with full affect is not simply one of catharsis, but of reintegration. Symptoms, feelings, and behaviors that previously seemed inexplicable bizarre, and ego-alien become comprehensible; the patient becomes more comprehensible to herself, and more able to construct meaning in her life history. In addition, the relief of particular posttraumatic symptoms following recovery of memory is often dramatic. This process has been well documented in the literature on victims of many types of overwhelming trauma, ranging from child abuse to rape, torture, and combat (Burgess & Holmstrom, 1979; Horowitz, 1976; Niederland, 1965; van der Kolk, 1986).

We believe that the task of recovering and validating traumatic memories should be approached by both therapist and patient with caution and respect for the risks involved. Careful attention should be given to the social and therapeutic support structure that permits the task to be carried out in safety, and to questions of timing and pacing. We recommend methods that allow

the patient to retain the greatest possible control over the process. In the case of child sexual abuse, gathering information from family members or physical reexposure to the environment in which the abuse occurred is frequently sufficient to stimulate recall.

Finally, we note that even those patients who have preserved their memories of abuse intact face similar tasks of integration of the experience, grieving for the lost childhood, and creation of new meaning from a desolate history. For patients who have relied primarily on dissociation rather than repression, the retelling and reliving of the experience with full affect plays a role similar to the recovery of memory for patients with amnesia. The role of the therapist in both instances is similar: to protect, to bear witness, and in so doing, to make it possible for unspeakable things to be told and unbearable feelings to be borne.

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REFERENCES

- Briere, J. (1984, April). *The effects of childhood sexual abuse on later psychological functioning*. Paper presented at the Third National Conference on Sexual Victimization of Children, Washington, DC.
- Burgess, A. W., & Holmstrom, L. L. (1979). Adaptive strategies and recovery from rape. *American Journal of Psychiatry*, *136*, 1278-1282.
- Carmen, E. H., Reiker, P. P., & Mills, T. (1984). Victims of violence and psychiatric illness. *American Journal of Psychiatry*, *141*, 378-383.
- Densen-Gerber, J., & Benward, J. (1976). *Incest as a causative factor in anti-social behavior: An exploratory study*. New York: Odyssey Institute.
- Emslie, G., & Rosenfeld, A. A. (1983). Incest reported by children and adolescents hospitalized for severe psychiatric problems. *American Journal of Psychiatry*, *140*, 708-710.
- Finkelhor, D. (1979). *Sexually victimized children*. New York: Free Press.
- Freud, S. (1896). The etiology of hysteria. *S.E.*, *3*.
- Gelinas, D. J. (1983). The persisting negative effects of incest. *Psychiatry*, *46*, 312-332.
- Goodwin, J. (1985). Post-traumatic symptoms in incest victims. In R. Pynoos & S. Eth (Eds.), *Post-traumatic syndromes in children*. Washington, DC: American Psychiatric Press.
- Herman, J. L. (1981). *Father-daughter incest*. Cambridge, MA: Harvard University Press.
- Herman, J. L. (1986). Histories of violence in an outpatient population. *American Journal of Orthopsychiatry*, *56*, 137-141.
- Herman, J. L., Russell, D. E., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. *American Journal of Psychiatry*, *143*, 1293-1296.

- Herman, J. L., & Schatzow, E. (1984). Time-limited group therapy for women with a history of incest. *International Journal of Group Psychotherapy*, *34*, 605-616.
- Horowitz, M. J. (1976). *Stress response syndromes*. New York: Aronson.
- Jacobson, A., & Richardson, B. (1985, May). *Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry*. Paper presented at the annual meeting of the American Psychiatric Association, Dallas, TX.
- James, J., & Myerding, J. (1977). Early sexual experience and prostitution. *American Journal of Psychiatry*, *134*, 1381-1385.
- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female*. Philadelphia: Saunders.
- Landis, C. (1940). *Sex in development*. New York: Harper & Row.
- Masson, J. M. (Ed. & Trans.). (1985). *The complete letters of Sigmund Freud to Wilhelm Fliess: 1887-1904*. Cambridge, MA: Belknap.
- Meiselman, K. (1978). *Incest*. San Francisco: Jossey-Bass.
- Nelson, B., Miller, J. B., Bryer, J. B., & Krol, P. A. (1986). *Childhood abuse as a factor in adult psychiatric illness*. Unpublished manuscript, Stone Center, Wellesley College, Wellesley, MA.
- Niederland, W. G. (1965). The role of the ego in the recovery of early memories. *Psychoanalytic Quarterly*, *34*, 564-571.
- Rosenfeld, A. A. (1979). Incidence of a history of incest among 18 female psychiatric patients. *American Journal of Psychiatry*, *136*, 791-795.
- Russell, D. E. (1984). *Sexual exploitation: Rape, child sexual abuse, and sexual harassment*. Beverly Hills, CA: Sage.
- Sachs, R., Goodwin, J., & Braun, B. (1986). The role of childhood abuse in the development of multiple personality disorder. In B. Braun & R. Kluff (Eds.), *Multiple personality and dissociation*. New York: Guilford.
- Stone, M. H. (1981). Borderline syndromes: A consideration of subtypes and overview, directions for research. *Psychiatric Clinics of North America*, *4*, 3-24.
- van der Kolk, B. A. (1986). The scope of psychological trauma in psychiatry. In B. A. van der Kolk (Ed.), *Psychological trauma: The long-term impact of overwhelming experiences on children and adults*. Washington, DC: American Psychiatric Press.
- Walker, L. (1978). Battered women and learned helplessness. *Victimology*, *2*, 525-534.