THE FALSE MEMORY CONTROVERSY: IMPLICATIONS AND CONSIDERATIONS FOR COUNSELING ADULTS WHO ALLEGE CHILD SEXUAL ABUSE

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Margaret S. Casillas

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DEDICATION

This research paper is dedicated to my mother and children

Mrs. Imogene Costello

and

Albert and Francine Casillas

who have given of their love and encouragement

and provided many educational opportunities for me.

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ABSTRACT

The question of repressed memory versus false memory has gained momentum as awareness of child sexual abuse has increased. This paper reviews and evaluates current literature on repressed memories and false memories, and, in so doing, describes a counseling construct which allows for repressed memories but protects both client and therapist from manipulation of the outcome due to counseling techniques. An overview of child sexual abuse naturally leads to questions about memory. It is necessary to understand how memory works in children and adults to evaluate the phenomenon of false memory syndrome. Therapists must be cautious in counseling techniques when the validity of memories are in question to prevent influencing the outcome. The seriousness of the consequences to both clients and their families begs for concrete research and guidelines for therapy.

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CHAPTER I

INTRODUCTION

In the past decade, society's growing awareness of the extent of child sexual abuse has led to an expansion of efforts to help victims. However, as knowledge of child sexual abuse increases, new questions are raised. Questions such as: Who are the victims of child sexual abuse? How reliable is the memory of a child? How often are repressed memories of child sexual abuse claimed by adults? Can a therapist actually implant memories during the course of therapy? Are these recovered memories actually real or are they false memories? These questions are at the center of a growing debate on how best to determine the validity of sexual abuse allegations.

In assessing the validity of children's claims of child sexual abuse, the child's cognitive development relating to sexual maturity, language and memory must be examined (Benedek & Schetky, 1987). For this study how a child's development occurs is important because research of adult's memories of childhood abuse is examined. Adults appear to have better language skills and are more cognitively developed than children. In examining memory of children and adults, research has found children's memories to be more fragmented as well as less complete than those of adults (Johnson & Foley, 1984).

According to Bass and Davis (1988), the number of adults divulging victimization as children and turning to mental health professionals for help is increasing. As the numbers increase, professionals dealing with adults in the mental health field are faced with the dilemma of false memory. Loftus (1993), while acknowledging repression as a part of the foundation on which psychoanalysis is built, questions the authenticity of "repressed" memories of child sexual abuse. Some questions that therapists must address

objectively according to Yapko (1993) are those of truth, memory, and credibility: Can every spontaneous memory be believed? Can memories be inadvertently suggested by therapists? Perhaps most importantly, can an individual integrate suggested memories into real memory as if they were factual?

Calof (1993), on the other hand, defends the spontaneous emergence of repressed child sexual abuse memories and further states that fundamental misconceptions about therapy have led to the conclusion that many accounts are actually false memories. While therapists may unwittingly suggest traumatic memories or inadvertently pressure clients to jump to the conclusion that child sexual abuse took place, these are the exceptions to the rule and not the norm. Calof points out these rare occurances should not discredit the phenomena of spontaneous emergence of such memories. Wylie (1993), asserts that memory and emotion of the event can be separated because the brain was so overwhelmed by the child sexual abuse experience. The false memory controversy has in many instances forced therapists to take a clear stand either for or against the existence of false memories even though there are documented cases of false memories of child sexual abuse.

The purpose of this study is to examine the false memory phenomenon and its continuing impact on mental health professionals and how the professionals are addressing this issue. The literature reviewed will be analyzed and evaluated to determine the most effective therapy for adult child sexual abuse victims while avoiding possible implantation of false memory. The research will also be evaluated to determine future research needs.

CHAPTER II

CHILD SEXUAL ABUSE

The actual extent of child sexual abuse is difficult to know since some people choose not to reveal the abuse; however, as more and more adults come forward to claim they were sexually abused as children, the mental health professional has been challenged to find objective and caring ways to help these clients while trying to determine the validity of these claims. Family characteristics and patterns in homes where children have been sexually abused have been examined. Research has focused on the victim and the perpetrator examining the characteristics of both. It is becoming increasingly clear that therapists must have a good understanding of the phenomenon of child sexual abuse. They should understand the prevalence of abuse, the characteristics and patterns of families where abuse commonly takes place, and the symptoms that children and adults may present.

