Forensically Informed Psychotherapy: Balancing Clinical and Legal Perspectives

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In today's climate of controversy and litigiousness, mental health clinicians face an anxiety-provoking dilemma: how to provide the services that initially led them into the field, while protecting themselves and their clients from risks related to today's complex legal and ethical issues. A task force created by The American Psychological Association to explore the impact of the legal climate on clinicians found that lawsuits have had a "chilling effect" on therapists (Seppa, 1996). Some clinicians respond by practicing "lawsuit therapy," attempting to minimize the chances of being sued by carefully screening words and actions, or avoiding certain kinds of cases altogether. Unfortunately, the cases avoided are, too often, those most in need of assistance. The treatment of family violence, particularly child sexual abuse, has been significantly affected by the current climate.

Although it is not necessary to hold a law degree in addition to clinical training, there are some valuable insights to be gained from the legal/forensic perspective, which can assist clinicians in providing legally and therapeutically sound services. This article is intended to help therapists consider how legal issues may affect and inform their clinical practice. Whereas the focus is on the treatment of issues related to sexual abuse, many of the concepts may also apply to more general cases. Forensic interviewing and evaluation, however, require specialized training that is not within the scope of this article (for further information, see Guidelines published by APSAC, 1995a; the Committee on Ethical Guidelines for Forensic Psychologists, 1991; the American Psychological Association, 1994; the American Academy of Psychiatry and the Law, 1989).

The following areas will be discussed in this article: role of the therapist, competence, treatment approach, case management issues, confidentiality, and documentation. The discussion of these areas is intended to stimulate thought, not to be held as a standard without room for exceptions or flexibility on the part of the therapist.

Therapist Role

The most important task in conducting forensically informed psychotherapy involves understanding the role of the therapist. There is an inherent conflict in trying to function as both the therapist and the investigator (Greenberg and Shuman, 1997; Deaton and Carsel, 1995a,b; and APSAC, 1995a,b). The role of the therapist is to form a therapeutic alliance with the client, allowing the symptoms and concerns of the client to be addressed by providing an atmosphere of support and acceptance. Deaton and Carsel (1995a) point out that therapists cannot also be impartial investigators, as they are not trained in investigative techniques, and the role of investigator would "interfere with their ability to provide a supportive healing environment to victims (p.3)." In fact, a therapist's efforts to investigate allegations could compromise the investigation by legal agencies.

In addition, the sources of information in therapy versus those in an investigation or forensic evaluation are very different. In contrast to the multiple sources of information obtained by an investigator on a fact-finding mission, the information a therapist obtains is primarily from the client. Even when collateral information is sought out, the therapist may do so only with consent of the client, and the information is sought to inform the treatment plan, rather than to confirm or invalidate the client's report. The APSAC (1995b) statement on therapist roles specifically notes that "clinicians whose work with a client is confined to therapeutic services are not obliged to seek corroboration of a client's account."

A guiding principle is that the therapist is not investigating the case, and it is, therefore, not within the therapist's role to make a determination regarding the veracity of allegations.

Therapists must remain firm in their role, despite requests from others to make judgements or recommendations that fall outside that role. For example, a children's social worker or judge may ask or order that the therapist make a judgement on whether a child has been abused, or whether visitation with an alleged perpetrator should occur. It is within the role of the therapist to provide information that has emerged in treatment, assuming the applicable consent has been obtained, or in cases where there is a legal and ethical obligation to do so. The therapist can describe disclosures and can identify symptoms that may be related to or consistent with alleged sexual abuse. As discussed below, it is important not to make direct causal assumptions regarding symptoms, or to define symptoms as exclusively reflective of sexual abuse or trauma. A guiding principle is that the therapist is not investigating the case, and it is therefore not within the therapist's role to make a determination regarding the veracity of allegations.

Similarly, the therapist is not evaluating all family members, and, therefore, would be generally unable to make recommendations regarding the appropriateness of reunification or visitation. Therapists may be asked to broaden their role, such as monitoring a visit and then making recommendations. However, those who are tempted to make such recommendations jeopardize their therapeutic alliance with the client. For example, the therapist's opinion may not be similar to that of the

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client, or a recommended course of action may result in problems (a child who wishes to reunify with a family is not returned home, or a child is revictimized during a recommended visit) The client, then, is left to cope with the resultant problems, without the support and safety of an independent therapeutic relationship.

