Guidelines for the Treatment of Adults Abused or Possibly Abused as Children

(with Attention to Issues of Delayed/Recovered Memory)

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*These guidelines** provide practicing clinicians with information regarding psychotherapy with adults who (1) disclose an abuse history (physical, sexual, emotional) at the beginning of therapy; (2) do not disclose abuse despite having knowledge and memory about such events in their past; (3) report new (delayed or recovered) memories of abuse during the course of therapy; and/or (4) suspect past abuse but have no clear memories of having been abused. The more common clinical scenario involves an individual who has retained memory for past abuse but recalls additional events or details during therapy. The less common scenario is for an individual to have totally absent memory of abuse and to later develop highly detailed memory. Practitioners should expect a range of memory presentations and must work to neither suggest nor suppress abuse-related issues that arise in the course of therapy.*

Treatment of abuse-related psychological effects follows the established principles of practice for generic psychotherapy; yet, specialized knowledge and skills are required to address the complex issues that often are involved. These guidelines outline general principles for posttrauma treatment of abuse, along with cautions and recommendations for working with delayed/recovered memories when they emerge during the course of therapy. This document is not intended to be overly prescriptive nor does it constitute a formal standard of care; rather, it summarizes the present consensus among experts in postabuse and posttrauma treatment regarding ethical and competent practice and takes into consideration critiques

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**These practice guidelines are evolving, adapted in part from outlines and suggestions by Carolyn C. Battle, Ph.D., David Calof, RMHC, Stephen Lindsay, Ph.D., Nancy Perry, Ph.D., Joan A. Turkus, M.D., Michael Yapko, Ph.D. and others and in the aftermath of the NATO Advanced Study Institute on Recollections of Trauma, Port de Bourgenay, France, June, 1996.

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and suggestions offered by memory researchers. Furthermore, these guidelines can be modified as needed for different mental health disciplines, theoretical orientations, and cultural considerations. They are expected to evolve as additional clinical information and research data become available on a number of topics pertinent to this treatment (e.g., posttraumatic response, the psychobiology of trauma, memory for traumatic versus nontraumatic events, dissociation, etc.). For this reason, practitioners are advised to keep abreast of developing and newly published research and literature relevant to this treatment and this population.

I. GENERAL TREATMENT ISSUES AND RECOMMENDATIONS

1. Practice within the established code of ethics and practice standards

First and foremost, the mental health practitioner is advised to abide by the ethical code and standards of practice for his/her discipline. As of yet, no formal practice standards have been adopted for posttrauma treatment (in general or for postabuse and delayed/recovered memory issues). Professional organizations are only currently devising principles, recommendations, and statements as precursors to the development of standards of practice; consequently, clinicians must exercise caution and sensitivity when working with these issues. Interim guidelines and policy statements are now available from the following professional organizations: American Medical Association, American Psychiatric Association Board of Trustees, American Psychological Association (Working Group on the Investigation of Memories of Childhood Abuse and Board of Directors), American Psychological Association Division 17 (Counseling Psychology) Section on Women, American Professional Society on the Abuse of Children (guidelines under development), American Society of Clinical Hypnosis, Australian Psychological Association, British Psychological Society Working Party on Recovered Memory, Canadian Psychiatric Association, and The International Society for the Study of Dissociation. Most can be ordered through the respective association's public affairs or publications departments.

2. Develop specialized knowledge and competence

The mental health practitioner who works with abuse-related cases has responsibility for developing specialized knowledge in issues of abuse, trauma, memory, and posttrauma treatment as well as developing competence in this treatment. In all likelihood, these issues were not addressed during the practitioner's formal clinical training since they have been largely absent from the medical and mental health curricula; therefore, they must be learned through supplemental focused training, continuing educa-

tion, professional reading, and through ongoing participation in consultation, supervision, and peer study/support groups. An additional training issue pertains to students or novice therapists who, due to their apprentice status, may have neither the knowledge nor skills to work effectively with the complexities and high-risk situations inherent in many of these cases. Trainer/supervisors must closely monitor the trainee's ability to understand and manage the dynamics of these cases and, wherever possible, assign cases that are commensurate with the trainee's knowledge and developmental progression as a therapist.