Most researchers agree that child sexual abuse usually occurs in dysfunctional homes. According to Bradshaw (1988) dysfunctional families transmit family rules from one generation to next. These rules state how children should be raised as well as stress the importance of family secrecy. These children are also taught to respect and obey adults without question, which can easily set the stage for child sexual abuse to occur. A child in this type of home will usually grow up and function from a shame-based personality.

Alexander (1992) and Finkelhor and Barron (1986) have identified certain family characteristics that appear to be predictors of increased risk of sexual abuse. These include the absence of a biological parent, marital conflict and violence, a poor relationship

between the child and parent, having mothers who worked outside the home or were emotionally distant or frequently ill, and the presence of a stepfather. These characteristics double a girl's vulnerability to sexual abuse. Alexander also asserts that child sexual abuse can occur when the child has an insecure attachment with their primary caregiver. These family characteristics appear to create an environment where child sexual abuse can easily take place.

Estimates regarding the number of children who are abused very widely. However, virtually all studies find a significantly larger number of girls being abused. The first national survey of adults regarding child sexual abuse reports 27% female and 16% male victimization rates (Finkelhor, Hotaling, Lewis, & Smith, 1990). The National Center for Child Abuse and Neglect (1988) reports that girls are nearly four times as likely as boys to be sexually abused, and others (Pierce & Pierce, 1985) have indicated that between 80 and 90% of all reported victims are girls. An analysis by Stephens, Grinnell, and Krysik (1991) of data collected by child protective services on 191 cases of such abuse found that 84% of all reported victims of child sexual abuse were girls, which appears to agree with Pierce & Pierce's earlier findings. Finkelhor (1979) suggests that approximately 25% of all girls and 10% of all boys in the United States are abused by the age of 18 years. Still others (Bass & Davis, 1988) report that 33% of all girls and 14% of all boys are sexually abused by the time they reach age 18. According to Kelley (1990) reliable estimates of the number of children sexually abused each year are difficult to obtain simply because so many cases of sexual abuse go undetected and therefore unreported. There are also methodological weaknesses in studies of sexual abuse such as

a lack of standardized instruments to assess child sexual abuse. While the estimates of the occurance of child sexual abuse varies, one would have to admit that there are far too many victims of child sexual abuse.

In reviewing the literature it would appear that males are the perpetrators in the majority of child sexual abuse cases. Tackett-Kendall and Simon (1987) collected and analyzed data from 365 adults who had been molested as children. In this sample 97% of the perpetrators were male and 62% of that number were biological fathers or father-surrogates. Stephens, Grinnell, and Krysik (1991) found in their review of data collected by child protective services that 98% of the perpetrators were males. Further, in 54% of all reported cases the perpetrator was an individual in the father role and in 79% of all cases a family member was the perpetrator.

While no one may know the true number of child sexual abuse victims, researchers tend to agree that the symptoms of child sexual abuse are varied. Some of the symptoms include anxiety, fear, depression and dysphoria, poor self-esteem, inappropriate sexual behavior, immaturity, nightmares, guilt, and behavior problems such as running away, substance abuse and self injurious behavior. In a study done by Pisaruk, Shawchuck, and Hoier (1992), the behavioral characteristics of victims of child sexual abuse were compared with non-abused children. This study found that sexually abused children were more emotionally disturbed than the non-abused children. The sexually abused children reported significantly greater levels of depression and dysphoria than the non-abused children. Some caution should be exercised in accepting these results as the sample size was small (n=17) and all data was collected through self-report.

Research has identified some long-term symptoms associated with child sexual abuse. Some of these symptoms are anger, hostility, depression, guilt, low self-esteem, self-destructive behavior, sexual and relationship problems, substance abuse, and communication difficulties (Briere & Runtz, 1986; Donaldson & Edwards, 1989). Unresolved feelings of anger and hostility appear to be common among adults who have experienced sexual abuse as children. Many of these adults have problems with expressing feelings, identifying emotions and incongruence between affect and behavior (Leehan & Wilson, 1985). In their work with female survivors of child sexual abuse, Bass and Davis (1988) found that victims either denied their anger or turned their anger toward others. It was noted that some victims were afraid of expressing their anger because of past experiences.

