



Autobiographical memory specificity among people with recovered memories of childhood sexual abuse

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ABSTRACT

Individuals who report to have recovered memories of childhood sexual abuse (CSA) almost by definition believe that these memories were previously inaccessible for them. We examined whether poor autobiographical memory specificity for all kinds of events (i.e., events not necessarily related to CSA) may underlie such impressions of amnesia. Thus, we examined whether people who report recovered memories of CSA ($n = 44$) would exhibit more difficulty retrieving specific autobiographical memories compared to people who never forgot their abuse experiences (continuous memory group; $n = 42$) and people without a history of abuse (controls; $n = 26$). The standard Autobiographical Memory Test (AMT) was administered to these 3 groups along with measures of depression and posttraumatic stress disorder symptomatology. Controls were significantly better at retrieving specific autobiographical memories relative to individuals with continuous and recovered CSA memories, who did not differ from each other. Thus, reduced autobiographical memory specificity was not particularly pronounced in people with recovered memories of CSA. Poor autobiographical memory specificity is unlikely to explain the impression of amnesia reported by this group.

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1. Introduction

While conducting a study on mood-congruent memory in suicidal patients, Williams and Broadbent (1986) accidentally discovered that many of their participants tended to produce overgeneral autobiographical memories. An individual is said to have such overgeneral memories if he/she experiences difficulties in retrieving specific autobiographical memories, i.e., memories of personally experienced events happening at a particular place and lasting less than a day (Williams & Broadbent, 1986). Research addressing this phenomenon is important because the relative inability to retrieve specific autobiographical memories has been found to be associated with a poor problem-solving ability in clinical patients (e.g., Pollock & Williams, 2001; Sutherland & Bryant, 2008), poor ability to imagine future events (for review, see Williams et al., 1996), and poor long-term outcome in clinically depressed patients (e.g., Peeters, Wessel, Merckelbach, & Boon-Vermeeren, 2002).

Many clinicians have suggested that a history of trauma, particularly during childhood, leads to changes in memory functioning (e.g., Van der Kolk & Van der Hart, 1995). These changes are

believed to serve a protective role in that they reduce the emotional impact associated with traumatic experiences. According to Williams (1996), poor autobiographical memory specificity would also serve a regulatory function. The idea here is that retrieving autobiographical memories in a less specific way minimizes their negative connotations. Traumatized individuals, who experience this, would therefore adopt a less specific retrieval style (see for further details Raes, Hermans, de Decker, Eelen, & Williams, 2003).

Empirical support for the idea that trauma history is critical for poor autobiographical memory specificity is, however, mixed. Indeed, there appears to be no consistent relationship between trauma exposure and a less specific retrieval style, implying that a mere history of trauma is not a sufficient condition for this style. Rather, psychopathological symptoms often associated with a trauma history (e.g., posttraumatic stress disorder, depression) appear to be the driving force behind this phenomenon (for review, see Moore & Zoellner, 2007; see also Kleim & Ehlers, 2008). For example, McNally, Litz, Prassas, Shin, and Weathers (1994) observed reduced autobiographical memory specificity in Vietnam combat veterans with posttraumatic stress disorder (PTSD) relative to well-adjusted veterans without PTSD (for similar results in people suffering from acute stress disorder see Harvey, Bryant, & Dang, 1998). Another study by McNally et al. on veterans with PTSD further supports this link (McNally, Lasko, Macklin, & Pitman, 1995). Additionally, studies have documented a relationship between

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a less specific autobiographical retrieval style and depression (e.g., Wessel, Meeren, Peeters, Arntz, & Merckelbach, 2001).

One particular group that has received only little research attention when it comes to autobiographical memory specificity is the group of patients who say they have recovered memories of childhood sexual abuse (CSA). According to Schooler (1999; p. 205), “An individual who reports recovering a memory for trauma is really indicating two sentiments: (a) that abuse occurred and (b) that there was a period of time in which the memory was not available.” It is interesting to speculate about the second part of Schooler’s definition. More specifically, the question arises why people have the sentiment that autobiographical details are not available to them, i.e., why they have an *impression* of amnesia (Loftus, Joslyn, & Polage, 1998).

Some authors have speculated that a less specific retrieval style may underlie the subjective experience of amnesia typically reported by people who recover CSA memories (e.g., Dalenberg, 1996; Rassin, Merckelbach, & Muris, 2000). To the best of our knowledge, only one study has looked at autobiographical memory specificity in people with recovered memories (McNally et al., 2006). McNally and colleagues tested people without a history of abuse and people with continuous memories, recovered memories or repressed memories of CSA. The people with recovered memories reported to have recovered long-forgotten memories of CSA, while the repressed group consisted of adults who believed they had been sexually abused during childhood, but had no memories of CSA. Although McNally et al. (2006) did not find a clear-cut pattern of a less specific retrieval style in their groups, there were indications that the repressed group tended to experience the greatest difficulty in retrieving specific memories.

