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Amnesia, Partial Amnesia, and Delayed Recall among Adult Survivors of Childhood Trauma

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Clinical experience suggests that adult survivors of childhood trauma arrive at their memories in a number of ways, with varying degrees of associated distress and uncertainty and, in some cases, after memory lapses of varying duration and extent. Among those patients who enter psychotherapy as a result of early abuse, three general patterns of traumatic recall are identified: (1) relatively continuous and complete recall of childhood abuse experiences coupled with changing interpretations (delayed understanding) of these experiences, (2) partial amnesia for abuse events, accompanied by a mixture of delayed recall and delayed understanding, and (3) delayed recall following a period of profound and pervasive amnesia. These patterns are represented by three composite clinical vignettes. Variations among them suggest that the phenomena underlying traumatic recall are continuous not dichotomous. Future research into the nature of traumatic memory should be informed by clinical observation. © 1994 Academic Press, Inc.

INTRODUCTION

The past 20 years have witnessed a profound transformation in public and professional awareness of violence in the lives of women and children. Today, an ample literature documents the high prevalence of sexual assault in our society and the extensiveness of childhood physical and sexual abuse (Russell, 1984, 1986; Wyatt, 1985; Finkelhor et al., 1990; Sorenson et al., 1987; National Victims Center, 1992). Media attention has ensured widespread public awareness of these issues. Victim advocacy has realized important improvements in the professional treatment of victims, and feminist activism has helped to secure significant legal reform (Koss & Harvey, 1991; Harvey & Herman, 1992). Many states, for example, now allow victims of childhood trauma to file charges once they have achieved majority age (see, e.g., Washington, 1989; Lofft v. Lofft, 1989) or have acquired new memories or new understandings of abuse experiences located in the distant past (e.g., Riley v. Pressnell, 1991; Munsey v. Kellett, 1992).

It is in the changing forensic context of newly secured victim rights that aggressive challenges to victim credibility have received renewed attention among researchers, clinicians, defense attorneys, and the general public. Recently, in a few highly publicized court cases child abusers have been convicted of crimes or held liable for damages for abuses committed in the distant past (e.g., California

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v. Franklin; Commonwealth of Massachusetts v. Porter). The successful prosecution of these cases, and the possibility of new litigation, has prompted defense attorneys and some academic investigators to question the accuracy, authenticity, and forensic legitimacy of child abuse claims brought forward by adult complainants.

Of particular concern to these investigators is the phenomenon of delayed recall of traumatic childhood events following a period of full or partial amnesia. Loftus (1993a, 1993b), for example, has speculated that most if indeed not all delayed memories of childhood trauma are confabulations inculcated by the suggestive power of self-help literature and the leading questions of naive or unscrupulous psychotherapists. Ofshe and Watters (1993) claim that the phenomenon of repressed memory simply does not exist and that delayed recollections of childhood trauma are fictions resulting from intense pressures placed on vulnerable patients by practitioners whom they label "recovered memory therapists."

The confabulation hypothesis has several major flaws. First, and most importantly, it overlooks the evidence from documented cases in which the reports of adults who remembered childhood abuse after a period of amnesia have been independently confirmed by abundant evidence (Commonwealth of Massachusetts v. Porter, 1993). Second, it fails to explain how individuals might be induced to reconcile the contradiction between newly acquired but fictitious memories of childhood trauma with prior (and presumably more accurate) memories of happy family life. Although the power of therapist suggestion is regularly invoked by proponents of the confabulation hypothesis, there is no evidence to suggest that psychotherapists have the degree of power and influence that would be required to produce this effect. Indeed, there is no empirical evidence to suggest that psychotherapy is a factor at all in the majority of cases of delayed recall.

In the absence of convincing theory or systematic empirical evidence, those who advance the confabulation hypothesis rest their argument on the appeal of anecdotal reports. Loftus (1993a, 1993b), for example, cites a small number of high profile forensic cases to posit a virtual epidemic of false memories and false allegations, which she attributes in turn to widespread psychotherapeutic manipulation and an apparently hypnotic potency of the self-help book *Courage to Heal* (Bass & Davis, 1988). Whatever research may ultimately reveal about the accuracy of traumatic recall and the authenticity of adult memories of childhood trauma, these generalizations go far beyond the reach of available data and cast a chill on serious scientific dialogue.

