APSAC

Volume 5 Number 4 Winter 1992

THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

RESEARCH AND PRACTICE

The Question of Objectivity in the Survivor Therapist

—by Diana M. Elliott

APSAC's *Advisor* recently featured two articles on survivors of child abuse in the helping professions (Courtois, 1992; Sexton, 1992). Sexton noted that mental health professionals who are survivors of childhood abuse often feel compelled to hide their history in order to maintain professional credibility. It is clear that such concerns are well founded, at least in terms of society's current response to abuse and survivors.

In the County of Los Angeles, for example, child evaluators and expert witnesses in the area of childhood sexual abuse have been questioned about their personal abuse history while testifying in the case of an abused minor. There is an assumption that acknowledging such a history will damage the expert's objective credibility and thus hurt the legal case. This can cause significant distress for the would-be witness who is a survivor, and who may fear not only that s/he will hinder the minor's chances for justice, but that s/he may be publicly humiliated in the process.

The appropriateness of what appears to be a violation of the therapist's right to privacy protected by the constitution is a battle that will be fought primarily not by clinicians but by attorneys in the legal arena. While this issue awaits resolution, there are, as of yet, insufficient data available from which to address the court's legitimate concerns that objectivity be maintained in legal matters or to refute attorneys' discrediting questions posed to the clinician while on the witness stand. This silence is somewhat surprising, since sexual abuse researchers are in a unique position to examine issues related to the impact of childhood abuse on professional practice. Perhaps this reticence is motivated by a fear of giving "the other side" information that will make advocacy for children more difficult. Such reluctance, however, will not make the problem go away—instead, the absence of clear data may allow unduly negative or pejorative arguments by opposing counsel to continue unchallenged. Ultimately, we will do better as a profession if *we* examine these issues ourselves, and interpret them in the context of our understanding of clinical practice and practitioners.

As a preliminary step toward obtaining accurate information on therapists, the author examined the abuse histories and psychological symptoms of nearly 3,000 professional women across the United States. This sample included 340 mental health workers and more than 2,500 women from 11 other professions (including attorneys, CPAs, engineers, etc.). In a forthcoming article in *Professional Psychology: Theory and Practice*, Elliott and Guy (in press) report a higher rate of childhood abuse among psychotherapists compared to individuals working in other professions. Compared to non-therapists, mental health professionals reported a significantly higher rate of both

continued on page 9

MEDICINE

Failure to Thrive

—by Randell Alexander

Failure to thrive (FTT) is a life-threatening condition, whose diagnosis generates considerable confusion among professionals. Estimates of its frequency range up to 1% of all pediatric hospitalizations and 10% of children followed in rural outpatient clinics (Mitchell et al., 1980). When FTT is classified as neglect, foster care often is recommended. Yet standards vary, lower socio-economic groups probably are more likely to be reported for this type of child abuse, and community opinions differ as to whether specific cases should be labelled neglect and how they should be treated. How has FTT become such an acceptable and relatively common diagnostic entity given the murkiness surrounding the subject?

History

Feeding and malnutrition problems have always been present for a certain proportion of the population. With very high mortality rates in the 1800's, efforts were directed towards more humane institutional living conditions. Pediatrics developed as a medical discipline around the turn of the century, in large part in response to feeding specialization. Holt described children who "ceased to thrive" in his textbook *Diseases of Infancy and Childhood* (Holt, 1899). By 1933, a later edition referred to "failure to thrive" (Holt and McIntosh, 1933). Henry Dwight Chapin spoke of "atrophic infants" in describing children wasting away in poor home environments (Chapin, 1908). Psychological factors were blamed for both malnutrition and developmental deficits in institutionalized children, in pioneering work by R. A. Spitz (Spitz, 1945). His concept of "hospitalism" included the combination of "anaclitic depression," malnutrition, and growth failure. In effect, he blamed FTT on emotional deprivation, the idea being that one could waste away from lack of love (Stevenson, 1992). The concept of "maternal deprivation syndrome" also arose from this viewpoint. In 1969, strong evidence emerged

continued on page 11

Research

–Diana M. Elliott

continued from page 1

sexual abuse (42.8% compared to 31.0%) and physical abuse (13.8% compared to 5.9%). Other types of childhood trauma or loss, including death of a parent, death of a sibling, parental alcoholism, and mental illness of a parent were also higher for therapists than for individuals working in other professions. Additionally, therapists were more likely to experience more than one of the aforementioned traumas or losses in their childhood than were non-therapists. Finally, therapists reported more dysfunctional dynamics in their family of origin than did women from other professions.