Using the Autobiographical Memory Test (AMT; Williams & Broadbent, 1986), we examined to what extent people reporting continuous memories of CSA, people with recovered CSA memories, and controls experience difficulties retrieving specific memories from their past. We tested the idea that people reporting recovered CSA memories would display a less specific retrieval style relative to the other two groups. Finding such a pattern would account for the impression of amnesia that people with recovered memories have.

2. Method

2.1. Participants

We recruited individuals with a history of CSA through advertisements in local newspapers. The advertisements invited people to participate in our research when they had a history of CSA that had never been forgotten or had *recovered* memories of being sexually abused as a child. CSA was defined as presence of “hand/mouth to genital” and “genital to genital” contact. People who thought to qualify for one of these groups were invited to come to our lab. In order to control for issues such as childhood sexual curiosity, only individuals who reported a reasonable age gap (i.e., >10 years) between themselves and the perpetrator(s) at time of the events, were included. Controls were recruited by means of internet advertisements and flyers distributed in several public places. The study was approved by the standing ethical committee of the Faculty of Psychology and Neuroscience, Maastricht University.

Based on a semi-structured memory interview (e.g., Geraerts et al., 2009), participants were assigned to one of the three groups: (a) the *continuous memory group* consisting of participants who stated that they had never forgotten about their abuse ($n = 42$), (b) the *recovered memory group* consisting of people who claimed there was a period in their life in which they apparently

had no memory for the abuse ($n = 44$). This group entailed both participants who claimed that they had spontaneously recalled CSA memories outside a therapeutic context ($n = 28$) and participants who stated that they had gradually recovered their memories of abuse during treatment, provoked by therapeutic techniques or as a result of actively attempting to reconstruct the “empty holes” in their memory ($n = 16$), and finally (c) the *control group* consisting of participants who reported no history of abuse in either childhood or adulthood ($n = 26$). Participants who could not be properly classified into one of the three groups due to a mixed profile, were excluded from the study ($n = 8$). An example of a mixed profile would be someone who is reporting continuous memories for event A (e.g., abuse by an uncle) in combination with recovered memories for event B (e.g., abuse by the father). Importantly, given that we were interested in whether reduced autobiographical memory specificity might account for the impression of amnesia reported by people with recovered memories, we examined whether our participants had a history of traumatic brain injury which might provide an organic reason for the amnesia (see McNally, 2005). None of the participants with recovered CSA memories reported to have experienced traumatic brain injury in the past.

During the semi-structured memory interview, people were inquired about the nature and duration of their CSA experiences. We explored whether our CSA groups differed in terms of self-reported age at onset and ending of their abuse. In case of multiple CSA experiences (i.e., different abusive experiences caused by different perpetrators starting at different ages), we decided to focus on the self-reported beginning and ending of the *first* (earliest) CSA experience reported.

Twelve % of the people in the continuous group, 11% of the people in the spontaneously recovered memory group, and 0% of the people in the recovered in therapy group failed to provide information about the age at onset of the abuse. Moreover, 14% of the people in the continuous group, 11% of the people in the spontaneously recovered memory group and 19% of the people in the recovered in therapy group failed to provide information about how old they were when the abuse ended. Mean ages at beginning of the first CSA experience in people reporting continuous memories, spontaneously recovered memories, and memories recovered in therapy were 8.5 years ($SD = 3.7$), 9 years ($SD = 3.4$), and 6.2 years ($SD = 3.8$), respectively. Mean ages at ending of the first CSA experience in people reporting continuous memories, spontaneously recovered memories, and memories recovered in therapy were 13.8 years ($SD = 4.6$), 12.5 years ($SD = 3.8$) and 8.2 years ($SD = 4.6$), respectively. A borderline significant group effect was found with respect to the age at onset of CSA, $F(2,75)^1 = 3.01$, $p = 0.06$, $\eta_p^2 = 0.07$. Post-hoc analyses (LSD) showed that people with in therapy recovered memories of abuse differ from people with continuous and spontaneously recovered memories of abuse (all $ps < 0.05$). No significant difference between people with continuous and spontaneously recovered memories of abuse was found ($p = 0.60$).

With respect to the age at the ending of the CSA, a significant effect of group was found, $F(2,73)^1 = 8.09$, $p = 0.00$, $\eta_p^2 = 0.18$. Post-hoc analyses (LSD) showed that people with in therapy recovered memories of abuse differ from people with continuous and people with spontaneously recovered memories of abuse (all $ps < 0.01$). No significant difference between people with continuous and spontaneously recovered memories of abuse was found ($p = 0.24$).

¹ Due to missing values, these degrees of freedom fluctuate and deviate from the total subsample of continuous and recovered memories.

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