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Recounting Graphic Sexual Abuse Memories in Therapy: The Impact on Women's Healing

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This retrospective study investigates the impact on women's functioning of recounting during their therapy the graphic details of sexual abuse they had experienced in childhood. Fifty-nine participants residing in Southern Ontario were divided into two groups: those who spent more time ($N = 19$) versus less time ($N = 40$) in therapy recounting graphic abuse details. Results revealed that the group who had spent more time recounting abuse memories: (a) had mean functioning scores that were significantly lower before and during therapy, but that did not significantly differ after therapy; (b) recovered more memories of abuse during therapy, and (c) were more likely to have participated in hypnosis, and to report having been encouraged to remember details of abuse. Participants rated as most therapeutic those approaches that assisted them to increase their understanding of the abuse. Strategies related to acceptance, understanding, and making meaning were most important in promoting healing.

KEY WORDS: sexual abuse; therapy; memory work; healing; recovered memories.

THE IMPACT OF RECOUNTING GRAPHIC DETAILS OF ABUSE MEMORIES ON WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE IN THERAPY

This retrospective study examines how adult women who had been victims of sexual abuse during childhood ("CSA") experienced working with abuse memories in therapy. A follow-up to an earlier, exploratory, qualitative study (Ewing & Avis, 2000), the current study addresses questions about the impact on survivors of childhood sexual abuse of recounting graphic details of abuse memories during their therapy.

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REVIEW OF THE LITERATURE

Controversy Surrounding the Therapy of CSA Survivors

Therapy with adult survivors of CSA has become a subject of contentious debate among researchers, clinicians and the general public since the emergence of the False Memory Syndrome Foundation in 1992. This foundation, and some researchers, has proposed that false memories for a traumatic event are actually implanted by therapist suggestion. These critics of memory work in the therapy of adults abused as children equate recovered memories of abuse with memory distortions deliberately created in laboratory settings (Loftus, 1993; Loftus & Coan, 1995), and suggest that such work underlies the increasing number of sexual abuse allegations (Whitfield, 1995).

In contrast to the position that memories recovered after a period of forgetting are false, implanted memories, there is compelling evidence, in cases where the authenticity of the abuse has been verifiable, that memories of abuse may indeed be forgotten, and then recovered

at a later time, (Herman & Schatzow, 1987; Williams, 1994). In a review of 25 studies examining whether previously unremembered memories of abuse can return to consciousness, Scheflin and Brown (1996) concluded that amnesia for CSA *does* occur, recall of CSA *can* be delayed after a period of forgetting, and that recovered memories *are* generally accurate.

The "false memory" debate has led clinicians and researchers to re-examine the benefits and risks associated with different types of memory work used in therapy with clients who may have been sexually abused in childhood. Recent writers in the area of trauma and memory have criticized the polarized views promoted within the debate surrounding recovered memories of CSA, stating that categories of "true" and "false" memories are an artificial, forced choice dichotomy (Pope & Brown, 1996), particularly given evidence supporting the fragmentary nature of abuse memories and the time span over which memories of trauma are remembered (Gold *et al*., 1999). Recently, there appears to be a greater consideration of less polarized, both/and positions which acknowledge both that, under certain conditions and with certain individuals, some therapeutic practices are more likely to lead to errors in recall, or even the creation of inauthentic memories, *and* that authentic memories of earlier sexual trauma may be forgotten and then recovered at a later point in time (Berliner & Briere, 1999; Enns, 1996; Lindsay & Read, 1995; Poole *et al*., 1995; Pope & Brown, 1996; Pope & Tabachnick, 1995).

Memory Work Techniques Promoted by Clinicians

A review of the literature written from the perspective of clinicians who work with CSA survivors reveals a wide variety of approaches which stem from differing theoretical conceptualizations regarding recovery from trauma. Some clinicians advocate the use of memory techniques which have been critiqued for their potential to create "false memories" by both "false memory syndrome" proponents as well as by some cognitive psychologists (Loftus, 1993; Loftus & Coan, 1995). Other clinicians critique many of the same memory work techniques, although more from disagreement about what facilitates clients' healing in therapy than from concern about false memory creation (Dolan, 1991; Gil, 1988; Piers, 1999; Rivera, 1996).

Uncovering, Abreaction and Catharsis

Aspects of commonly used therapeutic approaches to working with sexual abuse trauma draw on concepts from the psychoanalytic tradition, specifically those of uncovering, abreaction and catharsis. In this theoretical orientation, healing is expected to derive from making unconscious memories conscious (uncovering), and releasing the associated emotions connected to the memory (abreaction) to provide relief to the client (catharsis). Approaches that emphasize such memory retrieval and expression of negative affect are described by a number of clinicians (e.g., Courtois, 1992; Draucker, 1992; Jenson, 1995; Olio, 1989; Simonds, 1994), while others place greater emphasis on re-living or re-experiencing trauma as a means to healing (Claridge, 1992; Kirschner, Kirschner, & Rappaport, 1993). Another related approach is flooding, the repeated exposure of a client to memories of traumatic events. This technique has been commonly used to reduce posttraumatic stress symptoms with rape victims, veterans and children, as well as with adult survivors of CSA (Berliner & Briere, 1999; Smucker *et al*., 1995).

