Journal of Traumatic Stress, Vol. 10, No. 4, 1997

Adult Memories of Childhood Trauma: A Naturalistic Clinical Study

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The clinical evaluations of 77 adult psychiatric outpatients reporting memories of childhood trauma were reviewed. A majority of patients reported some degree of continuous recall. Roughly half (53%) said they had never forgotten the traumatic events. Two smaller groups described a mixture of continuous and delayed recall (17%) or a period of complete amnesia followed by delayed recall (16%). Patients with and without delayed recall did not differ significantly in the proportions reporting corroboration of their memories from other sources. Idiosyncratic, trauma-specific reminders and recent life crises were most commonly cited as precipitants to delayed recall. A previous psychotherapy was cited as a factor in a minority (28%) of cases. By contrast, intrusion of new memories after a period of amnesia was frequently cited as a factor leading to the decision to seek psychotherapy. The implications of these findings are discussed with respect to the role of psychotherapy in the process of recovering traumatic memories.

KEY WORDS: memory; childhood trauma; psychotherapy.

In a society increasingly aware of the high prevalence of child abuse, growing numbers of adult survivors have come forward to seek psychiatric treatment and, in some cases, to seek legal redress for crimes committed in the distant past. Evidence based upon delayed recall of traumatic childhood experiences is now admissible in court in many states. In this context, questions have been raised concerning the credibility of adult memories of childhood trauma. A social climate of acrimonious debate has hampered

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0894-9867/97/1000-0557$12.50/1

serious investigation of traumatic memory and threatens to have a chilling effect on the clinical care of traumatized people (Applebaum & Zoltek-Jick, 1996; Bowman & Mertz, 1996; Harvey & Herman, 1994; Herman, 1995).

Researchers who study normal memory differ in their perspective on questions of reliability. One school emphasizes the degree to which memory is prone to retrospective distortion, error, and suggestion (Loftus, 1979; Loftus & Loftus, 1976). It is a long-established finding of laboratory research with normal subjects that accuracy of memory can be influenced by the demand characteristics of the situation in which recall occurs (Marquis, Marshall, & Oskamp, 1972; Muscio, 1915; Saks & Hastie, 1978). Overall, studies of memory distortion in both children and adults suggest that errors in recall are most likely to occur in retrieval conditions marked by biased, repeated and misleading questions posed to particularly suggestible subjects. By contrast, errors are least likely to occur under conditions of freely generated narrative report (Ceci & Bruck, 1993; Fivush, 1994; Goodman, Quas, Batterman-Faunce, Riddlesberger, & Kuhn, 1994; Pezdek & Roe, 1994; Saywitz & Moan-Hardie, 1994).

Another school of thought maintains that normal memory, despite its flaws, is a reasonably sturdy source of information about the past (Brewin, Andrews, & Gottlieb, 1993). Supporting this point of view is a body of laboratory research demonstrating that while memory for peripheral detail may be subject to influence and error, memory for the central, most salient aspects of events is remarkably durable, accurate, and impervious to suggestion. Events marked by strong emotion are particularly well remembered (Bower, 1992; Christianson, 1992). Animal studies of the neurological substrates of memory suggest further that emotional arousal enhances memory storage and consolidation (McGaugh, 1990, 1995).

Extrapolating these findings to the phenomenon of traumatic memory, one might predict that memory for traumatic events would be very deeply engraved. And indeed, this prediction is borne out by clinical observation. Intrusive, vivid and unvarying recall of traumatic events is frequently reported by traumatized people, and constitutes one of the diagnostic criteria for posttraumatic stress disorder (PTSD; American Psychiatric Association [APA], 1994). The occurrence of amnesia following traumatic exposure, however, runs counter to intuition and prediction. If terrifying events are unforgettable, how can they be completely forgotten? This apparent paradox has led some laboratory researchers simply to dismiss the possibility that traumatic amnesia and delayed recall might be authentic phenomena. Loftus (1993), has speculated that most if not all delayed memories of childhood trauma must be fictitious. In support of this hypothesis, she has cited laboratory studies in which conscious manipulation and deception

have been successfully employed to implant false memories of a common, non-traumatic event in some suggestible subjects. Extrapolating from this model to the naturalistic setting of clinical practice, she has contended that psychotherapy could be a major source of confabulated recall. Similarly, Lindsay and Read (1994) have speculated that psychotherapy might be responsible for instilling illusory memories of childhood trauma in large but unspecified numbers of patients. Underlying this hypothesis are two unstated and unproven assumptions; first, that psychotherapy patients are particularly suggestible, and second, that a clincial setting creates the kind of biased, manipulative or overtly coercive environment that favors memory distortion or outright confabulation. These assumptions, if true, would discredit both patients and clinicians as sources of scientifically valid data.

