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Working With Adult Clients Who May Have Experienced Childhood Abuse: Recommendations for Assessment and Practice

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The delayed memory debate has generated many questions about therapeutic practices that are likely to be beneficial and detrimental to clients. This article proposes components of optimal practice for working with adult clients who may have been abused as children. The recommendations are organized around the following themes: (a) competence, (b) assessment and treatment planning, (c) psychotherapy process and technique, (d) memory issues, (e) and ethics. The authors emphasize the importance of a collaborative therapeutic relationship and urge clinicians to proceed cautiously when encountering treatment issues for which scientific knowledge and consensus are still evolving.

In the wake of the delayed memory debate, the therapeutic procedures of clinicians have been exposed to increased scrutiny, and some authors have concluded that therapists are often unprepared to respond effectively to clients' concerns or are responsible for leading clients to believe that they have been abused when there is no basis for such a conclusion (e.g., Lindsay & Read, 1994; Loftus, 1993; Poole, Lindsay, Memon, & Bull, 1995). Several recent articles have addressed therapeutic practices from the standpoint of risk management and the legal concerns that practitioners may face (e.g., Frank, 1996; Knapp & VandeCreek, 1996). This article adds to the emerging literature on psychotherapy practice with clients who may have experienced abuse by proposing practices that we believe will support the best interests of clients. Our intent is to avoid (a)

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assuming a legalistic tone that may be experienced as confining or (b) emphasizing numerous behaviors that therapists should avoid. Rather, we emphasize optimal practice.

This article is the outgrowth of several years of discussion and consensus building among us. A strength of our collaboration grows from the fact that we hold a variety of perspectives that are related to our different theoretical orientations and employment in different types of roles (as educators or practitioners) and practice settings (college and university counseling centers or independent practice). Earlier versions of this article have been presented at and tested with audiences at American Psychological Association (APA) meetings (e.g., Campbell & Enns, 1994; Courtois, Campbell, & Enns, 1995) and Association for Women in Psychology conferences (Gilbert & Brown, 1997; Gilbert & Forrest, 1996). Information gained from these sessions has resulted in further reflection, revision, and clarification of essential versus nonessential elements of exemplary practice.

The purpose of this article is to provide practitioners and trainers with guidance for conducting evaluation and psychotherapy with adults who may have a history of abuse. Because treatment may proceed on matters unrelated to abuse at the outset, our recommendations are intended to be applicable to a broad range of theoretical orientations and psychotherapy experiences. Clients may disclose sexual or physical abuse on intake, report memories of abuse during the course of treatment, or experience no autobiographical memory of abuse but wonder if they have been abused. Another typical scenario is one in which the client has always recalled some aspects of abuse but remembers additional details while in psychotherapy. Because the process of psychotherapy is not always predictable, our recommendations are designed to assist practitioners in making appropriate transitions so that the treatment process may continue with minimal interruption and within the context of the practitioner's theoretical approach. Although our primary intent is to focus on psychotherapy with adult survivors of child sexual abuse, we believe that these recommendations are relevant to psychotherapy that addresses the sequelae of other types of childhood abuse.

Psychologists should exercise caution when working with abuse-related issues about which the field's knowledge is incomplete and evolving. Our intent is to educate practitioners and trainers regarding clinical issues and to encourage them to strive toward implementing optimal practices. To that end, we review contemporary theory and research regarding trauma, memory, and treatment efficacy but caution that this article should not be construed as defining practice standards.

Establishing Competence

Despite the fact that many adults who seek therapy have abuse histories, training programs have been remiss in educating students in the diagnosis and treatment of this population (Alpert & Paulson, 1990; Payne, 1995; Pope & Feldman-Summers, 1992). Nevertheless, competence is an important prerequisite for working with clients who have experienced abuse. Because many practitioners have not had the benefit of such training, they must take responsibility for developing their competence in this area. Practitioners should consider augmenting their knowledge of such subjects as basic memory principles, autobiographical memory, infantile amnesia, implicit and explicit memory, the psychobiology of trauma, traumatic memory research, the strengths and limitations of techniques designed to gain greater access to memory, research on the prevalence and impact of abuse, typical coping skills and strengths of trauma victims, variables associated with resilience, forms of dissociation and the similarities and differences between repression and dissociation, and the manifestations of posttraumatic stress disorders. We invite readers to consult a variety of important educational sources on these topics, including Alpert, 1995; Alpert et al., 1996; Banks and Pezdek, 1994; Campbell, 1994; Contratto and Gutfreund, 1996; Courtois, 1996, 1997c; Enns, McNeilly, Corkery, and Gilbert, 1995; Frank, 1996; Herman, 1992b; Knapp and VandeCreek, 1996; Lindsay and Read, 1994; Loftus, 1993; Pope, 1996; Pope and Brown, 1996; Pressley and Grossman, 1994; Reviere, 1996; Scheflin and Brown, 1996; and Yapko, 1994.

Supervision and consultation are advisable for mental health practitioners. Such resources are especially helpful to those working with abuse survivors because of the many high-risk situations that may arise. Furthermore, practitioners should be aware of experiences and biases that might influence their work with abuse and trauma survivors. Those practitioners with a personal history similar to the client's, as well as those with limited experience with abuse and trauma issues, should be aware of the potential for overidentification or underidentification with the client and seek consultation when warranted (Figley, 1995; Pearlman & Saakvitne, 1995).