In fact, aberrations in memory are central to the description and diagnosis of traumatic disorders. Symptoms diagnostic of post-traumatic stress disorder (PTSD) include, for example: intrusive recollections of traumatic events, nightmares and waking state flashbacks in which salient aspects of the traumatic event are reexperienced, reenactment sensations, and both amnesia and hypermnesia. Like other PTSD symptoms, these disturbances of memory may be apparent immediately following the traumatic event or "after long periods of apparent adjustment" (American Psychiatric Association, 1987).

Epidemiological and clinical studies have documented a high prevalence of PTSD among sexually abused children and among adult survivors of childhood sexual abuse (National Victims Center, 1992; Rowan & Foy, 1993). In addition,

early, prolonged and repeated abuse and abuse by a primary caretaker have been associated with a long-lasting traumatic syndrome (Browne & Finkelhor, 1986; Briere, 1984; Herman, 1992). Among survivors of severe and protracted childhood sexual abuse, this syndrome has been found to include severe disturbances of memory and consciousness and complex dissociative reactions (Putnam, 1985, 1990; Putnam, Post, Giuroff, Silberman, & Barban, 1983; Briere & Runtz, 1988; Briere & Conte, 1993; Chu & Dill, 1990; Goodwin, 1989; Herman, 1992).

Criticisms of clinical research associating amnestic phenomena and delayed recall with childhood trauma focus on the largely retrospective nature of these studies and on their reliance on largely unverifiable self-reports of childhood histories by the patients whose symptoms are being described. Herman and Schatzow (1987) found, however, that among a group of women incest survivors, recently remembered histories of childhood sexual abuse were, in fact, independently verifiable. In a recent prospective study, Williams (1993) found that 38% of 129 women subjects evidenced varying degrees of amnesia for child sexual abuse incidents that had been documented 17 years earlier.

It is our impression that amnesia, partial amnesia, and delayed recall are relatively common factors in the clinical presentations of adult survivors of childhood trauma. The majority of these individuals do not enter psychotherapy solely or even primarily to acquire memories of an unremembered but suspected abuse history, however, but for help in understanding and managing the distress associated with memories already acquired. Some are hoping to contain a flood of newly intrusive and unwelcome remembrances; some are wanting to understand better the psychological impact of histories that are at least partially recalled; and some are wanting to give context, comprehensibility, and meaning to a bizarre and troubling assortment of relatively new and longer-standing remembrances. Virtually all bring with them into psychotherapy a combination of long-remembered and more recently recalled material.

The position taken in this paper is twofold: *first* that traumatic remembrance (including delayed recall) is not an all-or-none phenomenon, but a complex and continuous one; and, *second* that clinical observation is a reasonable starting point for scientific inquiry into the nature of traumatic memory. One aim of this paper is simply to describe the variations in traumatic recall that are frequently witnessed in clinical settings by ethical, observant, and reliable psychotherapists. Another is to counter an increasingly adversarial relationship between memory researchers who are relatively less familiar with clinical realities than they might be and clinicians who feel placed on the defensive by sweeping accusations of professional malfeasance. Toward these ends, this paper presents and discusses composite clinical vignettes drawn from adult survivors of childhood trauma currently being treated in our clinic.

ADULT REMEMBRANCES OF CHILDHOOD TRAUMA: THREE CASE VIGNETTES

Each year the client population served by The Cambridge Hospital Victims of Violence (VOV) Program includes a number of adults (62 in 1993) who report at least one instance of sexual or physical abuse before age 18. Among these pa-

tients, three general patterns of traumatic remembrance can be identified: (1) relatively continuous and complete recall of childhood abuse experiences coupled with changing interpretations (delayed understanding) of these experiences, (2) partial amnesia for abuse events, accompanied by a mixture of delayed recall and delayed understanding, and (3) delayed recall following a period of profound and pervasive amnesia. These patterns are illustrated by clinical vignettes drawn from the intake interviews and clinical records of several patients.

Vignette Number 1: Continuous Recall, Delayed Understanding

Carol B. is a 25-year-old single woman. She lives with two roommates in an apartment in Cambridge and is enrolled as a graduate student in a nearby university.

