Survivors of Sexual Abuse Allege Therapist Negligence

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In two recent litigation cases, adult survivors of sexual abuse claimed that their current symptomology was linked to the failure of mental health professionals to provide appropriate treatment. If mental health practitioners are to be held accountable for providing acceptable standards of treatment, these standards must be based on empirical evidence of the efficacy of treatment methodologies. This article provides a review of the professional literature and determines that with the exception of time-limited group treatment, which appears to reduce symptoms in some survivors of sexual abuse, there is an absence of clear evidence of treatment efficacy. Other data point to low consumer satisfaction with treatment, the absence of evidence for a consistent symptom presentation in survivors of sexual abuse that confounds standardizing treatment approaches, and iatrogenic effects of some forms of treatment. The authors conclude that, at this time, there is little empirical data to support the development of standards of practice for treating women who have been sexually abused as children.

Traditionally, negligence suits in psychiatry have been based on lack of diligence, referring to the psychiatrist's failure to inquire into the patient's previous treatments, failure to make proper use of consultation, and failure to follow up on the patient's progress.[1] More recently, psychiatrists and other mental health professionals are facing malpractice suits that focus on misdiagnosis in the area of previous sexual abuse of patients. In one such case, a father successfully sued his daughter's therapists on the grounds that they negligently implanted or reinforced false memories that he had abused her as a child.[2] In another, a woman and her parents won a jury verdict on the basis of allegations that her psychiatrist failed to investigate memories of sexual abuse that she later recanted.[3] This legal trend has shifted the focus from failure to provide proper medical treatment to failure to properly substantiate memories of sexual abuse in the course of psychotherapy. Recently, the authors of this article became involved in another dimension of negligent practice, cases in which adult survivors of sexual abuse claimed that the inability of mental health professionals to provide appropriate treatment was responsible for their current level of distress.

In the first case presented here, a woman sought recompense through civil

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litigation against a child welfare agency for not providing adequate treatment 20 years ago when she was 12 years of age. Over the past 20 years, the complainant has suffered from depression, suicidal ideation, suicide attempts, cocaine and alcohol abuse, unemployment, and disruptive relationships. The case was resolved when the parties reached an out of court financial settlement. In the second case, the complainant alleged that the psychiatrist who treated her 15 years earlier failed to meet appropriate standards of care for a psychotherapist dealing with incest victims. Specifically, she contended that following her psychiatric admissions for acute psychotic episodes at the age of 17, the psychiatrist should have engaged in exploratory psychotherapy, which would have encouraged her to discuss and come to terms with the fact that she had been sexually abused. The case was left unresolved due to the physician's death while the case was subjudice.

To be guilty of malpractice, there must be proof that (1) a professional has failed to conform to acceptable standards of care, (2) the patient was harmed or damaged, and (3) there is a causal connection between the breach of standards of care and the patient's harm or injury.[1] If, indeed, mental health practitioners and child welfare agencies are to be held accountable for not providing an acceptable standard of care in cases of women who have been sexually abused as children, it is first necessary to determine what are the acceptable standards of care for adult survivors of sexual abuse. It is our premise that legally prescribed standards of care must be based on empirical evidence that certain modes of treatment in fact reduce the level of distress experienced by women who are adult survivors of sexual abuse. This article provides a review of the professional literature in an attempt to determine whether such empirical studies support the use of particular treatment methodologies, which could then provide a basis for standards of care.

Long-Term Consequences of Childhood Sexual Abuse

Studies reported in the professional literature suggest that women who have been sexually abused as children later develop many symptoms of posttraumatic stress disorder (PTSD).[4–6] Symptoms experienced by adult survivors of sexual abuse increase with the increased severity and longevity of the abuse. Women with long-standing abuse, including the horrors of forced oral and vaginal intercourse, often develop a complex PTSD, the symptoms of which are pervasive and do not easily abate.[7–10] Symptoms commonly experienced by these women include intrusive imagery of the incest, feelings of detachment or constricted affect,[4] uncontrolled rage,[11] feelings of worthlessness and hopelessness,[5] lack of sexual response and relationship difficulties,[12] sleep disturbances, and nightmares.[13] In addition, interpersonal relationships appear to be the arena in which many of the long-term problems related to sexual abuse are manifest.[14]

While there is considerable evidence that a substantial portion of victims exhibit various difficulties of adjustment in

adulthood, one cannot be certain that these difficulties are the direct result of victimization. Other factors in the histories of many victims may well contribute to later difficulties. These factors include family discord and disruption,[15–18] parental blaming of the child for victimization, insensitive handling of the child victim by parents, police, courts, and social agencies,[8, 19] genetic risk factors,[20] and other life stressors.[21]