Assessment, Diagnosis, and Treatment Planning

Initial Assessment

Screening for childhood abuse and trauma may be appropriately accomplished as part of an initial assessment. Initial assessment questions explore general themes, which provide a foundation for pursuing more specific issues at a later point. General questions may focus on biographical information, family background, medical history and current medical concerns, and the client's mental health problems. We recommend that therapists inquire about a wide range of traumatic experiences that the client may have encountered, including physical abuse, psychological abuse, neglect, sexual abuse, accidents, medical trauma, and natural disasters. Direct questions about childhood abuse are appropriate as part of an initial, comprehensive assessment (Courtois, 1997a, 1997b, 1997d; Polusny & Follette, 1996; Pruitt & Kappius, 1992).

Assessment as Collaboration

Assessment should be understood as a shared and ongoing experience between the practitioner and the client. The client and the therapist work collaboratively to identify hypotheses about the nature and source of the client's problems. Whenever possible, the client is encouraged to name or define the causes and meaning of her or his own experiences. Such naming on the part of the client is frequently empowering to the client (L. S. Brown, 1994, 1997).

The practitioner should be attentive to content areas that the client is reluctant to discuss. If a client's response to a query about possible abuse or trauma is negative, the practitioner proceeds to other issues that are of importance to the client. However, as new issues emerge over the course of therapy or the client becomes more emotionally prepared to tolerate the discussion of traumatic events, further assessment is appropriate (Courtois, 1997a, 1997b, 1997d).

Assessment of Symptoms

If the client discloses a history of abuse or trauma, the practitioner should screen for posttraumatic symptoms. Careful assessment is necessary for determining whether the client is prepared to deal with traumatic memories and for planning optimal interventions (Cole & Putnam, 1992; Courtois, 1995, 1997a, 1997b, 1997d; Herman, 1992b; Litz & Weathers, 1994; Wells, Glickauf-Hughes, & Beaudoin, 1995). Abuse-related trauma may be manifested through a wide range of problems. The practitioner may wish to use one or more of a variety of instruments designed for obtaining an abuse or trauma history and assessing current reactions to past abuse (see Appendix). We also recommend two recent books that are designed to educate practitioners about the use of trauma assessment scales (Briere, 1997; Wilson & Keane, 1997).

The practitioner should be cognizant that multiple experiences can contribute to a profile suggestive of abuse. A wide array of symptoms has been associated with abuse and trauma, and no one set is definitely indicative of a history of childhood sexual abuse (Cole & Putnam, 1992). As a result, the practitioner avoids unwarranted inferences about the meaning of a client's symptoms or a client's limited memory for some periods of childhood (Courtois, 1997a, 1997b, 1997d). If the client exhibits a constellation of symptoms often associated with abuse but does not disclose such a history, the practitioner does not suggest to the client that she or he was abused but should assist the client in exploring various circumstances that may be related to her or his symptoms.

The practitioner gathers information about the impact of race, culture, social class, ethnicity, disability, sexual orientation, and gender and is attentive to the way in which these variables may influence the long-term impact of trauma. The practitioner is mindful of his or her own cultural biases and notes ways in which the client's experiences provide a foundation for coping and strength (Enns, 1996).

Assessment of Client Resources

The practitioner explores the client's strengths and coping capacities and communicates to the client that these sources of resilience will provide a foundation for developing new skills (L. S. Brown, 1994; Morrow & Smith, 1995). In addition, the therapist also seeks information about the client's formal and informal support systems and identifies ways in which these resources can assist the client.

Because abuse and trauma often result in relationship problems (Cole & Putnam, 1992), the practitioner assesses the nature of the client's interpersonal relationship patterns. Relevant issues may include the client's capacity for trust and intimacy, fears about abandonment or intrusiveness by others, or tendencies to isolate oneself from or overinvest oneself in others.

Diagnosis

The practitioner is aware of the potential for inappropriate labeling of abuse survivors with pejorative diagnoses or diagnostic categories that do not adequately account for the variety of trauma reactions. We encourage the use of conceptual models and diagnostic categories that take better account of the multifaceted nature of the posttraumatic experience. For example, the proposed diagnostic categories Disorders of Extreme Stress Not Otherwise Specified or Complex Post-Traumatic Stress Disorder may provide a useful conceptual model for clinicians who desire to organize complex patterns of trauma symptoms in a meaningful way. Such conceptualizations may convey the adaptive nature of many posttraumatic symptoms and the role that symptoms play in facilitating client coping and survival (L. S. Brown, 1994; Herman, 1992a, 1992b).

Treatment Planning

In working with abuse victims, practitioners' treatment planning requires consideration of a variety of issues, including general considerations, issues regarding the use and distribution of power, and questions regarding how to proceed when treatment plans must be modified.

