- I get discriminated against because of my diagnosis of borderline. I get refused treatment. I get thought of as difficult and unhelpable.
- the label "borderline" is used by providers as such a weapon against the consumer that I may not diagnose it even if it is there.
- Being labeled borderline - means "you are the problem".

Misdiagnosis Invalidates Experience Of Survivor - Leads To Maltreatment and Is Retraumatizing

- Diagnoses that do not recognize the possible role of abuse experience in the development of symptoms, may invalidate survivors' perceptions by releasing their families from responsibility for their pain. Disorder is conceived as intrinsic to the clients themselves rather than as having external roots. Again, victim is blamed.

- Misdiagnosis results in hurtful or not helpful medications and treatment.

- Misdiagnoses of Borderline and Schizophrenia deny and disconfirm the abuse experience. Survivors should be given diagnoses such as Post traumatic Stress Disorder or Dissociative Disorder, which not only characterize their symptoms but also correctly recognize the etiology.

- Denial of abuse as central to etiology, diagnosis and treatment, and disbelief in abuse related diagnoses - results in misdiagnosis and inappropriate or damaging treatment.
  - I was in system for 25 years and was not correctly diagnosed for MPD until 1991. I was diagnosed schizophrenic, borderline, obsessive/compulsive disorder, major depression, manic depression - all incorrect, all not my experience of myself.
  - Due to disbelief that MPD exists, clearly dissociative patients with trauma histories are misdiagnosed as partial complex seizures or temporal lobe epilepsy
  - Getting no response when I say I have DID and PTSD - hurts
  - Asking "what is your diagnosis", and if you say PTSD or MPD, recording something different than what you say - hurts
  - When they don't believe in DID, MPD, we must pretend to get into the hospital. We have to say we're going to kill ourselves, even when we're not.

- Denying and discrediting person's perception of self by:
  - eg. Saying there is no such thing as MPD
  - Ignoring or refusing to take seriously clients knowledge of diagnosis which reflects their experience of self as survivor of abuse. Persisting in assigning diagnosis client opposes.

Lack of Mental Health Professionals Who Understand Your Experience and Can Help You - Leaves You Alone and Desperate As You Were As A Child

- I can't find anyone to work with who understands what is going on with me, who knows what they are doing and can help me work on trauma. Those who can don't qualify for Medicaid.

- Its hard to find psychiatrists who understand the physiological effects of trauma and who will work <u>with</u> you regarding meds.

- Sometimes its better to have no one at all then to be with people who don't know what they're doing

Being Treated As If You Aren't Intelligent, As If You Don't Have a Brain - Conveys Inferiority and Replicates Abuse

- "I may be "crazy", but I'm not stupid!"

- You must not laugh or answer "incorrectly" when you are asked questions, or you will get into trouble. So you "think" your own answers in your head, for example:
  - "When you listen to the radio, do you hear voices?" (Not when I turn it off, depends on if the music is playing...)
  - The doc looks at his watch to see what date it is, then asks "Do you know what day it is? " (Yeah, if I look at your watch!)
  - "Do you have spiritual hallucinating?" (Thats the only way I stay on this planet!)

- You're treated as if you are at kindergarten to 2nd grade level intelligence, then are asked questions to prove your competency, like "how many oceans are there, how many continents?"

Using Helpful Techniques and Theories In Hurtful Ways - Replicates Childhood Abuse

- Being global in treatment, as if 1 recipe works for all. (Misuse of Linehans program)
- If you don't fit their latest favorite theory or program, you're out of luck
- Use of behavioral modification in a perverted, twisted way
- I didn't feel I had an identity as Mrs. Jones, so I asked to be called "Jennifer". They responded "No, we want to treat you with respect". But they needed to respect my way of asserting identity and control

Being Expected To Trust People Who Have Hurt Me or Who Have Allowed Others To Hurt Me - Replicates Relationship With Abuser And Those Who Should Have Protected Me *(First 5 items are from presentation by Mary Auslander, survivor and professional)*

- I don't feel safe with people in a profession that has done so little about the oppression that goes on in every psych unit in this country. That does not bother about how humane their treatment is, inpatient and outpatient

- I don't feel safe where a culture of violence exists and is allowed to continue in public mental health institutions. Where abusers are allowed to keep their jobs and no one protests.

