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The Trauma–Memory Argument

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The trauma–memory argument proposes that memories of childhood trauma can affect adult behavior outside awareness and that such unconscious memories can return to awareness even after long delays. Unfortunately, this conclusion is based on case reports of unknown representativeness and on clinical studies which are methodologically flawed or do not consider alternative explanations. Of particular concern is the general lack of independent verification of the ostensibly forgotten memories. The trauma–memory argument is plausible, in at least some respects, given what we know about the processes of remembering and forgetting, but considerably more research is needed before it can serve as a basis for scientifically sound clinical practice.

THE TRAUMA–MEMORY ARGUMENT

An increasing number of researchers, clinicians, and members of the public at large have become interested in two related propositions: (1) that memories of childhood incest, sexual abuse, and other trauma can affect adult behavior outside awareness and (2) that such unconscious memories can return to awareness, even after long delays. This *trauma–memory argument* (e.g., Bass & Davis, 1988; Fredrickson, 1992; Herman, 1992; Terr, 1994) begins with a child who has been the victim of trauma. Under certain circumstances, it is argued, the child defensively invokes a mental process such as repression or dissociation, which in turn results in an amnesia for the trauma. Nevertheless, representations of the trauma have been encoded in memory; these representations persist and affect subsequent experience, thought, and action in the form of intrusive images, bodily feelings, repetitive dreams, and other mental and behavioral symptoms. The presence of these symptoms, then, may be taken as a sign that a traumatic memory exists. At some later time, this unconscious memory may be recovered spontaneously in response to the appearance of certain cues in the environment, or it may be exhumed by means of certain therapeutic techniques such as guided interviews, hypnosis, and barbiturate sedation.[1] Exhumation of the original traumatic memory is an important step in the recovery process; in cases where the memory cannot be verified, its essential accuracy is demonstrated by its explanatory value, in the context of the person's presenting symptoms and overall life history.

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[1] The phrase *exhumed memory* was coined by Paul Buttenweiser (1993). In my view, it perfectly captures the process by which ostensibly forgotten events are ostensibly discovered in the course of therapy or self-help; I also prefer it because it is neutral with respect to the mechanism (e.g., repression or dissociation) ostensibly responsible for the ostensible forgetting.

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If all of this seems familiar, it is because it *is* familiar. It is the same argument that Freud made about hysteria, abreaction, and catharsis 100 years ago, as he began to promote psychoanalysis as a technique of psychotherapy (e.g., Breuer & Freud, 1893–1895/1955). It is an interesting argument, but there is one problem with it. While we can agree that the exploitation and mistreatment of children, including incest and other forms of sexual abuse, is a major social problem, the scientific evidence supporting the rest of the trauma–memory argument was scant a hundred years ago (Schimek, 1987; see also Macmillan, 1991), and the situation has not really changed 100 years later (Baker, 1992; Kihlstrom, 1995a,b; Loftus, 1993; Yapko, 1994).

For the most part, evidence for the trauma–memory argument comes in the form of clinical case reports, similar to Freud's, in which a person, typically an adult receiving counseling or psychotherapy, recovers long-forgotten memories of abuse, trauma, deprivation, and neglect. Such cases are often vivid and sometimes compelling, but we are all too familiar with their limitations as evidence: data collection is likely to be nonsystematic and even biased; data can be condensed and elaborated as it is collected; interpretation can be confused with reporting; hypotheses cannot be tested; and causal inferences cannot be made. Most important, we have no idea how representative a particular case, or series of cases, is—or how much we can generalize from it to the population at large. These problems are compounded when, as in the paper by Harvey and Herman (1994), the report presents *composite* cases: composites may be useful literary devices, but they should not be confused with scientific evidence.

There is, of course, a considerable body of clinical research implicating childhood trauma, including incest and sexual abuse, in adult psychopathology. For example, Herman, Perry, and van der Kolk (1989) found a high incidence of incest and sexual abuse in a group of women with borderline personality disorder. There are many similar studies, especially in the domain of eating disorders and dissociative disorders (for a review, see Spiegel & Cardeña, 1993). Unfortunately, all of these studies are based on retrospective self-reports, raising the possibility that the patients' memories may be biased by their current clinical state (not to mention the biases of the interviewer); moreover, the claims of incest and sexual abuse are rarely corroborated by independent evidence. What we need are prospective studies of the adult outcomes of victims of confirmed child abuse. Even if such studies yield positive results, however, we need to separate the effects of the abuse as such from the effects of the patient's social identification, including self-identification, as a victim of abuse. More to the point of this commentary, we would need to evaluate separately the effects of abuse which is remembered from abuse for which the victim is amnesic.