General considerations. As in all psychotherapeutic work, practitioners adhere to basic principles of empathy, genuineness, and respect for their clients. As such, the client's views, goals, and values are to be respected and are to serve as a guide for the treatment process. We recommend that practitioners engage in thorough treatment planning and exploration of the client's readiness to address abuse and trauma issues before they are considered as a primary focus of treatment. We suggest that in doing so, the practitioner assess for the client's general level of personal integration as well as the client's ability to bind anxiety and control the discharge of affect (Pearlman & McCann, 1994). Care should also be taken to ensure that specific therapeutic strategies are consistent with the client's current concerns and with her or his capacity to accomplish the goals in question. For example, specific treatment modalities, such as behavioral treatment for managing trauma-based fears or relaxation or hypnosis techniques for dealing with anxieties, may be used at selective points during therapy. However, such procedures are anchored within a more comprehensive treatment plan that focuses on the maintenance of maximal current coping.

At some point in the therapy process, attention may be directed to the past. Work with the client's memory, especially when it is directed toward issues surrounding traumatic experiences, should occur in the context of an ongoing therapeutic relationship. In addition, the practitioner takes special care to determine that the treatment modality selected is appropriate to the client's needs. Therapy with abuse victims may take place over a long period of time and may include breaks from treatment. When a client returns to therapy after a hiatus, the practitioner is advised to assess the client's current functioning.

The use of power. Because feelings of loss of personal control and helplessness are often consequences of abuse and

trauma, it is especially important for the psychotherapy relationship to model a cooperative, collaborative, and supportive partnership. We view the role of the therapist as helping the client regain power over his or her own life, and we believe that this goal is best accomplished when the client is treated as a respected collaborator. In our view, this principle should be incorporated in the treatment plan so that the client and practitioner cooperate to identify hypotheses about the client's problems and how they can be treated.

Although we support a collaborative model, we wish to emphasize that this position should not be construed as a relinquishment of responsibility for the therapy process by the practitioner. At the outset of treatment, for example, clients frequently rely heavily on the judgment of the practitioner. The practitioner uses his or her expertise to provide leadership and direction in assisting clients as they make choices and determine treatment goals at a level commensurate with their functioning.

When the focus of treatment changes. Sometimes trauma issues emerge while the client is participating in a therapeutic context that was not intended to deal with such issues. When these issues arise, the client and practitioner should reevaluate the treatment plan. Numerous alternatives are available at this point. For example, the client and therapist may decide to change the focus of treatment and address abuse-related issues or to continue with the current plan and postpone discussion of abuse or trauma. In the latter case, the practitioner may agree and continue with the original treatment plan. However, the plan should be modified to incorporate new knowledge about abuse. Such revision might include raising the issue with the client from time to time to determine whether, for example, the anxiety generated by the new information is being adequately contained. Or if the client and therapist decide to address the new material, the treatment plan should reflect this choice. Finally, if the practitioner is not trained, experienced, or comfortable addressing abuse issues with the client, referral to another practitioner may be considered.

If abuse-related trauma emerges as an issue, the practitioner and client discuss how they will proceed. During this conversation, the therapist is attentive to the client's level of integration and readiness to discuss trauma-related content and adopts a position of openness to the possibility of trauma without prematurely drawing a conclusion regarding the historical accuracy of the client's memories. Doing so requires that the practitioner explore issues in an open-ended and nonsuggestive manner but, at the same time, demonstrate support for the client's search for answers and recognize and communicate that absolute answers or "truth" about what happened in the past may not be found (Courtois, 1997a, 1997b, 1997d; Herman, 1992b).

Psychotherapy

The Process of Psychotherapy

The literature on psychotherapy with abuse survivors has consistently proposed three basic stages of therapy: a psychoeducation and stabilization phase, a trauma resolution phase, and a reintegration phase (e.g., Briere, 1992; D. Brown, 1995a; Courtois, 1997a, 1997b, 1997d; Herman, 1992b; van der Kolk, McFarlane, & van der Hart, 1996). Treatment models are still evolving, and research is limited; as a result, models will need to be modified as more complete information emerges. There is general consensus that in optimal circumstances, therapy related to abuse issues generally proceeds over a significant period of time in a progressive but not necessarily linear and straightforward manner. However, limitations associated with client or agency resources or with managed care may preclude providing long-term care. When short-term treatment is used, the practitioner assesses the client's progress and set treatment goals that are attainable within the confines of the limitations imposed and the client's needs.

The first stage of trauma resolution work, psychoeducation and stabilization, involves assessment of the client's strengths, coping skills, defenses, and self-perceptions. Important tasks include helping the client establish a sense of safety and stability, increase coping skills, enhance self-care activities, develop tolerance for stronger emotion, achieve greater mastery over symptoms, and experience improved daily functioning. The practitioner also assists the client in creating and strengthening social support systems. An early focus on safety and coping may also decrease the client's initial distress. When working with clients who experience active and intrusive posttraumatic symptoms, it is especially important to help the client gain control over his or her intense sensations and feelings before engaging in in-depth exploration of traumatic memories.