A more fruitful point of departure for the study of traumatic memory lies, we believe, in respectful attention to the large body of existing literature based on clinical observation of traumatized people. Amnesia as well as hypermnesia is recognized as one of the cardinal symptoms of PTSD (APA, 1994). Memory disturbances have been described in many traumatized populations, including disaster and accident victims, combat veterans, and concentration camp survivors (van der Kolk, 1994, 1996). In adult survivors of childhood abuse, nine retrospective studies, employing varying methodologies, have addressed the question of memory continuity. Six are studies of patients in treatment (Briere & Conte, 1993; Cameron, 1994; Gold, Hughes, & Hohnecker, 1994; Herman & Schatzow, 1987; Loftus, Polonsky, & Thompson-Fullilove, 1994; Roesler & Wind, 1994), and three are community studies (Elliot & Briere, 1995; Feldman-Summers & Pope, 1994; Grassian & Holtzen, 1996). All studies have found a spectrum of memory disturbances, with some subjects reporting continuous memory of their childhood abuse and some reporting a period of partial or complete amnesia. The proportion of subjects reporting a period of complete amnesia ranges from 19% (Loftus et al.) to 59% (Briere & Conte), with most studies reporting between 20 and 50%.

Two community studies have focused on subjects whose recall of childhood abuse could be independently corrorborated. Grassian and Holtzen (1996) surveyed 42 men and women who had been victims of sexual abuse by a parish priest. The perpetrator, who acknowledged molesting numerous children over the course of many years, was ultimately convicted of his crimes. Of these subjects, 47% reported a period in which they had no memory of the abuse. In a prospective study of 129 women with documented histories of childhood sexual abuse, Williams (1994, 1995) reported that 38% failed to recall the incidents described in their medical records. An additional 16% described a previous period of amnesia followed by delayed recall of the abuse. Subjects reporting amnesia and delayed recall

did not differ from those with continuous memory in the accuracy of their reports. This study, which far surpassed the retrospective clinical literature in sophistication of research design and methodology, nevertheless produced results that are quite consistent with previous clinical reports.

Several clinical studies have also addressed the issue of corroboration of patient accounts of childhood trauma. Herman and Schatzow (1987) found that a majority (74%) of 53 outpatients reporting histories of childhood sexual abuse also reported obtaining confirming evidence from independent sources. Patients with delayed recall did not differ from those with continuous memory in their ability to obtain confirmation. In a study of female adolescent patients, Westen, Ludolph, Misle, Ruffins, and Block (1990) obstained independent confirmation in all 14 cases where childhood sexual abuse was reported. Coons (1994), in a chart review of inpatients with dissociative disorders, reported collateral information confirming the patients' accounts of childhood abuse in 20 out of 21 cases (95%). Silk, Lee, Hill, and Lohr (1995) obtained independent confirmation of patients' reports of childhood sexual abuse from family interviews in 8 of 11 cases (73%). And Kluft (1995) reported that 13 of 19 patients (68%) with dissociative disorders were able to obtain documentation of traumatic events remembered in the course of psychotherapy. These consistent results indicate that patients' retrospective reports of childhood trauma are generally credible and present no unusual problems with verification. The presumption that patients in psychotherapy might be particularly prone to confabulate is not borne out by these data.