An exception regarding therapist recommendations is related to the victim's expressed wishes. If a child has communicated information relevant to visitation—either fear of the alleged perpetrator or a desire to visit—the therapist can and should communicate this information to the social worker and/or court (again, with appropriate consent). While the therapist is providing relevant information, the decision-making remains in the jurisdiction of the court or child protection agency. Alternatively, a team of therapists or family preservation workers who work with all family members may collectively have enough information to make appropriate recommendations.

Competence

Ethical guidelines of all mental health disciplines require clinicians to function within their scope of competence. This is particularly true for treatment of child sexual abuse and adult victims of early abuse. Such cases may not be recommended for trainees or interns, particularly in legally complicated circumstances, or should be undertaken only with close supervision by experienced professionals. Licensed clinicians should seek out regular consultation from other professionals as well as ethics and legal committees, as appropriate, to ensure that the highest quality of care is being provided and that legal issues are being properly addressed.

Clinicians must be knowledgeable regarding mandatory reporting guidelines, as well as community standards regarding the provision of care and interaction with other disciplines and agencies Clinicians should also make their clients aware of these issues as part of their informed consent process when beginning treatment.

Continued education and training to keep abreast of new developments in the field is imperative, as is being able to demonstrate an understanding of both sides of difficult or controversial issues. For example, the research regarding children's suggestibility illustrates the benefit of understanding both sides of an issue Defense attorneys have used the work of researchers, such as Ceci and Bruck (1993), Leichtman (1995), and Loftus (1993), to argue that overzealous investigators, fanatical therapists, or disturbed parents (usually mothers) have suggested or implanted false memories of abuse in both children and adult clients Recent court cases show that such arguments are being used successfully, with therapists being held liable for damages to clients as well as to third parties, including the accused perpetrators.

The suggestibility research provides useful information about the manner and circumstances in which people may be easily suggestible, such as when there is weak memory of the event, or if the questioner is seen as intimidating or already having knowledge of the event (see review by Reed, 1996) Informed therapists can incorporate these findings into clinical practice, for example, by not giving the impression that they already know about alleged abuse, by giving the client permission to say "I don't know" and to correct the therapist, and by avoiding the use of certain types of questions (for example, forced choice questions, repetitive questions) The informed clinician who is confronted about a treatment approach can address the limitations of the research, describing how research methods differ from the process of therapy and, thus, may not be directly applicable It is important to note that the suggestibility research shows that recantation of true allegations is as much a risk as the creation of false accusations.

Therapists should rely on treatments that are empirically derived or are generally accepted by the profession (Knapp and VandeCreek, 1996) For example, cognitive-behavioral techniques to reduce post-traumatic stress symptoms have been found to be effective (Foa & Rothbaum, 1998), whereas the use of such techniques as age regression and body work has been questioned (Knapp and VandeCreek, 1996) Maintaining awareness of legal developments and liability issues helps ensure that therapeutic boundaries and methods of treatment meet professional standards of care.

Treatment Approach/ Case Management

In general, the treatment approach for the therapist dealing with an alleged victim of sexual abuse, whether child or adult, is to maintain a neutral, unbiased stance in approaching the case

For cases in which there is more than one victim, it is recommended that a separate therapist sees each client, and that the therapists do not discuss the details of the allegations with each other For general treatment cases, it is often clinically indicated to have separate therapists for individual clients to maintain impartiality and confidentiality and to allow clients to avoid feeling that they are "sharing" their therapist There are additional legal concerns in cases of child sexual abuse A major problem in the McMartin preschool case (People v Buckey, 1990) and other multiple-victim cases was the use of staff to interview and treat multiple victims, lending fuel to the argument that the interviewer/therapist was contaminated by knowledge of other allegations and suggested the abuse across victims

Therapists generally do not determine the veracity of sexual abuse allegations or reports by clients However, that is not to say that therapists do not offer professional support to clients struggling with these issues. Alpert (1995) describes a number of criteria that clinicians can use to explore the sexual abuse hypothesis, including the presence of different types of validation, establishing the alleged perpetrator's character and opportunity to abuse the victim, the victim's recall of

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details of the abuse, the victim's initial sense of strong conviction that he/she was abused, coping strategies including shutting down or out, inappropriate behavior, issues around reality testing including disturbed relationship to his or her body, and evidence of phobias and prohibitions that may be abuse-related. Alpert discusses the necessity of examining competing hypotheses, such as other childhood events or trauma, and notes that the therapist "silently considers possibilities while actively helping the patient to explore (p. 386)." Courtois (1996) also recommends adopting a neutral therapeutic stance, supporting exploration of information and hypotheses by clients, using open-ended questions, and keeping cognizant of possible sources of influence on the client. Courtois urges therapists to be cautious and to explore alternative explanations over an extended period of time.