The finding that therapists experience a higher rate of child abuse than non-therapists raises the specter of the wounded healer whose needs may be as salient as those of the client.

The finding that therapists experience a higher rate of child abuse than non-therapists raises the specter of the wounded healer whose needs may be as salient as those of the client. However, as noted in Elliott and Guy (in press), the data do not support such an image. Despite the higher rate of abuse, therapists reported fewer symptoms of psychological distress on the Trauma Symptom Checklist-40 (TSC-40; Briere and Runtz, 1989) than did women in other professions. Further, therapists reported less disruption in their interpersonal relationships compared to non-therapists.

Additional analyses focusing specifically on survivor therapists—not reported in the aforementioned paper—suggest that survivor therapists have fewer interpersonal difficulties than either abused or nonabused non-therapists and that they have equivalent levels of psychological distress. On the other hand, this relative advantage did not pertain when survivor therapists were compared to nonabused therapists. Mental health professionals with no reported history of abuse recounted fewer interpersonal difficulties and fewer psychological symptoms than did their survivor cohorts. Finally, survivor therapists were more likely to have received psychotherapy as an adult (83%) than were nonabused therapists (71%), survivor non-therapists (52%) and nonabuse non-therapists (37%).

Despite the higher rate of abuse, therapists reported fewer symptoms of psychological distress on the Trauma Symptom Checklist-40 than did women in other professions. Further, therapists reported less disruption in their interpersonal relationships compared to non-therapists.

There are obvious limitations to these data. For example, the sample is comprised entirely of women. Additionally, the therapist subsample was composed primarily of LCSWs (63%), with psychologists, psychiatrists, and psychiatric nurse practitioners with a certification to provide individual psychotherapy comprising the remainder of the sample (37%). Thus, these data should be considered preliminary and used as a starting point from which other researchers generate and examine appropriate empirical questions.

Given the limitations, however, these data have important implications. First, the good news: As a group, survivor therapists report healthier interpersonal relationships than either survivor non-therapists or nonabused non-therapists. Their symptomatology on the TSC-40 (including anxiety, depression, dissociation, post sexual abuse trauma, sexual problems, and sleep disturbance) is essentially equivalent with the symptom picture of survivors in other professions, despite a greater likelihood among survivor therapists to have experienced multiple traumas and loss. Thus, for instance, the survivor therapist testifying before a challenging attorney has a lower probability of interpersonal difficulties than the attorney facing her (regardless of the attorney's abuse history), and approximately the same likelihood of abuse-related psychological distress.

The "bad" news is that therapists are, indeed, more likely than other professionals to have been abused as children. Finding a higher rate of abuse among therapists may be disconcerting for some people, particularly if there is a vested interest in maintaining an idyllic image of the therapist's childhood.

Given the above, an interesting question arises: Why are mental health professionals more likely to have an abuse history than non-therapists? Two hypotheses were examined in Elliott and Guy (in press). First, therapists may be better able to label their maltreatment as abuse than non-therapists. Thus, the data may reflect, not a higher incidence of abuse among therapists, but rather, a better reporting rate of the abuse by individuals in the helping professions. This hypothesis was not supported by the data, however. Given behavioral definitions of sexual abuse, therapists were no better at labeling that which is sexually abusive than were non-therapists.

A second hypothesis examined by Elliott and Guy (in press) suggests that abuse survivors are drawn to the mental health profession not because of their experience as victims, but because of their experience in treatment. Thus, the strength of the relationship between child abuse and professional choice may actually be a function of having been in treatment and not uniquely related to the individual's profession. The finding that 83% of the survivor therapists had sought treatment as adults seems to lend credence to this hypothesis. However, as with the first, this hypothesis was not supported by the data. The strength of the relationship between child abuse and professional choice remained highly significant when statistically controlling for the impact of a treatment history.