Discussion of the specific memories of abuse and the impact of these memories is likely to be important at some point in the therapeutic process. The second stage of trauma resolution involves active acknowledgment of trauma as the client struggles with the essence and meaning of the abuse and grieves past and current losses. Although "remembering in and of itself is not healing" (Auerhahn, Laub, & Peskin, 1993, p. 436), the activity of acknowledging and working through memories in a safe therapeutic environment is often central to decreasing the distorted processing of material, transforming memories, reconstructing the self, and providing new perspectives about the past (Courtois, 1988, 1992; Davies & Frawley, 1994; Herman, 1992b; Koss, Tromp, & Tharan, 1995). The client's responses are monitored carefully, and the timing and pacing of memory work should be reviewed regularly by the therapist and client (Gold & Brown, 1997; Pearlman & McCann, 1994). As noted by Herman (1992b), "avoiding the traumatic memories leads to stagnation in the recovery process, while approaching them too precipitately leads to a fruitless and damaging reliving of the trauma" (p. 176).

The third dimension is that of reintegration. In this stage, the client deals with unresolved issues, such as relational, sexual, familial, and social concerns, and makes plans for focusing on new goals and developmental tasks. The client works toward achieving a new sense of purpose, mastery, control, competence, self-acceptance, and health (Harvey, 1996; Herman, 1992b).

Specific Techniques

Hypnosis. There is general consensus that hypnosis can be appropriately used to contain trauma responses and reactions, manage anxiety, strengthen self-soothing abilities, and increase clients' self-confidence. When used for these purposes, by those who are adequately trained and experienced in the use of hypno-

sis and with discretion and careful attention to suggestibility variables, hypnosis may be appropriately used in trauma resolution therapy (Hammond, 1995; Kluft, 1995). However, controversy exists regarding whether hypnosis should be used for memory recovery. Individuals who participate in hypnosis may experience enhanced recall of emotionally salient material (Hammond et al., 1995) but may also recall more inaccurate details (Dinges et al., 1992). Hypnosis, or the prehypnotic instructions given to hypnotized individuals, also tends to increase confidence in images, whether accurate or not, and may therefore interfere with the reconstruction of valid memory (Hammond, 1995; Hammond et al., 1995; McConkey, 1992; Nagy, 1995; Orne, Whitehouse, Dinges, & Orne, 1988; Sheehan, 1988). The use of hypnosis may also increase the power differential between client and practitioner.

Given the controversial nature of and conflicting evidence about hypnosis, we urge practitioners to proceed with care and articulate a well-founded rationale when using hypnosis. Until more data are available, we believe that a conservative approach to the use of hypnosis is necessary, and we recommend that therapists avoid the use of hypnosis for memory retrieval. If the practitioner and client agree to use this treatment modality for purposes other than memory retrieval, such agreement should be made in a collaborative manner that allows the client to control as much of the psychotherapy process as possible. By using informed consent to implement a collaborative approach and relying on a neutral and nonleading approach, the clinician can decrease the likelihood that the client will develop pseudomemories during a hypnotic state. The clinician can also minimize the possibility of memory distortion by establishing neutral and realistic expectations about hypnosis and by educating clients about the nature of hypnosis, including the reality that any memories that may spontaneously emerge during hypnosis cannot be verified as accurate without independent corroboration (D. Brown, 1995b; Hammond, 1995; Hammond et al., 1995; Yapko, 1995). The clinician may use scales of hypnotic responsiveness to identify individuals who are highly hypnotizable and, thus, may be more susceptible to influence or the development of pseudomemories while hypnotized (Hammond, 1995).

In state jurisdictions, court testimony that is based on hypnotically refreshed memory is barred, and practitioners considering this technique for any reason should fully inform their clients about this possible infringement on their legal options (Hammond, 1995). Even with informed consent, clinicians should not use hypnosis for memory retrieval. If a client has any pending legal actions, the use of hypnosis or any similar technique should be avoided.

Expressive techniques. Memories that were encoded in states of high emotional arousal may be more readily remembered in circumstances that resemble the client's affective state at the time he or she experienced the original trauma (Briere, 1992; Rogers, 1995). Therapists exercise caution in using techniques (e.g., art, drama, music therapy, imagery, journaling, body work, massage; see Vogel, 1994, for descriptions) that may recreate the affective experiences associated with abuse and potentially retraumatize the client. Although reentry into these affective states may facilitate the expression of emotion and help clients integrate traumatic memories in a meaningful manner, the therapist is attentive to the amount of material that the client can safely work through at one time. The therapist helps the client develop skills to establish boundaries around, or limit the intensity of, traumatic material. Confrontational methods that attack personal identity or defenses are generally ill advised. Finally, many expressive techniques have limited empirical support. When working with clients who may have experienced childhood abuse, the practitioner uses additional caution and establish a sound rationale for the use of such procedures as part of the overall treatment plan.

Techniques for reducing posttraumatic stress symptoms. In recent years, a variety of techniques have been proposed for decreasing the anxiety, fear, intense emotions, and dysfunctional cognitions associated with the sequelae of abuse and trauma. These techniques include widely accepted and widely investigated techniques, such as systematic desensitization, anxiety management training, coping imagery, stress inoculation, flooding, and cognitive strategies that involve the challenging of dysfunctional cognitions (Rothbaum & Foa, 1996). However, new and relatively untested techniques for working with trauma victims, such as eye movement desensitization and reprocessing (EMDR; F. Shapiro, 1995), have also been increasingly proposed as important tools for decreasing posttraumatic reactions. We recommend that practitioners seek training in the techniques they use to help clients decrease distress and inform clients about their rationale and goals, the potential costs as well as benefits of the methods, and the treatment efficacy of the procedures (see also the section titled *Informed Consent*). Clinicians should proceed cautiously in implementing recently developed techniques, such as EMDR, for which there is limited or conflicting evidence about treatment effectiveness (DeBell & Jones, 1997) and obtain informed consent specific to these techniques.