- I don't feel safe where human rights are always put aside.

- I don't feel safe where psychiatry maintains its extra legal power

- I don't feel safe where mental health professionals base what they do on belief in their own expertise and not on consulting with clients

- I don't feel safe when I've been abused in mental health settings and no one believed or helped me

- Sexual revictimization of clients by mental health professionals. Recent study found 50% of clients had been sexually abused.

- As soon as I learn to trust someone in the system, they move to another job

- I got traumatized because of trusting people, so asking me to make a contract with you demands I trust you - which I can't.

Being Afraid Of Being Hurt In Mental Health Services If I Tell The Truth - Reenacts Original Abuse

- In Crisis Services: feeling controlled, patronized, or scared that staff will do something to hurt me. ie: If I tell them that I'm not in control and not safe, are they going to lock me up? this is worst, because "freedom is all you have".

- I hide symptoms like hearing voices, so I will not be labeled schizophrenic

- I cover up when people ask if I'm suicidal. Because they'll think you're going to kill yourself and then will commit you.

- I got off meds and felt I had come back to life. Two weeks later I went back to the mental health center and told them I was no longer taking meds. They then "noticed" I had opinions, and labeled me "opinionated and noncompliant". I shouldn't have told them

- Telling the truth about your feelings and thoughts will get you locked up, medicated, restrained. So you don't tell.

- Confiding your intense feelings and needing to talk to someone about them, gets you carted off to the ER.

- Abuse or mistreatment within mental health agencies, staff and clients are scared to talk about it

Lack Of Privacy and Violation Of Confidentiality - Replicates Childhood Abuse

- What you tell the psychiatrist and others is not kept private. Information about client is talked about openly with other clinicians, treatment team members, etc. without the permission of the client. etc. Psychotherapeutic intervention should be limited to relationship with trusted therapist.

Unrealistic Expectations : Being Set Up For Failure - Not Understanding Impacts Of Trauma

- Expecting me to achieve what I cannot possibly achieve. Expecting:
  - that you can "get better" fast
  - that you should "make progress" by going from one step to the next upwards, when recovering from trauma is a cyclical process.
  - that you succeed in voc rehab programs, placements, residential places, which don't accommodate for cyclical nature of recovery

- Being expected to "pull yourself up by the bootstraps"

- Being expected to be independent - to do for yourself, at times when you really can't because of new memories, flashbacks, overwhelming fear, etc.

- Insisting a person contract for safety: in the presence of dissociation, even the most earnest contract can fail.

- Holding person responsible for things beyond his/her control

- Professionals need to accept their own limitations. They need to recognize that they can't "fix it", we have to do that. When they try to "fix" us and we don't get "better" according to their expectations Vs the reality of what we are capable of, they give up on us, or get angry at us, and don't want to work with us anymore.

Professionals Who Have Not Dealt With Their Own Childhood Abuse -

- May be hurtful to survivors or threatened by them.
  - I could hear if she would say, "I think you should work with someone else, I can't deal with these issues."

Not Having Opportunities To Be Productive or To Help Others - Tears Down Self-Esteem and Exacerbates Sense of Being Worthless

– I'm kept away from helping others because I'm thought of as being mentally ill.

Protocols That Make No Sense and Rules That Are Made And Changed Arbitrarily By Providers - Replicates Environment of Abuse

- Protocols cause you to avoid getting the help you need, out of fear.
- Suicide protocol that comes out a depression model, produces anger, and makes no sense to trauma survivor. Asking "Are you feeling safe? do you have a plan? is meaningless. Of course you have a plan. I have several, one for Monday, one for Tuesday etc. If you are obsessed with killing yourself, your mind is on it all the time, because in 5 minutes you may not want to live.
- Being involuntarily committed when I just need someone to talk to.

