

Memory Repression in Adult Survivors of Childhood Sexual Abuse

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Abstract

Introduction

The terrible reality of childhood sexual abuse cannot be forgotten in the debates over the validity and processes of traumatic memory. Sexual abuse profoundly influences the whole being of the victim.

Aim

The purpose of this paper is to explore processes and outcomes of not remembering childhood sexual abuse.

Conclusion

It is relevant to holistic nursing, how childhood sexual abuse and the victim's coping processes affect long-term biopsychosocial health. Recovered memories are part of the healing process. "Putting away" traumatic childhood memories of sexual abuse, whether voluntarily or unconsciously, has a logical purpose that can be seen from classic psychoanalytic, cognitive, and holistic theories.

Key words

sexual abuse, memory, adults

Introduction

Freud presented *The Aetiology of Hysteria* in 1896, and brought forth the scientific discussion of adult survivors of childhood sexual abuse (Gay, 1989). It historically was common practice to blame the victim when abuse was discussed at all (Bolen, 2001). Freud's seduction theory laid the groundwork for belief that the child was precociously seeking the sexual experience, even though a year later he retracted the theory (Freyd, 1997).

Paradigms shifted very slowly. In the 1970s the National Center on Child Abuse and Neglect

was established and comprehensive research began (Bolen, 2001). The feminist movement challenged the sociocultural context. A new freedom of speech grew out of the Vietnam War; secrets were brought out of the dark. The victim was no longer held culpable. The empirical research in childhood sexual abuse was diverted in the 1990s with emerging controversies about false memories induced by counselor suggestion (Bolen, 2001). It is not within the scope of this paper to address the abundant literature available on the controversies about false memories. The influence of controversy on

sociocultural thought and the victim nonetheless does need consideration.

The American Psychological Association (2003) reports that most people who were sexually abused as children remember the episodes. The victim may not understand the abuse or may not report or discuss the experience. The memory may only hold fragments of the experience. Most victims choose to keep the secret from others, and choose to not think about the secret themselves (APA, 2003). Total repression with recovered memory years later is rare.

Definitions

Suppression. Suppression is a conscious, voluntary process identified in psychoanalysis as a defense mechanism to exclude unacceptable thoughts and desires (Reber & Reber, 2001).

Repression. A construct of psychoanalytical theory, repression is an involuntary defense mechanism where hurtful events are stored in memory but not accessible to consciousness (Mayer, 1995).

Dissociation. Dissociation describes the process where memories are separated from conscious thought (Reber & Reber, 2001). This is a potentially reversible amnesia where stressful traumatic memories are blocked from recall. The amnesia is too extensive to be similar to normal forgetting (Butler & Spiegel, 1997). Dissociation is directly linked to self-deception (Gregory, 1998).

Childhood Sexual Abuse: A sexual encounter with a child under the age of consent is childhood sexual abuse. Sexual abuse takes

many forms that include explicit sexual talk, exhibiting, sexual fondling, lack of privacy to bathe or undress, masturbation, and sexual intercourse.

Childhood Sexual Abuse Prevalence

Studies conducted in 19 countries have reported prevalence rates for sexual abuse ranging from 7% to 34% among girls, and from 3% to 29% among boys (WHO, 1999). Sexual abuse of a child has begun as early as infancy, with the average age of onset ranging from 6 to 10 years old (Briere & Runtz, 1988; Jehu, 1988). Child abuse is found in all societies and ordinarily is a highly guarded secret wherever it takes place (WHO, 1997). Most cases of abuse and neglect go unreported. Statistics are not reflective of actual incidence (Hopper, 1998).

Feelings of shame coupled with a lack of physical evidence of abuse commonly accompany secrecy in the aftermath of abuse. Defenses formed in moments of childhood trauma are deeply rooted because they were connected to survival (Bratton, 1999). These coping mechanisms were functional at the time of the incident, but are harmful when continued into adulthood.

Long-term effects of childhood sexual abuse

Survivors of sexual abuse frequently have a legacy of both psychological and physical problems throughout life. The range of potential adverse adult outcomes is extensive. Child sexual abuse presents as a risk factor for a wide range of subsequent problems (Mullen, &

Fleming, 1996). There appears to be no unique pattern to these long-term effects.