Abuse history. Carol's history includes a relatively benign childhood until age 11 when her parents divorced. From that time, her father showed little interest in her. When Carol was 13 her maternal uncle visited the family and for a short time became her primary adult companion. She remembers that she adored him and thought of him as her "best friend." Carol also recalls that her uncle began molesting her almost immediately. "At first, I didn't know what was going on. I really liked him. I couldn't believe he would hurt me. By the time I did get it, I felt responsible—like it was something I was doing." The abuse occurred as often as twice a week and escalated when she was 14 to include a single incident of vaginal intercourse. It ended shortly thereafter when her uncle moved away. Carol has seen him only intermittently since then. She never disclosed the abuse, and never really thought of it as abuse: "I just felt ashamed and relieved that he was gone."

Continuity of recall/precipitants to delayed recall and delayed understanding. At age 25, Carol reports that she "never forgot" her uncle's abuse, but that she did succeed in not thinking about it for many years. Recently, a number of events have caused her to recall and become increasingly preoccupied with the past. A few months ago, Carol ended a relationship with a man she had hoped to get closer to. Since then, she has wondered and worried about her seeming inability to tolerate sexual intimacy and closeness. Then, last month she learned from her mother that her uncle had returned to the area and was asking about her. Carol's mother wants her to attend a family reunion at which her uncle will be a guest of honor. Carol reports becoming "undone" by this news, feeling momentarily terrified and struggling to keep her distress to herself.

Qualitative features of traumatic recall. Carol's response to these events is shocking to her. She feels depressed, intensely anxious, is unable to concentrate, and has moments of "real rage." Her volatile emotional state and her preoccupation with memories of the abuse have caused Carol to review and rethink the past. Today, she labels the experience abuse and holds her uncle responsible. She wonders if the rape is implicated in her difficulties with intimacy and sexuality. She thinks about disclosing the abuse to her mother, but feels overwhelmed when she imagines doing so. She does not want to see her uncle, nor does she want to explain her reactions to her family.

Therapy goals/memory assessments. At this point, Carol is seeking psychotherapy to help her understand and repair the impact of the past on her current and future life. Her aims are to contain and stabilize her runaway emotions, to make new sense of the past, and to think through the issue of disclosure. At this point, Carol feels no need to uncover additional memories and no need to confirm the memories she has. She judges her memories of the past to be "reasonably complete" and generally accurate. "I may not be able to tell you the exact day and date, but I do know what grade I was in, where we were, and what I was wearing the day he raped me."

Vignette Number 2: Partial Amnesia, Delayed Recall, and Delayed Understanding

Sarah G. is a 34-year-old woman currently separated from her husband of 11 years, a sporadically violent man with a long history (like herself) of polysubstance abuse. She is the mother of a 9-year-old daughter, Tracy. She and her daughter are living temporarily with a friend who is about to leave the area. Sarah has been sober for 11 months.

Abuse history. Sarah describes herself as someone who "always gets involved with the wrong guy." She reports a series of abusive relationships beginning in junior high, and a history of alcohol abuse beginning in early adolescence. Sarah remembers growing up in a "sometimes close, sometimes crazy and sometimes violent home" in which "all hell could break loose if mom and dad were drinking." Sarah has "always known" that she was sexually abused by her oldest brother. Recently, however, she has begun to think more about the abuse and has recalled "stuff I'd really forgotten about." The abuse began after Sarah's brother joined the army, on his first visit home. It occurred repeatedly thereafter, whenever he was home on leave. The abuse ended when Sarah was "12 or 13" and began menstruating. "There was never any explanation. It just stopped. It was like it had never happened."

Continuity of recall/precipitants to delayed recall and delayed understanding. Sarah's recollections of childhood are complex. She has relatively detailed recall for events up to age 8 or 9 but "real blank spaces after that." She also reports relatively complete recall from age 12 to age 15. Her memory after age 15 is compromised by her substance abuse but has improved with sobriety. And she has long-remembered aspects of her brother's abuse. Recently, however, Sarah learned that she was "only 9 years old" on her brother's first visit home. "Somehow, I thought I was older." Other details of the abuse had been forgotten, too. For example, Sarah remembers, now, that the abuse began on a night when her parents were drunk and fighting with one another. She was hiding in her room, frightened by the yelling and the violence. "He came into my room, held me, made me feel safe." On that night and other nights, her brother would first soothe and comfort her and then plead with her to "be nice to him, too." "Later, he would act like he was mad and it was my fault."