Interpersonal relationships appear to be affected by child sexual abuse. Brown and Finkelhor (1986) found that those individuals who experienced child sexual abuse had parenting difficulties, difficulty in relating to men and women, and continuing problems with parents. With the use of the Impact Interview Scale, Gorcey, McCall-Perez, and Santiago, (1986) found that sexually abused women reported more difficulty in relating to both males and females and also had problems with engaging in sexual intimacy. Twenty-five percent of the sample expressed anger and mistrust of women and 50% expressed anger, fear, and/or distrust of men. Herman, Russell, and Trocki (1986) examined clinical and nonclinical samples of adult females who were victims of incest. The women reported negative feelings about sex, men, and/or themselves, and also had difficulty in building or maintaining intimate relationships.

CHAPTER III

REPRESSION OF CHILD SEXUAL ABUSE IN ADULTS

Some researchers have suggested that one of the reasons child sexual abuse is underestimated is due to repression of traumatic memories (Cohen & Mannarino, 1993). It is necessary, therefore, to examine the literature on repression. According to Loftus (1993), between 18% and 59% of adults who were sexually abused as children report having repressed the memories of the abuse to some degree. In a study done by Briere and Conte (1993), 450 adult clinical clients who had reported sexual abuse histories comprised the sample group. The subjects were asked the following question. "During the period of time between when the first forced sexual experience and your 18th birthday was there ever a time when you could not remember the forced sexual experience?" Fifty nine percent of the sample answered yes to this question. Therefore, Briere and Conte interpreted the results to say that 59% of the subjects had experienced amnesia at some time in their life. However, it appears that subjects could have answered "yes" for a number of different reasons. For example, Loftus (1993) suggested that a "yes" in some cases might only mean that the subject did not want to remember the abuse because of the emotional consequences of remembering. If Loftus's assertion is true it may also indicate that 59% of adults may not truely repress the memory; instead they may choose not to remember.

Herman and Schatzow, (1987), gathered data on 53 women who were in short term therapy for incest survivors. They found that only 28% of the women reported severe memory deficits. These figures vary, according to Loftus, because of the difficulty in posing a question that asks someone to remember a memory they had forgotten.

Donaldson and Edwards (1989) and Briere (1989), as well as others, have associated Post-Traumatic Stress Disorder (PTSD) with child sexual abuse. In order to make a diagnosis of PTSD, the Diagnostic Statistical Manual of Mental Disorders IV (APA, 1994) requires the presence of several symptoms. Criteria for this diagnosis include: The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone; and the response of the individual was intense fear, helplessness, or horror. "The traumatic event is persistently reexperienced; persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness; persistent symptoms of increased arousal not present before the trauma" (p. 428). When the trauma is persistently avoided it may include amnesia for an important aspect of the event. The duration of these symptoms must be more than one month and the disturbance significantly impairs one's social or work life. One of the ways in which the traumatic event may be reexperienced is the feeling of the event recurring and also dissociative episodes such as flashbacks.

The many similarities in symptoms between child sexual abuse survivors and other trauma survivors have led many researchers to conceptualize the impact of child sexual abuse as a form of PTSD. A study conducted by Wolfe, Gentile, and Wolfe, (1989) concluded two main points: a) Child sexual abuse meets the criteria for "trauma" as defined by DSM III-R; b) clinical descriptions show that substantial numbers of child sexual abuse victims display at least some PTSD characteristics. Since the structured interview was developed by and used by the authors, one could question the collection of

the data presented, but with nearly half of the children displaying PTSD symptoms some weight should be given to this research.

In a study done by McLeer, Deblinger, Atkins, Foa, and Ralphe (1988), 31 children with histories of sexual abuse who were currently involved in outpatient treatment were examined. The child and parent(s) were given a structured interview developed by the authors. Several standardized instruments were also used to assess the children. The instruments were the Self Esteem Inventory (SEI), the State-Trait Anxiety Inventory for Children (STAIC), the Children's Depression Inventory (CDI) and the Child Behavior Checklist (CBC). The determination of a PTSD diagnosis was made by comparing interview data to the DSM-III criteria for PTSD. Forty eight percent of the sample met full diagnostic criteria.