Some clinicians are critical of the idea that healing must involve clients redescribing their trauma stories in order to abreact, stating that this approach represents "a reenactment rather than a resolution of the original trauma" (Rivera, 1996, p. 104) and equating it with unnecessary retraumatizing of the client (Dolan, 1991; Gil, 1988).

Retelling the Abuse Story to Promote Integration

Whereas some clinicians have promoted clients retelling their stories of abuse and expressing the emotions accompanying these memories as a way to heal abuse trauma, other clinicians stress that healing results not from traumatic memories becoming desensitized or exorcized, but rather from these memories becoming integrated. Integration models of trauma outline the etiology of traumatic stress as a phasic process of continually reliving and denying the trauma that continues so long as the trauma is not assimilated into the individual's consciousness (Horowitz, 1976; Kolk, 1987). Therapeutic facilitation of integration occurs through bringing traumatic events into awareness so that these events may be put into perspective. The trauma integration theory has influenced clinicians such as Herman (1997), who emphasizes the importance of reconstructing the traumatic event in a way that includes "a full and vivid description of the traumatic imagery" (p. 177), including the emotions and bodily sensations associated with the memory, as well as other clinicians who promote memory work not as a means to have clients relive the past, but rather to have abuse memories and their associated affect integrated (Gil, 1988; Harvey, 1999; McCann & Pearlman, 1990).

Memory Work and Meaning

Alternatives to retelling traumatic memories as a means to promote catharsis or to facilitate integration include altering or reconstructing abuse memories and changing the meaning or understanding of what the client remembers about her abuse (Adams-Westcott & Isenbart, 1996; Herman, 1997; Kamsler, 1990; Meiselman, 1990; Pope & Brown, 1996; Silver *et al*., 1983). Interventions that promote the reconstruction of traumatic memory have been put forward by Penn, who invites clients to remain present to their memories of abuse but only in the service of changing details "into something that is self-protective and systemic, connected to others" (Penn, 1998, p. 301). Dolan (1991) promotes the resolution of trauma by facilitating clients gaining access to new information that will lead to an alternative understanding of their abuse memories. Wade (1997) advocates clients gaining new understanding of their victimization history by inviting them to remember ways in which they resisted abuse, using memory work as a catalyst for remembering acts of defiance rather than acts of subjugation.

Memory Work from the Client's Perspective

Although much has been written from the perspective of researchers and clinicians about the risks and benefits of memory work in therapy, there is much less written about how clients, the survivors themselves, experience this work as part of their healing process. One study that has described what child sexual abuse survivors have found helpful in their therapy cited validation, understanding, empathy, advocacy and the absence of blame or contempt as important (Armsworth, 1989). A second study by Ewing and Avis (2000) found that participants identified as particularly helpful the therapist's flexibility, feeling a sense of control over the therapy process, remaining grounded during the therapy, and receiving knowledge and information. Participants in this study noted that working with abuse memories in therapy had both positive and negative impacts on their functioning.

The paucity of outcome studies from the client's perspective is particularly notable given the strongly written recommendations and cautions by researchers and clinicians about memory work. Allegations of irresponsible therapy that have arisen from the "false memory" debate and the concerns about retraumatizing clients point to the importance of such research. Exploring how clients themselves experience memory work in their therapy adds a perspective that is currently lacking and addresses the question of whether, in the client's experience, this work facilitates healing or is experienced as harmful and/or retraumatizing.

The Present Study

The present study addresses a current gap in the literature regarding memory work in the CSA survivors' therapy by examining the impact of memory work from the client's perspective, specifically its impact on the client's functioning and the process of healing. The study examined whether memory work is experienced as beneficial or detrimental by comparing the functioning of women whose therapy differed in the degree to which it involved recounting graphic details of abuse. It was hypothesized that clients whose therapy involved a greater focus on recounting abuse details would report lower functioning during and after their therapy compared with those whose therapy had less focus on recounting abuse details.

The following specific research questions about female CSA survivors' therapy were examined for this study: (a) What types (visual, bodily, affective, etc.) of abuse memories did women experience before, during and after the course of therapy? (b) What specific interventions did participants' therapists use to work with explicit memories in therapy? (c) How did women who spent more time in therapy recounting graphic details of abuse differ in self-reported functioning before, during and after therapy as compared with women who spent less time in therapy recounting the details of their abuse memories? (d) To what degree did participants' therapy focus on describing detailed memories of abuse; on containing or controlling memories of abuse; and/or on understanding abuse experiences and learning new skills? (e) How helpful did participants find each of these foci in healing from abuse experiences? and (f) what therapy approaches do participants believe are important in order for healing to occur?