A third hypothesis, offered by some in the addictions field, is that the therapist's abuse history leads him or her to be "co-dependent" and, as a result, to become a psychotherapist—presumably for the con-

continued on next page

Research

–Diana M. Elliott

continued from page 9

tact with psychologically disabled individuals. Although this question is not easily addressed, especially given the problems associated with the concept of co-dependence (Briere, 1992), there is another possibility that is worthy of equal consideration: By virtue of their direct experience with family violence and psychological distress early in life, the therapist-to-be may have been made aware of the reality of suffering and trauma in the world, and thus may have developed a mission early in life to help others similarly afflicted. Supporting this hypothesis is an equivalent finding reported among medical professionals: as children, they were more likely to have had physically ill members of their immediate family than nonmedical personnel, perhaps causing them to be more aware of physical suffering and, thus, influencing their decision to enter the medical profession.

To the extent that this sample is a true representation of the mental health field in general, it would suggest that therapists who are survivors of child abuse are a substantial subset rather than a small minority within the mental health profession, with approximately 46% of this sample experiencing physical and/or sexual abuse prior to the age of 16. Survivor therapists as a group experience more psychological pain than do nonabused therapists. This is not a particularly surprising finding. It would have been the anticipated finding if the comparison being considered were abused versus nonabused non-therapists. Successful treatment of a survivor does not equate to the elimination of psychological pain.

The survivor therapist testifying before a challenging attorney has a lower probability of interpersonal difficulties than the attorney facing her (regardless of the attorney's abuse history), and approximately the same likelihood of abuse-related psychological distress.

As a clinician, I have heard clients who were reaching the end of their treatment report a heightened awareness of that which is painful and/or unjust in everyday life. This awareness, while causing some internal pain, also resulted in these particular survivors feeling more alive (or "awake" as one survivor phrased her experience). These same survivors also reported an increased ability to experience delight in the very simple pleasures of life. Thus, at least part of what is accomplished in treatment is not the surcease of pain, but an incorporation of the experience of joy while acknowledging the depth of pain that life has held for many survivors.

When the issue of a clinician's abuse history is raised in the legal arena, there is the implication that a history of child abuse and the experience of abuse-related symptomatology equate to a lack of objectivity. This is, however, an issue that is most appropriately addressed through empiricism rather than intuition. The data reported in Elliott and Guy (in press) neither support nor refute this assumption; they suggest only that survivor therapists, like others abused as children, suffer post-abuse effects. The assumption that psychic pain experienced by therapists has an adverse impact on their ability to provide treatment relatively free from countertransferencial issues has yet to be tested. It may be that survivor therapists who endure greater emotional pain (based on their personal experience of that which is truly tragic), but who are able to contain and use their pain are at least as capable as the non-survivor therapists of understanding the client's pain in a therapeutically helpful manner.

One final implication of these data is a compassionate one, although it may appear stigmatizing to some: The fact that some therapists suffer significant abuse-related distress suggests that the child abuse field should provide active outreach for therapists who are especially affected by their abuse history. The field should be cognizant that not all therapists may be able to provide optimal psychological services to their clients, at least prior to their own successful psychotherapy. Whether such therapists are particularly affected in working with other abuse survivors is unknown at present, since the Elliott and Guy study neither directly studied therapists in the child abuse field, nor evaluated the clinical skills of therapists as they relate to different client populations. As was noted by Courtois (1992), the survivor therapist's decision of whether or not to provide direct services to others is ultimately based on both personal and professional ethics—the same criteria by which nonabused therapists assess their capacity to provide services.

It seems clear, and is reasonable, that survivor therapists have some unique needs that are important for the therapeutic community to address. There are, however, no empirical data to substantiate the assumption that a child abuse history significantly impairs a clinician's ability to make objective evaluations of others. Indeed, being a survivor may equip a therapist to be especially helpful and insightful in certain clinical circumstances. Thus, assumptions related to the potential bias of the survivor therapist should be critically examined through further research on and by professionals in the child abuse field.

References

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects.* Newbury Park, CA: Sage.

Briere, J. and Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4,* 151-163.

Courtois, C. (1992). Invited response to Dan Sexton. *The APSAC Advisor, 5,* 17-18.

Elliott, D.M. and Guy, J.D. (in press). Mental health versus non-mental health professionals: Child trauma and adult functioning. *Professional Psychology: Theory and Practice.*

Sexton, D. (1992). Helpers and healers: Are we really who we say we are? *The APSAC Advisor, 5,* 17.

Diana Elliott, PhD, is a clinical psychologist and the Director of Training and Research in the Sexual Abuse Crisis Center at Harbor-UCLA Medical Center.

Special thanks to the editors of Professional Psychology: Theory and Practice *for permission to summarize data from an article in press.*