
Commentary

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We are fortunate to have this videotape, which captures the moment of recall of previously unavailable memories of childhood abuse, together with a compelling allegation of sexual abuse made 11 years earlier by the then 6-year-old child. This tape is currently a unique document, although, as discussed later, there is every reason to believe that similar examples could be obtained by a systematic study of previously videotaped child abuse evaluations. The quality of this example owes much to the professional care exercised by Dr. Corwin, both at the time of the initial evaluation in 1984 and again when obtaining an informed consent prior to viewing the evaluation tape. Corwin's careful attention to the problem of leading questions and the possibility that the child had been threatened and told to lie (which indeed she does report) permits us to accept Jane Doe's reports as truthful rather than suggested or coerced.

The qualities of Jane Doe's personality contribute to the credibility of this example. Both at ages 6 and 17, she is clearly an intelligent person who is open and direct in discussing what has happened to her. In both interviews, she demonstrates that she is independent and not easily led or intimidated. She is genuine and believable.

WHAT VIDEOTAPE IS AND IS NOT

The advantage of videotape is that it permits us to replay over and over again events such as Jane Doe's initial disclosure or her later recall. We can meticulously trace the threads of interactions, determine exactly what was said when, accurately time shifts in affect, and note congruencies or discrepancies between emotion and content. Dr. Paul Ekman's work has been most illuminating in this respect, illustrating the enormous amounts of information captured by videotape and the ways in which it can be systemically extracted for scientific analysis.

But those of us who use videotape in our clinical or research work note that often something is missing

when one compares the experience of being there in the room with what is recorded on the tape. In particular, the experience of affect is diminished by videotape. The "vibes" are somehow missing. On tape, people appear emotionally flatter and less animated than in life. Indeed, actors know that to appear "normal" on television, they must exaggerate their expressions and gestures. One should keep this in mind when viewing videotapes of clinical material.

HOW REPRESENTATIVE IS THIS EXAMPLE OF DELAYED RECALL OF CHILDHOOD ABUSE?

According to the stereotype promulgated by critics of delayed recall of childhood trauma, the typical patient is a woman who presents for treatment with common complaints such as depression, anxiety, or marital difficulties. She is allegedly told that these may actually be disguised symptoms of childhood sexual abuse, the memories of which she has "repressed," and that she should be treated with "memory recovery therapy." In the course of such treatment, the therapist "implants" false memories for abusive childhood experiences, leading the patient to mistakenly accuse her innocent parents or others of heinous crimes. Obviously, Jane Doe does not fit this stereotype, which, indeed, has never been scientifically established as representative of delayed recall cases.

Jane Doe represents, in my experience, a more typical clinical presentation in that she is aware that there are missing memories. She knows about the allegations of child abuse. She has read the reports and seen pictures of her burned feet. She just cannot recall the events. This is an example of knowing something but not remembering it actually happening—a clinical distinction that has long been made by therapists working with such patients. What is especially noteworthy is the intensity of Jane Doe's wish to re-

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solve the psychologically painful dilemma that she is experiencing. She is aware that important information is missing from her life history, and she is deeply troubled by the contradictions between her parents' accounts. She needs to know the truth because it will shape how she relates to her mother, with whom she has recently resumed contact, and how she will remember her dead father for the rest of her life.

In the majority of cases, the driving pressure to recall such missing memories comes from the patient, not the therapist. Corwin, like many therapists facing insistent demands to help recall missing memories, is trying to slow down this process and carefully consider what it may mean. Indeed, the clinical literature is replete with cautions about proceeding too rapidly with the process of retrieving traumatic memories. These cautions are rarely acknowledged by critics. Discussions of the delayed recall phenomenon, particularly in the popular media, often neglect to mention the pressure exerted by the patient on the therapist to fill these painful voids and to reconcile dissonant family versions of reality.

WHAT DOES THIS CASE TELL US ABOUT THE NATURE OF DELAYED RECALL?

The Dynamic Nature of Unavailable Memories

One of the important insights offered by this case is evidence of the dynamic nature of the missing memories. Jane Doe is unable to volitionally recall the events described in her documented allegations against her mother, although she remembers talking about the allegations with Dr. Corwin. These are memories for two distinct sets of experiences separated in time, location, and the individuals involved, but they are dynamically associated by their content. She can recall one set but not the other. When she does finally retrieve them, they are recalled as a package ("I remember saying about the pictures, I remember it happening that she hurt me," p. 106).

Later, as Jane Doe struggles with the issue of what it means for her relationship with her mother, she provides another glimpse into the dynamics of why the recall of such memories is painful: "... so I don't

remember if it was just, that's what I mean, I don't know if it was accidental if she just accidentally hurt me, or if, because I don't see her face, but I know it was her" (p. 106). A few minutes later she says, "I have to believe that to some extent my mom did hurt me. If it's that she doesn't remember that she hurt me, or that she just didn't see what she did as hurting me, on top of that I made it worse, as I told the story, as I made it seem worse or that she did it and didn't remember" (p. 108).

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The complex, fragmentary, and somewhat contradictory nature of what she says reveals the operation of dynamic psychological processes at work that attempt to accept, integrate, and reconcile affectively charged content. She expresses the greatest emotional relief with respect to her father: "and I'm glad now that I don't have to keep trying to convince myself that my dad ever lied to me, because for a while after he died, I was convinced that I would have to keep trying to convince myself that he told me those things about my mom that weren't really true. That puts that to rest in my mind" (p. 108).