A history of childhood sexual abuse has been linked to fear, anxiety, depression, insomnia, obesity, headaches, aggression, anger, hostility, poor self-esteem, substance abuse, suicide attempts, and sexual dysfunction (Bridgeland, Duane, & Stewart, 2001; Cornman, 1997; Hall, 1999; Hall, 2000; Knisely, Barker, Ingeroll, & Dawson, 2000; Roberts, 1996; WHO, 1997). There is a strong incidence of long-term psychological problems for survivors of childhood sexual abuse (Abrahamson, 1998; Creedy, Nizette, & Henderson, 1998; WHO, 1997). Adults who had experienced childhood sexual abuse were twice as likely to suffer mental health disorders and have a higher incidence of depression and lower self-esteem (Zlotnick, Mattia, & Zimmerman, 2001). Survivors showed a higher discrepancy between their perceived present self and the ideal self, indicating that survivors did not feel they were functioning at ideal level (Freshwater, Leach, & Aldridge, 2001). A strong and stable correlation was found between childhood abuse and attempted suicide (Bridgeland et al., 2001).

There are higher rates of eating disorders in those who have experienced childhood sexual abuse (Romans, Gendall, Martin, & Mullen, 2001). Alexander et al. (1998) found that 57% of fibromyalgia patients reported a history of sexual abuse. Patients treated for chronic intractable back pain had a significantly higher history of childhood sexual abuse (Pecukonis, 1996). The incidence of childhood sexual abuse is elevated

among women with irritable bowel syndrome (Heitkemper et al., 2001).

Survivors cannot be stereotyped. Some transcend the experience and become outspoken advocates for societal change (Steed, 1995). Others adopt risky life styles such as prostitution, promiscuity, and substance abuse (Hall, 2000). Recovery is possible (Steed, 1995). Transcendence through the experience involves telling the secret and being supported. The therapeutic process is about opening to and remembering the truth, understanding the imprint of childhood sexual trauma, and discovering meaning in the experience (Parse, 1998; Steed, 1995).

The Processes of Remembering or Not Remembering

Memory

The brain has an innate, genetically programmed capacity to learn. Memory is a synaptic result of life experiences and learning. Memory is an abstract reconstruction of events based on the way they were perceived, stored, and recovered, not as they actually occurred. The processes of memory have been broken into four stages: encoding, storage, retrieval, and recounting.

Encoding. Encoding is the process of transferring short-term memory to long-term memory. The encoding can be automatic, as with most episodic and semantic information, or it can be effortful, such as when memorizing a list of terms (Plotnik, 2002).

Storage. Storage refers to the organization of memories in the brain. There are two general

types of long-term memory, declarative and procedural. Declarative (explicit) memories concern facts and events. They typically consist of both semantic and episodic elements. Procedural (implicit) memory, in contrast, concerns mostly motor skills, some cognitive elements, and conditioned emotional memory. Procedural memories direct behavior and action (LeDoux, 2002). The distinction between procedural and declarative memory is relevant because they have been shown to involve different brain systems. The hippocampus, parahippocampus, and limbic system are all involved in explicit memories (LeDoux, 2002).

Retrieval. Retrieval is the process of transferring long term memory back into short-term memory where it can be recalled and recognized (Plotnik, 2002). Several things potentially can interfere with the retrieval process, including interference from other memories, ineffective retrieval cues, organic damage, and deliberate desire not to remember. The controversy about false memories being induced is relevant in this process as well as the next process, recounting.

Recounting. Recounting is the retelling of the experience. Assembling memories into a narrative is closely associated with autobiographical reasoning, which consists of the interpretation and evaluation of memories (Singer & Bluck, 2001). These narrative and autobiographical aspects of memory alter the way memories are processed, and are a central focus of the therapeutic environment. Memories can be changed by the environment in which they are recounted such as suggestion of a therapist (American Psychiatric Association,

2000). All of the processes involved in memory are subject to the holistic influence of developmental stage, prior learning, emotional state, and sensory data at the time of the event, post-memory questioning, and description.