Seeking information or corroboration. Some clients may seek outside sources of corroboration or information (e.g., medical and school records, witnesses, other victims) regarding abuse experiences. Although the material gained from this exploration may be useful in the therapy process, careful timing and evaluation of client readiness for dealing with the potential consequences of such a search for information are very important. Before the client pursues a search, the practitioner helps the client explore and anticipate the possible outcomes of such an inquiry (Courtois, 1997a, 1997b, 1997d; S. Shapiro, 1995).

Interventions involving the family of origin. Many clients wish to ask family members for information about their past. When the abuse history is unclear or has never been discussed openly, consulting the family poses significant risk as well as potential for gain (Kluft, 1995). The practitioner explores the client's motivations and readiness to engage in interactions with the family and help the client weigh the risks and benefits of disclosure or confrontation. In some circumstances, such as when other family members may be currently at risk for abuse, it may be necessary to deal with family issues at an earlier stage than would be ideal for the client.

The practitioner may also need to assist the client in setting limits regarding unwanted and intrusive contacts by family members. If there is risk to the client of further abuse, including verbal abuse or harassment, it is especially important for the practitioner and client to assess the potential costs and risks of continuing, limiting, or terminating contact with the family. The

practitioner may wish to help the client set clear goals regarding limit setting, anticipate his or her family's reactions and his or her responses to those reactions, and rehearse potential scripts for talking with family members (Courtois, 1997a, 1997b, 1997d).

Pursuing litigation. Practitioners neither encourage nor discourage the client from exploring legal options (Courtois, 1997a, 1997b, 1997d). Most practitioners are not trained to provide legal advice. Furthermore, the context of psychotherapy is not well suited to supporting legal claims. It is appropriate, however, for the therapist to explore the client's goals and motivations as well as the costs and benefits of pursuing legal action (APA, 1992; L. S. Brown, 1995; Pope & Brown, 1996) and to refer the client for legal consultation. Because of the dual roles that ensue, the practitioner should avoid serving as an expert witness for clients that she or he is treating (L. S. Brown, 1995; Courtois, 1997a, 1997b, 1997d; Greenberg & Shuman, 1997).

Group therapy. Individual psychotherapy is often the treatment of choice for clients who are beginning to explore the consequences of abuse in their lives. However, clients enter psychotherapy with widely divergent levels of psychological functioning and understanding of past traumatic events. Group therapy may be the treatment of choice for some clients, such as those who have difficulty managing the intensity of one-to-one contact (Courtois, 1988), those who are likely to have strong transference reactions to an individual therapist (Ganzarian & Buchele, 1993), those whose symptoms manifest themselves primarily in interpersonal distortion (Herman & Lawrence, 1994), and those who feel "unique in their wretchedness" (Yalom, 1995, p. 5). Group approaches may also be useful supportive modalities for clients in individual therapy. Such groups may provide a setting in which clients can practice new coping and interpersonal skills, develop the ability to trust others, experience decreased isolation and increased support, and build capacities for assisting others.

Assessment prior to the initiation of group therapy is vital (see Courtois, 1988, for a detailed discussion of group screening questions). Because social comparisons to other group members may influence the personal perceptions of clients, the practitioner should not refer individuals to an abuse therapy group if they have suspicions of having been abused but have no autobiographical memory about abuse. Practitioners make efforts to ensure that clients assigned to group modalities have the capacity to tolerate hearing about the pain of others without being retraumatized. At screening, practitioners inform potential group clients about goals, ground rules, boundary issues, group structure, and group procedures. This information is central to helping members make informed choices about their participation in the group and increasing the likelihood that members will experience safety and consistency within the group.

Within the group, leaders attempt to foster healthy group norms that convey the validity of each person's experience. In doing so, the group leaders guard against group dynamics that may subtly pressure or coerce clients to feel, think, or behave in uniform or predetermined ways. If such dynamics arise, practitioners take corrective action. We also advise against highly confrontational approaches that can recapitulate past abuse and overwhelm the client. Finally, practitioners should be mindful to ethical guidelines for working with groups (e.g., APA, 1973; American Group Psychotherapy Association, 1991; Association for Specialists in Group Work, 1989).

Self-help. Under the appropriate conditions, self-help books and groups are useful adjuncts to individual therapy. Such resources may assist clients in monitoring their progress, decreasing isolation, and developing coping skills (Lieberman, 1993). However, because these resources often oversimplify complex issues, we recommend the following approaches in the use of self-help materials with clients. First, self-help materials and groups designed for survivors of abuse with continuous memory should not be used to help clients with no memory of abuse explore whether they were abused. In this context, such materials may be overly suggestive and potentially harmful. Other forms of self-help, such as a book or group on managing stress, may be more appropriate and useful. Second, the practitioner should have basic familiarity with self-help materials or groups before recommending them. When recommending these resources, it is prudent for therapists to provide some guidance regarding how to use them, along with any cautions about known strengths and limitations of the book or group (Courtois, 1997a, 1997b, 1997d). For example, the practitioner should encourage clients to be cautious about any self-help books or groups that promote self-diagnosis or checklists of symptoms that are assumed to be indicative of abuse. Likewise, practitioners should note the problems associated with groups that may apply pressure on the individuals to adopt a specific point of view or belief (Enns et al., 1995). Finally, it is advisable to encourage clients to develop their own critical thinking skills regarding self-help books and groups.