Nor can the extent of later adjustment problems among victims be determined with any degree of precision. Much of the evidence is derived from studies of adult clients of therapists or social agencies or individuals who are involved with the criminal justice system. By definition, these clients are having problems in their lives and may not be representative of the general population of victims. Further, the significance of difficulties among victims cannot be ascertained due to the absence of control or comparison samples of nonvictims.[9, 15, 22] As such, it is not absolutely clear whether the general population of victims has a higher prevalence of emotional disorders than nonvictims.[8] Recent studies have even suggested that the development of PTSD as a response to traumatic events is relatively rare.[21, 23]

Thus, while there is no doubt that many victims who present for therapy experience significant distress and problems with adjustment, the etiology of these problems is not definitively causally linked to sexual victimization. This lack of a causal relationship complicates attempts to articulate standards of practice in treatment.

Efficacy of Treatment for Adult Survivors of Child Sexual Abuse

Several clinical practitioners have written instruction manuals regarding the treatment of adult survivors of childhood sexual abuse.[24–26] This literature provides some useful treatment guidelines for practitioners who are unfamiliar with this population. However, these clinical prescriptions represent subjective impressions about what is effective treatment, not empirically tested methods, and thus cannot be regarded as forming the basis for standards of care.

Treatment approaches recommended in professional journals span a broad range of theories and interventions including wilderness therapy,[27] litigation against the offender,[28] psychoanalytic psychotherapy[29, 30], empowerment,[31] and group treatment.[32, 33] A critical review of this literature reveals many articles on clinical impressions, but little research data on outcome of treatment.[33, 34] These clinical impressions are often contradictory to the impressions of other authors. For instance, while one author favors litigation against the offender,[28] several other authors argue that such an approach is not therapeutically beneficial in the majority of situations and in fact can result in significant added stress and distress for the client.[35–37] Similarly, while some advocate psychoanalytic psychotherapy,[29, 30] others view such an approach as impossible if not damaging.[38, 39] While some authors point to the importance of recollecting and reliving the memories of abuse,[29] other authors suggest a "here and now" approach with these clients.[40] For

these authors, interpersonal dysfunction is not simply determined by past relationships but also by the consistent reinforcement of dysfunctional patterns as a result of behavior in current relationships.[41] Therefore, a focus on current relationships is seen to offer a concrete opportunity to modify implicit expectations about relationships and the self, and failure to do so is seen as sabotaging therapy.[14]

There is some evidence that short-term, time-limited group treatments are effective in reducing depressive and other symptoms.[32, 33, 42] Some authors have found that while group treatment models were generally helpful for victims of incest, there were individual predictors of outcome. Women who did well for instance, were better educated, employed, had lower initial levels of distress and depression,[42, 43] and had experienced forms of sexual abuse that did not include vaginal penetration or oral-genital contact.[43]

In light of limited information on treatment efficacy, a therapist treating sexually abused women is faced with the dilemma of proceeding with treatment without the assurance that the intervention will result in no further harm, which contradicts the principle of nonmaleficence central to most codes of professional conduct.[44]

Comorbity with Other Psychiatric Diagnoses

Treatment for victims of sexual abuse is further confounded when one considers other mental health problems that are frequently faced by survivors of childhood trauma. There is considerable research literature associating childhood sexual abuse with a broad spectrum of adult symptoms and pathology across both Axis I and Axis II of the DSM-IV.[6, 15, 45, 46] Adult survivors of sexual abuse have been found to have higher rates of substance abuse and suicide attempts,[47–49] anxiety and hostility,[50] and eating disorders.[51] Patients with multiple personality disorder have been found to have experienced and extremely high incidence of sexual abuse, ranging from 75 to 90 percent.[51–54] Similarly, patients with borderline personality disorder have high reported rates of sexual abuse.[47, 55, 56] Herman *et al.*[57] suggest, in fact, that the most significant descriptive discrepancy between diagnostic criteria for borderline personality disorder and chronic PTSD is the absence in the criteria for borderline personality disorder of a recognizable stressor in the patient's history. They propose that the observed gender difference in borderline personality disorder may be a real phenomenon related to the greater vulnerability of girls to prolonged, sustained sexual abuse in childhood.

