Recollections of Trauma

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REPORTED AMNESIA FOR CHILDHOOD ABUSE AND OTHER TRAUMATIC EVENTS IN PSYCHIATRIC INPATIENTS

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1. INTRODUCTION

By the close of the NATO Advanced Study Institute on Recollections of Trauma, it appeared that the first hurdle to reaching consensus over the credibility of reports of delayed memory for sexual abuse had been cleared. As the contents of other chapters in this volume show, there seems to be general agreement that both delayed recall of sexual abuse and false reports of sexual abuse do occur. Controversy remains, however, about the prevalence of amnesia for sexual abuse experiences, the prevalence of reports of recovered memories for sexual abuse that did not occur (so-called false memories), the processes involved in forgetting of sexual abuse experiences, and the accuracy of recovered memories of abuse (see Harvey & Herman, 1994; Lindsay & Read, 1993). To clarify our use of the term amnesia throughout this chapter, we mean a lack of recall of life experiences that one would be expected to recall because of their personal salience.

One impediment to progress in understanding memory for traumatic events has been the tendency of researchers and clinicians to focus very narrowly on sexual abuse experiences. By broadening the focus of inquiry to a wider range of traumatic events, we might learn much about the credibility of reports of amnesia for sexual abuse and the processes involved in recall and forgetting of sexual abuse experiences. Specifically, one broader question that might be asked by researchers and clinicians is what patterns of amnesia are reported across different types of abuse experiences and traumatic events? While there is relatively little empirical research on the prevalence of reported amnesia for sexual abuse, some research is available on the prevalence of amnesia for other types of traumatic events. Amnesia for traumatic events has been reported in studies of soldiers, concentration camp victims, rape victims, and refugees (Carlson & Rosser-Hogan, 1991; Loewenstein, 1996; van der Kolk, 1996). In general, these studies have found that a greater

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severity of trauma is associated with a greater prevalence of amnesia for the trauma (Loewenstein, 1996).

Given that amnesia for traumatic events has been associated with a variety of traumas, it seems worthwhile to investigate whether patterns of reported amnesia for sexual abuse among various populations are consistent with each other and with patterns of reported amnesia for other types of traumatic experiences. In general, reports of childhood physical abuse experiences and other traumatic experiences have been less subject to controversy than are reports of childhood sexual abuse. Reports of sexual abuse have been questioned because of concern that psychotherapy clients may falsely report sexual abuse as a result of the influence of overzealous therapists and popular books on childhood sexual abuse (Lindsay & Read, 1993).

We do not dispute the point that misleading information on sexual abuse and memory has been widespread in the media (and among some mental health professionals) and that this misinformation has surely influenced some people to make false reports about childhood sexual abuse. These false reports may result either from false beliefs that abuse did occur or because of intentional misreporting. Both types of false reports of sexual abuse might be motivated in some cases by secondary gain. But these factors seem unlikely to be influencing reports of amnesia for other types of childhood abuse or other traumatic experiences. There is almost no popular press or media discussion about amnesia for physical abuse or other traumatic experiences, and we know of no civil litigation involving recovered memories for physical abuse or other traumatic experiences. If amnesia is reported for physical abuse experiences and other traumatic events, this will, in general, lend credibility to reports of amnesia for sexual abuse experiences.

Other questions that might be asked by researchers and clinicians include whether levels of amnesia for experiences are associated with particular aspects of the experiences or with various trauma-related psychiatric symptoms. Findings in studies of diverse populations that support hypothesized relationships between levels of amnesia and aspects of trauma and symptoms would reduce the likelihood that the findings reflect confabulated reports of amnesia. While confabulation of experiences and symptoms is always a possibility in an individual case, it seems unlikely that large numbers of subjects in independent studies at different sites could confabulate their reports in such a way that the hypothesized patterns in relationships between variables would be emerge.