Maintaining a neutral stance requires active effort on the part of the therapist, particularly in the face of disclosures or recantations by a client. For example, a client may ask or even demand that the therapist express belief of the client's memories. Knapp and VandeCreek (1996) state:

> Although patients may become angry with a therapist who expresses uncertainty about the literal truth of their childhood memories, the patients are better off with a therapist who honestly holds judgement in abeyance. Clinical skill is required to balance the patients' need for emotional support with their need to remain open to alternative explanations in the presence of ambiguous or conflicting evidence (p. 455)

In addition to understanding mandated reporting situations, such as suspected child or elder abuse, clients should also know that a therapist's duty may include releasing information in case of danger to self or others.

In response to new disclosures or recantations of previous disclosures, the therapist should listen objectively, allow the client to express feelings, and explore any circumstances related to the client's statements. For new disclosures, the therapist may be mandated to report the information to law enforcement officials for further investigation. The therapist should, in most cases, discuss the reporting obligation with the client, provide anticipatory guidance concerning possible events following the report, allow the client to process feelings related to the report, and address any safety issues.

When assessing clients, it is important not to attribute symptoms solely or specifically to sexual abuse. The nature of symptoms related to sexual abuse varies widely. Most symptoms are the result of multiple factors and can reflect a variety of difficulties that may or may not include sexual abuse. Up to one-third of sexual abuse victims may report no symptoms (Kendall-Tackett, Williams, & Finkelhor, 1993). Intake procedures or routine mental status exams can include assessment for abuse. Notable authors, such as Carlson (1997) and Briere (1997), identify standardized instruments available to assist clinicians who wish to take this approach (e.g., the Trauma Symptom Inventory, Briere, 1996). Therapists must remain alert to the possibility of sexual abuse, given the common use of victim coping strategies, such as denial and avoidance, but they cannot assume that a particular symptom or lack of childhood memory indicates repressed abuse. Ultimately, it is up to the client to determine what happened to him or her. Roth and Friedman (1998) note that "therapists should refrain from confirming or disconfirming the validity of memories and instead assist patients in arriving at their own conclusions (p. 98)."

The therapist structures treatment toward stabilizing the client and addressing any initial safety issues, followed by treating the presenting symptoms and problems, enhancing coping skills, enhancing social support, and addressing safety and prevention skills for the future. Treatment should assist clients in resolving trauma-related symptoms and placing the traumatic event(s) in a meaningful context or perspective (Roth and Friedman, 1998). A wide literature may be referred to for information regarding treatment modalities for victims of sexual abuse and PTSD (see Alpert (1995); Briere (1992, 1997); Gil (1996, 1991), Herman (1992), and Friedrich (1990)).

Confidentiality

Informed consent procedures should be meticulously followed for cases involving allegations of abuse. Prior to beginning treatment, therapists should review with their clients the relevant mandatory reporting guidelines and other issues regarding confidentiality. In addition to understanding mandated reporting situations, such as suspected child or elder abuse, clients should also know that a therapist's duty may include releasing information in case of danger to self or others. Finally, therapists should review with the client how much and under what circumstances information will be shared with other agencies or legal professionals (e.g., children's social workers, schools, other health professionals). The consent of the client (or parent/legal guardian for a minor) is generally required before treatment information may be released to other agencies/professionals.

Therapists should release treatment information with caution, as a release may be considered to be a waiver of the privilege, and the therapist has no control over what others may do with the information once it leaves the therapy setting. It is often beneficial to provide treatment information in writing, especially when the therapist's statements are to be used in a legal context such as by a court or child protection agency. Written information is less likely to be misconstrued or taken out of context.

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Therapists and/or their records may be subpoenaed during various civil or criminal legal proceedings. In the face of a subpoena, the therapist should not automatically release information. Clinicians should discuss the requested information with their client(s) and support the clients in understanding the impact of releasing such records. Even clients who may be requesting release of records to support a legal endeavor may not fully appreciate that privilege is an "all-or-none" issue. They should be informed that once privilege is waived, all information provided by the client to the therapist may subsequently be accessed by both sides in a legal proceeding. Should the client still wish to release information following discussion of the ramifications, the therapist may then release the requested records or testify within the limits of the therapist's role. Should the client wish not to release subpoenaed information, the appropriate response by the therapist is to assert the privilege on the client's behalf and let a judge determine whether to overrule the client's wishes. The possibility that a judge may order release of information over a client's expressed wishes should be explained to the client. Seeking legal consultation is always a good idea when faced with these situations. Some malpractice insurance companies offer free legal assistance to policyholders.