3. Maintain an awareness of transference, countertransference, secondary traumatization, and self-care issues

The therapist should strive to maintain an awareness of transference, countertransference, secondary (or vicarious) traumatization, and burn-out issues that characterize these cases. Self-monitoring, self-analysis, and supervision/consultation assist in therapeutically managing rather than inappropriately reacting to or enacting patient issues. The practitioner should, whenever possible, maintain a varied caseload, avoiding one that is overly taxing and/or one comprising only abuse and trauma cases. Furthermore, the practitioner would be well advised to avoid becoming isolated in work with these patients and to engage in adequate self-care, including a variety of social outlets. It is crucial that the therapist also monitor the status of his/her mental health, seeking additional support and personal therapy during times of intense stress or crisis. When a therapist has a personal history similar to the patient's, over- or underidentification may be problematic and additional consultation may be necessary to maintain a therapeutic role and perspective.

4. Provide information about treatment and establish a therapeutic contract

The practitioner should consider using some sort of "Rights and Responsibility Statement" at the initial meeting to provide the prospective patient with information about the practitioner's therapeutic orientation and practice and the mutual rights and responsibilities of patient and therapist. Such a document is tailored to the needs and practice preferences of the individual clinician and discusses numerous issues, including assessment and diagnosis; consent to treatment, goal-setting, and treatment planning; scheduling; fees and payment; insurance issues; limits of confidentiality and reporting requirements; therapist availability and absences; cancellation and therapy termination policies; adjunctive evaluations and treatment; collateral assessments; the use of contracts for specific issues; safety issues; the use of hospitalization and medication and how deter-

mined, etc. A signed Informed Consent Statement can be used in conjunction with this general orientation statement and more specific forms prepared when any specialized technique (e.g., hypnosis, Eye Movement Desensitization and Reprocessing) is introduced and given consideration.

Preliminary information about how the practitioner works with abuse and trauma and delayed/recovered memory issues can also be included and can be supplemented with more specific materials, as needed. For example, the American Psychiatric Association Statement on Delayed Memory, a concise but comprehensive overview of these issues, can be attached to the "Rights and Responsibility Statement." This introductory material provides the basis of a mutual understanding of the practitioner's approach that is addressed in more depth and detail during the course of treatment, as discussed below.

5. Begin with a comprehensive assessment including questions about past abuse/trauma and use psychological testing and ancillary assessments as warranted

The practitioner begins treatment with a comprehensive psychosocial and personality assessment. Questions about experiencing or witnessing problematic family and childhood events (such as family violence of any sort, intra- or extrafamilial sexual contact, serious childhood medical conditions, significant family crises) should be included among other questions in the initial history-taking. These provide a baseline of information and further indicate to the potential patient the legitimacy and importance of these events and the practitioner's openness to discussing them.

At the outset of treatment, some individuals with a positive history of abuse and trauma will spontaneously disclose, others will make a direct disclosure only upon direct inquiry, others will deliberately not disclose even with direct inquiry, and others will not have such information. Nondisclosure or a "disguised presentation" of a positive history is not uncommon and may be part of the individual's posttraumatic (avoidance/dissociative) response. For this reason, assessment should be considered as ongoing throughout the course of treatment and is reinitiated as warranted by the emergence of any new memories, issues, and symptoms. The therapist must recognize, however, that a significant number of individuals who seek therapy do not disclose because they have a negative abuse/trauma history and thus have nothing to disclose. In this circumstance, the therapist should make no assumptions regarding the meaning of a lack of disclosure and, in particular, should not assume that the individual is consciously or unconsciously concealing an abuse history.

Psychological testing should be considered as part of the assessment. Generic screening and assessment instruments (e.g., the MMPI, MCMI, Beck Depression Scale, SCL-90) can be used to provide general assessment and diagnostic information (including comorbid conditions). In the case of known or strongly suspected abuse/trauma in the patient's background, trauma specific instruments (e.g., Dissociative Experiences Scale, Impact of Events Scale, Structured Clinical Interview for Dissociation, Traumatic Antecedents Questionnaire, Clinician-Administered PTSD Scale, the Structured Interview for Disorders of Extreme Stress, The Trauma Symptom Inventory) can provide information on trauma-related symptoms not covered systematically in the more generic instruments.

As part of the comprehensive assessment, records should be requested for any previous psychological (and, at times, medical) treatment so that issues of assessment, diagnosis, and course of treatment can be reviewed. Additionally, the practitioner should consider the utility of a second opinion, formal consultation, and ancillary assessments (e.g., psychiatric and/or medical examinations and treatment) as needed. This applies to a variety of issues but may be especially important in cases of variable/spotty or delayed/recovered memory to rule out other explanations for memory loss (e.g., organic conditions, alcoholism, or other disorders that affect memory). It is helpful for the practitioner to develop a network of professionals who are comfortable working with and consulting on the wide array of conditions and complications that typically arise in these types of cases.