12-step programs are sometimes very shaming and retraumatizing for both male and female abuse survivors - May Replicate Abuse

Medical Procedures With No Understanding Of Trauma - Can Replicate Childhood Abuse

- GYN gave DNC without preparation or without knocking me out.

Poverty Is A Set Up For Revictimization

Distancing and Objectifying - Replicates the Original Abuse and Prevents Healing Relationship

- Beginning of "us and them" starts with training.
- Use of professionalism as a cloak, to keep distance from you - hurts.
- They look at you and treat you like you are a bug, an object. Clinical reviews, team meetings. You feel like a specimen on view. It frightens me that professionals, especially psychiatrists, are in this as a business. They are fascinated by people as "subjects".

15

On Being Invisible in the Mental Health System

Ann Jennings, Ph.D.

This chapter brings into question one of the basic assumptions operating in the public mental health field today: that mental illness is biological or genetic in origin and is therefore treatable primarily by symptom control or management. A case study of my daughter Anna, a victim of early childhood sexual trauma, is used to demonstrate the need for inclusion in the field of an additional view of the etiology of mental illness. Forces supporting the emergence of a new trauma paradigm are highlighted.

ANNA'S STORY

From the age of 13 to her recent death at the age of 32, Anna was viewed and treated by the mental health system as "severely and chronically mentally ill." Communication about who she was, how she was perceived and treated, and how she responded took place through

NOTE: The reader is forewarned that to provide a realistic account of Anna's experience and her attempts to communicate it to others, explicit language and graphic descriptions of her behavior are included.

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her mental health records. A review of 17 years of these records reveals her described in terms of diagnoses, medications, "symptoms," behaviors, and treatment approaches. She was consistently termed "noncompliant" or "treatment-resistant." Initially recorded 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.

WHAT HAPPENED TO ANNA?

Anna was born in 1960, the third of five children, a beautiful, healthy baby with a wonderful disposition. At the age of about two and a half, she began to scream and cry inconsolably. At four, we took her to a child psychiatrist who found nothing wrong with her. When we placed her in nursery school, her problems seemed to lessen.

That Anna was being sexually abused and traumatized at the time is clear now, verified in later years by her own revelations and by the memories of others. Her memories of abuse by a male baby-sitter were vivid, detailed, and consistent in each telling over the years. They were further verified by persons close to the perpetrator and his family, one of whom witnessed the perpetrator years later in the act of abusing another child.

Anna described the experience of being forcibly restrained and sexually violated at the age of about three and a half: "He tied me up, put my hands over my head, blindfolded me with my little T-shirt, pulled my T-shirt over my head with nothing on below, opened my legs and was examining and putting things in me and all that . . . ugh. It hurt me. I would cry and he wouldn't stop. To do that when I was a little kid was like . . . uh, I don't know . . . it made me feel pretty bad. I remember after

he did that I was walking toward the door out of the room and I was feeling like I was bad. And why not Sarah and Mary (her older and younger sisters) and why just me? And I had this feeling in me that I was bad, you know . . . a bad seed . . . and that I was the only one in the world."

Evidence that Anna was betrayed and sexually violated at an even earlier age by another perpetrator, a relative, came to light eventually through the revelations of a housekeeper whom Anna had confided in at the time. She had told this woman that a man "played with her where he wasn't supposed to" and that the man "hurted her." This abuse was kept secret for nearly 30 years.

Anna remembered trying to tell us, as a little child, what was happening, but there was no one to hear or respond. When she told me a man "fooled" with her, I assumed she meant a young neighborhood boy, and cautioned his parents. When we took her to a physician, she experienced the physical examination as yet another violation. "I remember the doctor you took me to when I told you. He did things to me that were disgusting (pointing to her genital area)."