This chapter will report results of a study of psychiatric inpatients that sheds light on the prevalence of amnesia for different types of abuse and other traumatic events. We will also briefly review findings relating to the relationships between level of amnesia for abuse and aspects of abuse experiences and between levels of amnesia for abuse and other trauma-related symptoms.

2. DESCRIPTION OF THE STUDY

The present study was designed to investigate the relationships between aspects of childhood physical and sexual abuse and adult psychological symptoms in psychiatric inpatients. We measured a number of variables that represent aspects of abuse experiences including the severity, duration, and age of onset of abuse experiences. We also measured some variables that are thought to moderate or exacerbate responses to traumatic experiences. These include later traumatic experiences and childhood experiences of neglect, dysfunctional behaviors in caretakers, and social support. Adult psychological symptoms we measured included posttraumatic stress disorder (PTSD) symptoms, dissociation, depression,

anxiety, self-destructiveness, somatization, and aggression/hostility. This brief description of the study will include those aspects of the methods and measures used that are relevant to subjects' amnesia reports. A more complete description of the study's methods and findings can be found elsewhere (Carlson, Armstrong, Loewenstein, & Roth, in press).

Subjects for the study were psychiatric inpatients at a large, non-profit, psychiatric hospital serving an urban and suburban population. We attempted to recruit every patient admitted to the hospital during a three and one-half year period who was between the age of 30 and 45 (in order to minimize variation across subjects in the length of the recall period for childhood experiences). Of 2458 patients admitted, were able to obtain therapist permission to interview and to contact a total of 581 patients before they were discharged. Completed interviews were obtained for 217 of these patients. Those not interviewed (364) were unavailable because they declined to participate (180), were discharged before an interview could be completed (126), or for other reasons (58). Of 217 subjects interviewed, 126 (58%) were females and 91 (42%) were males. The average age of subjects was 38 (SD = 4.8). In terms of race, 82% were white, 16% black, and 2% some other race. The sample was socioeconomically diverse and diverse in terms of marital status.

Chart diagnoses was obtained for 178 patients received the following diagnoses: affective disorders (64%), dissociative disorders (30%), substance use disorders (31%), anxiety disorders (25%), other disorders (25%), and schizophrenia (7%). These add to more than 100% because many subjects received more than one diagnosis. The unusually high rate of dissociative disorders is the result of a dissociative disorders treatment unit at the hospital. In order to enhance generalizability of the findings, analyses were also calculated for the subsample of subjects (n=155) who were treated on psychiatric units not specializing in treatment of dissociative disorders. These subjects received diagnoses of affective disorders (75%), other disorders (28%), substance use disorders (26%), dissociative disorders (14%), anxiety disorders (12%), and schizophrenia (8%).

In the context of this study, subjects were administered structured interviews about their sexual experiences and experiences with physical force as children and about their symptoms of PTSD. The interview about sexual experiences inquired about experiences before the age of 18 with an older person or involving force. The interview was a modified version of that used by Jacobson and Richardson (1987). Subjects were asked about specific, behaviorally-defined experiences in a neutral manner. Experiences ranged from less intrusive behaviors such as being kissed or hugged in a sexual way to more intrusive behaviors such as having someone put their penis in the child's vagina or anus. The interview about physical abuse inquired about experiences of physical force before the age of 18 that were not in the context of fighting with other children. Here subjects were asked about physical force experiences using items from the Conflict Tactics Scale (Straus, 1979). These range from experiencing someone throw, smash, hit, or kick something to being threatened with a gun or knife.

Following completion of each abuse interview, subjects were asked "Was there ever a time when you didn't remember these things happening to you or didn't remember part of what happened to you?" Subjects who reported never having a period of not remembering the experiences were classified as reporting having had no amnesia. Those who reported not remembering part of their abuse experiences for some period were categorized as reporting having had partial amnesia. Those who reported not remembering all of their abuse experiences for some period were categorized as reporting having had total amnesia.