METHOD

Participants and Procedure

The study questionnaire was distributed to women in Southern Ontario aged 20 and older who had completed therapy related to their childhood sexual abuse experiences. Although the research questions are recognized as also important in relation to the therapy of male survivors, participation was restricted to female participants because all of the literature reviewed was based on women's experience, and because the questionnaire

was developed based on data from an earlier qualitative study examining women's perspectives (Ewing & Avis, 2000). Participants were recruited through advertisements placed in newspapers and through notices posted in various community agencies in Southern Ontario. Prospective participants were asked to telephone an answering service set up specifically for the study. A recorded message informed them of the nature of the study, what their participation would entail, and invited them to leave their name and address if they wished to receive a questionnaire by mail. Those doing so were mailed a letter describing the study, a list of distress centers that they could telephone in case of distress arising as a result of filling out the questionnaire, a consent form, the questionnaire, and a stamped envelope in which to return them. Participants' self-identification as CSA survivors was considered sufficient verification of their status. The questionnaire consisted primarily of closed-ended questions with Likert-type response choices. Questions were also included to obtain the following demographic information: participants' age, race, relationship status, number of children, and employment status. A few questions also addressed aspects of participants' previous therapy experiences, including age at first entering therapy, number of therapists seen, length of time with each therapist seen, date when the last therapy ended and the professional title of the person(s) seen in therapy. Participants who had participated in more than one series of therapy sessions, with one or more than one therapist, were asked to consider all of their therapy experiences in answering the questions.

In response to recruitment efforts, 119 questionnaires were requested and mailed out, and 76 were completed and returned, representing a 64% return rate. Of the questionnaires returned, seven were ineligible for inclusion because the respondents were still participating in therapy at the time of completing the questionnaire. An additional 9 questionnaires were excluded because respondents indicated that no memory work which involved retelling the details of memories of being sexually abused had taken place in their therapy. One questionnaire was excluded because it was only partially completed. This resulted in a total sample size of 59 women.

Variables

Five variables were examined to address the research questions: (1) participants' types of memories before, during and after therapy; (2) participants' functioning in five areas before, during and after therapy; (3) the impact of working with abuse memories on participants' functioning; (4) the helpfulness of therapy approaches experienced; and (5) participants' beliefs about what is important for healing from sexual abuse to occur.

Table I. Frequencies of Types of Abuse Memory Experienced Before, During, and After Therapy

	Time relative to therapy					
	Before		During		After	
Memory type	*n*	(%)	*n*	(%)	*n*	(%)
Visual/explicit memories	49	(83)	45	(76)	39	(66)
Flashbacks of strong feelings	51	(86)	45	(76)	27	(46)
Flashbacks of bodily sensations	42	(71)	42	(71)	30	(51)
Disconnected visual images	33	(56)	29	(49)	20	(34)
Memories always remembered but not labeled as abuse until later	20	(34)	26	(44)	18	(31)
Recovered memories	16	(27)	35	(59)	17	(29)
Nightmares	37	(63)	34	(58)	22	(37)

Explicit and Implicit Memories Before, During and After Therapy

Participants were asked to check off items on a checklist to identify what types of abuse memories (e.g. visual, sensory, nightmares, flashbacks, etc.) they had at three points in time: before, during and after therapy. The items were generated from the literature describing types of abuse memories commonly experienced by CSA survivors and appear in Table I.

Functioning

A functioning measure was developed for this study that was based on findings from a qualitative study that explored women's experiences of memory work in therapy (Ewing & Avis, 2000). The functioning measure consisted of five items which related to the quality of the following: relationship with partner/significant other, physical health, work, sense of well-being and self-esteem. Participants were asked to rate their functioning on the five items at three points in time: (a) before therapy, (b) during therapy, and (c) after therapy. For each measure, participants were asked to rate the quality of their functioning on a 5-point scale ranging from (1) "very poor" to (5) "great." Functioning scores for each of the five items were collapsed to create a single total functioning score. To determine the appropriateness of collapsing the five functioning scores to create one total functioning score at each of the time periods, Cronbach alpha coefficients were examined. It was decided to collapse the items to one total functioning score as the five functioning items for each of the three different times had acceptable levels of internal

Table II. Frequency of Memory Work Approaches in Participants' Therapy

Memory work approach/technique	All participants ($n = 59$)		Higher recounting ($n = 19$)		Lower recounting ($n = 40$)	
	n	(%)	*n*	(%)	*n*	(%)
Encouragement from the therapist to remember details of the abuse	37	(63)	16	(84)	21	(53)
Sharing the details of the abuse memories with a group of women	38	(64)	14	(74)	24	(60)
Age regression to remember details of the abuse	22	(37)	12	(63)	10	(24)
Age regression to change meaning or understanding of the abuse memory	14	(24)	5	(26)	9	(23)
Retelling/recounting details of the abuse to the therapist	54	(92)	18	(95)	36	(90)
The therapist guiding you to remember forgotten abuse memories	12	(20)	6	(32)	6	(15)
Writing abuse memories in a journal	41	(70)	16	(84)	25	(63)

Note. Higher recounting = participants whose therapy involved more time spent recounting or retelling the abuse details to the therapist; lower recounting = participants whose therapy involved less time spent recounting or retelling the abuse details to the therapist.

consistency as revealed by Cronbach alpha coefficients which were .77, .70, and .78, respectively.

Perceived Impact on Functioning of Work with Graphic Abuse Memories

Participants were asked to rate how they believed memory work that involved retelling the graphic details of their abuse memories impacted their functioning on a 5-point scale ranging from (1) "very negative impact" to (5) "very positive impact" for each of the five items (relationship, physical health, work, sense of well-being and self esteem) at two time points: during therapy, and after therapy. The five functioning items were collapsed to create one total functioning score at the two time points based on an examination of the Cronbach alpha coefficients. These coefficients for the five item impact measures for the two different time points were .85 (during therapy) and .85 (after therapy), revealing internal consistency.