The trauma Anna experienced was then compounded by the silence surrounding it. She tried to communicate with her rage, her screams, and her terror. She became the "difficult to handle" child. Her screaming and crying were frequently punished by spankings and confinement to her room. No one then could see or hear her truth; sexual abuse did not "exist" in our minds. When later, as a young girl, she withdrew within herself, somehow "different," and "apart" from her peers, we attributed it to her artistic talent or independent personality. We did not see or attend to the terror, dissociation, loneliness, and isolation expressed in her drawings, nor did we heed the hints of trouble expressed by her behaviors. Two grade school psychologists were alone among the professionals we encountered in sensing the turbulence underneath her silence. "Anna is confused about her sexual identity," one reported, "you must help her." The other wrote, "It would seem that Anna has suppressed or repressed traumatic incidents."

Chaos and parental conflict existed in Anna's family from the age of 11 to 13. Though her four brothers and sisters survived the multiple geographic moves, alternative lifestyles, disintegration of their parents' marriage, and episodic violence and alcoholism, Anna did not. She "broke" at the age of 13. A psychiatrist prescribed Haldol to "help her

to sleep." She suffered a seizure in reaction, requiring emergency hospitalization. Thus was she introduced to the mental health system.

ANNA'S INVISIBILITY IN THE MENTAL HEALTH SYSTEM

Anna was a client of the mental health system for 19 years, until age 32. For nearly 12 of those years, she 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 schizo-typal 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. Chronic with acute exacerbation, subchronic, and chronic courses of schizophrenia were identified. 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; psychosocial rehabilitation; intensive case management; group therapy; and every conceivable psychopharmaceutical 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. It 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 she took her life, 10 years and 15 mental hospitals later.

There was one exception. When Anna was 25 years old, the chief psychologist on a back ward of a state hospital listened to her after a suicide attempt, and took what she told him seriously. He initiated a new treatment approach that addressed her experiences of sexual abuse. Antidepressant medication was prescribed, but psychotropic drugs were viewed as suppressing the thought processes and emotions she needed to feel fully and begin healing. Rather than relying on drugs as a solution to escalating stress, Anna was helped through these crises and taught how to deal with them. Art therapy was de-emphasized and art lessons were begun, building her artistic talent and increasing her self-esteem. Discussions began about what she needed so that she could leave the hospital and live in the community.

This situation was not to last. The state hospital was closed because of rampant and intractable abuse. Anna's treatment team disbanded. She returned to the system of public mental institutions and community mental health agencies, a world where she was—once again—invisible and undefended. In and out of the "protected environments" of mental health institutions, she repeatedly experienced coerced or manipulated sex, verbal and physical abuse, and rape. When she "broke," she became like a three- or four-year-old consumed by rage and terror. The thoughts, voices, and nightmares that tormented her were sexual and torturing in nature. Violent itches, twitching, stabbing pains, ice cold spots, and innumerable other somatic symptoms invaded her slight body.

Over her remaining years, in community agencies, acute psychiatric hospitalizations, medical and psychiatric emergency rooms, and the back wards of state mental institutions, she experienced night terrors

and insomnia; fears of being taken over by outside forces and of "becoming someone else"; voices telling her she was evil, commanding her to be raped and punished; and eating disorders, dysmenorrhea, and amenorrhea. She painted self-portraits covered with tears, bodies in bondage without hands or arms, and images of multiple persons and sexual acts. She was plagued by intrusive thoughts of abusing her own child, of being tortured, of being "seen" naked by everybody, and of people "getting off sexually" on her torment.