Information about amnesia for traumatic events other than childhood abuse was obtained using the Structured Interview for PTSD (SI-PTSD) (Davidson, Smith, & Kudler, 1989). At the beginning of this interview, subjects are asked "Did you ever experience an ex-

tremely stressful event, such as serious physical injury, combat, rape, assault, captivity, being kidnapped, being burned, seeing loss of life, your own life being threatened, destruction of property, or threat of harm to you or your family?" As part of the assessment for DSM-III-R Criterion C for PTSD, subjects were asked "Is there an important part of the event that you cannot remember?" Scores for this item were assigned by the interviewer who rated the client's psychogenic amnesia on the following scale: "0" = no problem, "1" = mild; remembers most details, "2" = moderate; some difficulty remembering significant details, "3" = severe; remembers only a few details; "4" = very severe; claims total amnesia for an important aspect of the trauma. For the purposes of this discussion, subjects were categorized as reporting no amnesia if their psychogenic amnesia rating was 0 or 1; they were categorized as reporting partial amnesia if their psychogenic amnesia rating was 2 or 3; they were categorized as reporting total amnesia if their psychogenic amnesia rating was 4.

3. AMNESIA FOR DIFFERENT TYPES OF TRAUMA

Of the 217 men and women interviewed in the study, 136 of them reported childhood forced sexual experiences, 194 reported childhood physical force experiences, and 168 reported one or more traumatic events on the SI-PTSD. Within the group of 168 reporting traumatic experiences on the SI-PTSD, some reported only childhood abuse experiences as traumatic events, some reported both childhood abuse and other traumatic experiences, and some reported only non-abuse traumas. The amnesia reports of the latter group of 75 subjects are of most interest here because they shed light on lack of recall for traumatic events other than abuse. Table 1 shows the rates of no, partial, or total amnesia across sexual abuse, physical abuse, and non-abuse traumas.

These same calculations were conducted for the subset of subjects who were treated on psychiatric units not specializing in the treatment of dissociative disorders. Table 2 shows the results of these analyses.

The results for the subset of subjects is somewhat different from the analysis for all subjects, with fewer subjects reporting total amnesia and more subjects reporting no amnesia. This difference is not surprising given that the units not specializing in treating dissociative disorders would be expected to have patients with less severe trauma histories and less problems with amnesia. Overall, however, the results for both sets of analyses show that, while there are differences in the rates of different reported levels of amnesia across sexual abuse, physical abuse, and other traumas, substantial numbers of subjects report having experienced partial or total amnesia for physical abuse experiences and other traumatic experiences. This finding supports the notion that the phenomenon of amnesia is not unique to sexual abuse experiences. This finding isn't surprising given observations of amnesia in victims of traumas such as disasters, accidents, and combat (for a review of the

Table 1. Levels of reported amnesia across different types of abuse and traumatic experiences

Type of experience	Reported no amnesia	Reported partial amnesia	Reported total amnesia
Sexual abuse (n=136)	38%	21%	41%
Physical abuse (n=194)	57%	23%	20%
Non-abuse traumas (n=75)	61%	19%	20%

Table 2. Levels of reported amnesia across different types of abuse and traumatic experiences for patients from general psychiatric units

Type of experience	Reported no amnesia	Reported partial amnesia	Reported total amnesia
Sexual abuse (n=96)	50%	19%	31%
Physical abuse (n=105)	66%	23%	11%
Non-abuse traumas (n=66)	68%	17%	15%

literature see van der Kolk, 1996 and Loewenstein, 1996) and the fact that severe physical abuse can be quite traumatizing to children.

It is interesting that a larger percentage of those physically abused reported no amnesia for the abuse compared to the percentage reporting no amnesia for sexual abuse. If this finding is confirmed through replication studies with other populations, it might lead us in the direction of asking why people are less likely to have amnesia for physical abuse experiences than for sexual abuse experiences. One possible explanation that awaits further consideration and study points to the secretive nature of sexual abuse experiences. Most often, sexual abuse occurs in private so that there are no witnesses to confirm the experience afterward or to remind the person of the experience. In fact, many people never discuss their sexual abuse experiences with anyone. Physical abuse, on the other hand, is not as likely to be a private act and may be observed by others such as family members who reinforce the memory of the experience in various ways. Furthermore, sexual abuse may leave no physical evidence of its occurrence, while physical abuse often leaves scars or bruises. These physical signs of the experience may serve as cues to remind the person of the experience. They may also serve to inform others of the experiences who, in turn, reinforce the memory of the abuse. Clearly, much more research is needed to confirm our finding of differences in amnesia rates for sexual and physical abuse and to explore possible explanations for them.