Records should reflect significant events and symptoms as reported by the client, any diagnoses given, and interventions provided. Records should be kept using a neutral, fact-based approach.

For the treatment of minors, clinicians should be well versed in their respective state laws. For example, minors in California, who are over the age of 12 years and have been sexually assaulted or abused, have the capacity to consent to their own treatment. Minor clients and their parents should be made aware of how much information about the minor's treatment will be shared with the parents.

Documentation

The established standard of care is to maintain records that accurately reflect the course and progress of treatment. In today's climate, it is especially important that documentation be forensically sound. As Scheflin (1998) observes, two opposing views regarding documentation have been put forth. First, "if little is in the notes, there is little to charge the therapist with violating" (p.118). The alternate view holds that thorough notes will demonstrate due care. Gutheil (1980) confirms this second viewpoint by observing that "if it isn't written, it didn't happen." Records should reflect significant events and symptoms as reported by the client, any diagnoses given, and interventions provided.

Records should be kept using a neutral, fact-based approach. History and especially allegations should be documented as "reported by" the client. The use of neutral language is recommended, including the word "alleged" where appropriate (e.g., "alleged sexual abuse," "alleged perpetrator"). The lack of such language may imply that the therapist has made a judgement about the veracity of the information and is no longer neutral.

A distinction should be made between "progress" and "process" notes. At one time, clinicians were expected to keep two sets of notes, one reflecting in brief statements the progress of the case and one reflecting the therapist's thoughts, hypotheses, and transference/countertransference issues. Clients and legal professionals were only provided access to the "public" progress notes. Legal professionals are now knowledgeable about the dual-note system and will subpoena both sets of notes. Therefore, therapists should be very careful about what is documented. Preferably, only one set of notes should exist, which reflects the fact-based progress of the case. Guthiel (1980) recommends that the clinician writing progress notes imagine a hostile attorney perched over his or her shoulder, reading the chart aloud. Given the rights of patients to access their own records, it may also be helpful to imagine the client perched over the other shoulder. Nothing should be written in such a manner that the therapist would not want the chart read out loud in front of the client.

Good, thorough records can document not only what the therapist did but can support assertions about what did not occur in therapy. For example, Scheflin (1998) and Courtois (1996) recommend that therapists document efforts to educate patients about recovered memory issues, as well as interventions, such as not advising abuse-related confrontation with others or legal action by the client. Professional consultations may also be important to include in the record. Such an approach may assist the clinician in defending against claims that memories of abuse were suggested within the therapy.

Conclusion

Mental health clinicians, particularly those who treat victims of sexual abuse, are faced with complex legal demands relevant to every aspect of practice. The treatment of sexual abuse is a challenging field. Many therapists may be discouraged from engaging in such treatment, as the stress related to working with traumatized victims is compounded by daunting legal challenges and a threatening social climate. However, it is helpful to keep the current controversy and legal debate regarding sexual abuse in perspective. Finkelhor (1995) describes the current "backlash" in the area of child sexual abuse as an expected and limited counter-movement to

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the promotion of awareness of child abuse. He notes that public support remains strong for the prevention, treatment, and prosecution of abuse. Finkelhor suggests responding to the backlash proactively, rather than reactively. It is hoped that this article will assist clinicians in responding to the current climate in a proactive manner, by enhancing their understanding of their role and by promoting increased confidence in their method of practice and ability to help their clients.

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- Child abuse and neglect fatalities claimed the lives of an estimated 1,197 children in 1997. Children under age 4 accounted for more than 75% of fatalities. Two percent of fatalities (14) occurred while the child was in foster care. Twenty-three of 31 states reporting indicated no fatalities in foster care. Child fatalities in families receiving family preservation services in the past 5 years accounted for 16.3% of deaths (64). In families reunited in the past 5 years, 2.7% (10) fatalities occurred
- Two-fifths of victims referred to CPS received no services after investigation or assessment. More than 90% of victims who received court actions had court-appointed representatives.
- Thirty-one states reported that 636,079 families received preventive services, the most frequently offered being family planning, parenting education, substance abuse treatment, crisis intervention, domestic violence services, emergency housing assistance, emergency shelter, and respite care. The most commonly cited funding sources were the Children's Trust Fund; Title IV-B-2, Safe and Stable Families; Title XX, Social Services Block Grant; and the Maternal and Child Health Block Grant