Retraumatizing the Victim

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Editor's note: Stigma can take many forms. When diagnosis and treatment themselves are stigmatizing, the consequences are devastating. In the case of Ann Jennings' daughter, the outcome was tragic.

My daughter Anna was a victim of early childhood sexual trauma. She was never able to find treatment in the mental health system. From the age of 13 to her recent death at the age of 32, she was viewed and treated by that system as "severely and chronically mentally ill." A review of 17 years of mental health records reveals her described in terms of diagnoses, medications, "symptoms," behaviors, and treatment approaches. She was consistently termed "non-compliant" or "treatment resistant." Although it was initially recorded, her childhood history was dropped from her later records. Her own insights into her condition were not noted.

When she was 22, Anna was re-evaluated after a suicide attempt. For a brief period, she was rediagnosed as suffering from acute depression and a form of post-traumatic stress disorder. This was the only time in her mental health career that Anna agreed with her diagnosis. She understood herself, not as a person with a "brain disease," but as a person who was profoundly hurt and traumatized by the "awful things" that had happened to her, including sexual torture by a male babysitter.

Invisibility

For nearly 12 years, Anna was institutionalized in psychiatric hospitals. When in the community, she rotated in and out of acute psychiatric wards, psychiatric emergency

rooms, crisis residential programs, and locked mental facilities. Principal diagnoses found in her charts included: borderline personality with paranoid and schizotypal features, paranoia, undersocialized, conduct disorder aggressive type, and various types of schizophrenia including paranoid, undifferentiated, hebephrenic, and residual. Paranoid schizophrenia was her most prominent diagnosis. Symptoms of anorexia, bulimia, and obsessive compulsive personality were also recorded. Treatments included family therapy, vitamin and nutritional therapy, insulin and electroconvulsive "therapy," psychotherapy, behavioral therapy, art, music and dance therapies, psycho-social rehabilitation, intensive case management, group therapy, and every conceivable psycho-pharmaceutical approach to treatment including Clozaril. Ninety-five percent of the treatment approach to her was the use of psychotropic drugs. Though early on there were references to dissociation, her records contain no information about or attempts to elicit the existence of a history of early childhood trauma.

Anna was 22 when she learned, through conversation with other patients who had also been sexually assaulted as children, that she wasn't "the only one in the world." It was then that she was first able to describe to me the details of her abuse. This time, with awareness gained over the years, I was able to hear her.

Events finally became understandable. Sexual torture and betrayal explained her constant screaming as a toddler, her improvement in nursery school, and the re-emergence of her disturbance at puberty. They explained the tears in her paintings, the content of her "delusions," her image of herself as shameful, her self-destructiveness, her involvement in prostitution and sadistic relationships, her perception of the world as deliberately hurtful, her isolation, and her profound lack of trust. I thought with relief and with hope that now we knew why treatment had not helped. Here at last was a way to understand and help her heal.

The reaction of the mental health system was to ignore this information. When I or Anna would attempt to raise the subject, a look would come into the professionals' eyes, as if shades were being drawn. If notes were being taken, the pencil would stop moving. We were pushing on a dead button. This remained the case until Anna took her life, 10 years and 15 mental hospitals later.

The tragedy of Anna's life is daily replicated in the lives of many individuals viewed as "chronically ill." Their disclosures of sexual abuse are discredited or ignored. As during

early childhood, they learn within the mental health system to keep silent.

Silence

A wall of silence isolates childhood sexual abuse from the consciousness of the public mental health system. No place exists within the system's information management structures to receive this data from clients.

A biologically based understanding of the nature of "mental illness" has for years been the dominant paradigm. It has determined the appropriate research questions and methodologies, the theories taught in universities and applied in the field, the interventions, treatment approaches and programs used, and the outcomes seen to indicate success.

The mental health system viewed Anna and her "illness" solely through the lens of biological psychiatry. The source of her pain, early childhood sexual abuse trauma, was an anomaly—a contradiction to the paradigm, and so could not be seen.