She would often flash back to experiencing her childhood trauma, screaming in terror and pleading for help. On one such occasion, I went with her to a psychiatric emergency service. Calmed enough to answer questions, she stated her diagnosis to be post-traumatic stress disorder. The psychiatrist seemed to be recording this information on the form. When my daughter went over and looked at what she had written, she turned to me and said, "Mom, she wrote down 'schizophrenic.' "

She disclosed in words and behavior fragmented details of the awful things that had happened to her. Once while in restraints she screamed over and over again, "I'm just a sex object, I'm nothing but a sex object." She told her therapist of the "voices" inside her saying "I'm a very young person," "I want you to help me," and "The baby is crying." Once she called her therapist late at night, pleading for her to come to the hospital because "the baby wants to talk to you." Permission was denied by the psychiatrist in charge.

Believing herself to be "bad," "disgusting," and "worthless," as child sexual abuse victims often do,[1-10] she hurt, mutilated, and repeatedly revictimized herself. She put cigarettes out on her arms, legs, and genital area; bashed her head with her fists and against walls; cut deep scars in herself with torn-up cans; stuck hangers, pencils, and other sharp objects up her vagina; swallowed tacks and pushed pills into her ears; attempted to pull her eyes out; forced herself to vomit; dug her feces out so as to keep food out of her body; stabbed herself in the stomach with a sharp knife; and paid men to rape her.

Again and again, as victims of sexual assault often do,[1-11] Anna sought relief through suicide. She tried to kill herself many times—slashing her wrists, attempting to drown herself, taking drug overdoses, poisoning herself by spraying paint and rubbing dirt into self-inflicted wounds, slitting her throat with a too dull razor, and hanging herself from the pipes of a state hospital. She dared men to kill her—on one

occasion by throwing her off a bridge and on another by stepping on her back to break it. Many times she would have succeeded had it not been for outside interventions or her own fears of dying or eternal damnation.

Many of the mental health professionals she encountered were highly skilled in their disciplines. Many genuinely cared for Anna; some grew to love her. But in spite of their caring, her experience with the mental health system was a continuing re-enactment of her original trauma. Her perception of herself as "bad," "defective," a "bad seed," or an evil influence on the world was reinforced by a focus on her pathologies, a view of her as having a diseased brain, heavy reliance on psychotropic drugs and forced control, and the silence surrounding her disclosures of abuse.

In the months prior to her death, Anna and I began to reconstruct her story. She completed over 200 pages of detailed memories of her childhood from birth to age 15. In her own words, including her writings and artwork, and the memories of her brothers, sisters, and others who had been close to her, she spoke her truth. "Mom," she said, "I'm gonna try not to live in these places, because I want to get my *life*—find some friends—get out some day. Maybe this book will help. Maybe someone will come along and understand me. And they won't just say 'drugs, drugs, drugs!' " She gave her doctor a draft of her book. He did not read it.

Four days after her 32nd birthday, after another haunted sleepless night, she hung herself, by her T-shirt, in the early morning bleakness of her room in a California State mental hospital. She was found by a team of three night staff who were on their way in to give her another shot of medication.

THE WALL OF SILENCE AND INVISIBILITY

The tragedy of Anna's life is daily replicated in the lives of many individuals viewed as "chronically and severely mentally ill." Unrecognized and untreated for their childhood trauma, they repeatedly cycle through the system's most expensive psychiatric emergency, acute inpatient, and long-term institutional services. Their disclosures of sexual abuse are discredited or ignored. As happened during their early childhood, they learn within the mental health system to keep silent.

Clinicians who acknowledge the prevalence of traumatic abuse and recognize its etiological and therapeutic significance are deeply frustrated at being denied the tools and support necessary to respond adequately. Sometimes, as Anna's psychologist did, these clinicians leave the mental health system entirely, deciding they can no longer practice with integrity within it.

A seemingly impenetrable wall of silence isolates the reality and impact of childhood sexual abuse from the consciousness of the public mental health system. No place exists within the system's formal information management structures to receive these data from clients. We do not elicit the information, nor do we record it. Yet to respond therapeutically without such knowledge is analogous to "treating a Vietnam veteran without knowing about Vietnam or what happened there."[12] Why, with childhood sexual abuse an open issue for discussion and treatment elsewhere, is it not addressed in the public mental health system?