Sarah's memories appear to have been triggered by a series of events: First, when Sarah first left her marriage, she and her daughter stayed briefly with

Sarah's parents—reentering the home where the abuse took place. It was here that she learned from her mother how old she was when her brother joined the military. Second, Sarah's daughter recently had her ninth birthday, and "I suddenly saw how little 9 is." And, finally, Sarah hears in her husband's appeals for reconciliation "the same words, the same tone of voice" that her brother would use to cajole her into complying with his sexual demands.

Qualitative features of traumatic recall. Sarah's clinical presentation is complex. On the one hand, she is able to recall in great detail (but with little in the way of affect) much of the violence that characterized her marriage and other relationships. She'd thought she had fairly complete recall of her childhood, too, and believed that she remembered her brother's abuse "fairly well." Now, she realizes that in fact she had forgotten altogether when and how it began and that she "lost" parts of her childhood from age 8 or 9 to age 12. Her newer memories are accompanied by considerable distress: intrusive recollections, disrupted sleep, feelings of sadness and despair, low self-esteem, and, in her words, "shock." "How can you just forget stuff like this?"

Therapy goals/memory assessments. Sarah is less concerned with her memories of past abuse than she is with her history of involvement in abusive relationships and with the task of protecting herself, her daughter, and her sobriety in the future. As she recalls her brother's abuse and reexamines the often violent and alcoholic home in which the abuse occurred, she wants "to make it different for Tracy." Sarah is hoping that psychotherapy will help her maintain her own and Tracy's safety and acquire the self-confidence she requires. She believes that with sobriety, more memories of her childhood will emerge. Her goal is to be "ready to handle whatever comes up." She has not sought to confirm her memories but has learned from an older sister that her brother once "got in trouble" for molesting a cousin.

Vignette Number 3: Profound Amnesia and Delayed Recall

Emily B. is a 45-year-old married woman. She and her husband recently relocated to the Boston area where she'd grown up. Emily has two siblings and an aging paternal aunt in this area. She was referred to psychotherapy by a local psychiatric emergency service, where she appeared in a state of confusion and despair following a reunion with her sister, whom she had not seen for many years.

Abuse history. Emily is the youngest of three children raised by their father and two paternal aunts following their mother's untimely death when Emily was 4 years old. The aunts were extraordinarily severe in their approach to punishment and discipline. Emily recalls that she and her siblings were frequently beaten with belts and "other objects," locked in closets, blindfolded for long periods of time, deprived of food, and subjected to verbal assaults and humiliation. Their father did not engage in this abuse, but he also did not protect them. At some point in her childhood—"maybe I was 10 or 11, but maybe I was younger than that"—Emily's father began molesting her. Once the abuse began, it escalated to include oral, anal, and vaginal penetration and by the time she was 13, it

assumed violent and sadistic proportions. As far as Emily knows now, the abuse continued until she ran away at age "15 or 16."

Continuity of recall/precipitants to delayed recall. When Emily left home, she cut off all contact with her family. By the time she met and married her husband, she had "completely forgotten" the sexual abuse. "I never forgot the beatings, though." Among the major precipitants to Emily's remembrance of the sexual abuse are her return to the geographic area in which she was raised and her renewed contact with an older sister. It was while visiting this sister and hearing "one family horror story after another" that Emily began feeling extremely agitated and fearful. That night, she was awakened with terrifying dreams and for several days afterward was flooded with memories of her father's abuse. Since then, Emily has spent a great deal of time with her sister and has confirmed many of her new memories. She has learned that her sister and brother were also sexually abused by their father.

Qualitative features of traumatic remembrance. Emily's remembrance of the cruelty which she and her siblings endured at the hands of their paternal aunts is qualitatively different from her memories of sexual abuse by her father. The memories of physical abuse have long formed a part of Emily's autobiographical narrative. She can recall when it began, how she felt at the time, how the children tried to "stick together," and how determined she was "to get away." When she discusses this abuse, she does so with sadness, but also with distance. It is in the past. Her strongest feelings are for the memories of her mother's illness and death—these are events that ushered in the abuse that was to follow.

Emily's memories of sexual abuse are quite different. She feels no distance from those memories. She can suddenly feel frightened and overwhelmed. She has awakened from dreams to experience herself as a child again and her husband as the personification of her father. She can recall intricate details of the abuse ("like how he smelled and how he breathed") and yet cannot recall what led to what. She does remember now that as a child she would pretend to be asleep when her father entered her room. "I think I got good at it. I think I learned to believe it was a dream."