Helpfulness of Therapy Approaches Used

Using a 5-point scale ranging from (1) "none" to (5) "most of the time," participants were asked to rate how much time their therapy focused on the following approaches: (a) memory work related to retelling the graphic details of their abuse memories, (b) containing or controlling intrusive memories, (c) learning new life skills, and (d) increasing their understanding of the abuse. For each approach, participants were also asked to rate how helpful it was in assisting them to heal from their abuse experiences and move on with their lives using a 5-point scale ranging from (1) "very unhelpful" to (5) "very helpful." To determine which memory work techniques were part of their therapy, participants were asked to check off items from a checklist (items appear in Table II).

Beliefs About What is Important for Healing

Participants were provided with nine items describing aspects of therapy and asked to rate on a 5-point scale how important each was in promoting healing from their sexual abuse experiences from (1) "not at all important" to (5) "essential for healing." These items were taken from the therapy literature as well as from Ewing and Avis' (2000) study.

RESULTS

Statistical Analysis

Questionnaire responses were analyzed using repeated measures analysis of variance (RM ANOVA) and *t*-test statistical procedures. The dependent variables for the RM ANOVAs were: (a) the clients' perception of their change in functioning from pre- to post-therapy, and (b) the perceived impact of memory work involving retelling graphic details of abuse memories on functioning. The independent variables were (a) the degree to which therapy focused on recounting graphic details of childhood sexual abuse (between group measure), and (b) the time period (before therapy, during therapy or after therapy (within group measure). To create the two groups of participants for the between group measure, participants who reported that they had spent "a lot of time" or "most of the time" in therapy describing, retelling or recounting the graphic details of their abuse experience, ($N = 19$, referred to as "the higher recounting group") were contrasted with women who reported spending "very little time," "a little

time," or "a fair amount of time" doing this type of memory work ($N = 40$, referred to as "the lower recounting group"). The decision to identify participants who spent "a fair amount of time" recounting abuse details as part of the lower recounting group was made with the belief that these participants were more similar to those spending "a little" or "very little" time doing this work than to those spending "a lot" or "most of the time." Women who spent a fair amount of time recounting abuse details would also have spent a fair amount of time involved in alternative therapeutic activities. Similarly, the therapy of women who spent "very little" or "a little" time recounting abuse details clearly involved a significant number of other therapeutic activities.

Descriptive statistics were included to describe (a) what abuse memories women experienced before, during and after the course of therapy, (b) the specific memory work interventions that were part of participants' therapy, and (c) aspects of therapy that participants believed promoted healing from abuse. These data were collated and tabled.

Participant Characteristics

Demographic Information

Participants ranged in age from 20 to 62 with a mean age of 38. Ninety-six percent of the sample was Caucasian, 2% were Afro-Caribbean, and 2% had mixed Caucasian/First Nations ancestry. Forty-six percent of participants were married, 16% were divorced, 18% were single, 7% were living in common-law relationships, 5% were separated, 4% were widowed, and 4% were in relationships but not co-habitating with their partners. Seventy-three percent of the participants had children. Thirty-five percent of the women were employed full-time, 34% were employed part-time, 14% were students, 12% were unemployed, and 5% were retired. Of the participants who worked full- or part-time, 5% were homemakers or at-home moms, 7% were unskilled laborers, 39% did clerical work or were employed in the services sector, and 49% had professional qualifications.

Therapy Experiences

The means, ranges and standard deviations describing aspects of participants' therapy experiences are presented in Table III. The average age that participants first entered therapy was 26. Participants had seen an average number of four therapists. Their most recent therapy experience averaged 23 months in duration, and an average 4 years had passed since the women's last time in therapy. An independent samples *t*-test comparing the total length of time in therapy of those women whose therapy involved more time recalling and retelling graphic details of abuse relative to those whose therapy involved less time, revealed no significant difference between the groups.

Table III. Attributes of Participants' Therapy

Attribute	*n*	Range	*M*	*SD*
Age at first entering therapy	59	5–52	26	10.43
Number of therapists seen	56	1–20	4	3.74
Months in therapy				
Most recent	58	1–156	23	28.92
Second-most recent	54	.25–120	17	20.92
Third-most recent	46	1–144	18	22.40
Years since last therapy ended	59	.05–18	4	3.92

The qualifications of the last three professionals seen by participants were: 25% social workers, 20% marriage and family therapists, 19% psychiatrists, 13% "other," 10% psychologists, 8% clergy, 4% M.D.s and 1% nurses. The "other" category comprised wide-ranging qualifications including play therapists, hypnotherapists, child and youth workers, drug/alcohol counselors, "women abuse counselors," and individuals who had simply been referred to as "therapists."

Types of Abuse Memories Experienced

Table I outlines the percentage of participants who experienced different types of abuse memories before, during and after their therapy. The percentage of participants who experienced five of the seven types of memory (visual/explicit memories, flashbacks of strong feelings, flashbacks of bodily sensations, disconnected visual images and nightmares), decreased over the three time periods from pre- to post-therapy. For two types of memory (memories always remembered but not labeled as abuse until later, and recovered memories), more women reported experiencing the memory type during therapy than before and after.