Deblinger, McLeer, Atkins, Ralphe, and Foa's (1989) study provides additional support for conceptualizing the impact of child sexual abuse as a variant of PTSD. Deblinger et al. reviewed the charts of children admitted to an inpatient psychiatric hospital. Out of the 155 charts, 29 had a reported history of sexual abuse. These 29 were matched with children who had no history of abuse and children who had a history of physical abuse. A checklist of PTSD symptoms was developed by the authors by outlining characteristics found in the DSM-III. The charts were then reviewed to determine the presence of PTSD. Of the three groups, the child sexual abuse group had the highest percent of PTSD, 21%, while the physical abuse group had 7% and the "no abuse" control group had 10%.

Briere (1989) found survivors of child sexual abuse commonly exhibit psychological withdrawal from the outside world or a numbing of general responsiveness. He proposes that dissociation or psychological escape from pain develops early in life as a coping mechanism. Other researchers (Bass & Davis, 1988; Briere & Runtz, 1986) have also reported dissociation occurring in survivors of child sexual abuse. Perhaps the most dramatic example of dissociation is that of multiple personalities. According to the DSM VI, (APA, 1994), multiple personality disorder has often been preceded by severe abuse, including sexual abuse.

CHAPTER IV

FALSE MEMORY SYNDROME

False memory syndrome is gaining plausibility with the general public, the legal system and mental health professionals. It has been perhaps too easy for clients and therapists alike to accept child sexual abuse as an explanation for the suffering and long term problems the client has experienced in his life. This can easily happen from the therapist's point of view without proper training and understanding of how human memory works. From the client's perspective, it is often seen as a relief to identify a specific incident as the cause of their discomfort. Popular writings have also exacerbated the tendency to accept child sexual abuse as the cause of problems. False memory syndrome points out a need to be concerned about damaging relations within family systems and for vigilance in proper interviewing techniques.

False memory is the phenomenon of recovering a memory, often during the course of therapy, which turns out to be false. The question of false memory has lately become a widely debated topic. Several researchers (e.g. Calof, 1993; Loftus, 1993; Yapko, 1993) suggest that some alleged cases of sexual abuse did not in fact occur and that the memories were occasionally implanted or suggested by the media, a friend or in some cases even a therapist. Efforts to examine what impact suggestion has on memory have increased and several studies have been done.

Loftus, Miller, and Burns (1978) examined susceptibility to misinformation and found that as the original memory fades, a person becomes more vulnerable to suggestion. This appears to have great implications when examining false memories, especially when adults are recalling memories of childhood events. In Loftus and Hoffman's (1989) review

of the literature on misinformation and memory they conclude that when people do not have an original memory, they may accept misinformation and use it as their own memory. Loftus and Loftus (1980) assert "It may not be possible, in some instances, to ever discover from interviewing someone what actually happened in that person's past. Not only might the originally acquired memory have departed from reality in some systematic way, but the memory may have been continually subject to change after it was initially stored" (p. 419).

In Loftus and Davies' (1984) review of literature they found that both children and adults are susceptible to suggestive information in many situations. It was also stressed that both children and adults need to be interviewed objectively and the interviewers need to be cognizant of their own preconceived ideas which might interfere with the interview. Baron, Beattie, and Hershey (1988) found that subjects tend to look for evidence that corroborates their hunches rather than looking for evidence that disconfirms their hunches.

Most researchers and therapists now agree that some memories of child sexual abuse are in fact not true. The False Memory Syndrome Foundation was established in 1992 by concerned professionals and affected families. Groups such as this offer support to parents and family members who feel they have been wrongly accused of child sexual abuse (Wylie, 1993). One does not have to look far to find articles that depict the pain of these families. An anonymous article (Doe, 1991) was written by a mother whose family was being destroyed by accusations of child sexual abuse against the father. Recently, Newsweek (Woodward, Annin, & Cohen, 1994) ran a story about a man named Steve Cook who charged Cardinal Joeseph Bernardin, a priest in the Catholic church with child

sexual abuse, then withdrew the charge saying he did not have an actual memory. Yapko (1994) states that abuse as well as false accusations happen and health professionals must become better at distinguishing the difference between the two.