6. Develop a diagnostic formulation over time and after considering a range of information

A preliminary diagnosis is made after careful consideration of the individual and his/her presenting information, symptoms, and level of functioning. Individuals who have been abused often have a variety of comorbid conditions and thus meet criteria for a number of diagnoses, including possibly Posttraumatic Stress Disorder (PTSD). Optimally, multiple diagnoses should be listed hierarchically according to their urgency and their order in the treatment process (with the understanding that treatment of one issue often—but not always—has a simultaneous effect on others and/or allows for the emergence of previously unavailable material once the original concern is successfully treated. Obviously, treatment strategies will vary according to the patient's individual diagnostic picture and general psychological condition.

When past abuse/trauma is in question, a diagnosis of PTSD is gener-

ally not made because Criterion A (i.e., witnessing, experiencing or being confronted with a traumatic event) necessary for making the diagnosis is not definitively met; however, when the symptom picture is posttraumatic without the patient's conscious knowledge of a specific trauma history, the diagnosis might be held in abeyance or given provisionally. A posttrauma and postabuse treatment model (see item 7 for a description) is adopted when PTSD is formally or provisionally diagnosed. For patients who suspect abuse yet do not have posttraumatic symptoms, a more generic treatment strategy is recommended.

7. Follow the consensus model of sequenced treatment for trauma

The practitioner is advised to establish a treatment plan that conforms with the consensus model of posttrauma treatment that is sequenced and organized initially around patient stabilization/functioning and that addresses traumatic content as necessary. The treatment is individualized and titrated according to the patient's status, needs, and available resources, is systematic rather than *laissez-faire*, and organized in progressive stages and tasks. The trauma is addressed according to a careful plan rather than haphazardly after the patient has developed the skills and defenses necessary to address both traumatic content and affect. Following pretherapy assessment, three stages of treatment are generally outlined in this model: (1) directed towards personal safety, stabilization, and functioning, the resolution of immediate problems and crises, the improvement of current personal and interpersonal functioning, the teaching of coping and self-soothing skills, and the development of the therapeutic alliance; (2) addressed to the traumatic content and emotions, titrated to the individual's capacities; and (3) directed towards issues remaining after the trauma resolution stage. As noted in item 6, when no trauma history is known or determined from available information, a more generic model of treatment is advisable. This three-stage model with its initial emphasis on present-day issues and functioning resembles more generic treatment. Thus, its adoption provides for an adequate course of treatment for a patient with questions about a trauma history, whether or not such a history is later determined.

II. ISSUES PERTAINING TO MEMORY

8. Ascertain personal and professional assumptions and biases and work for a stance of supportive neutrality

The practitioner must monitor personal and professional assumptions and biases and avoid leading questions, specific suggestions, premature

closure of exploration, and/or the ready acceptance of the individual's recollections as historical truth. The practitioner should also assess his/her ability to tolerate and support a patient's uncertainty about the past. An open and nonauthoritarian perspective is especially important with patients who are excessively dependent or suggestible or with those who have high hypnotizability. It is advisable to adopt a neutral therapeutic stance to the possibility of abuse, to ask open rather than closed or suggestive questions, and to encourage exploration and the cross-referencing of information without drawing premature conclusions. According to Judith Herman, M.D., therapists must be technically neutral but be morally cognizant of the prevalence and possibility of abuse. Being neutral and open-ended in technique does not mean that the therapist is in denial about abuse as a serious and common occurrence or about its possibility in the patient's past. Rather, it is the patient who must come to a understanding of and comfort with his/her personal history. This, of necessity, may include living with uncertainty, a circumstance that may be highly distressing, requiring support and empathy (and, at times, empathic confrontation) on the part of the therapist.

9. Watch assumptions about incomplete and spotty childhood memory

The practitioner should not assume that an individual who cannot remember much from childhood is repressing or denying childhood abuse. Normal memory for childhood is spotty, childhood (infantile) amnesia generally ends between the ages of 2-1/2 to 3-1/2, and older children remember more detail and with greater accuracy than younger children. The therapist should make note of an individual's report of circumscribed time periods in childhood and/or adolescence with totally absent memory (especially if observed and corroborated by others and if other signs and symptoms indicative of a possible abuse history are available, e.g., medical records, outside validation or corroboration, the client obviously dissociates). Even so, periods of complete amnesia in childhood or adulthood are not, in and of themselves, enough of a basis on which to make an exclusive determination of childhood sexual abuse in the absence of other information.