A few studies have specificially addressed the role of psychotherapy in retrieval of traumatic memories. Feldman-Summers and Pope (1994), in a study of psychologists, found that 18 of 32 (56%) subjects reporting amnesia and delayed recall of childhood abuse named their personal psychotherapy as a factor in their recall; in eight cases (25%) psychotherapy was the only factor identified. Poole, Lindsay, Memnon, and Bull (1995), in a survey of psychologists in the US and Britain, found that 85% had seen patients who recovered memories of childhood sexual abuse during the course of treatment. Andrews et al. (1995), in a survey of 810 British psychologists, found that 92% had seen at least one patient reporting childhood sexual abuse in the previous year. Sixty percent of the repondents had at some time seen at least one patient who reported amnesia and delayed recall of childhood trauma. Thirty one percent reported that memory retrieval had occurred prior to any therapy, 23% reported that at least one patient retrieved memories while in treatment with them, and 19% reported that retrieval had occurred during the course of a previous therapy. These studies suggest that patients with histories of childhood abuse, including those reporting periods of amnesia and delayed recall, are com-

monly seen in clinical practice, and that with such patients psychotherapy often plays a part in the memory retrieval process. It is not clear, however, how commonly psychotherapy might be the central, sole or initiating factor in delayed recall.

Particular concern has been raised regarding the heightened risk of suggestion with therapeutic use of cueing techniques or altered states of consciousness to facilitate memory retrieval. Poole et al. (1995) found that 31% of the 145 US psychologists in their survey reported using hypnosis for memory retrieval, while Andrews et al. (1995) found that 10% of their British sample reported this practice. In the latter study, hypnotherapists were particularly likely to be cautious and skeptical about the accuracy of memories retrieved in therapy. The majority of psychologists in Poole's study also considered the risk of fostering illusory memories theoretically possible, but had rarely if ever seen such a case in practice. Brown (1995) in a review of the literature, noted that while no experimental studies have been conducted on memory performance or suggestibility effects in therapy, the risk of inducing pseudomemories must be taken into consideration in establishing the standard of care in trauma treatment.

The present study was undertaken to shed further light on the role of psychotherapy in memory retrieval by studying patients at the point of initiation of therapy. The study focused on the manner in which patients seeking treatment in a psychiatric clinic for crime victims spontaneously described their memories of childhood trauma. The clinicians who conducted the initial evaluations of these patients had not been instructed to ask any specific or probing questions regarding the nature of traumatic memories, but rather to record information that the patients volunteered. Thus the interview format approximated the ideal condition of free recall. Furthermore, because the evaluation interviews were conducted prior to the establishment of an ongoing treatment relationship, we expected that the therapist's contribution to the patient's narrative would be minimized. In reviewing written summaries of these evaluations, we hoped to capture those aspects of the experience that emerged as most salient to the patient.

Method

Subjects were adult outpatients seeking to enter treatment at a public hospital-based psychiatric clinic specializing in the treatment of victims of violent crime. The clinical intake records of all new patients who had completed a three-to-four-session evaluation between July 1, 1992 and June 30, 1994 were reviewed. The charts of all patients who reported childhood

histories of physical abuse, sexual abuse, or witnessing domestic violence were selected for study.

Patient evaluations had been conducted by program staff or advanced clinical trainees under staff supervision. The evaluations followed the format outlined in the APA (1995) Practice Guideline for Psychiatric Evaluations of Adults, with emphasis on open-ended, empathic inquiry that allowed patients considerable latitude to define their most salient concerns. The written summaries of the evaluation interviews contained a verbatim statement of the chief complaint, a detailed description of the presenting problem and precipitants to seeking treatment, a review of past medical and psychiatric history, an extensive developmental, family and social history, a mental status report, and a multi-axial DSM-III-R diagnostic formulation.

For this study, the patients' descriptions of their memories were rated for continuity on a tri-partite scale, from continuous recall to complete amnesia with delayed recall. If the patient reported information that would corroborate his or her memories, the type of corroboration was recorded. In cases involving some degree of delayed recall, the precipitants to recall were rated in ten categories. All charts were also reviewed to identify precipitants to seeking treatment, using similar categories. Each chart was rated by one of the two authors. Both authors also independently rated a randomly selected group of 10 charts. Interrater reliability was .75 or above on all items. Data analysis was carried out by simple tabulation.