Traumatic memory

The moment of trauma brings forth a sense of helplessness. The event “overwhelm(s) the ordinary systems of care that give people a sense of control, connection, and meaning” (Herman, 1997, p. 33). The secret of childhood sexual abuse evokes shame and further repression of the trauma (Fredrickson, 1992). Family members deny or keep the secret. Traumatic memories lack a verbal narrative, lack context and are encoded instead as images and emotional sensations.

Perceptual and environmental factors play an important role in memory organization. Ferry, Roozendaal, and McGaugh (1999) first reported that hormonal and neurotransmitter levels in the amygdala during an episode greatly influence the consolidation of memories of the episode. The inference is that a stressful event will be encoded more forcefully, and may be recalled differently. LeDoux (2002) reports that moderate emotional arousal strengthens memory encoding, but highly stressful experiences impair encoding.

High levels of stress cause the sympathetic nervous system to begin a cascade of hormonal response. Cortisol blood levels rise. Cortisol binds with and disrupts the hippocampus, impairing explicit memory function (Kim, Lee,

Han, & Packard, 2001). This study examined the role of the amygdala in modulating the effects of stress on the hippocampus of rats. Experimental lesions on the amygdala were used to block the effect of stress, though hormonal cascades including cortisol continued. Stressed animals showed impaired long-term memory (Kim et al., 2001). The amygdala modulates stress effects on the hippocampus and influences memory. Alternative processes and motivations for forgetting are possible and probable. There are likely many ways to remember or forget.

Forgetting

All memories are vulnerable to distortion, decay, and complete loss. "Forgetting usually occurs imperceptibly with the passing of time" (Schacter, 2001, p. 1724). Can the trauma of sexual abuse be so profound that the experience is forgotten? There is logic in the use of amnesia. The stress and anxiety are great. Freyd (1997) wrote that the blockage is "a natural and inevitable reaction to childhood sexual abuse" (p. 4). Memory suppression not only reduces the anxiety of reality, but not *always* being conscious of the abuse, if the abuser is a caregiver, may be necessary for survival. After the abuse, "forgetting" occurs on an explicit declarative level, but the episodes are still known on an implicit, procedural level. These memories may surface as learned behaviors of distrust or poor self-perception (Freyd, 1997).

The experimental study of repression of traumatic memory is ethically difficult. Researchers, however, have been able to

identify the ability to *willingly* forget. Anderson and Green (2001) found that voluntary suppression impaired later memory; though manipulating the memory of a word list is not comparable to the traumatic experience of childhood sexual abuse. This study does not address whether memory repression is an involuntary defense mechanism or an example of self-deception. Mechanisms are available in the brain to "prevent unwanted declarative memories from entering awareness" (p. 366). The research can be applied to repressed memories of adult survivors of childhood sexual abuse. Victims who want to forget the experience encounter triggers that bring back the unwanted memory. The victims can deliberately prevent awareness of the triggers. The practice of forgetting reinforces suppression of memory (Anderson & Green, 2001).

Repression, Dissociation, and Suppression

Fredrickson (1992) describes the repression as a multifaceted event influenced by predisposing factors, profoundly shaped by the event, and reinforced by the social network of the family. Predisposing factors such as the age at the time of the trauma will influence memory-encoding ability. Very young victims may not have the recall ability or thought processes to process the event with any order. Childhood amnesia is the common term that refers to the "lack of episodic memory of childhood. Perhaps procedural memory can exist for early childhood, even when declarative memory does not" (Freyd, 1996, p. 120). Pain, shock, sexual sensation, rage, and shame bombard the internal and external senses. The rush of hormones from the

sympathetic nervous system influences encoding. Dissociation numbs the horror.

The reaction of the family to the event further reinforces repression. If the child had been traumatized in a motor vehicle accident, the incident would be part of the normal family discussions, offering indirect support to the victim and allowing integration of the experience into their self. The family involved in childhood sexual abuse uses denial mechanisms and prevents the victim from talking about the experience and incorporating the event into who they are. The combination of the complex cognitive avoidance mechanisms and social prohibitions against talking about the events may "further undermine encoding, storage, and/or retrieval of these memories" (Butler & Spiegel, 1997, p. 16).

