Blind to Betrayal: New Perspectives on Memory for Trauma

by Jennifer J. Freyd

In 1992, Frank Fitzpatrick's recovered memories of childhood sexual abuse rocked the mental health and legal professions. This was not the first case of recovered memories for sexual abuse by any means, but it was a dramatic one. Dozens of victims of the Reverend James R. Porter began to come forward only after Fitzpatrick, a Rhode Island insurance adjuster, acted on his own just-recovered memories. Most of the victims said they had always remembered the abuse, but others, like Fitzpatrick, had forgotten it for more than 20 years.

How and why would anyone forget something so apparently significant as childhood molestation, then remember it decades later? Fitzpatrick's revelations added fuel to a smoldering controversy that was soon to burst into flames — the now familiar dispute about recovered memories. Fitzpatrick's memories were corroborated by the reports of other victims and by Porter's own statements. But in many other cases the truth is difficult to determine, for there is little or no corroboration. The alleged perpetrator vigorously denies the accusation, declaring the memory to be a product of therapeutic suggestion. Were these memories true or false? By the mid-1990s there was a vitriolic and confusing controversy about memory and trauma that extended from professional venues to the popular media.

As we approach the end of the century, some of the bitterness and chaos is dissipating, and we have gained some knowledge and humility. Scholars have reminded us that the study of traumatic stress has a long history. In the 19th century and again after both world wars, psychiatrists and psychologists grappled with many of the issues that are troubling us now. We have learned that exposure to trauma can profoundly alter both individuals and larger social groups and that one kind of change affects attention, perception, and memory.

We have learned to step back from the conceptual muddle that emerges under conditions of heated disagreement and examine the issues more dispassionately. These are deeply perplexing and slippery topics. What is the nature of memory, and how is it changed by exposure to trauma? How do the awareness and memory of trauma influence the possibility of healing or prevention? To define more precisely what we know and do not know, we must untangle the several issues involved and ask scientifically tractable questions. First, we must distinguish between phenomena, motivations, and mechanisms. The phenomena are apparent forgetting and later remembering a significant event (or series of events). Why they occur is a question of motivation, how they occur a question of mechanisms.

In describing the phenomena of recovered memory, it is critical to separate the two dimensions: accuracy (how true or false is a memory?) and persistence (how accessible is it to explicit recall?). The two are not necessarily correlated. There is no good evidence that the accuracy of a memory depends on whether it is experienced as continuously available or as recovered after years of forgetting. Furthermore, we can usually measure only perceived persistence, and people are often mistaken about that. They may believe they have always remembered something they have only recently recalled or believe that they have only recently learned for the first time about an event they once described to another person. Therapists should be skeptical about all uncorroborated memories, whether they are newly recovered or not. Any memory can be true or false or a mixture of the two. We must live with uncertainty, for there are no general rules. Furthermore, much harm can be done by premature efforts to validate or invalidate, judge or label memories.

Perhaps the most exciting development to emerge in the second half of the 1990s is the explosion of empirical research on memory malleability, memory persistence, and memory for trauma. The challenge of understanding memory and the awareness of trauma requires an approach in which knowledge from various fields is brought to bear. Particularly promising is the collaboration between trauma researchers and cognitive psychologists.

We now have a much clearer picture of the conditions that make human memory vulnerable to suggestion and distortion. We are beginning to understand the relevance of factors such as event plausibility and social authority. Studies have amply documented the phenomena of forgetting and remembering trauma – not just sexual abuse but a variety of other kinds (although research has shown that the rate of forgetting varies for different

types of trauma, a result that is highly relevant to questions of motivation and mechanism).

Through new research in cognitive science and cognitive neuroscience, we are also making progress in elucidating the mechanisms and brain structures involved in alterations of memory.

For example, Anne DePrince and I have recently found a relationship between basic mechanisms of attention and individual differences in reports of dissociative experiences. Many studies have shown a strong relationship between high levels of dissociation and traumatic experience. We discovered that high dissociators have difficulty with a task requiring selective attention but are actually superior to low dissociators when divided attention is required instead; they are apparently better able to focus on more than one thing at a time.