Results

One hundred thirty patients completed evaluations during the time period under review. Of these, 97 reported a history of childhood trauma. Twenty charts were excluded from the study because they lacked a full evaluation report. The remaining 77 charts formed the data base for the study. Subjects were 67 women and 10 men ranging in age from 18 to 64 years of age, with a mean age of 32.6 years (SD = 10.74). Though none of the patients required inpatient or emergency treatment during the course of the evaluation, their level of functioning in the community varied widely, ranging from excellent functioning with only moderate distress to severe impairment and psychiatric disability. This variation is reflected in the patients' Axis V (Global Assessment of Functioning) scores, which ranged from 20-85 with a mean of 56.5 (SD = 14.34). The most frequently assigned diagnosis was PTSD (n = 52, or 68%), followed by major affective disorder (n = 36, 46%), an anxiety disorder other than PTSD (n = 28, 36%), sub-

stance abuse (n = 18, 23%), dissociative disorder (n = 9, 12%), and dysthymic disorder (n = 8, 10%).

The types of childhood trauma reported were as follows: 59 patients (77%) reported sexual abuse, 53 (69%) reported physical abuse, and 24 (31%) reported witnessing intrafamilial violence. Of the group who reported witnessing violence in the home, all but two patients also reported having been directly victimized as well. Forty five patients (58%) reported exposure to two or more types of childhood trauma, and 12 (16%) reported exposure to all three types.

Table 1 summarizes the manner in which patients described the continuity of their memories. A majority of patients reported that they had always remembered their childhood experiences. Thirteen patients reported a mixture of continuous and delayed recall. In this category, some patients who had experienced more than one type of abuse made a distinction between their continuous memories for one type of abuse and delayed recall of another. Others reported that they had always known that they were abused, but had initially remembered only a few incidents, and later remembered other, often earlier instances of abuse. Twelve patients described a period of complete amnesia followed by delayed recall of their childhood trauma. Finally, 11 patients did not offer sufficient information to characterize the continuity of their memories.

The types of childhood abuse reported did not differ significantly among the three groups of patients. However, we noted that the 12 patients who described a period of complete amnesia were more likely than others to report memories of only one type of abuse. In this group, eight patients reported sexual abuse only, one reported physical abuse only, and four reported both sexual and physical abuse.

Table 2 summarizes the precipitants to delayed recall named by the 25 patients who reported this experience. The type of precipitant most frequently identified was an idiosyncratic, trauma-specific reminder whose meaning could be understood only in the context of the patient's history.

Table 1. Continuity of Memory

Continuity of Memory	Number of Patients	% of Total
Continuous memory only, no delayed recall	41	53
Continuous memory and delayed recall	13	17
Complete amnesia and delayed recall	12	16
Uninformative charts	11	14
Total	77	100

Table 2. Precipitants to Delayed Recall of Childhood Trauma

Type of Precipitant	Patients with Delayed Recall (n = 25)	%
Trauma-specific reminder	12	48
Recent life crisis/milestone	10	40
Psychotherapy	7	28
New information from another person	5	20
Change in close relationship	5	20
Abstinence from drugs or alcohol	5	20
Altered state experience	5	20
Unspecified precipitant	4	16
Illness or injury	2	8
Book, article, or TV program	2	8

Examples included a chance meeting with a childhood friend, returning to a former neighborhood, or learning of the violent death of a relative. A recent life milestone or crisis was the second most commonly identified precipitant. Examples included leaving home for the first time, beginning an intimate relationship, or starting a family. Some patients related the emergence of their abuse memories to an increasing awareness of their own difficulties as parents and their fears that they might treat their children as they had been treated. A previous psychotherapy was identified as a precipitant to delayed recall in seven cases, and as a sole precipitant in two. Five patients identified an experience in an altered state of consciousness, such as a vivid dream, meditation, or hypnosis, as a contributory factor; in no case was an altered state experience the sole precipitant to recall. More than half the patients (n = 14, or 56%) who reported delayed recall described a sequence of events leading to a process of memory recovery over time, rather than a single event resulting in the sudden eruption of a memory. The mean number of precipitants cited was 2.5, with a range of 1 to 5.