Some of the more persistent forms of childhood sexual abuse can lead to severe types of dissociative disorders such as multiple personality disorder (Nichols, 1992). Briere's self-trauma model suggests that these defense mechanisms serve an important function, that of "reducing the internal impact of trauma to the point that it eventually can be accommodated by existing self-capacities" (Briere, 1996, p. 141). Dissociation reduces the stress by decreasing awareness of the experience. The child is numbed to the pain. The trauma is encapsulated; therefore, the child does not continue to integrate the experience cognitively with the ongoing development of the self. Some adult survivors split those experiences into multiple personalities (Nichols, 1992). The

continual use of dissociation prevents future opportunities to learn to tolerate painful life experiences without avoidance (Briere, 1996; Nichols, 1992).

The sexually abused child understandably uses suppression in an attempt to get through the overwhelming traumatic experience. The dissociation provides a perceptual numbing, called upon to decrease anxiety by decreasing awareness of the traumatic event (Briere, 1996). Continued use of dissociation, however, would reduce opportunities to learn how to tolerate stress without avoidance. Coping mechanisms needed to survive the experience are over-practiced and become maladaptive (Bratton, 1999).

The experience of childhood sexual abuse alters attachment and trust dynamics, affects developmental stages, and distorts the perception of self (Briere, 1996). Self-trauma theory hypothesizes that there is failure of internal ability to integrate the experience into the self. This trauma in turn triggers the intrusive symptoms of Post-Traumatic Stress Disorder. The trigger may be an unconscious response to a stimulus relating back to the original abuse trauma.

Post-traumatic Stress Disorder

Symptoms of anxiety, dissociation, and avoidance behavior characterize posttraumatic stress disorder (PTSD). Studies have drawn parallels between Vietnam veterans diagnosed with PTSD and survivors of childhood sexual

abuse. Developmental disorders include loss of attachment, reduced self-esteem, and fewer interpersonal relationships (WHO, 1997).

Dissociation correlates with posttraumatic symptom severity in adulthood (Johnson, Pike, & Chard, 2001). Female childhood sexual abuse survivors (n=89) aged 18 to 56 years participated in a Southeastern United States Center for Traumatic Research study. A method of structured interviews with standardized measures collected data of current PTSD, depression, dissociation, and abuse characteristics. Researchers found that traumatic dissociation was significantly related to PTSD, depression, and dissociation symptom severity in adulthood. If a woman dissociates during childhood sexual abuse she becomes unable to integrate and process the experience. Another relevant finding in this research was that abuse characteristics did not predict the severity of symptoms in adulthood, but correlated to dissociation severity during the abuse (Johnson, Pike, & Chard, 2001).

False Memories

Memories are subject to change. The 1990s brought forth a considerable controversy concerning the validity of repression (Loftus, 1993; Loftus, 1994; Pope 1998). Memories recovered in therapy were sometimes found to be false and subsequent accusations ruined lives. The American Psychological Association concluded that it was possible to recover memories and it was possible to construct convincing false memories (APA, 1998). There are other possible tragic consequences of the

debate over false and true recovered memories. There may be disbelief when genuine sexual abuse is revealed. The fear of not being believed because of the public controversy may stop a victim from sharing their story. The American Psychological Association and the American Psychiatric Association released a joint statement that cautioned against the possibility of discrediting patients traumatized by abuse, because of public confusion over false or true memories (American Psychiatric Association, 2000).

Remembering Again

The molester imposes a conspiracy of silence on the child, with threats or promises. Secrecy is the cornerstone of childhood sexual abuse and influences the child's ability to develop normally into a healthy adult. The incest secret molds the core of the victim's identity (Briere, 1996). It is difficult for a child to keep a secret. A "secret wants telling, that is its power" (Poston & Lison, 1989, p. 76). This secret carries and it is easier to put the experience "away" where the victim is not reminded of the trauma. Sexual abuse puts the victim at risk for memory repression. "Memory repression thrives in shame, secrecy, and shock" (Fredrickson, 1992, p. 23).