While many individuals turn to therapy for answers, still others look to popular writings. Loftus (1993), Yapko (1993), and Lynn and Nash (1994) suggest that recent publications of the incest book industry may be helping to create false memories in some clients. One book these researchers point to is The courage to heal by Bass and Davis (1988). This book gives possible abuse victim the following advice: "Even if your memories are incomplete, even if your family insists nothing happened, you still must believe yourself. Even if what you experienced feels too extreme to be possible or too mild to be abuse, even if you think 'I must have made it up,' ... you must come to terms with the fact that someone did those things to you" (p. 87); "If you think you were abused and your life shows the symptoms, you were" (p. 22). These and other similar statements lead Loftus, Yapko, and Lynn & Nash to question the appropriateness of these books when the abuse issue is still in question.

An understanding of how human memory works is necessary when treating possible child sexual abuse victims. In Loftus and Loftus's (1980) review of literature on the permanence of stored information in the human brain, they suggest there is strong evidence that substitution often occurs, whereby incorrect or misleading information replaces the original information stored in the brain. When reports of memories are recovered either spontaneously or through memory probes, Loftus and Loftus say the memories may in fact be fragments of past experiences that have come from

reconstruction or they may have been constructed at the time of report and have little or no relationship to past experiences. In other words, when an individual recalls an event, they are reconstructing the event and not just recalling the event.

According to Loftus (1980) it may be impossible in some instances to ever know what actually happened in a person's past from interviewing the person. Every time a person recalls an event they must reconstruct the memory and therefore the memory can be colored by life experiences since the original event occurred, suggestions by others, listening to others recollections, or the individual can be looking at the event in a new context.

Research on children's memory must be included since adults are talking about abuse that happened to them as children. Pynoos and Nader (1989) studied children's memory and their proximity to violence. In this study they examined the memories of elementary school children who had experienced a sniper attack at their school. They found, when the children freely recalled the event, the proximity to the violence influenced the child's memory of the event. In general, the children who were on the playground during the sniper attack minimized the threat to them. Children who were not at school during the attack tended to place themselves closer to the attack, recalling the event as if they were there. In her review of literature, Loftus (1993) suggests that people regularly fail to remember significant life events a year after the event occurred.

Autobiographical memory refers to the memories a person has of his own life experiences. This is distinct from episodic or specific factual memory. Linton (1986)

asserts that while people believe personal memories actually depict exactly what happened at a given time and place, these memories can be in error.

A study by Haugaard, Reppucci, Laird, and Nauful (1991), compared girl's and women's ability to recall events. The sample consisted of 142 girls from pre-school an kindergarten classes and 23 women. Subjects were randomly assigned to a group and were shown one of two videotapes. Twenty-nine percent of the children from the total sample recalled an event that did not even occur although none of the women did. This research underlines the need for therapists to consider the reliability of memories encoded as children.

When adults experience trouble in relationships and life in general they sometimes turn to mental health professionals. During the course of therapy some of these adults choose to undergo hypnosis. Many researchers, including Calof (1993), Ewin (1994), Loftus (1993), and Yapko (1994) suggest therapists must be well trained in hypnosis and should proceed carefully when using this technique.

Smith's (1983) review of literature found, while hypnosis has apparently at times been of value in solving crimes by enhancing memory, research efforts to demonstrate improved memory by hypnosis have not been successful. What the studies do demonstrate quite clearly, however, is that witnesses interrogated under hypnosis are more suggestible, showing a greater tendency to agree with the interrogator. Loftus and Loftus (1980) recognize that hypnosis is often used in treatment as a retrieval technique believed to be capable of reactivating detailed memories that have been repressed for many years. Loftus and Loftus suggest that with hypnosis people may just relax or concentrate more and

therefore may be willing to share more. Lynn and Nash (1994) note that as therapists are unable to reliably distinguish accurate and false memories, they are not in a position to provide clients with incentives for distinguishing accurate and false memories. Lynn and Nash also say that because therapists want to build and maintain positive rapport with their clients, they are not likely to ask their clients to evaluate the "historical validity of a certain memory" and go on to warn that even with hypnosis clients do not literally return to their childhood.

Lynn, Myers, and Sivec (1994) caution therapists to be aware of the client's interest and to guard against projecting their own agenda in the course of their work. Yapko (1994) also warns that therapists must be careful about allowing their personal beliefs and philosophy to influence the method and technique of treatment.