A PARADIGMATIC EXPLANATION: THE INABILITY TO SEE

Although rehabilitative, psychotherapeutic, and self-help approaches operate within the system, the dominant paradigm within which these approaches are subsumed is clearly that of biological psychiatry. Thomas Kuhn, in his analysis of the history and development of the natural sciences,[13] brought the concept of "paradigm" into popular usage. He defined paradigms as "the conceptual networks through which scientists view the world." Data that agree with the scientists' conceptual network are seen with clarity and understanding. But unexpected, "anomalous" data that do not match the scientific paradigm are frequently "unseen," ignored, or distorted to fit existing theories.

In the field of mental health, 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.

Paradigmatically understood, the mental health system was constructed to view Anna and her "illness" solely through the conceptual lens of biological psychiatry. The source of her pain, early childhood sexual abuse trauma, was an anomaly—a contradiction to the paradigm, and as such, could not be seen through this lens. Her experience did not match the professional view of mental illness. It did not fit within the system's prevailing theoretical constructs. There was not adequate language available within the professions to articulate or label it. There were not reimbursement mechanisms to cover its "treatment." It was not addressed in curricula for professional training and education, nor was there support for research on the phenomena. There were no tools—treatment, rehabilitation, or self-help interventions—for responding to it. And there was no political support within the field for its inclusion. Screened through the single lens of the biological paradigm, Anna's experience could not be assimilated. It had to be "unseen," rejected, or distorted to fit within the parameters of the accepted conceptual framework.

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. Table 15.1 illustrates that retraumatization.

The effect of this institutional retraumatization was to continually leave Anna "in a condition that fulfilled the prophecy of her pathology."[14] 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. Several years ago, she had been through a crisis period without medication. For days following, she asked for me to hold her. She talked softly about her feelings, crying gently, showing trust through touching and hugs. One day after her newly prescribed meds were beginning to take effect, she said to me with a flatter voice and her eyes again haunted, "Mom, the feeling of love is going away." As her feelings of rage, grief, and terror were suppressed, so were her feelings of love and laughter, caring and intimacy, isolating her again from herself and from others and preventing the possibility of healing.

(text continues on p. 338)

TABLE 15.1 Institutional Retraumatization

	Early Childhood Trauma Experience	*Common Mental Health Institutional Practices*
Unseen and unheard	Anna's child psychiatrist did not inquire or see signs of sexual trauma. Anna misdiagnosed.	Adult psychiatry does not inquire into, see signs of sexual trauma. Anna misdiagnosed.
	Anna's attempts to tell parents and 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 that of family. 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 preverbal 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 perpetrators' abuse.	Unable to escape institutional abuse. Locked up.
	Dependent as child on family, caregivers.	Kept dependent. Denied education or skill development.
	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," "restraint." Arms and legs shackled to bed.

TABLE 15.1 Continued

	Early Childhood Trauma Experience	*Common Mental Health Institutional Practices*
	Abuser "blindfolded me with my little T-shirt."	Cloth would be thrown over Anna's face if she spit or screamed while strapped down in restraints.
	Abuser "opened my legs."	Forced four-point restraints 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 "noncompliant," "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 medications, restraint, loss of "privileges," and seclusion.
Powerless	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, overmedication, and so forth, 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 a child, constant threat of being sexually violated.	As mental patient, constant threat of being stripped, thrown into seclusion, restrained, overmedicated.
Discredited	As a child, Anna's reports of sexual assault were unheard, minimized, or silenced.	As a mental patient, Anna's reports of adult 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.	Anna retraumatized by helping professionals/psychiatry.
	Disciplinary interventions were "for her own good."	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 arbitrarily disrupted based on needs of system. No continuity of care or caregiver.