Issues Regarding Memory

The Accuracy of Memory

The APA Working Group on the Investigation of Memories of Childhood Abuse (Alpert et al., 1996) reviewed the scientific literature on both trauma and memory and concluded that events that were forgotten can be remembered but that pseudomemories can also be constructed. The British Psychological Society (BPS; 1995) also appointed a working party to investigate these issues. They concluded that "therapy-induced" false beliefs can occur and there is significant evidence for incorrect memories (i.e., the events occurred, but details are incorrect), but there is little evidence for the creation of false memories. They also concluded that scientific research supports the possibility that memory can be recovered despite total amnesia for past events.

Thus, both the BPS working party and the APA working group accepted the possibility that individuals may develop false beliefs or memories with incorrect details or may recover valid and historically accurate memories. Both groups also stated that the mechanisms by which these memory processes occur are not well understood. As a result, we think it is best for practitioners to avoid making determinations about the accuracy or inaccuracy of a client's memories but maintain an open mind regarding the client's resolution of this matter. Thus, one important role for the practitioner is to help the client deal with the possibility that his or her knowledge of the past may remain incomplete.

Exploring Memories

The therapist's approach. We recommend that an initial exploration of memories of abuse begin with the client's open-ended narrative description. Follow-up questions may be used to explore aspects of memories that need clarification (Frank, 1996). The most valid picture of the past is likely to emerge if the client and therapist suspend immediate judgment about the historical accuracy of the various sensations, images, cognitions, and emotions that the client experiences and sort through this material over time (Herman, 1992b). Constructing such a picture often requires time, patience, and tolerance of ambiguity and uncertainty (Courtois, 1988, 1992, 1995, 1997a, 1997b, 1997d; Herman, 1992b).

The practitioner is alert to potential and subtle ways in which he or she may influence the client to retrieve certain memories, including any implicit expectations that the client should recover a memory as a result of a certain procedure. The therapist should also be attentive to clues that the client may be attempting to please the therapist by being a "good client." Some writers caution practitioners to be especially careful about these issues with clients who are highly suggestible or hypnotizable (e.g., D. Brown, 1995a, 1995b; Courtois, 1995, 1997a, 1997b, 1997d). Although it is important for therapists to be attentive to the possibility of suggestibility on the part of clients who are retrieving memories, a recent study found that clients who had recovered memories of abuse were less suggestible than nonabused psychiatric clients (Leavitt, 1997). Given the difficulty of reliably assessing suggestibility in the therapy context, it may be protective of clients' welfare simply to be mindful of these issues with all clients.

Through education about the therapeutic process, the practitioner helps the client understand that although working with traumatic content is important, it is only one of the many aspects of psychotherapy that can foster improvement. For example, it is important for practitioners to balance exploration of new memories with efforts to help clients gain closure regarding previously remembered events. Achieving resolution about such memories may decrease symptoms, increase the accessibility of new material, and prepare clients to deal with additional memories that may surface (Briere, 1992; Gold & Brown, 1997).

Some individuals believe that they do not remember abuse and express a desire to recover memories. If an evaluation concludes that the exploration of memory appears therapeutically useful, it is prudent for the practitioner to educate the client about the malleability and limitations of memory. The practitioner makes efforts to ensure that the discussion of the limitations of memory is not construed by the client as a denial of abuse in general or as it relates to the client's experience but, rather, is seen as an effort to help the client understand the complexities and ambiguities of memory.

Client issues. Even victims of abuse with continuous memory often doubt themselves. Such persons may request reassurance that their memories are historically accurate as they struggle to make sense of their perceptions. The practitioner supports the client's efforts to achieve healing and meaning without making statements or inferences about the accuracy of her or his memories. At times it may be difficult for the client to distinguish between support of him or her as a person and support of the memory per se. Given this reality, the practitioner and client may need to address this issue directly and frequently as a relationship concern.

A person who wonders if repressed trauma may be a cause of his or her psychological discomfort should also be encouraged to explore various reasons for such discomfort rather than assuming that abuse did or did not occur. The practitioner may inquire about what variables contributed to the client's suspicion that he or she was abused, explore these issues with the client, and correct any misinformation. The practitioner may need to help the client live with uncertainty about details of the past and help the client modify a belief that recovering memories will achieve complete resolution of his or her problems (Courtois, 1997a, 1997b, 1997d).

Living with uncertainty. For some individuals, uncertainty about whether or not abuse occurred will be indefinite, particularly if the memories in question originate from the years associated with infantile amnesia (Howe & Courage, 1993; Usher & Neisser, 1993). If a client reports suspicions of being abused during infancy, the therapist should explore the basis for these beliefs. Some clients will need support and guidance in order to live with the knowledge that the historical reconstruction of certain events is not within their capacity. In such cases, the therapist may explain that an important goal of psychotherapy is for the client to gain a personally meaningful sense of his or her own history, regardless of the extent to which memories are retrieved or whether they can be confirmed (Herman, 1992b).