To examine the association between memory work and prevalence of recovered memories, a *t*-test was performed to establish whether women in the higher recounting group differed from those in the lower recounting group in their experiencing of recovered memories during therapy. A significantly higher number of women in the higher recounting group reported recovering abuse memories during therapy ($M = .84$, $SD = .37$) relative to the women in the lower recounting group ($M = .48, SD = .51$), $t(57) = 2.81$, $p < .01$.

Memory Work Approaches/Techniques

The frequencies of different memory work techniques used in the participants' therapy are reported in Table II. Retelling or recounting the details of the abuse experience to the therapist was part of therapy for 92% of the participants, while over 60% reported that the following approaches were part of their therapy: encouragement from the therapist to remember explicit details of the abuse; sharing the details of the abuse memories with a group of women; and writing the details of the abuse memories in a journal. Twenty percent of the participants indicated that the therapist had guided them to remember abuse that they had forgotten.

T-tests were performed to examine if the greater rate of memory recovery in the higher recounting group was associated with differences in frequencies of particular memory work approaches. Significant results were found for the approach "age regression, or going back in time using techniques like relaxation or hypnosis for the purposes of recalling or remembering the details of the abuse," $t(57) = 3.00$, $p < .01$. As seen in Table II, 63% of the women in the higher recounting group reported that this approach was part of their therapy in comparison to 24% of women whose therapy involved less recounting. The only other approach that was found to occur significantly more in the higher recounting group was "the encouragement from the therapist to remember explicit details of the abuse," $t(57) = 2.43$, $p < .05$. Eighty-four percent of participants in the higher recounting group reported that this occurred in their therapy relative to 53% of the lower recounting group.

Comparison of Higher and Lower Recounting Groups

A repeated measures analysis of variance (RM ANOVA) was performed to compare the functioning of women in the higher and lower recounting groups from pre- to post-therapy. The results are illustrated in Fig. 1. They reveal significant main effects for group (higher versus lower recounting), $F(1, 57) = 10.90$, $p < .01$, and for time (pre- to post-therapy), $F(2, 57) = 175.26$, $p < .001$, as well as a significant interaction effect of time and group, $F(2, 57) = 11.01$, $p < .001$. A post-hoc pairwise comparison of the means with a Bonferroni adjustment revealed that participants in the lower recounting group had higher functioning scores both before, and during therapy, but not after therapy, relative to women in the higher recounting group. To examine how the functioning of all the participants differed in the three time periods, post-hoc comparisons of the means with Bonferroni adjustment for multiple comparisons were performed and revealed non-significant differences between time 1 and time 2 (before therapy and during therapy). Significant differences were found between time 1 and time 3 (before therapy and after therapy) and between time 2 and time 3 (during therapy and after therapy). To test whether there was a correlation between level of functioning before therapy and time spent recounting details of abuse memories, a Pearson product-moment correlation was performed. Results indicated that there was a significant negative correlation between functioning before therapy and time spent recounting abuse details in therapy, $r = -.357$, $p < .01$, accounting for 13% of the variance.

There was a concern that the variable describing the time elapsed since participants' therapy had ended could potentially confound the results and change the pattern of findings of the RM ANOVA. A repeated measures analysis of co-variance (RM ANCOVA) indicated that this was not the case, and the pattern of findings described previously remained stable. An RM ANCOVA was also run to examine whether the number of therapists seen by participants would confound the results. Again, the results for this test were not significant, and did not result in changes to the previously reported findings for the RM ANOVA.

The two groups of participants (higher versus lower recounting) were also compared on their beliefs about the impact of describing or recounting abuse details on their functioning during and after therapy. The results of the RM ANOVA showed no significant main effects for group, but revealed a main effect for time, $F(1, 57) = 119.60$, $p < .001$. An interaction between group and time was also found, $F(1, 57) = 8.52$, $p < .01$. To examine the interaction effect more closely, a post-hoc comparison of the means was performed and revealed significant differences between the impact at time 2 compared with time 3 of recounting abuse details, and showed that while participants believed that recounting details had a negative impact on their functioning during therapy, they also believed it had a positive impact their functioning after therapy.

Helpfulness and Time Spent Focused on Different Therapeutic Approaches

Of the four therapeutic approaches examined, participants reported spending significantly more time on the approach "increasing your understanding of the abuse" ($M = 4.33$, $SD = .97$) compared with "learning new life skills" ($M = 3.58$, $SD = 1.19$, $t(56) = -4.94$, $p < .001$), "containing or controlling intrusive memories" ($M = 3.40$, $SD = 1.12$, $t(57) = -5.60$, $p < .001$) and "describing,