Table 3 describes the events preceding and leading up to a decision to seek treatment. A recent life crisis or milestone was the most commonly cited precipitant, followed closely by a change in a close relationship. Once again, a sequence of events rather than a single incident was cited in the majority of cases (n = 50, or 65%). The mean number of precipitants was

Table 3. Events Leading to Evaluation for Psychotherapy

Precipitants to Evaluation	Number of Patients	% of Total
Recent life crisis/milestone	38	49
Change in close relationship	37	48
Flooding/intrusion of memories	35	45
Other/idiosyncratic	17	22
Abstinence from drugs or alcohol	10	13
Problem with previous therapy	7	9
Illness or injury	7	9
New information from another person	7	9
Altered state experience	6	8
Book, article or TV program	2	3
Anniversary of traumatic event	2	3

2.2, with a range of 1 to 5. Flooding or intrusion of traumatic memories was the third most common precipitant for seeking treatment, cited in 45% of cases. Of the 25 patients reporting some degree of amnesia and delayed recall, the majority (n = 17, or 68%) cited distress over their recently acquired memories as a reason for seeking treatment. Twelve of these 25 expressed the hope that treatment would help control unwanted intrusions of traumatic memory; only two expresssed eagerness to acquire additional memories.

Although patients were not specifically asked whether they had any information which might confirm their memories of childhood abuse, 33 patients (43%) spontaneously described some type of corroboration. Only seven patients described having undertaken an active search for evidence that might confirm their memories; the majority of patients who had such evidence had not actively sought it. Among the 25 patients who reported some degree of amnesia and delayed recall, nine (36%) reported having obtained confirming evidence for their memories, while among the patients who did not report any memory deficits, a slightly larger proportion (24 of 52, or 46%) reported obtaining corroboration. The difference between the two groups was not statistically significant. The types of confirming information reported by patients are given in Table 4. The most common types of confirmation came from family members who told the patients that they had either directly witnessed or indirectly known of the abuse. Eleven patients described confirming information that was meaningful only in context

Table 4. Sources of Memory Confirmation

Confirmation Source	Number of Patients	% of Total
Indirect witness (e.g., family member knew of abuse)	12	16
Idiosyncratic sources	11	14
Direct witness (e.g., family member witnessed abuse)	10	13
Disclosure by another victim of same perpetrator	10	13
Multiple sources	10	13
Perpetrator charged with similar crime	6	8
Indirect evidence (e.g., medical record of injuries)	4	5
Physical evidence	1	1
Admission by perpetrator	1	1

and hence difficult to categorize. For example, one patient had recently learned from a former classmate that her abuser, a revered junior high school teacher, suddenly left the school and the community "under a cloud," and soon afterwards married an adolescent girl who had been his pupil. This type of information is listed as an idiosyncratic source. Of the patients who reported this type of evidence, seven also had confirmatory information from other sources. Ten patients reported obtaining more than one type of confirmation. It should be noted that interviewers did not attempt to verify independently the information given by the patients.

Discussion

The clinical setting in which this study was conducted is an outpatient psychiatric clinic of a public hospital with a teaching mission and a mandate to serve indigent clients. The Victims of Violence Program, in particular, is a setting known for offering feminist-informed treatment to crime victims, both men and women (Harvey & Harney, 1997). As such, it might be expected to attract patients who identify themselves as survivors of childhood abuse. The selective nature of our patient population may account for some

differences between our findings and those of previous investigators, and may limit the generalizability of our data. However, the main findings of this study are congruent with previous studies documenting memory disturbances in a considerable proportion of patients with histories of childhood trauma.

In contrast to some previous studies, patients reporting memory deficits were clearly a minority of this particular clinical population. It is possible, of course, that the 11 patients who did not characterize their memories in fact had experiences of amnesia and delayed recall which they simply neglected to mention. We consider this possibility unlikely, however, because most of the patients who reported such experiences found them highly distressing and difficult to ignore. Indeed, in this study, two thirds of the patients who described some degree of amnesia and delayed recall cited the intrusion of traumatic memories as one of their reasons for seeking treatment.

Our data also suggest that delayed recall of childhood trauma is often a process that unfolds over time rather than a single event, and that it occurs most commonly in the context of a life crisis or developmental milestone, with a trauma-specific reminder serving as the proximate cue to new recall. Psychotherapy was not implicated in the early stages of delayed recall in most cases. However, the retrieval of traumatic memories, once begun, proved to be a powerful incentive for entering psychotherapy. Patients rarely sought treatment with a goal of recovering more memories; rather, they wished to gain more control over intrusive, involuntary reliving experiences and to make sense of the fragmented, confusing and disturbing recollections they already had.