Our results suggest that dissociation is linked to the creation of a special cognitive environment. Traumatized persons may use dissociation and dual-tasking to control the information by keeping threatening material away from consciousness and other mental functions. Special cognitive strategies are required for functioning in an environment in which experiences, memories, and thoughts are not integrated. The habitual creation of a divided cognitive environment may have both adaptive and maladaptive consequences, depending on the context and the demands of the situation.

These findings have important clinical implications. High dissociators sometimes create chaos in their lives, but they have cognitive strengths as well as deficits, and clinicians might help them find appropriate contexts for their skills. Clinicians must understand the cognitive forces behind the chaos and remain alert to the possibility that certain dissociative responses have current adaptive value.

New perspectives and data on motivations for forgetting traumatic experiences are also available. We have various ideas to explore, from psychoanalytic conceptions of the need to avoid overwhelming pain or conflict to innovative theories about the need to believe in a safe world. I have been testing hypotheses arising from my theory of betrayal trauma, which focuses on betrayals of trust such as those that occur in child sexual abuse. According to the New York Times (July 1992): "Mr. Fitzpatrick's retrieval of the repressed memories began, he said, when 'I was feeling a great mental pain...' Mr. Fitzpatrick...slowly realized that the mental pain was due to a 'betrayal of some kind,' and remembered the sound of heavy breathing. 'Then I realized I had been sexually abused by someone I loved,' said Mr. Fitzpatrick."

I propose that what I have called knowledge isolation (including memory repression, dissociation, and unawareness) serves a survival function in necessary human relationships when betrayal occurs. Human beings are often exquisitely sensitive to betrayal or cheating; we detect the betrayal and then respond with strong negative emotions that guide us away from the betrayer. However, under some circumstances this very sensitivity can cause more problems than it solves. It can risk a relationship we may need or believe we need. Child abuse by a caregiver (and some other traumas) are especially likely to produce such an implicit social conflict. Withdrawing from a caregiver could further threaten the victim's life. For a child who depends on an abusive caregiver, the situation demands that information about the abuse be blocked from mental mechanisms that control attachment (bonding) behavior. The blocking may be partial (for instance, affecting emotional responses only), but in many cases it leads to a more profound disruption in awareness and autobiographical memory. Thus studies show that rates of amnesia are highest when the relationship between victim and perpetrator is close, as in parental or incestuous abuse.

Betrayal is a central factor not only in child abuse but also in many cases of memories recovered by adults in situations of dependence. Vietnam veterans with post-traumatic stress disorder (PTSD) often recall a betrayal by a commanding officer only many years later. Battered wives may forget and then remember abuse by their husbands. In my laboratory, we are studying relationship dependence, memory persistence, and other influences in greater detail. Preliminary results support our prediction that the greater the victim's dependence on the perpetrator, the less persistent the memories of abuse.

The role of betrayal in traumatic forgetting has important implications for clinical understanding and treatment. It suggests that in traumas leading to psychological disorders, the threat to life and social betrayal are distinct dimensions of harm. The symptom cluster known as post-traumatic stress disorder may better be understood as arising from these two independent dimensions of trauma. Threats to life may be the main source of fear, anxiety, hyperarousal, and intrusive memories. Social betrayal is likely to be the chief source of dissociation, numbness, and constricted or abusive relationships. The most severe traumas (e.g., rape, much child abuse, many combat experiences, the Holocaust) involve high levels of both social betrayal and threat to life; in these cases, both classes of symptoms are likely to be present.

Clinicians are most likely to be helpful when they understand the separate origins of these different classes of symptoms. There are reasonably effective

treatments for fear, anxiety, and hyperarousal, but numbing, dissociation, and avoidance have proved more difficult to dispel. According to betrayal trauma theory, survivors of childhood abuse (and adult betrayal traumas) have learned to cope with an inescapable social conflict through internal disconnection. The treatment therefore must concentrate on social relationships and the cognitive mechanisms that support them, with the aim of promoting integration and deeper external connection.

These methods need not be at odds with those used to address anxiety, fear, and hyperarousal, but the focus is different. One way to promote internal integration is to establish a healthy relationship that supports the verbalization of traumatic experiences and promotes the internal re-coding of disjointed and fragmentary sensory memories. The clinician can use this relationship to encourage the patient's efforts to relearn trust and test reality. Thus the potential to heal internal disconnection is most fully realized in the context of what was broken in the first place – an intimate and trusting relationship.

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