Medication can be helpful, if used cautiously, with the full understanding and consent of the patient. But without particular knowledge of trauma and of the kinds of medications that can alleviate symptoms and facilitate recovery from trauma, medications can cause incalculable damage. For Anna, the system's reliance on psychopharmaceutical treatment was a metaphor for her original trauma. As sexual assault had violated physical and psychological boundaries of self, forced neuroleptic drugs also 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."

THE EMERGING PARADIGM

Although the established paradigm may help to alleviate the suffering of those whose mental illness is strictly genetic or biological in nature, it is failing for a significant group whose histories contain sexual and/or physical trauma. Rising cognizance of this failure is one of several factors currently affecting the mental health field, indicating the possibility that a new paradigm, based on trauma, is emerging. The extraordinary resistance to such a paradigm is also indicative of its power and its eventual emergence.

RESISTANCE TO A TRAUMA PARADIGM

Paradigm shifts, though they mark the way to progress and opportunity, are always initially resisted. They cause change, disrupt the status quo, create tension and uncertainty, and involve more work.[15] Resistance to a sexual abuse trauma paradigm has existed for over 130 years, during which time the etiological role of childhood sexual violation in mental illness has been alternately discovered, then denied. In 1860, the prevalence and import of child sexual abuse was exposed by Amboise Tardieu,[16] in 1896 by Sigmund Freud,[17] in 1932 by Sandor Ferenczi,[18] and in 1962[19] and 1984[20] by C. Henry Kempe. Each exposure was met by the scientific community with distaste, rejection, or discreditation. Each revelation was countered with arguments that in essence blamed the victims and protected the perpetrators. Freud, faced with his colleagues' ridicule of and hostility to his discoveries, sacrificed his major insight into the etiology of mental illness and replaced his theory of trauma by the view that his patients had "fantasized" their early memories of rape and seduction.[16] Today, 100 years later, in spite of countless instances of documented abuse, this tradition of denial and victim-blame continues to thrive.

Psychiatrist Roland Summit refers to this denial as "nescience" or "deliberate, beatific ignorance." 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."[21]

At this point in history, however, multiple and divergent forces are confronting nescience with truth. Although these forces 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 "the radical prospect of recovery."[21]

IMPLICATIONS FOR MENTAL HEALTH ADMINISTRATORS AND POLICYMAKERS

Mental health administrators and policymakers are in a unique position today to prevent the re-creation of tragedies such as my daughter Anna's. The tools and resources they need to do so can be found in the following forces supporting the emergence of the new trauma paradigm.

- Among the most significant forces for change are the victims themselves. For the first time in history, survivors of sexual trauma are speaking out—revealing their experiences of having been sexually violated as children, lobbying politically for services and legislative action, challenging societal denial and nescience, and keeping the reality of the

sexual assault of children in the arena of public awareness. Growing numbers of these survivors are recipients of mental health services and former mental patients with post-traumatic stress and dissociative disorders. After years of hospitalization and misdiagnoses such as borderline personality disorder, major depression, and schizophrenia, they talk of how they could not have begun to heal had not someone recognized and responded therapeutically to their childhood experiences of abuse and torture. Finally, ex-patients in the mainstream consumer movement are beginning to reveal their experiences of sexual violation, the ways in which they felt retraumatized by treatment in psychiatric hospitals and institutions, and their ongoing struggle to heal from both childhood abuse and adult institutional revictimization.