10. Do not automatically assume sexual abuse from a set of symptoms

No one symptom or set of symptoms (either initially or long-term) is pathognomonic of childhood sexual abuse, so the practitioner should not automatically and conclusively assume an abuse history due to particular symptoms, especially when no memory of abuse is available. The therapist nevertheless needs to be alert to the emergence of signs and symptoms

commonly associated with a trauma history that are not immediately consciously available to the patient. In such a circumstance, the therapist needs to encourage exploration of the possibility of abuse or other trauma because denial and other dynamics may make personal acceptance difficult, if not impossible, without outside support. A return to more formalized assessment might also be considered at this point.

11. Be open to the possibility of other childhood trauma besides sexual abuse

The practitioner should be open to the possibility that other childhood events and trauma (e.g., parental separation and divorce; family violence; significant deaths—including suicides—and illnesses; medical conditions requiring invasive techniques, pain, and physical immobility; serious accidents; and natural disasters) might account for a patient's posttraumatic symptoms. Sexual abuse should not be assumed or suggested as the only possibility. Most psychological disorders develop from, and are influenced by, a number of events (as well as other factors, such as the child's premorbid personality and personal resilience, the nature and severity of the stressor(s), family functioning, sources of outside support, etc.).

12. Keep adequately detailed records

The practitioner should keep records in sufficient detail to document the main issues and events in the therapy, to articulate and track symptomatology and the treatment plan, and to chronicle all major communications with the patient. Patient records should be neutral in tone and based on fact and behavior rather than on the therapist's speculations. The chart should include mention of any erroneous expectations and misinformation regarding abuse and memory held by the patient and should document the provision of factual and more accurate information and the discussion of process issues regarding memory retrieval (e.g., information about the delayed memory dispute, the functioning of human memory, including its reconstructive nature, current information about memory processes for trauma, the patient's responsibility for making a determination about his/her own experience, the maintenance of a stance of therapeutic neutrality, and various techniques and their efficacy and substantiation). Additionally, notes should document memories and events as "reported by" the patient rather than as historical reality and specifically document any attempts by the patient to get the therapist to confirm or believe an abuse history based on recovered memories alone, especially when corroboration is missing. During sessions when the patient is struggling with issues of unclear memory or reporting recovered/delayed memories, the therapist might consider taking process notes.

13. Do not use hypnosis (or related techniques) for memory retrieval per se

Hypnosis is one of the most controversial techniques in the delayed/repressed memory controversy. At present, available research is quite conclusive that memories that emerge as a result of hypnosis can be compelling yet inaccurate and that the veridicality of these memories should not be assumed (although some may well be accurate). The potentially confounding nature of hypnosis (or any similar technique) makes its use inadvisable to uncover, discover, or rework delayed memories of abuse. Rather, its use should be restricted to such therapeutic tasks as ego strengthening, coping, self-soothing, temporizing and pacing, etc. Moreover, hypnosis should not be used if a patient is involved in any type of legal proceeding or has any likelihood of taking any legal action in the future (whether related to past abuse or not). The use of hypnosis may result in the inadmissibility of material in any forensic proceeding. Similar to any other specialized technique, hypnosis should be used only if the therapist has been trained in its use and with the informed consent of the patient.

A recently developed technique, Eye Movement Desensitization and Reprocessing (EMDR), shows promise for use with memories of trauma; however, it too should be used conservatively and with caution, in keeping with the following:

> EMDR should be used by a trained and licensed clinician experienced with this population. It is noted for reprocessing (emotional resolution and cognitive restructuring) of memory and many clinicians report that previously unrecalled memories may arise during treatment. While this means that many associated events can be effected rapidly. . .images emerging during treatment cannot be assumed to be historically accurate (Shapiro, personal communication, 1996).

14. Ascertain the individual's understandings and expectations about memory, therapy, and any sources of influence and social compliance issues. Correct misinformation

If, at the outset or during the course of treatment, an individual suspects a nonremembered history of abuse and has unrealistic expectations of therapy and/or misinformation about abuse, trauma, and memory, the practitioner should inquire about these matters. In particular, possible sources of influence, social compliance, or misinformation should be determined. These might include exposure through reading and viewing biased or overzealous material, participation in abuse-focused self-help activities and therapy groups (including on the internet and in "chat rooms" devoted to abuse-related issues and topics) and participation in previous therapy—especially if unconventional, of the sort that provided or sup-

ported erroneous information or a certain perspective regarding abuse and memory issues, and/or emphasized the use of hypnosis for memory retrieval. The practitioner must correct specific misinformation and guide the individual to a broadened understanding of the malleability and reconstructive nature of memory, the currently unanswered questions about memory for trauma, and the ways memory issues will be addressed in therapy. Concerning the latter, the practitioner educates the individual about the sequenced treatment strategy (as described above in item 7) that is holistic rather than solely focused on abuse and memory retrieval.

