

Guidelines

Managing sexual abuse disclosure by adult psychiatric patients – some suggestions

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The main principle of the Children Act 1989 is that the welfare of a child at risk of abuse or neglect takes precedence over all other considerations. In complying with the Act, these considerations may include the principle of medical confidentiality and the health and safety of some adult patients. Nowhere is this more poignantly illustrated than in the case of childhood sexual abuse disclosure by a distressed psychiatric patient who may be unprepared or unwilling to cooperate with the immediate reporting and ensuing investigation of their abuse as required by the Act.

The dilemma facing psychiatrists and other professionals in the mental health field is that compliance with the law in reporting such allegations as soon as they come to light risks driving away other victims who may be in desperate need of help but initially reluctant to report the abuser. If this were to happen and the abusers remained free to perpetrate their crimes, it would be an ironic turn of events for a piece of legislation designed to protect children. Confidentiality need not be maintained at any price and there are situations where it must be subjugated to the greater public good. However, it is often difficult to determine the level of risk to children which justifies reporting the allegations against a patient's wishes. This indicates a clear need for discussion on how to comply with the Act while at the same time safeguarding the interests of the patients reluctant to report abuse.

The following guidelines have been prepared for Southmead Division of Psychiatry to supplement local Child Protection Procedures and offer guidance to mental health professionals in dealing with sexual abuse disclosure by patients. They are far from comprehensive, but hopefully will provide a starting point for discussion towards a consensus on how to address this complex and increasingly common problem.

Background

Disclosure of childhood sexual abuse is on the increase, particularly by adult psychiatric patients.

Recent as well as historical abuse is reported. It is plausible that psychiatric disorder in adulthood would be more likely in individuals abused as children (Palmer *et al.*, 1992).

The victims are presently thought to be predominantly women, but abused men are beginning to come forward for help in increasing numbers.

Disclosure of sexual abuse poses extremely difficult ethical, therapeutic and legal dilemmas for psychiatric professionals who are recipients of such information. This is because

- (a) the information is received in confidence, in the setting of a trusting psychotherapeutic relationship and the context of continuing treatment
- (b) in most cases the object is release and catharsis and, at least initially, no retribution is sought or contemplated
- (c) local child protection procedures and guidelines on reporting, which are designed to prevent further abuse, offer little guidance in dealing with historical or current sexual abuse disclosed by adult psychiatric patients
- (d) it is sometimes difficult to reconcile one's duty under the Children Act and responsibility to one's patient, particularly when the patient threatens self-harm or suicide if the abuse is reported
- (e) the coercion of a patient who has voluntarily disclosed the abuse to become involved in a police investigation or prosecution can end up reinforcing the victim's sense of helplessness and betrayal, further perpetuating the effects of abuse
- (f) similarly, passive acceptance of disclosure can lead to collusion which perpetuates the effects of abuse
- (g) a determined patient who refuses to cooperate with investigation can thwart attempts to ensure the protection of children who may be at risk.

The following guidelines relate to revelations or allegations which come to light in the course of

psychiatric assessment or treatment under the care of a consultant psychiatrist, where clinical responsibility is assumed by the consultant as the Responsible Medical Officer (RMO).

General considerations

Multidisciplinary approach to psychiatric care is accepted good practice, but ultimate responsibility for the patient's management lies with the RMO.

Unless there is some other overriding concern, such as the knowledge of substantial risk to or ongoing abuse of children, the first priority is clearly the patient's health and safety.

Sexual abuse disclosure needs to be handled with sensitivity and compassion. Time may be needed for reflection so that a decision is taken which best serves the interests of both patient and society. The intention is not to subvert the law, but to uphold it without compromising the patient's interests.

The context in which the disclosure occurs can be crucial in determining response. Careful consideration must be given to the patient's psychiatric condition, emotional state, stage of treatment and circumstances leading to disclosure.

Betrayal of trust is a major theme in sexual abuse. Extreme care must therefore be taken not to betray the patient's trust and every effort should be made to avoid divulging information without the patient's permission, except where children are considered to be at risk in which case reporting is mandatory. Even then reporting should not be undertaken without the patient's knowledge.

The patient as victim

As soon as the facts about the abuse have been established, and if the abuser is alive and may have contact with other children, the patient's permission must be sought to report the abuse and initiate an investigation. The patient should be reassured, reminded that other children may be at risk and persuaded that further suffering and damage must be prevented.