As a result of this paradigmatic "blindness," conventionally accepted psychiatric practices and institutional environments repeatedly retraumatized Anna, re-enacting and exacerbating the pain and sequelae of her childhood experience. The table following this article illustrates that retraumatization.

Self-fulfilling Prophecy

The effect of institutional retraumatization was to leave Anna "in a condition that fulfilled the prophecy of her pathology." (S. Stefan, unpublished manuscript, "The Protection Racket: violence against women," University of Miami, 1993). This was especially true in the use of psychotropic medication. Survivors of trauma tell us the capacity to think and to feel fully is essential for recovery. Psychotropic drugs continually robbed Anna of these capacities.

Medication can be helpful if used cautiously, with the patient's full understanding and consent. But without knowledge of which medications can alleviate symptoms and

facilitate recovery from trauma, medications can cause incalculable damage. For Anna, psycho-pharmaceutical treatment was a metaphor for her original trauma. As sexual assault had violated physical and psychological boundaries of self, forced neuroleptic drugs intruded past her boundaries, invading, altering, and disabling her mind, body, and emotions. She once said to me, "I don't have a safe place inside myself."

Denial

Although the established paradigm may help alleviate the suffering of those whose mental illness is strictly genetic or biological, it is failing for a significant group whose histories contain sexual and/or physical trauma. This group may be as high as 50 to 70 percent of women hospitalized for psychiatric reasons, according to J. Briere and M. Runtz in *New Directions for Mental Health Services,* 1991). But a new paradigm, based on trauma, is emerging.

Paradigm shifts are always initially resisted. They disrupt the status quo, create tension and uncertainty, and involve more work. Resistance to a sexual abuse trauma paradigm has existed for over 130 years, during which the etiological role of childhood sexual violation in mental illness has been alternately discovered and denied. Each exposure was met by the scientific community with distaste, rejection, or discredit. Each revelation was countered with arguments that blamed the victims and protected the perpetrators. Today, despite countless instances of documented abuse, this tradition of denial and victim-blame continues to thrive.

Psychiatrist Roland Summit refers to this denial as "nescience," in Psychiatric Clinics of North America (1989). He proposes that "in our historic failure to grasp the importance of sexual abuse and our reluctance to embrace it now, we might acknowledge that we are not naively innocent. We seem to be willfully ignorant, "nescient."

An Emerging Paradigm

The cost of such nescience is high in material as well as human terms. Anna's hospitalizations alone totaled $2,718,720. But now, multiple and divergent forces are confronting nescience with truth. These forces include:

- the victims themselves, speaking out for the first time
- a growing body of research based on a trauma paradigm
- political support for this paradigm as legislation turns its attention to women's issues
- new therapeutic approaches to sexual trauma
- formation of new professional associations based on the experience of trauma
- legal attention to the treatment of women in psychiatric institutions
- the advent of health care reform, which seeks to find more cost-effective, less restrictive treatment

Although the forces of truth will continue to meet resistance, they appear to be forming a powerful movement that will help to protect children from adult violation and will promote acceptance of a trauma-based paradigm recognizing the pain of individuals like my daughter, and offering them what Roland Summit calls "the radical prospect of recovery." The table that follows illustrates Anna's retraumatization by conventionally accepted psychiatric practices and institutional environments.

EARLY CHILDHOOD TRAUMA EXPERIENCE	**COMMON MENTAL HEALTH INSTITUTIONAL PRACTICES**
Unseen, unheard	
Anna's child psychiatrist did not inquire into or see signs of sexual trauma. Anna misdiagnosed.	Adult psychiatry does not inquire into, see signs of, or understand sexual trauma. Anna misdiagnosed.
Anna's attempts to tell parents, other adults, met with denial and silencing.	Reports of past and present abuse ignored, disbelieved, discredited. Interpreted as delusional. Silenced.