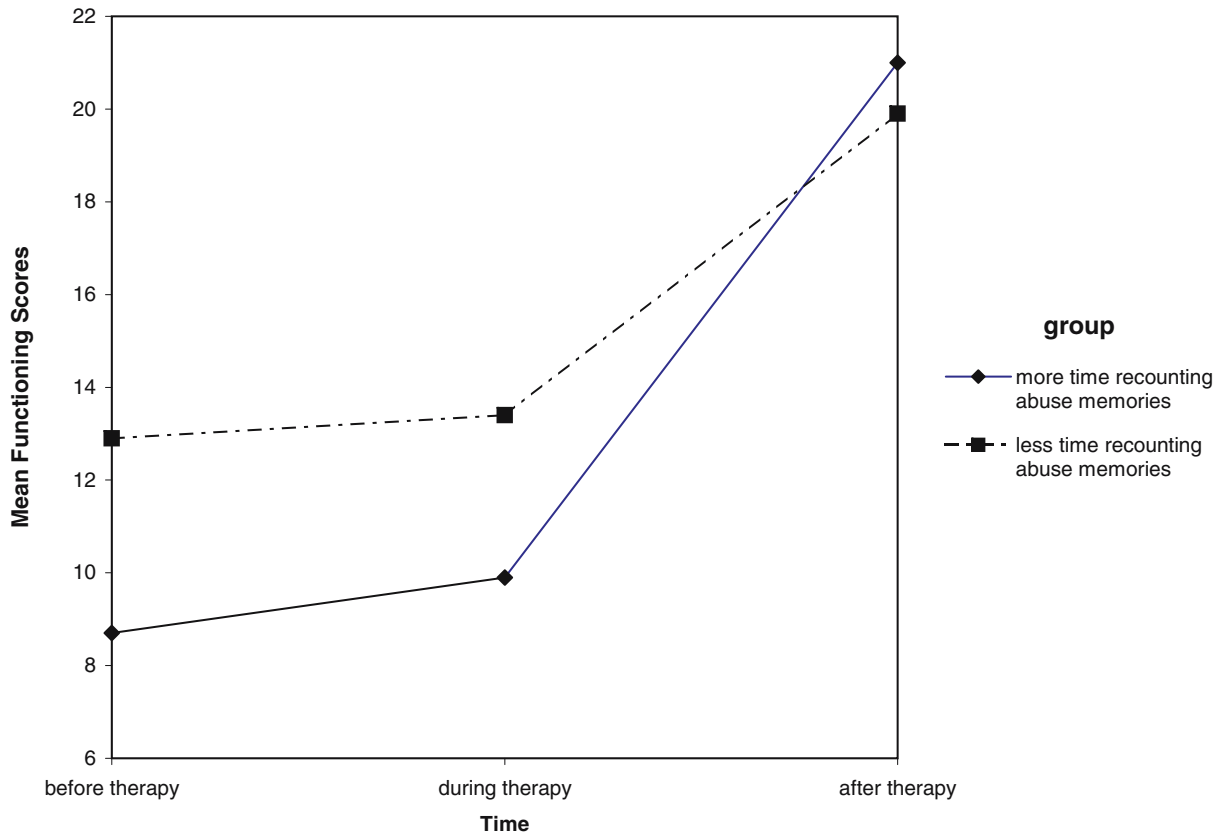

Fig. 1. Comparison of mean functioning scores of women who spent more vs. less time recounting abuse memories in therapy from pre- to post-therapy.

retelling or recounting graphic details of abuse experience" ($M = 3.09$, $SD = .88$, $t(58) = -8.78$, $p < .001$). The approach "increasing your understanding of the abuse" received significantly higher ratings for helpfulness by participants ($M = 4.61$, $SD = .74$) relative to "describing, retelling or recounting graphic details of abuse experience" ($M = 4.27$, $SD = .93$, $t(58) = -2.35$, $p < .05$), "containing or controlling intrusive memories" ($M = 4.22$, $SD = .81$, $t(55) = -2.74$, $p < .01$), and "learning new life skills" ($M = 4.20$, $SD = .80$, $t(56) = -2.98$, $p < .01$). Paired sample t-tests revealed no significant differences in the helpfulness ratings given to the approaches "describing, retelling or recounting graphic details of abuse experience," "containing or controlling intrusive memories," and "learning new life skills."

Beliefs About What is Important for Healing to Occur

The means, ranges and standard deviations of participants' ratings of the aspects of therapy they believe are important for healing appear in Table IV. Participants rated "accepting that there was trauma, even if the details are not clear" as the most important item for promoting healing ($M = 4.72$, $SD = .52$). High ratings were also given to "having a good relationship with your therapist" ($M = 4.52$, $SD = .77$), "making some meaning, or increasing your understanding of the abuse experience" ($M = 4.49$, $SD = .74$), and "understanding the feelings and body experiences of flashbacks" ($M = 4.42$, $SD = .77$). The items receiving the lowest helpfulness ratings by participants were "going back into your memories to relive abuse experiences from your childhood" ($M = 3.50$, $SD = 1.30$), and "recalling the traumatic pictures or the details of the abuse" ($M = 3.60$, $SD = 1.22$).