These data remind us that remembering autobiographical material is normally an active process, characterized by shifting emphases, changing interpretations, and repeated evaluation of the meaning of particular events in relation to an ongoing life narrative. A century ago, Janet (1889) observed that the defining abnormality of traumatic memory was its frozen, wordless, intensely emotional quality and its dissociation from the narrative stream of ordinary autobiographical memory. In a recent study confirming these observations, van der Kolk and Fisler (1995) noted that subjects with traumatic memories described them as vivid somatosensory and affective reliving experiences that initially could not be integrated on a semantic/linguistic level. Only over time were the majority of their subjects able to tell a story about their traumatic experiences. Many of the patients in our study described their memories in similar terms. Bremner, Krystal, Southwick, and Charney (1995) have hypothesized that abnormalities of hippocampal processing may underlie this incapacity to construct a narrative of the traumatic event. Siegel (1995), who concurred in this hypothesis, has suggested

further that psychotherapy may play an important part in the reprocessing and integration of traumatic memories. It appears that our patients often sought psychotherapy with such a goal in mind.

We find it significant, in this regard, that few patients had actively sought independent confirmation for their memories; indeed the majority of those who reported having obtained such confirmation had not actively sought it, and most patients expressed no particular interest in conducting a search for validating evidence. Rather, like most patients who enter psychotherapy, they were seeking help in creating an internally coherent story of the past in order to make sense of their present symptoms or interpersonal problems. It is not clear whether the confirmation sources these patients described would have been considered convincing by forensic standards. In all likelihood some sources, such as direct eyewitness accounts or the testimony of other victims of the same perpetrator, would have met these standards and others, such as accounts by a relative or acquaintance who knew of the abuse indirectly, would not. The forensic standard of evidence, however, was essentially irrelevant to these patients, since none was seeking legal redress.

Finally, our data suggest that some patients reporting amnesia and delayed recall can indeed obtain independent confirmation of their traumatic memories, and appear to do so with about the same frequency as those with continuous recall. Therefore, particular skepticism regarding the credibility of memories recovered after a period of amnesia would appear to be unwarranted. Our clinical impression is that patients with major amnestic gaps often express more confusion, bewilderment, and doubt about the trustworthiness of their own perceptions than those with continuous memory. However, these doubts are rarely put to rest even by obtaining convincing evidence from outside sources. Rather, confusion tends to subside as the patient slowly pieces together an integrated autobiographical narrative.

Overall, the findings of this study do not support the supposition that psychotherapy plays a major role in instigating a process of delayed recall of childhood trauma. They suggest, on the contrary, that delayed recall of traumatic events may be a common precipitant for seeking psychotherapy. Our conclusions are limited, however, by the nature of our study population. We do not know whether these findings would be replicated in a general population of psychiatric patients, or in a community population. Future studies are needed to resolve this question.

Though psychotherapy may turn out to play a minor role in initiating recall of traumatic events, it often does play a role in enlarging and changing patients' understanding of their past. We believe that the proper role of psychotherapy is to provide an environment of confidentiality and em-

pathic, nonjudgmental attention, where uncertainty, complexity and ambivalence are tolerated. A stance of open-minded, reflective curiosity should prevail. Such an environment stands in marked contrast to the adversarial, polarized environment of the courtroom. We believe, however, that for most patients it is a far more appropriate setting for gaining understanding of the impact of traumatic events. Within such an environment, and with careful timing and pacing, exploration of abusive childhood experiences may be carried out safely. The purpose of such exploration is not the forensic documentation of facts, but the construction of an integrated, personally meaningful narrative that helps free the patient from the persistent noxious effects of traumatic events in the distant past (Brown, 1995; Harvey, in press; Herman, 1992; Siegel, 1995; van der Hart, Steele, Boon, & Brown, 1993). Future clinical research is needed in order systematically to document treatment outcome and establish preferred modalities of psychotherapy for patients with histories of childhood trauma.

Acknowledgment

This study was made possible by a grant from the William F. Milton Fund, Harvard Medical School.

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