Only two grade school psychologists saw trauma. Their insight ignored by parents.	Only two psychologists saw trauma as etiology. Their insight ignored by psychiatric system.
Secrecy: those who knew of abuse did not tell. Priority was to protect self, family relationships, reputations.	Institutional secretiveness replicates family's. Priority is to protect institution, jobs, reputations. Patient abuse not reported up line; public scrutiny not allowed.
Perpetrator retaliation if abuse revealed.	Patient or staff reporting of abuse is retaliated against.
Abuse occurred at pre-verbal age. No one saw the sexual trauma expressed in her childhood artwork.	No one saw the sexual trauma expressed in her adult artwork with the exception of one art therapist.
Trapped	
Unable to escape perpetrator's abuse. Dependent as child on family caregivers.	Unable to escape institutional abuse. Locked up. Kept dependent: denied education and skill development.
Sexually violated	
Abuser stripped Anna, pulled T-shirt over her head.	Stripped of clothing when secluded or restrained, often by or in presence of male attendants.

Stripped by abuser to "with nothing on below."	To inject with medication, patient's pants pulled down exposing buttocks and thighs, often by male attendants.
"Tied up," held down, arms and hands bound.	"Take down," "restraints"; arms and legs shackled to bed.
Abuser "blindfolded me with my little T-shirt."	Cloth would be thrown over Anna's face if she spat or screamed while strapped down in restraints.
Abuser "opened my legs."	Forced four-point restraint in spread-eagle position.
Abuser "was examining and putting things in me."	Medication injected into her body against her will.
Boundaries violated. Exposed. No privacy.	No privacy from patients or staff. No boundaries.
Isolated	
Taken by abuser to places hidden from others.	Forced, often by male attendants, into seclusion room.
Isolated in her experience: "Why just me?"	Separated from community in locked facilities.

"I thought I was the only one in the world."	No recognition of patients' sexual abuse experiences.
Blamed and shamed	
I had "this feeling that I was bad…a bad seed."	Patients stigmatized as deficient, mentally ill, worthless. Abusive institutional practices and ugly environments convey low regard for patients, tear down self-worth.
She became the "difficult to handle" child.	She became a "non-compliant," "treatment-resistant" difficult-to-handle patient.
She was blamed, spanked, confined to her room for her anger, screams, and cries.	Her rage, terror, screams, and cries were often punished by meds, restraints, loss of "privileges," and seclusion.
Controlled	
Perpetrator had absolute power/control over Anna.	Institutional staff had absolute power/control over Anna.
Pleas to stop violation were ignored. "It hurt me. I would cry and he wouldn't stop."	Pleas and cries to stop abusive treatment, restraint, seclusion, over-medication, etc. commonly ignored.

Expressions of intense feelings, especially anger directed at parents, were often suppressed.	Intense feelings, especially anger at those with more power (all staff), suppressed by medication, isolation, restraint.
Unprotected	
Anna was defenseless against perpetrator abuse. Her attempts to tell went unheard. There was no safe place for her even in her own home or room.	Mental patients defenseless against staff abuse. Reports disbelieved. No safeguards effectively protect patients. Personnel policies prevent dismissal of abusive staff.
Threatened	
As child, constant threat of being sexually violated.	As a mental patient, constant threat of being stripped, thrown into seclusion, restrained, over-medicated.
Discredited	
As a child, Anna's reports of sexual assault were unheard, minimized or silenced.	As a mental patient, Anna's reports of sexual assault were not believed. Reports of child sexual abuse were ignored.
Crazy-making	

Appropriate anger at sexual abuse seen as something wrong with Anna. Abuse continued—unseen.	Appropriate anger at abusive institutional practices judged pathological. Met with continuation of practices.
Anna's fear from threat of being abused was not understood. Abuse continued—unseen.	Fear of abusive and threatening institutional behavior is labeled "paranoia" by the institution producing it.
Sexual abuse unseen or silenced. Message: "You did not experience what you experienced."	Psychiatric denial of sexual abuse. Message to patient: "You did not experience what you experienced."
Betrayed	
Anna violated by trusted caretakers and relatives. Disciplinary interventions were "for her own good."	Anna retraumatized by helping professional/psychiatry; interventions presented as "for the good of the patient."
Family relationships fragmented by separation, divorce. Anna had no one to trust and depend on.	Relationships of trust get arbitrarily disrupted based on needs of system. No continuity of care or caregiver.

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