DISCUSSION

Participants' Memories of Abuse

For participants in the present study, therapy was associated with a decrease in the prevalence of many types of

Table IV. Descriptives of Participants' Beliefs About What is Important for Healing

Items	Importance (1 = not at all important, 5 = essential for healing)			
	n	Range	*M*	*SD*
Accepting that there was trauma	58	3–5	4.72	.52
Having a good relationship with your therapist	59	2–5	4.52	.77
Making some meaning, or increasing your understanding of the abuse	58	2–5	4.49	.74
Understanding flashbacks	59	2–5	4.42	.77
Learning to manage and contain intrusive memories of abuse	59	1–5	4.14	1.18
Knowing who the abuser was	56	1–5	3.79	1.26
Remembering parts of your childhood history that you had forgotten	57	1–5	3.77	1.13
Recalling the details of the abuse	59	1–5	3.60	1.22
Going back into your memories to relive abuse experiences from childhood	59	1–5	3.50	1.30

abuse memory. All memory types were reported by fewer participants from pre-to post-therapy with the exception of recovered memories, and memories that were always present but not labeled as abuse until a later time. A total of 59% of the participants reported recovering new abuse memories during their therapy. This recovery rate is lower than that reported by 71% of psychologists in a study by Pope and Tabachnick (1995). In the current study, 84% in the higher recounting group recovered new abuse memories during therapy relative to 48% of the women who did less recounting. In addition, a significantly greater percentage of women in the higher recounting group reported (a) doing age regression for the purposes of remembering details of abuse, and (b) that their therapists encouraged them to remember abuse details in therapy. Taken together, these findings lead one to hypothesize that, for participants in the current study, memory work intended to retrieve forgotten abuse memories, did, in fact, lead to more memories being recovered. This finding is similar to an earlier study in which psychologists whose therapeutic work focused more on memory recovery reported that 60% of their clients recovered memories of abuse in therapy relative to 35% of the clients of psychologists whose work had less focus on memory recovery (Poole *et al.*, 1995). It is important to note that in the Poole et al. study, the clients recovering memories had initially denied that they had been abused. In contrast, for the majority of participants in the current study, the recovered memories were not their first abuse memories, but were, rather, additional memories of abuse.

The finding that 48% of participants in the lower recounting group reported new abuse memories recovered during therapy, suggests that something other than just a focus on memory recovery likely contributed to memories resurfacing. Participants in Ewing and Avis' (2000) study reported that a safe therapeutic environment in which they felt free to open up was the most influential factor in abuse memories emerging or becoming clearer. Here, memory recovery was a secondary effect rather than a primary goal.

The Relationship Between Recounting Abuse Memories and Functioning

The current study compared the functioning of women from pre- to post-therapy whose therapy differed in the degree to which it focused on recounting graphic details of abuse. All participants rated their functioning significantly higher after therapy compared to before and during therapy, indicating that participating in therapy was associated with an after therapy improvement on numerous measures of functioning. Unexpectedly, although the higher recounting group rated their functioning as lower before as well as during therapy than the lower recounting group, their functioning rating did not differ significantly from the other group after therapy. Following therapy both groups were functioning at an equally high level. This study found the therapy of the high recounting group (who reported significantly lower functioning before therapy) was significantly more likely to involve hypnosis to remember forgotten details of abuse and encouragement from the therapist to remember abuse details. This finding suggests that the functioning level of clients coming into therapy may have influenced the approaches their therapists used in their therapy, as well as the amount of time spent recounting abuse details. It may also have influenced the participants' choice of therapist.

Counter to what the clinical literature might have predicted, the functioning ratings of the participants did not decrease significantly during therapy relative to before therapy, but rather remained at a low level. However, when asked how they believed their functioning was impacted by recounting detailed abuse memories, participants reported that the work negatively impacted their functioning at the time point "during therapy." Conversely, at the time point "after therapy," participants reported that they believed the recounting had a *positive* impact on their functioning, or the *opposite* effect of the impact at the earlier time period.

These findings suggest that participants believed that recounting abuse details in therapy had temporarily

impeded functioning. It remains unclear why they believed recounting abuse details had a negative effect on their functioning during therapy, while their absolute functioning scores remained unchanged from pre- to post-therapy. It is possible that the participants' distress resulting from recounting abuse details did not further reduce their functioning ability that was already at a low level before they began therapy. What is clear from the study results is that participants felt some temporary negative impact during therapy from reviewing abuse details, while it had assisted their post therapy functioning and was associated with an improvement in functioning scores.

Factors that Facilitated Participants' Healing

Participants were asked to rate the proportion of time spent and helpfulness of four therapy foci: describing, retelling or recounting graphic details of abuse; containing or controlling intrusive memories by becoming grounded in the present; learning new life skills; and increasing understanding of the abuse (including an understanding of strengths, personal abilities and gaining information). The results indicated that participants spent significantly more therapy time increasing their understanding of the abuse than in the other foci, and that they found this focus to be the most helpful in assisting them to heal and move on with their lives. This result suggests that recounting graphic details was not, in and of itself, behind the improvements in functioning seen in the participants from pre-to post-therapy. Rather, participants considered as most helpful to them therapeutic work addressing their understanding of, and meaning given to, their abuse experience.

The importance of meaning and understanding was also evident in what participants reported as most important for healing to occur. The items participants rated as most important were: accepting that there was trauma; having a good relationship with the therapist; making meaning or increasing understanding of the abuse; and understanding flashbacks. Although still given a fairly positive rating, rated least important were: reliving abuse experiences from childhood; and recalling the traumatic pictures or details of the abuse. Taken together, these ratings indicate that simply reviewing, reliving and describing abuse experiences were not seen by participants as being as important as gleaning a greater understanding or being able to make meaning about the abuse experience. These findings are in keeping with research reporting that CSA survivors who have been able to find meaning in their abuse experience seem to function at a higher level relative to those who do not (Silver *et al*., 1983). These findings also lend support to therapy approaches that focus on helping clients to gain a new understanding of their abuse experience (Adams-Westcott & Isenbart, 1996; Dolan, 1991; Herman, 1997; Kamsler, 1990; Meiselman, 1990; Pope & Brown, 1996; Wade, 1997).