With respect to the question of amnesia for childhood trauma, the evidence is even more scanty, and even more ambiguous. The most commonly cited study, by Herman and Schatzow (1987), was based on 53 participants in a therapy group for incest survivors. Of these, 14 patients had a severe amnesia for their abuse: they strongly suspected that they had been abused, but could not remember it clearly. As part of the therapeutic process, the patients were offered the opportu-

nity to gather evidence that would corroborate their memories, or suspicions, of abuse. Herman and Schatzow reported that such efforts were successful for 39 of the cases, or 74%. But remember that 39 of the group members had little or no amnesia to begin with: it wouldn't be surprising if these individuals were able to validate their memories. Further, Herman and Schatzow (1987) reported that their amnesic patients reported an average age of onset for the abuse of 4–5 years of age, while the nonamnesic patients reported onsets at about 8–11 years of age. They concluded that "massive repression appeared to be the main defensive resource available to patients who were abused early in childhood . . ." (p. 9). But there are other possibilities. For example, the authors failed to consider the impact of infantile and childhood amnesia arising from physiological, cognitive, and environmental changes occurring normally over the course of early development. Moreover, there is another alternative: lacking actual memories for abuse, but believing that they were incest survivors and knowing something of the concept of repressed memory, these patients may have *assumed* that their abuse occurred during that period, early in childhood, when their memories were poorest. Thus, the dating of their abuse may be based on attributional processes, not fact retrieval.

A similar criticism applies to another major study claiming to provide evidence for repression of childhood sexual abuse, that of Briere and Conte (1993). In this research, a total of 468 patients with self-reported histories of sexual abuse (mostly women) were recruited by their therapists and asked to complete a questionnaire. Almost 69% of these patients reported that they had not remembered their abuse at some point in time after it had occurred. By far the strongest predictor of amnesia was the age of the patient at the time the abuse began: patients who had been amnesic for their abuse claimed they had been molested earlier than those who had not experienced amnesia. Again, it is important to understand just how ambiguous this finding is: the molestation was self-reported, but not independently corroborated and there was no distinction made between repression and ordinary forgetting due to infantile and childhood amnesia and other benign factors. For Briere and Conte (1993), as for Herman and Schatzow (1987), it is entirely possible that many of the ostensibly amnesic patients had inferred that they were molested as children and then attributed their molestation to a period in their lives covered by normal infantile and childhood amnesia.

In this respect, something of an advance was attempted by Williams (1993), who followed up a group of 129 women who had been treated for sexual abuse as children some 17 years earlier. Under the cover of a routine interview ostensibly concerning the medical care they had received as children, these subjects were asked questions about childhood sexual victimization. A total of 38% of the informants failed to recall the incident of abuse that brought them to the hospital, although many (68%) of these did recall other experiences of abuse. A small minority of the sample, 12%, denied that they had ever been abused in childhood. Even so, there is no reason to conclude that the forgetting was due to repression or dissociation as opposed to benign processes. The highest recall-failure rates occurred in women who had been abused before 7 years of age: perhaps these

events were merely forgotten, or covered by normal infantile or childhood amnesia. Perhaps, as well, these women merely failed to disclose incidents that they remembered perfectly well.

The Williams (1993) study is an important advance, because it allows for the independent confirmation of self-reports of childhood trauma, but, like its predecessors, it does not provide enough evidence to permit the conclusion that amnesia for victimization experiences is common. Nor does it provide any evidence that these experiences, or amnesia for them, are associated with pathological adult outcomes. Better methodology is required to distinguish between those who do not recall actual abuse and those who do not report it, and among the former, between memory failures that reflect repression, dissociation, and other pathological processes and those that are benign.

The trauma–memory argument derives its power from the social problem of child abuse and from the vivid case histories presented by its proponents. In some respects, it also gains some plausibility from scientific research on memory (Kihlstrom & Barnhardt, 1993). For example, studies of cued recall, recognition, and hypermnesia show that it is possible for people to remember at one point events that had been forgotten earlier. Similarly, research on hypnosis shows that people can block conscious access to particular memories and regain access sometime later and that in the meantime, the unconscious memories can have implicit effects on the person's experience, thought, and action.

In the final analysis, the available base of scientific evidence is simply too weak to support global assertions about trauma and memory, amnesia and recovery, and the like. As much as we sympathize with those who exhume memories of trauma, and the therapists and counselors who seek to help them, there is nothing in the available evidence that would permit us to have any confidence in any exhumed memory, in the absence of independent confirmation, or to have any confidence that there are causal links among trauma, amnesia, and psychopathology. To demur in this way is not to "cast a chill on serious scientific dialogue" (Harvey & Herman, 1994, p. 296). On the contrary, it is to hold clinical theory and practice up to established standards of scientific knowledge.

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