Stressful events in the adult survivor's life can trigger flashbacks, nightmares, and other symptoms of PTSD. These memories are intrusive. "The traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness" (Herman, 1997, p. 37). Memories are more easily retrieved from storage "when the emotional state at the time of the memory

formation matches the state at the time of retrieval” (LeDoux, 2002, p. 222). The amygdala activation during the similar emotional state organizes, stores, and retrieves implicit memory. According to Briere, this re-experiencing “is an inborn, self-healing activity” (1996, p.144). The psyche attempts to deal with the trauma by exposing the conscious mind to fragments of the past events. This incremental exposure allows a “gradual accommodation of cognitively unacceptable material” (Briere, 1996, p.144). Nightmares, recovered memories, and intrusive flashbacks, while distressing, provide a pathway to healing. These symptoms represent “the mind’s automatic attempt to desensitize and integrate affectively laden material by repeatedly exposing itself to small, moderately distressing fragments of an otherwise overwhelming trauma” (Briere, 1996, p.144).

Theoretical Perspectives of Memory Suppression

Psychoanalytic Theory. In the psychoanalytic / psychodynamic model, repression of traumatic memories functions as a defense mechanism against anxiety (Gay, 1989). The ego is protected from threatening thoughts and memories at the unconscious level. The suppression of sexual content such as rape or sexual abuse may displace and generalize to sexuality in general, creating a host of associations (Hall, 1954). This condition will create a combination of repression proper, which is the repression of a conscious thought or episode, and primal repression, which is the repression of drives such as sexuality (Freud, 1915).

Problems occur when the unconscious content of the mind is in conflict with the conscious. A general psychoanalytic approach to the problem would include intentionally searching for and exploring the repressed memories in order to bring the causal relations into consciousness where they can be identified for what they are (James & Gilliland, 2003). Once the repressed content has been exposed to consciousness, the repression and displacement lose their power to interfere with other psychic processes.

Cognitive Theory. From a cognitive perspective, the repression or forgetting has a similar function as the psychodynamic model – protection of the ego. The cognitive mechanism, however, differs from Freudian theories. Cloitre, Cancienne, Brodsky, Dulit, and Perry (1996) report that the subject may be selectively forgetting and remembering experiences at the conscious level. This happens because of attention being focused elsewhere, causing interference with the normal memory processing of the episode. A cognitive approach to the problem will necessarily focus on the survivor’s perceptions and attitudes toward the abuse (James & Gilliland, 2003). If a survivor’s concept of the experience can be changed, then the behaviors influenced by the episode(s) will change. The focus, in contrast to psychoanalysis, will remain on present attitudes, rather than past phenomena. The experience is explored only in the context of its influence on the present.

Holistic Approach. This existential, phenomenological, humanistic approach

contends that strength, transcendence, and growth come from finding meaning, even if the experience is perceived as negative. The therapist's role is to illuminate discovery of relevant personal meaning and guide the client to uncovering the authentic self. The therapist is genuine, wholly present, non-directing, and practices from the belief that the client has not only the responsibility but also the wisdom to make their life choices. Past events are acknowledged, but the focus is on creating an interpersonal helping relationship in the here-and-now. A genuine, trusting, unconditionally positive relationship will provide the framework for the patient to process the trauma, and to grow beyond it. A holistic nurse would say, "the abuse should never have happened, and I am sorry that it did. How are you different because you were abused? How did the abuse change you? How are you *better*, even though this very wrong thing happened to you?"

The holistic nurse will understand that the physical, psychological, and social manifestations outlined and common to adult survivors are the body's way of remembering the abuse. This somatic reflection of memory suppression reinforces the theory that all life experiences influence cell chemistry and register memory in cell tissue (Pert, 1999). Somatic symptoms develop from the continual emotional stress influencing physical health. Treating the symptoms of various disorders may provide some relief, but remembering, discussing the abuse, and integrating the experience into self-concept will allow true healing.

Conclusion

Many questions about traumatic memory and remembering childhood sexual abuse remain. What *is* known is that sexual abuse profoundly changes lives. Future research may answer some questions, but in the meantime, therapists are ethically obliged to serve those who report memories of childhood sexual abuse. Nurses must take a leading role in education of the public and professionals, and prevention of childhood sexual abuse.

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