Although participants reported being temporarily negatively impacted by recounting abuse details, they also said that after their therapy finished, they believed this work had a positive impact on their functioning. Both positive and negative effects of recounting abuse details were also seen in a study in which participants reported that memory work in their therapy resulted in negative short-term effects but seemed to result in positive long-term effects, specifically that the abuse memories came to have less power and control over them (Ewing & Avis, 2000). Although it is unclear exactly what accounted for the shift in impact ratings from negative to positive over time in the current study, it is possible that recounting the details of abuse acted as a catalyst for other healing processes that were highly rated by the participants, such as finding greater acceptance, meaning and understanding of the abuse.

Implications for Therapists

From the current study findings, what seems important for therapists to keep in mind is the high ratings that participants gave to a focus on increasing understanding and meaning in therapy. Some clinicians such as Herman (1997) and Meiselman (1990) have described recounting abuse details as important to facilitate increasing meaning and understanding. Given that participants in this study reported that recounting graphic abuse details negatively impacted their functioning at the time of participating in therapy, it seems important for therapists to be mindful of what their intentions are in doing such work, and to balance its potential risks and benefits, including temporarily impeding client functioning on the one hand, and promoting a change in understanding on the other. Simply asking clients to recount graphic abuse details without providing opportunities for new understandings of the abuse to be created might well impede client functioning without assisting healing. It could also be beneficial for therapists to explore ways to promote meaning generation that do not involve a prolonged period of describing abuse details.

The high rating given by participants to their relationship with their therapist as important for healing to occur is echoed in the work of Ewing and Avis (2000), whose participants identified being believed, supported and validated by the therapist as important. Similarly, Armsworth (1989) found that clients rated validation,

empathy and support as especially helpful in their therapy. It seems logical that these characteristics of the client-therapist relationship would also be helpful in mitigating the potentially retraumatizing effects of the client telling the details of her abuse story.

Limitations

There are some limitations to the current study findings. With respect to the sample, the degree to which the participants are representative of the general population of women who have experienced CSA and have participated in therapy is unknown. Because this study utilized a convenience sample whereby participants voluntarily contacted the researcher, the sample may be biased towards women who were more interested in talking about their experiences of abuse and therapy. The sample may also have contained higher functioning women relative to the general population of CSA survivors due, in part, to the stipulation that women not be attending therapy at the time of their participation. The mean length of time since participants had last been in therapy was four years. This relatively long length of time since attending therapy may have reflected a certain degree of stability, which may have translated into higher functioning scores reported for the period "after therapy."

The retrospective design of the present study was advantageous in that it asked participants to consider their therapeutic experiences collectively from a global post-therapy vantage point, allowing them to reflect more dispassionately on their functioning and experiences. There are limitations to the present study that are characteristic of retrospective studies generally. Specifically, it is possible that the retrospective design may have decreased the reliability of recall of participants. This study asked participants to recall their earlier recalling. Although this design may raise questions about reliability, it is not clear that memory of recall is less reliable than memory of any other event. A future study might expand upon the present findings by employing a prospective design to reduce errors in recall, providing a more controlled comparison of participants utilizing a pre-treatment measure as well as standardized measures of functioning. Such a study would also allow for better control of the effects of various therapy/therapist variables including number of therapists seen, and time elapsed since therapy ended. Finally, the present study was restricted to the perspective of women survivors. It would be important to expand this inquiry to determine how male survivors experience memory work in their therapy and if the healing process differs for men and women.

CONCLUSIONS

The findings of this study support a both/and position with respect to previous literature regarding the role of memory work with sexual abuse survivors that involves recounting graphic details of the abuse. Specifically, the findings revealed that women felt negatively impacted during their therapy by talking about abuse details, a result in keeping with warnings about this kind of memory work by authors such as Dolan (1991) and Gil (1988). Yet participants also believed that after therapy they were positively impacted by the earlier recounting of abuse details. This reversal of the ratings from the earlier time period is concordant with clinicians who support talking about abuse details as an important part of healing (e.g., Herman, 1997; Jenson, 1995). It is thus important that the findings of this study be viewed in their entirety, rather than isolating either the benefits or risks reported by participants, as either would fail to capture the complexity of the study findings, which also emphasize the importance of meaning and understanding in the process of healing.

In the present study it appeared that women in the higher and lower recounting groups took different paths toward healing. Future studies could address some of the questions arising from these study findings. It would be interesting to examine the relationship between clients' level of distress at the time of entering therapy, their choice of therapist, the interventions they receive in therapy and their journey to recovery. Such research could examine whether women with differing levels of distress from repressed abuse memories have needs for differing approaches to healing.

Hopefully, future research will continue to tap into the wisdom, experience and perspectives of women who have survived CSA, thereby increasing therapists' ability to be accountable to their clients. Continued promotion of an atmosphere of openness and collaboration in which traditionally opposing views are used to inform and expand one another could be beneficial to researchers, clinicians, and especially to CSA survivors seeking therapy as a means to find healing.

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