Lower levels of amnesia for non-abuse traumatic events than for childhood abuse experiences could be the result of a number of factors. As with physical abuse experiences, traumatic experiences other than abuse are more likely to have been witnessed by others who might provide cues for recall of the events. Furthermore, traumatic experiences other than abuse are less likely to be imbued with the kind of shame and secrecy that often accompanies sexual and physical abuse. Very often, a person's traumatic experience may be publicly acknowledged and openly spoken about, while this is rarely the case for abuse experiences. Support for this hypothesis would be provided if higher levels of amnesia were reported for a "shameful" traumatic event such as rape than for other kinds of traumatic events.

Table 3 shows a comparison of the levels of reported amnesia for sexual abuse in this study to those reported in five other similar studies (Briere & Conte, 1993; Elliott & Briere, 1995; Herman & Schatzow, 1987; Loftus, Polonsky, & Fullilove, 1994; Williams, 1995). In the table, the partial and total amnesia categories are combined because some studies did not distinguish between partial and total amnesia in their questions. This comparison highlights the differences in reported levels of amnesia for sexual abuse across studies. Likely contributing factors to these differences include differences in study methodologies such as how subjects were sampled and the exact question they were asked to determine amnesia level. Though no clear pattern emerges from this comparison in terms of a relationship between reported amnesia and level of mental illness (or population), the rates of partial or total amnesia for sexual abuse in the present study's inpatient population

Table 3. Levels of reported amnesia for sexual abuse across six studies

Study	Population	n	% reporting no amnesia	% reporting partial or total amnesia
Williams (1995)	general	129	53%	47%
Elliott & Briere (1993)	general	116	52%	42%
Loftus et al. (1994)	outpatient	52	75%	25%
Briere & Conte (1993)	outpatient	450	41%	59%
Herman & Schatzow (1987)	outpatient	53	36%	64%
Carlson et al. (1997)	inpatient	136	38%	62%

are roughly comparable to the rates of amnesia reported in two of the three outpatient studies. Again, we clearly need more systematic studies of the prevalence of various levels of amnesia before we can form any conclusions about the relative frequency of the phenomenon.

4. RELATIONSHIPS BETWEEN AMNESIA LEVELS AND OTHER VARIABLES

Results from our study reported elsewhere show that the level of amnesia for abuse is related to characteristics of the abuse experience and to trauma-related psychiatric symptoms (Carlson et al., in press). For example, level of amnesia for sexual abuse was significantly related to the extent of sexual abuse experienced by subjects, and level of amnesia for physical abuse was significantly related to the extent of physical abuse. In both cases, a greater extent of abuse was related to higher levels of amnesia. Furthermore, levels of amnesia for both sexual and physical abuse were significantly related to scores on measures of PTSD and dissociation. Symptoms of PTSD and dissociation have been associated with a wide range of traumatic experiences (see Carlson et al., in press). These findings of hypothesized relationships between level of amnesia and other variables seem to support the genuineness of the amnesia reports and indicate that this approach to the study of amnesia for abuse merits further consideration.

5. CONCLUSION

In conclusion, analyses of reported amnesia for abuse and trauma in our study of psychiatric inpatients indicate that a substantial proportion of inpatient subjects who experienced childhood physical abuse and non-abuse traumas report partial or total amnesia for their experiences. Differences in rates of amnesia for different types of abuse and traumas warrant further research as do relationships between amnesia levels, aspects of abuse, and trauma-related symptoms.

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