Yapko (1994) did a study on the beliefs of psychotherapists about hypnosis. Yapko collected data from 869 psychotherapists who were attending professional conferences and workshops. A written survey of general statements was given to each subject. In response to the statements, the subjects had a Likert scale range of responses. One of the statements was: "When someone has a memory of trauma while in hypnosis it objectively must actually have occurred". Thirty-one percent of those surveyed agreed either mildly or strongly. A second statement from the survey was: "It is possible to suggest false memories to someone who then incorporates them as true memories". The results indicated that 21% disagreed either strongly or mildly. Yapko concludes that a therapist's personal bias regarding hypnosis and memory may lead to a "search and rescue"

approach to therapy. This approach pivots on the therapist's belief that abuse took place and therapy becomes a search for the history of abuse that the client may have repressed.

Since some report memories of child sexual abuse occurring when the individual was only one year old or less, literature on childhood amnesia should be examined. Most empirical studies of childhood amnesia suggest that one's earliest recollection is between the age of three and four (Kihlstrom & Harackiewicz, 1982). In a study by Pillemer, Picariello, and Pruett (1994), preschool children were divided into one of two groups based on age. One group had a mean age of 3 1/2 years while the other group had a mean age of 4 1/2. All children were interviewed twice about an emergency school evacuation caused by a fire alarm going off. Two weeks after evacuation all kids were able to answer some memory questions. Seven years later 25 out of the 28 original students were questioned both formally and informally about the evacuation which occurred when they were in preschool. Overall the memory of the 4 1/2 year olds at the time of the event were much better then the 3 1/2 age group. Fifty-seven % of the older children were able to answer direct questions correctly while only 18 % of the younger children answered correctly.

In a study by Usher and Neisser (1993), adult's memories of four datable target events - the birth of a younger sibling, a hospitalization, the death of a family member, and making a family move were examined. The results showed that the earliest age of recall for hospitalization and birth of a sibling was age two, while earliest recall for death and family move was age three. While these results are striking, Loftus (1993), cautions that the subjects may have recalled stories about these events and not the actual event itself.

Even if one were to accept that some children do have memories starting around age 2, how would one explain some adults alleging child sexual abuse that occurred during infancy? This area appears to be difficult to research because of so many confounding factors that may or may not affect memory. Maybe the adult's memories of infant sexual abuse are true, but they could also be false memories.

The debate on false memory syndrome is not likely to be resolved easily. One criticism of research on false memory is that there is very little research on traumatic memory events. This type of research is very important as child sexual abuse is a traumatic event to the child. It is only in rare instances that accusations of child sexual abuse, based on memories recovered as an adult can actually be proven or disproven. As it is not yet known how to distinguish true memories from false memories, some clients may have to accept the fact that they may never know.

CHAPTER V

IMPLICATIONS FOR THERAPY

Baker (1992) suggests that reports of sexual abuse are on the increase. He attributes this increase to education and a rise in awareness. Along with the increased awareness and reports of child sexual abuse has come increased attention to the false memory phenomena. Therapists and researchers alike appear to have taken a firm stand either on the side of actual memory or false memory. According to Gardner (1991) this can be a mistake as this does not have to be an either-or question. Gardner believes that each situation where abuse has been alleged must be examined separately to see if it is valid. He points out that while intra-familial abuse occurs quite commonly, allegations of abuse made when there is a custody dispute have a high likelihood of being false. Researchers agree that child sexual abuse does happen. A diagnosis of child sexual abuse is very powerful and has the potential to destroy the family as well as the client (Yapko 1993, Gravitz, 1994, Loftus, 1993); therefore, therapy should be approached with the utmost care and the therapist must be open-minded.

One study by Shaffer and Cozolino (1992), focused on 20 outpatients who did not seek therapy with an awareness of childhood victimization but rather "pre-awareness symptoms" of anxiety, severe depression, or dissociation. The average length of therapy to the date of publication was seven years. Most subjects' initial memories were not as psychologically disturbed as the memories that came later. Many subjects had a progression of memories starting with sexual abuse by acquaintances, to sexual abuse by family members, to memories of ritual abuse including sexual abuse by several perpetrators of both sexes. Results such as these raise serious questions as to the most

appropriate and successful approach to therapy for clients who are unsure if child sexual abuse is actually an issue.