The high rate of comorbidity between childhood incest and adult mental health problems that span several diagnostic categories, raises questions regarding whether adult survivors of incest should be regarded as a distinct group. Several authors point to the absence of a consistent set of symptoms for sexual abuse survivors that clearly distinguishes them from other diagnostic groups.[34] This raises the question of whether treatments that attend to unique precipitating events are more effective that those directed to

clinical manifestations that cut across etiologic events. As a result, treatment approaches that have met with success with other populations, such as depressed patients or patients with borderline personality disorders, may be indicated. However, it is important to note that in one of the most comprehensive studies reviewing long-term outcome in borderline personality disorders, a history of childhood incest, parental brutality, or rape were associated with a "worse than average" outcome.[56] This suggests that even within this difficult-to-treat diagnostic category, women who are survivors of incest represent a population with particularly entrenched symptomology.

Validity of Reports of Abuse

In the two cases that prompted this review, complainants contended that if they had been treated for their sexual abuse, they would have been saved from suffering later in life. This reasoning suggests that mental health practitioners are obligated to provide treatment for emotional distress caused by sexual abuse and produces a further dilemma regarding the establishment of the validity of reports of abuse and the responsibility of the therapist to elicit disclosure of abuse. At present, controversy continues to rage in the professional literature on the validity of retrieved memories of abuse.[58-61] Some practitioners have contended that the unlocking of these memories is a critical step in the survivor's psychological healing.[62, 29] Recent evidence has suggested, however, that such an approach to treatment may result in erroneous assumptions of causality for difficulties that patients are experiencing and wrongful attributions of blame, the consequences of which have included successful litigation against the therapist.[3] Thus, there is a conflict between common therapeutic practice, in which allegations of abuse presented by patients are accepted as reality despite the negative attributions against others, and the law, in which there is a presumption of innocence unless proven otherwise.[63]

While there is no clear consensus as to whether memories of abuse can be entirely forgotten and then accurately recalled, the preponderance of literature suggests that "false memories" are possible in situations of high social influence, such as psychotherapy.[58, 63] Like all meaningful relationships, psychotherapy contains suggestive elements, and the content and process is shaped by all parties. As such, it is exceptionally difficult to assess the degree and sources of biasing social influence on memories retrieved in the therapeutic process.[63] Therefore, clinicians must be aware of their own beliefs and values and how these may affect patients and others. In addition, recollection of childhood sexual abuse, whether valid or not, is often accompanied by disequilibrium and periods of depression in which the victim regrets that the memories have surfaced.[21, 62] If clients are not informed of these possible short-term and long-term consequences of attempting to assist in recollection of childhood trauma, the damage done to the client and the therapeutic relationship may constitute unethical practice or maleficence.[45, 64]

Consumer Satisfaction as a Measure of Efficacy

In the absence of studies that evaluate the ability of treatment to reduce traumatic symptomology, consumer satisfaction is perhaps an important measure of efficacy. Some authors have conducted research attempting to understand the experiences of women in therapy. Armsworth[65] studied the responses of 30 incest survivors and their experiences with treatment. Women rated the helpfulness of individual therapy with a number of professionals and group therapy. Therapy with female psychologists received the highest ratings of helpfulness (4.46 on a Likert scale rating of 1 to 5), followed by support groups (4.43), and female psychiatrists (4.33). The lowest ratings were for therapy with male psychiatrists (1.33). When considering these findings, it is important to note that small sample size was a significant limitation of this analysis. In the Armsworth study, women rated the most helpful interventions as: (1) the client felt that she was believed; (2) she received support, empathy, and caring; (3) she was not blamed for the abuse; (4) the professional was not shocked or disgusted; (5) the client did not feel odd or alone; and (6) the therapist helped stop the abuse. Frenken and Van Stolk[66] interviewed 50 women who had been sexually abused as children. On average, each of these women had consulted 3.5 professionals for their traumatic reactions. Of this group, only 40 percent identified themselves as very satisfied, or satisfied, with the sum of the treatments that they had received. According to the women interviewed, 30 percent of the therapists with whom they disclosed their incest expressed disbelief, 38 percent blamed the victim, and 34 percent made light of the perpetrator's deeds. Thus, according to these reports, the majority of adult women who have sought therapy to deal with childhood incest do not feel that treatment was helpful or satisfying.