One of the aims of therapy must be to encourage victims either to report the abuse themselves or allow the therapist to report it on their behalf. A victim's wish to keep it a secret is a basic ingredient of the pathology of abuse, born out of fear, shame and helplessness. Professionals must be aware of the risk of collusion and the damage it can cause in the long term to the patient and possibly to other victims who could well become future psychiatric patients.

Allegations of abuse made by patients during an acute episode of illness must be treated seriously and sympathetically. However, it must be remembered that some psychiatric conditions may produce false allegations and, in the absence of corroboration by others, the RMO and the therapist who has

knowledge of the patient will have to make a judgement on the best course of action. If there is independent corroboration or the patient persists in making allegations after recovery, then these must be reported.

General practitioners should be reminded that if they become aware of the sexual abuse of one of their patients then they must take steps to report it before referring the patient for psychiatric treatment. A GP who receives the information at first hand is arguably better placed to undertake this than psychiatric professionals whose ability to work intensively with the patient may become compromised if their relationship is dominated at the outset by difficulties over reporting.

The patient as perpetrator/fantastist

General practitioners who wish to refer patients explicitly for help with paedophilia or other conditions posing risk to children should be advised that referrals cannot be accepted until the matter has been reported to the Police and Social Services. This allows the necessary investigations to be carried out before the patient arrives for assessment and avoids the psychiatric service becoming the sole channel through which such abusive behaviour is reported.

Past and present offences against children disclosed by a patient must be reported to the Police and Social Services.

Past offenders whose work or living situation brings them into close contact with children must be advised to seek alternative work and living arrangements. This advice should be a precondition for treatment. Failure to agree a treatment contract should leave the RMO/therapist no alternative but to report the risk to children to the Police and Social Services.

No patient willing to cooperate with treatment should be denied help. Well motivated fantasists who seek help voluntarily must be treated sympathetically and their privacy protected so long as there is no risk to children. It is important that they should not be driven away but referred to specialist teams with the expertise to help them.

The professionals

This is a difficult and stressful area of therapeutic work. Professionals who become involved in helping victims or perpetrators of sexual abuse require regular supervision and peer support.

Specialist supervision of the emotional consequences of working with these clients is best provided by the psychotherapy department. Supervision of day to day work by multidisciplinary teams and line managers is not an appropriate setting for dealing

with the intense transference issues which need to be contained by a clear boundary separating them from the normal working environment. This is particularly important as some staff who wish to work in this way may have also suffered as victims of abuse themselves.

Inexperienced staff and students should be advised not to enquire about abuse or ask known victims about details of their experience. Although they may be approached by patients making tentative attempts at disclosure, the general rule must be that inexperienced individuals should not invite discussion of a sensitive subject such as sexual abuse unless they are being supervised and trained to deal with it.

Involvement in the treatment of victims or perpetrators of sexual abuse should be optional. Psychiatric professionals who, for whatever reason, do not wish to engage in it must be allowed to opt out. Staff who have been victims of sexual abuse themselves are urged to seek professional advice and

help before becoming involved in the treatment of victims or perpetrators of abuse.

For those who wish to undertake this type of work supervision must be mandatory to ensure that the process can be survived by both professional and client.

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Reference

PALMER, R. L., CHALONER, D. A. & OPPENHEIMER, R. (1992). Childhood sexual experiences with adults reported by female psychiatric patients. *British Journal of Psychiatry*, **160**, 261–265.

Psychiatric Bulletin (1993), **17**, 288–290

Audit in practice

A child sexual abuse clinic

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It is only in the very recent past that health care professionals have accepted the reality of child sexual abuse (CSA), and it has only been classified as a separate category in *Index Medicus* since 1987. Since then, the literature has expanded enormously and various treatment strategies have developed.

As part of this development, the Charles Burns clinic, a regional child psychiatry unit in Birmingham, established a child sexual abuse (CSA) project in 1986, in response to the increasing number of referrals of children who had been sexually abused.

This specific project was established both with the aim of applying specialist skills in a new area,

and also as a way of regulating the number of cases seen in the clinic with competing demands on the service. It also serves to support professionals in a difficult area of work. Subsequent developments such as the juvenile sexual offenders service (JSO), and professional consultation services to other agencies were determined to some extent by the referrers. A limited service for sexually abused children is offered by all district based child psychiatry services in the region. We are as yet unsure of the factors which result in referral to our service, apart from our JSO service, which is unique in the region.