Although the clinician is open to the exploration of a patient's suspicions of abuse, it should be based on open-ended questioning and free narrative to lessen the possibility of suggestion. A scientific attitude involving the careful weighing of evidence over time and the avoidance of "jumping to conclusions" and premature closure is encouraged. It is crucially important that the practitioner not "fill in," "confirm," or "disconfirm" reported suspicions of a nonremembered abuse history but rather help the patient explore the content and its possible meaning while guarding against suggestion, pro or con. Individuals with positive histories of abuse and trauma often struggle with differentiating what is real and what is not, experience strongly ambivalent emotions, and require a supportive context in which to consider various perspectives. Similarly, individuals with suspicions but no memories and those with incomplete and reinstated memories must have the latitude to explore without constraint. Although the clinician maintains as much neutrality as possible, at times there is a need to educate or challenge the patient on material that is clearly improbable, seems delusional, and/or in which the patient is overinvested. As noted in item 10, a return to more formalized assessment might be in order.

15. Recommend self-help books and groups when familiar with their content and perspective

The practitioner should be cautious in recommending self-help books and should be familiar with the content of any book that is suggested. In the case of suspected abuse with no clear memory, a generic book on the effects of a painful childhood is initially preferable to a book on signs and symptoms of sexual abuse or a book on repressed memories that offers suggestive methods for retrieving absent memory. A related issue involves referrals to self-help or therapy groups. The patient with absent autobiographical memory for abuse is best referred to a heterogeneous group for general mental health concerns rather than a homogeneous abuse focused

one. A difficult circumstance arises when a patient with suspicions of abuse and sketchy memory has read books, viewed media presentations, or participated in groups that push a certain perspective or that offer erroneous information. The clinician must re-educate the patient and correct skewed content.

16. Support a patient's search for corroboration after adequate exploration and preparation in therapy

Some patients decide they want to seek outside sources of information regarding possible childhood abuse (e.g., medical and school records, witnesses, other victims, etc). The clinician can support a search as a means of gaining potential material to be assessed and weighed in the course of therapy. It is advisable, however, that the patient first explore the ramifications of such a search with the therapist and take action only after having achieved a relative degree of life and symptom stability and after adequate preparation. The patient should consider the range of possible consequences of a search, from positive to negative, and the relative probability of each. Possible responses should also be anticipated and prepared for—finding or not finding evidence and corroboration can be very unsettling. Optimally, a support system is in place to assist the patient with the results and the emotional consequences of a search.

17. Do not recommend family cut-offs on the basis of recovered memory

The practitioner should also be cautious in suggesting that the patient limit or cut off contact with family, especially when recovered memories form the basis for abuse suspicions or beliefs; however, in cases of a positive abuse history and reports of ongoing abuse or other clear and present danger, the practitioner is responsible for helping the patient assess the cost/danger in continuing contact (and may further have a duty to report). The therapist must keep the patient's safety paramount while helping him/her to recognize ongoing danger and learn assertive and self-protective strategies with unsafe or abusive others.

18. Contract for no unplanned/impulsive disclosures, confrontations, or legal initiatives

The practitioner should have a collaborative agreement with the patient that unplanned/impulsive disclosures, confrontations, or legal initiatives not be undertaken without extensive discussion in therapy. These actions are quite risky even when the patient has clear memory and some corroboration; when abuse is suspected or believed on the basis of recovered memory without corroboration, they are even riskier (for both patient and therapist). The cost benefits of these actions are best considered when the

patient's symptoms and life circumstance are stabilized and, in the case of known abuse, after the bulk of trauma-resolution work has been completed. They should only be undertaken following a period of careful planning and assessment of possible consequences, including family estrangement, threats and violence, legal initiatives, etc. Consideration should also be given to whether they should be done within or outside of the therapy. In either event, thorough preparation is recommended.

19. Do not encourage or suggest a lawsuit

It is not the practitioner's role to suggest a lawsuit. If the patient chooses to investigate this option, the therapist should encourage the gathering of comprehensive information on which to base decision-making. Litigation is enormously stressful and requires an extensive time commitment as well as the allocation of significant personal and financial resources. The plaintiff in a legal proceeding must meet a standard of proof that is not found as a patient in a clinical setting. Also, since the advent of the memory controversy, plaintiffs seeking damages for past abuse have been challenged on the basis of false-memory production, a challenge that has made the process even more difficult. Should a patient opt to initiate a lawsuit, the practitioner must keep the treatment and legal action separate and insist that the patient get a separate psychological expert; otherwise, the practitioner becomes engaged in a dual role relationship with the patient and therapy becomes derailed.

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