Several explanations for dissatisfaction with treatment experienced by adult survivors of sexual abuse are possible. First, as noted earlier, therapists are providing treatment without empirical data to support treatment choices. As such, dissatisfaction may stem from the fact that treatment is not effective in reducing distress. In addition, many victims of incest have turned to self-help books as a means of finding solace. These books frequently set up unrealistic standards of care by documenting unorthodox methods and dramatic cures. Further, many victims seek treatment from a variety of practitioners in an attempt to find the answer to reducing their distress. Therapists who use alternative methods may reinforce beliefs that mainstream mental health professionals have provided inadequate or inappropriate care. Finally, the dynamic of traumatic transference may contribute to feelings of dissatisfaction with treatment and a belief that the therapist may have exploitative intentions.[67, 68] Herman[7] suggests that many traumatized people feel rage at the caregivers who try to help them and harbor fantasies of revenge in order to reduce the disappointing, envied therapist to the same unbearable condition of terror, helplessness, and shame that they themselves have suf-

fered. These observations point to the fact that therapists should perhaps consider group treatment for adult survivors of childhood incest not only because of the demonstrated efficacy but also to reduce the possible negative consequences of traumatic transference.

The Case for No Treatment

We have discussed, up to this point, several difficulties with the provision of treatment to adult survivors of sexual abuse. These difficulties include the absence of clear evidence of treatment efficacy, low consumer satisfaction with treatment, the absence of consistent symptom presentation in survivors of sexual abuse, possible iatrogenic effects of memory retrieval and catharsis, and the impact of traumatic transference. In addition, it has been suggested that some of the most troubling symptoms associated with severe reactions to sexual abuse, such as borderline personality disorder and multiple personality disorder, are iatrogenic and a direct result of the interaction between the patient and therapist. That is, some therapists may reinforce dissociative tendencies[64] or, paradoxically, cause the patient to assume an increasingly sick or incompetent position in reaction to the therapist's hope and optimism.[69] Furthermore, by explaining that the patient's symptoms are the result of victimization, therapists may imply that undesirable or self-defeating conduct is acceptable and relieve the patient from the responsibility of self-control and healing.[64] This conclusion suggests that in some situations therapy may be contraindicated.

Frances *et al.*[70] suggest that no treatment should be recommended when (1) no response to treatment can be expected, or (2) when there is a risk that the patient may have a negative response to treatment. Thus, if the patient presenting for treatment suffers from borderline personality disorder and has a history of treatment failures, engaging in psychotherapy to explore childhood sexual abuse that caused or contributed to her current level of distress would not be recommended. Instead, brief treatment to resolved a circumscribed current life problem[40, 70] or relationship management aimed at reducing chaos, calming affect, and establishing clear boundaries is preferable.[69]

While therapists may find it difficult to acknowledge the limitations and risks of treatment and to accept that treatment may not benefit some extremely distressed and needy patients, no treatment may at times be the most responsible course of action. The therapist would thereby avoid the pretense of therapy when no beneficial therapy exists, protect the patient from iatrogenic harm, and allow the patient to discover her own strengths and capabilities.[70]

Summary

In summary, a review of the literature reveals that there is little to guide therapists regarding appropriate treatment for women who are adult survivors of childhood incest. There appears to be no clear consensus that the sequelae of childhood sexual abuse constitute a distinct entity due to the coexistence of other childhood traumas, such as physical and emotional abuse, and comorbidity with several other

psychiatric diagnoses. While the literature abounds in clinical impressions, these are not based on empirical data and are often contradictory. There is evidence that some treatment modalities, such as time-limited group psychotherapy, may be of benefit; however, this treatment is beneficial only for women who have higher initial levels of functioning and lower initial levels of distress. If we turn to treatment modalities for other concurrent psychiatric illnesses such as borderline personality disorder, it is the women with histories of childhood incest and brutality who have the poorest long-term outcome. In addition, studies on client satisfaction following mental health treatment for childhood sexual abuse has generally been discouraging.

It would appear, therefore, that at present there are no clear guidelines on which to base standards of practice for treating women who have been sexually abused as children. If the two cases that prompted this review are indicative of a trend of holding therapists accountable for the recovery of victims, then it appears that there may indeed be peril for many therapists who are now treating victims or who have treated victims within the past 20 years. In addition, most of the research in the area of treatment of sexual abuse has occurred since 1980, and prior to that time little information regarding the long-term effects of childhood sexual abuse and its treatment was available. This then raises a further question as to whether mental health practitioners and child welfare agencies should be held to standards that are currently acceptable or whether they should be judged according to the available knowledge at the material time.

Considering the high numbers of women presenting for treatment subsequent to childhood sexual abuse, mental health practitioners as a group have neglected their duty to conduct research into the means of relieving the suffering of these clients. In addition, it appears that many have been overconfident in claiming "expert" status in this area in the absence of research supporting the efficacy of their methods. At this time, there is an urgent need to establish research programs to assess which modes of treatment can assist in relieving the pain these women experience. Following from this research, we can set standards of practice that will serve to assist these women and, in turn, protect the therapists who are attempting to assist them.

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