The Multimodal Nature of Traumatic Memories

Clinicians have long reported that traumatic memories are often recalled in a mixed sensory, multimodal fashion with especially strong visual components (e.g., van der Kolk & Fessler, 1995). "And then it's like I took a picture, like a few seconds long, a picture of the pain, and what was inflicting the pain . . . that's all the memory consists of" (p. 106). Jane Doe's description of a "picture of the pain" is more than just a metaphor; it likely reflects a strong visual image (apparently spanning a few seconds of time) that also contains somatic components. This is typical of recalled traumatic moments.

The Accuracy of Delayed Recall

As critics of delayed recall of childhood trauma begin to concede that this does indeed happen in a substantial proportion of patients in treatment for childhood sexual abuse (e.g., Brewin, 1996), their fallback position has been that delayed recall may be considerably less accurate than continuously available memories of childhood trauma. This case does not provide definitive data with regard to this issue, but it

is noteworthy to compare the high degree of similarity between what Jane Doe says during the evaluation at age 6 and her delayed recall at age 17 of what she said at age 6.

Jane Doe (age 6): That Mother was putting her finger up my vagina and pulling my hair. (p. 100)

Jane Doe (age 17): I know what was said on the tape. On the tape it was said she put her fingers in my vagina. And she hurt me. (p. 106)

What psychological mechanism(s) could account for this example of delayed recall? For some time prior to her meeting with Corwin, Jane had been making a determined effort to recall the abuse—without success. Together with her foster mother, Jane had been exploring various ways, including recontacting her mother, to access her missing memories. None of these efforts were sufficient to cue her recall. Yet within a short time into her meeting with Corwin, she is able to retrieve these reportedly unrecalable memories. Why?

Research on memory retrieval suggests that the nature of the cuing process is exquisitely critical in facilitating (and shaping) recall. Corwin's physical presence, his voice and demeanor, together with the impending viewing of the evaluation tape, probably all contributed to facilitating Jane's recall in ways in which her mother's presence or attempts at reconstructing the context with her foster mother could not. Indeed, it is quite possible that her mother's presence actually impeded recall.

Does this mode of retrieval provide mechanistic evidence for dissociation, repression, denial, or isolation? Probably. However, it does not appear as if any single mechanism is solely responsible. Repeated viewings of the tape segment just before her recall seem to show that the memories are almost available to Jane Doe. Only minimal interventions are required on the part of the interviewer to elicit a conscious awareness of them. Corwin tells Jane to start with what

she can recall: "Just tell me what you can remember, of our meetings with me, things you may have said" (p. 105). With minor supplemental prompting from her foster mother she recalls the walls with varying

degrees of accuracy of the interview room, her striped sweatshirt, who brought her to the evaluation, and allegations of her feet being burned (which she can't recall happening) and then discusses her mother's apparent multiple personality disorder. Corwin then asks, "Do you remember anything about the concerns about possible sexual abuse?" To which Jane responds, "No. I mean, I remember that was part of the accusation, but I don't remember anything—wait a minute, yeah, I do. [Corwin: What do you remember?] Oh my gosh, that's really, really weird" (p. 105). This is followed by a pronounced affective shift with tears springing forth and her speech becoming choked up.

Thus Jane's delayed recall process is accompanied by or precipitates a marked shift in affective state. This is most compatible with a dissociative process (Putnam, 1988). Certainly a number of features of her history would predispose her toward increased levels of

dissociation. Research suggests that three factors account for much of the variance in dissociation: (a) trauma, particularly a history of early childhood trauma (van Ijzendoorn & Schuengel, 1996); (b) disturbances in the attachment relationship with a primary caretaker, especially having a dissociative mother (Main & Hesse, 1996); and (c) disturbed family relationships characterized by affective double binds and disavowal by a parent of the child's experience of reality (Spiegel, 1986). In dissociative patients, retrieval of hitherto inaccessible traumatic memories is often accompanied by a perceptible shift in affective/behavioral state, such as occurs when tears spring forth and Jane Doe's speech chokes up. However, examination of the tape suggests that other processes probably also contributed to her retrieval problems.

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The apparent ease with which heretofore inaccessible traumatic memories suddenly become available to Jane is typical of many clinical cases of delayed recall. For whatever reasons, the timing seems to be right for Jane to retrieve these memories. Many patients are similarly "primed" when they seek therapy for missing memories. This facilitating effect of the therapist in accessing missing traumatic memories should not be construed as iatrogenesis.

WHERE DO WE GO FROM HERE?

As is often the case, as many questions are raised by such a unique example as are resolved. Some of these focus on what has happened to Jane subsequently. Has she recalled other previously unavailable traumatic memories (e.g., how her feet were burned)? How has this affected her relationship with her mother? What did she mean by "really, really weird"? It would be interesting to see whether this experience has produced substantial changes in her life, for better or worse.

The larger set of questions has to do with how representative this example is and whether it suggests a fruitful empirical approach to resolving the acrimonious controversy about "false memories." Thousands of videotaped child abuse evaluations are a decade or more old. One possible study would involve recontacting the individuals and interviewing them about what they can recall about the evaluation process, the allegations, and the abuse events. Appropriate measures of personality, coping styles, memory functions and cognition, and so on would provide correlates that could account for some of the variance in who recalls

what and how accurately. Of course, blinding of the interviewer to details of the initial evaluation and other methodological concerns would be required. A further elaboration of such a study might include an evocative procedure using cuing and recognition paradigms to facilitate recall. Follow-up could assess the impact of this experience for subjects with continuously available memories and those with delayed recall.

In the meantime, this videotape of Jane Doe provides concrete evidence that delayed recall of traumatic childhood events does occur.

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