Therapy goals/memory assessments. Emily is currently overwhelmed by her memories. She is aware now of her extraordinary ability to "put things away," "to forget," and of the fact that these new memories are leaving her feeling "very young, very afraid." Emily's goals in therapy are "first of all to calm down," and later, "to try and make sense of things." She is unable to assess the completeness of her memories, is unsure about their accuracy, and at times doubts her own reality. She is unclear, still, about when and how her father's abuse began. Indeed, she is fearful that additional memories will simply cause her more distress, and she has no desire to seek additional confirmation of her memories. In fact, she tries hard, but without success, to avoid thinking about the past.

DISCUSSION

The clinical materials from which these vignettes were compiled suggest that adult survivors of childhood trauma arrive at their remembrances in a number of

ways. They differ from one another on many dimensions, including the age at which the remembered events first occurred, the frequency, duration, chronicity, and degree of violence and violation which attended these events, the social or ecological context in which the abuse occurred and in which protection was or was not afforded, and in the recency, clarity, and confidence with which they are able to recall the abuse. Most are able to confirm salient aspects of their histories even though they are unable to recall other, perhaps equally salient, features of those same histories.

Vignette Number 1

The patients represented by Vignette Number 1 report largely intact and continuous remembrance of their abuse experiences. Some, but not all, also report a much delayed understanding of their early experiences: a belated awareness of the abusive nature of the experience and a lifting not of the amnesia but of the veil of denial and minimization that enabled them to preserve secrecy and illusion. It appears that many patients who find themselves rethinking and reinterpreting a long-remembered past do so as a result of specific developmental or relational events.

Vignette Number 2

It is our impression that vignette number 2 is most characteristic of the adult survivors of childhood trauma who are seen in our clinic. Among these patients, the clinical presentation is mixed. It includes both newly recalled and continuously remembered events and a mixture of delayed recall and delayed understanding. The patients whose materials contributed to this composite generally reported partial amnesia for particular time periods, especially for periods associated with the onset and escalation of abuse and for abuse experiences located in early childhood. Contemporary precipitants to delayed recall also included developmental challenges and relational events. The content of newly recalled material often led to a review and rethinking of the remembered past and then ushered in new interpretations and delayed understanding of an abusive past. Often, these patients reported that their revised beliefs caused as much distress as their new memories.

Vignette Number 3

This vignette describes patients with the type of memory disturbance of concern to Loftus (1993a, 1993b). However, these patients do not conform in any other way to Loftus' generalizations. None of the patients represented in Vignette Number 3 had taken or anticipated taking legal action against an offender. All were less interested in uncovering additional memories than in understanding and containing the press of recently acquired memories. All reported severe and repeated sexual and physical abuse, beginning in early childhood and continuing into early adolescence. Many reported amnesia not only for the abuse that occurred, but also for whole eras of development (e.g., early or middle childhood)

and whole categories of experience (e.g., events inside the home or contacts with specific family members) as well. Most reported witnessing family violence as well, and many reported abuse by more than one perpetrator.

False versus Genuine Memories of Abuse

From our vantage point, characterizations of "false" versus "true" memory fail to capture the complexity of traumatic remembrance that is regularly witnessed in clinical settings. Neither these vignettes nor the patients whose experiences contributed to them fit such descriptions. Instead, the most apt characterization of the adult survivor is a person who arrives at adulthood with some, but not all, memories of the abuse intact, and who at some point in time begins to confront and rethink the past, blending new memories with earlier ones, new assessments with alternative ones, gradually constructing a meaningful and largely verifiable personal history: a history that is patently "true" though never complete and never wholly accurate in all detail. The process of discovering one's history is not an all or none event, but rather unfolds in a relational and developmental context accompanied by marked emotional and symptomatic changes. The veracity of the history does not hang on the accurate and detailed recall of specific events. The development of a complete narrative often includes a search for confirmation of facts and verification in the remembrances of others; however, the timing and circumstances of this verification process are idiosyncratic and highly variable.

Precipitants to Delayed Recall and Delayed Understanding

Clinical observation suggests that memories of childhood victimization—and reinterpretations of childhood events not originally understood as abusive—may resurface unexpectedly when lifecycle changes introduce new relational demands. The adult survivor may begin to recall a history of childhood trauma upon entering or ending an intimate relationship, for example. Memories may start to break through in the form of flashbacks or nightmares when the survivor gets involved in a sexual relationship, marries, or has a child. Delayed recall may occur when another victim of the same perpetrator discloses the abuse or when an aging perpetrator falls ill and expects his victim to care for him. It may be, of course, that virtually all remembrances are, in fact, instances of delayed recall and that delayed recall of traumatic events differs from normal memory not in its temporary absence from conscious awareness, but in the painful reexperiencing of the trauma itself and in the often bizarre and fragmentary nature of the memory.