Ethical Considerations

Numerous ethical issues arise in the treatment of trauma survivors that cannot be addressed here. We choose to emphasize some of the more salient concerns, including competence, informed consent, and record keeping. A discussion of these issues from the standpoint of risk management may be found in Frank (1996), Pope and Brown (1996), and Knapp and VandeCreek (1997).

Competence

Practitioners should be competent to provide the services they offer (Principle A: Competence; APA, 1992). In the case of treating survivors of trauma, the practitioner is well advised to assess assiduously his or her education, training, and experience to provide services to this population as well as to understand the personal demands such clients often present. Therapists should be aware of the importance of self-care as well as the potential for vicarious traumatization if their personal resources are overtaxed (Figley, 1995; Pearlman & Saakvitne, 1995).

In particular, the practitioner must remain mindful of her or his own needs and be able to separate them from those of the client. Certain therapist needs are potentially harmful and require careful scrutiny. They may include the need to rescue, the expectation that clients should experience intense affect in every session, the tendency to withdraw emotionally from clients or respond in a cold manner if they display negative or rejecting behaviors, the need to feel omniscient when dealing with issues that awaken the practitioner's vulnerabilities, and the tendency

to become paralyzed when facing clients' self-destructive behaviors (Figley, 1995; Pearlman & Saakvitne, 1995).

Informed Consent

Practitioners obtain informed consent in a manner consistent with APA's ethical standards and code of conduct (APA, 1992) "as early as is feasible in the therapeutic relationship" (p. 1605). However, informed consent and client education are not just ethical requirements. These procedures also demonstrate respect for client autonomy and clients' abilities to make judgments that are in their best interest. In the following sections, we review some of the more notable aspects of informed consent.

The process of informed consent. Contemporary scholars now understand that informed consent is not a single event. Rather, it is a recurrent, ongoing process of interactive dialogue (Packman, Cabot, & Bongar, 1994) involving communication, clarification, and decision making (Pope & Vasquez, 1991) throughout the therapy process (Gottlieb, 1997). In treating survivors of abuse, the process is adapted to numerous variables, such as the stage of therapy, the client's goals, the current state of psychological functioning, and the level of disclosure or awareness of an abuse history.

The timing and extent of informed consent, as well as the verbal or written nature of informed consent, may be influenced by the practitioner's theoretical orientation and personal style. Some authors recommend the use of written rights and responsibilities statements. We refer readers to Frank (1996) for a model of a written informed consent statement and Pope and Brown (1996) for an extended checklist of informed consent issues that therapists should consider.

Client education and treatment planning. Educating clients about the nature of responses to trauma, the expected treatment course, and their options and alternatives is of great importance from both an ethical and therapeutic standpoint. It is prudent to review goals that are appropriate for both short-term and long-term therapy, the limitations of and alternatives to psychotherapy, the risks and benefits of treatment, the issue of diagnosis, and, when relevant, information about the possible impact of managed care on the course of psychotherapy.

These issues may be raised frequently, and often are, during any phase of therapy. We view these events as opportunities for clients to collaborate in the treatment planning and experience greater empowerment. Furthermore, education about abuse and trauma-related symptoms and the process of therapy often decreases client self-depreciation, increases client confidence about her or his capacity to achieve healing, and imparts a sense of safety and predictability about therapy (Freyd, 1994; Meiselman, 1990; Williams & Sommer, 1994).

A more mundane, but no less important, aspect of client education includes the business of practice. Such matters may include cost, office procedures, session length, telephone contacts, and emergency procedures. We believe that clarity and consistency with regard to these matters contribute to good boundary management and an enhanced therapy process.

Limits to confidentiality. Abuse survivors are especially vulnerable to impulsive and self-destructive behavior (Herman, 1992b). At times, it may be necessary to violate confidentiality when a practitioner believes that her or his client is in imminent danger. We believe that such events are likely to be rare and can be prevented in many cases by sound and thoughtful planning as a matter of informed consent. This outcome may be accomplished by paying particular attention to the limits to confidentiality at the outset of therapy and by collaboratively developing contingency plans for such eventualities. Issues to be included in such a discussion may include the following: the practitioner's theoretical approach, emergency procedures, others who may be contacted in case of an emergency, and criteria for implementing emergency procedures. These matters may be revisited often during the course of treatment.

A note on touch and boundary management. Because sexual abuse involves the coercive use of touch, the therapist is cautious about initiating or accepting physical contact. Rather, we suggest that practitioners introduce a discussion regarding the meaning of specific types of touch to the client and seek the client's permission before engaging in any physical contact (Phelps, Friedlander, & Enns, 1997). In general, the use of touch should be the exception rather than a common practice.

If the client experienced ongoing trauma that affected his or her capacity for interpersonal relationships, the client may alternate between idealizing the therapist and being angry with the therapist, may repeatedly test the therapist regarding his or her trustworthiness, or may experience the therapist as an extension of the abuser. Such possibilities underscore the importance of consistent boundary management.