Bloom (1994) asserts that promoting patient responsibility for their lives, enhancing lifetime coping skills, and creating change before requiring insight seem to be the basis of the most successful psychotherapy. Since adults are able to assess childhood events with a different psychological perspective, understanding the adult perspective is necessary in putting possible accusations of child sexual abuse in perspective (Akman, Beitchman, Cassavia, daCosta, Hood, & Zucker 1992). In treating clients where child sexual abuse is a possible issue, attention must be paid to the questioning of these alleged victims. One must constantly be aware of the power of suggestion and of the possibility of leading the client. Since the cognitive levels of adults and children are different, one should be cautious when adults start interpreting memories they have as children. Therapists should remain objective when discussing alleged child sexual abuse. It appears there is a fine line to walk, as one needs to validate the client and yet be able to at least entertain the idea that these memories may in fact, be false.

According to Siegel and Romig, (1990), the therapist should allow sufficient time to build rapport, allowing the client to choose the starting point, and then pace the client. Siegel and Romig further state that therapists and clients must accept the fact that some survivors may never recall abusive situations. According to Baker (1992), therapists need to be aware that an individual's emotional life plays a key role in one's thinking and perceptions. Child sexual abuse usually occurs within the family and is a taboo subject. Whether it will be identified depends upon the action the victim and other family members

take (Daro, 1988). Family and victims may be reluctant to talk about the sexual abuse because of its lack of acceptance in society. Perhaps more importantly it must be recognized that memories may be influenced by many factors such as need for approval and the techniques of therapy.

CHAPTER VI

FUTURE RESEARCH

There is an increasing number of individuals reporting repressed memories of sexual abuse (Loftus, 1993). A current review of the literature indicates that several studies on memory, PTSD, and counseling techniques have several shortcomings. Clinical studies need to be examined to see if they apply to the general nonclinical population (Briere & Runtz, 1986). Standardized instruments must be developed and implemented to validate abuse-relevant measurements according to Briere and Runtz, (1993) and Rowan and Foy (1993). Briere (1992) states that with the increased awareness of child sexual abuse, many new measurement strategies have been tried. He further asserts that many researchers have tried homemade instruments which have questionable or unknown psychometric value. Briere and Runtz further suggest that some of the assessment instruments with known psychometric value should be tried by researchers and therapists.

The definition of child sexual abuse is not consistent throughout research (Browne & Finkelhor, 1986); therefore, it is somewhat difficult to compare studies on child sexual abuse. While statistics of child sexual abuse vary widely, one must also remember that according to MacFarlane (1978) demographic estimates suggest that there is a group of 10-20% of the general population who have been exposed to child sexual abuse as children and have not sought or received treatment. Methods are needed to collect data from these silent victims of child sexual abuse. More research needs to be done using nonbiased samples and matched control groups. Studies need to be done comparing adults who were abused as children and never sought treatment with adults who have sought treatment and were abused as children. The thought patterns and problems with

life relationships should be examined to see if any differences between the two groups exist.

In examining research of repressed memories of abuse recovered in therapy, one must be cautious. According to Loftus (1993), Yapko (1993) and others, several reasons for caution are pointed out. The therapist may have willingly or unwillingly directed the client to the belief that abuse did occur. The therapist's questioning technique must be examined and therapists must realize the power they have when dealing with an already emotional person who is looking for the answer for all the problems they are having (Yapko, 1993). The treatment strategies employed by some therapists must be examined as the therapist's own interpretation may label the memory as abuse before the client has come to that realization (Baker, 1992). Just because a person dreams or visualizes abuse, does this mean that in fact it is a true memory (Loftus, 1993)? More research needs to be done in this area of memory examining how traumatic events effect memory. For ethical reasons, this will not be an easy task; however; in daily life people do experience very traumatic events and these can be documented.

A significant number of individuals read self-help books looking for answers to their personal problems. This is very alarming because these books are usually loaded with suggestions of abuse (Yapko, 1993 & Loftus, 1993). Some of these books including The Courage to Heal (Bass & Davis, 1988) suggest that abuse probably took place even if one has no memory of the abuse. This causes rightful concern for Wakefield and Underwager (1992) and Yapko (1993) because child sexual abuse is not the root of every person's problems. It appears that when reading popular writings, one should have an

open mind. This can be hard for most individuals because they are usually looking for an answer to their problem (Loftus, 1993). Until tools can be developed to distinguish true repressed memories from false ones, therapists must proceed with caution.

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