Psychotherapy with Adult Survivors of Childhood Trauma

The case vignettes presented here are illustrative not only of the type of traumatic remembering that is witnessed in clinical settings, but also of the kind of issues that typically prevail in clinical work with trauma survivors. Most patients who enter psychotherapy for help in dealing with a traumatic past do so because

of what they do remember and not because of what they do not. Many enter psychotherapy after years of silence and secrecy, not after years of amnesia. They are hoping to better understand the impact of a long-remembered past. Others, like Carol in vignette 1, may find themselves newly preoccupied with long-remembered events and feel stunned by their extreme emotional reactions to new understandings of these events. They enter therapy for help in managing their distress, for assistance in absorbing and "metabolizing" their new understandings, and, sometimes, for help in resolving the issue of family disclosure. Still, others, like Sarah in vignette 2 and Emily in vignette 3 have acquired new memories that are deeply troubling. While these new memories may indeed become a focus of psychotherapy, psychotherapy is not the source of the memories. When clinicians work with trauma survivors who are experiencing distress as a result of traumatic remembrances, the work typically involves the containment of runaway affect and help with stabilization of functioning, not an archaeological search for more in the way of traumatic recall. Contrary to the portrait of clinical work with trauma survivors being promulgated by the popular press and the false memory literature, the aim of clinical exploration of the traumatic past is neither to uncover more and more horror, nor to assign blame and responsibility for adult life to others, but rather to help the adult survivor name and assign meaning and comprehensibility to the past, to facilitate the integration of traumatic remembrance into an ongoing personal narrative, and to help the patient grieve the past and be freed of it.

Future Research

Clinicians familiar with traumatic disorders emphasize the role of memory retrieval in a multidimensional recovery process and the danger inherent in premature or poorly paced traumatic recall (Herman, 1992; Lebowitz, Harvey, & Herman, 1993). To date, however, neither the phenomenon of delayed recall of traumatic memories nor specific approaches to memory work with trauma survivors have been subjected to systematic study. Required catalysts for these investigations are inquiries into the psychological mechanisms, biochemical mediators, and neurological substrata of delayed recall, on the one hand, and, on the other, conceptualizations of normal and traumatic memory that can facilitate collaborative inquiry by basic researcher and clinical investigator.

Three sets of issues raised by the phenomenon of delayed recall should be distinguished and considered separately. The first set of issues is *forensic* in nature and has less to do with what is "true" of a remembered past than with considerations of due process and the weight that ought be granted evidence brought forward as delayed recall. Should these memories be considered in the same manner as any other testimony? Ought they be supported by other forms of evidence? How should judges and jurors understand and make use of the research on confabulation, suggestion, and the fallibility of human memory?

The second set of issues focuses on the nature of *clinical* practice with adults who are reporting or wondering about an abusive past. What should psychotherapy with remembering adults look like? Should clinical practice with patients

who have long-remembered histories differ substantially from practice with patients who report newly acquired memories of abuse? How ought the therapist respond to patient speculations about the past? What is leading? What is not? How often is psychotherapy the sole or even the primary source of delayed recall? How widespread is therapist manipulation of patient recall? How suggestible are trauma patients? Is verification of an abuse history clinically necessary? If so, why? If not, why not?

A final set of questions are central to *memory research*. These concern the role of strong emotion in the encoding, storage, and retrieval of emotionally laden material. How does traumatic memory differ from normal memory? Does the emotional arousal characteristic of traumatic exposure heighten the probability of a deeply engraved memory? Might it instead have a disorganizing effect and actually interfere with memory storage? If traumatic memories are indeed indelibly stored at the point of exposure, then why and how do they get lost? How and under what circumstances are they retrieved?

Clinical observation is a reasonable and valid starting point for the scientific exploration of these issues. An adequate theory of human memory cannot ignore or dismiss clinical observations. On the contrary, a science of memory must be able to account for the aberrations of memory and consciousness repeatedly witnessed by ethical, reliable, and observant clinicians. Similarly, effective treatment of these phenomena can and must be informed by basic research.

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