Record Keeping

The APA (Committee on Professional Practice and Standards, 1993) and many state regulatory boards publish record-keeping guidelines. In working with victims of abuse-related trauma, we believe that a well-maintained record can lend significant support to the treatment process. In this section, we discuss some additional issues regarding notes, the writing of a history, and personal possessions.

Notes. We believe that case notes should be thorough in reflecting session content and process. Notes may include presenting problems, topics discussed in sessions, symptoms reported, the client's demeanor, interventions used and their relationship to therapeutic goals, direct quotations of the client and the practitioner, and homework assignments and client compliance with them. Notes are improved when they are concrete, descriptive, and as behaviorally oriented as possible (Courtois, 1997a, 1997b, 1997d; Pope & Brown, 1996).

Case notes include memories and events reported by the client. Such notes do not necessarily reflect historical reality. Therefore, we believe it is best to maintain accurate, neutral, and factually based records of communications with clients. Behavioral observations may be especially useful in cases in which an abuse history is suspected but unconfirmed, because they may help the therapist avoid confirmation bias regarding his or her speculations as well as potential therapist errors associated with reconstructive memory (Frank, 1996; Pope & Brown, 1996).

It is also advisable to document when the practitioner provides information about areas such as the delayed memory dispute, human memory processes, issues regarding historical accuracy of personal memories, and the nature of various tech-

niques and their efficacy. The therapist may also note any erroneous expectancies and misinformation held by clients and describe his or her efforts to convey accurate information.

Writing a history. Abuse and trauma survivors may reveal historical information in a confusing and fragmentary manner over an extended period of time. This rendition deprives the practitioner of a thorough and consistent history that is helpful in diagnosis and treatment planning. We have found it helpful to create an additional note when the chronological sequences of the client's history can be documented. When inconsistencies in the client's reports arise, the practitioner may choose to explore potential contradictions with the client as a means of gaining a more thoroughly elaborated past. Engaging in such conversation with the client not only helps prevent practitioner confusion, but also may be beneficial to the client and introduce greater coherence to the life of the client who is having difficulty remembering and ordering events from the past.

Personal possessions. Clients often bring materials to therapy, such as books, drawings, notes, and other personal possessions. These items are often given to the practitioner with vague intent. It is wise for the therapist to ask if the material is to be examined, if it is to be returned, or if it is to be kept with the client's record. In the latter instance, if the possession is accepted, it should be kept securely within the client's record. However, in our view, this material is not the property of the practitioner and should be returned to the client on request.

Conclusion

Many of the major points that we have conveyed in this article can be succinctly summarized as follows. We believe that psychotherapy for abuse survivors is embedded within a well-planned treatment program. Conceptual models that provide a foundation for the treatment program should account for the individual's personal development in interaction with the family, the social context, and traumatic events. Comprehensive diagnostic and assessment procedures provide important information for the formulation of a treatment plan and the competent treatment of abuse and trauma. Therapy for abuse-related problems often includes the following phases: psychoeducation and stabilization, trauma resolution, and reintegration. The practitioner is sensitive to individual differences in how the themes related to these phases are negotiated.

An empathic, supportive, and collaborative relationship is central to creating a context in which past abuses can be addressed. When the discussion and exploration of memory occurs, the practitioner is cognizant of the diverse needs of clients, the reconstructive nature of memory, and the various types and levels of memory about abuse that clients bring to psychotherapy.

Questions surrounding the treatment of abuse and trauma survivors have created much debate and controversy. We have deliberately avoided many of those issues in order to present those areas in which there is an emerging consensus among scholars and practitioners who work with these issues. We realize that we have left many questions unanswered but hope that this work helps clarify some outstanding issues, results in improved quality of services to clients, and leads to further elaboration of optimal treatment practices with adult survivors of child sexual abuse.

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(Appendix follows on next page)

Appendix

Measures for Assessing Symptoms of Trauma

Anxiety Disorders Interview Schedule—Revised (ADIS–R)

DiNardo, P., Barlow, D. H., Cerny, J., Vermilyea, B. B., Vermilyea, J. A., Himadi, W., & Waddell, M. (1985). *Anxiety Disorders Interview Schedule—Revised (ADIS–R.)* Albany: Phobia and Anxiety Disorders Clinic, State University of New York.

Clinician-Administered PTSD Scale (CAPS)

Blake, D. D., Weathers, F. W., Nagy, L. N., Kaloupek, D. G., Klauminzer, G., Charney, D. S., & Keane, T. M. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS–1. *The Behavior Therapist, 13*, 187–188.

Dissociative Disorders Checklist–II

Armstrong, J., Laurenti, M., & Loewenstein, R. (1991). *Dissociative Behaviors Checklist–II*. Towson, MD: Sheppard Pratt Hospital.

The Dissociative Experiences Scale (DES)

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability and validity of a dissociation scale. Journal of Nervous and Mental Disease, *174*, 727–735.

Gudjonsson Suggestibility Scale

Gudjonsson, G. H. (1984). A new scale of interrogative suggestibility. *Personality and Individual Differences, 5*, 303–314.

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Impact of Event Scale (IES)

Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine, 42*, 209–218.

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