• The number of studies, instruments, articles, books, and professional journals based on a trauma paradigm is multiplying, making visible the most hidden and most damaged victims of childhood sexual assault, and heightening awareness of such anomalies to the psychiatric paradigm. Research is revealing significantly higher prevalence rates of childhood sexual abuse among female psychiatric outpatients and inpatients (as high as 70 percent)[2,22] than is found in the general population. Many of these clients require emergency, acute inpatient care and long-term hospitalization services.[2-4, 11,21-48] Studies establish a history of childhood sexual trauma to have significant implications for diagnosis and treatment,[1,2,4,8,21,22,24,25,27-31,33,35,36,38,40,41,46-84] and the routine inquiry about childhood sexual abuse to be an essential component of emergency, acute inpatient and outpatient psychiatric protocols.[2,23,28,30,36,37,65,85-87] The growing pool of data indicates that when trauma is recognized and responded to in specific therapeutic interaction, possibilities of recovery exist even for those survivors of sexual abuse who are viewed as schizophrenic, depressive, or borderline.[21,31,55,70,78,79,83,88-95] Research findings showing inextricable connections between trauma, physiology, and the brain are now pointing the way to new relationships between these areas of data under a trauma paradigm.[96]

• Political support for a new trauma paradigm is growing as government-sanctioned committees are formed and local, state, and federal

governing bodies pass legislation requiring mental health systems to address issues of physical and sexual abuse trauma in their clients. One such notable step is a 1993 congressional mandate directing the national Center for Mental Health Services (CMHS) to pay attention to women's issues. After surveying the field, CMHS established its priority focus to be on physical and sexual abuse in the lives of women with severe mental illness.

• New therapeutic approaches to sexual and other trauma in persons with serious mental illness are being used and developed outside of and on the fringes of the public mental health system. Examples can be found in the dissociative disorder units of private psychiatric hospitals; in the work of art therapists using imagery and play therapy with traumatized children; in the treatment of severely traumatized war veterans; in the specialized victims and offenders services now serving individuals with severe mental illness; in incest survivor self-help groups; in rape treatment centers; increasingly in the field of child psychiatry; and in the work of private therapists.

• Respected national and international professional associations focused on research and treatment of severely traumatized children and adults have formed over the past decade, and networks of professionals, advocates, and ex-patient survivors increasingly proliferate.

• Women's rights and mental health litigators are being asked to recognize the connection between sexual violence, "craziness," and the treatment of women in psychiatric institutions. These connections are seen to have consequences for rights to treatment, rights to refuse treatment, and forced medication and seclusion and restraint cases.[14]

• Finally, a powerful force for paradigmatic change at this time in history is the advent of health care reform, introducing managed care, capitation, and the need for public mental health organizations to compete in providing quality services to consumers in a cost-effective way. Incorrect diagnoses and treatment exacerbates the condition of traumatized patients, making them dependent on the system's most restrictive and expensive services. An analysis of 17 years of Anna's records shows

that she was hospitalized a total of 4,124 days. The total cost for this hospitalization, figured at $640 a day, was $2,639,360! Not included in this analysis is the cost of social services, police, ambulance and legal/court services, conservator and patient advocacy services, residential treatment, psychiatric and therapist sessions, crisis services, day programs, and intensive case management estimated to be over $500,000 for a total cost of over $3,000,000. By comparison, intensive trauma-based psychotherapy, figured at $150 a session, two sessions a week, for 17 years, would have cost a total of $265,200. With studies showing prevalence rates as high as 81 percent[37] of hospitalized patients to have histories of sexual and/or physical trauma, the fiscal implications to exploring a trauma paradigm are obvious.

CONCLUSION

The ideas, practices, and standard operating procedures that got the public mental health field and its various agencies and institutions to where they are today will clearly not take them into the future. The rules have changed dramatically. Forces shaping a new paradigm include: health care reform and managed care; the need to compete and to deliver quality services in cost-effective ways; the emergence of political activism and public testimony on the part of ex-patient survivors of trauma; the proliferation of research and writing about sexual trauma and serious mental illness; the intense interest and debate around the import of sexual abuse for treatment; the developing legal interest in the system's retraumatization of sexually abused patients; the growth of private psychiatric hospital services for persons with dissociative disorders; and finally, the advances around the fringes of the public mental health field providing evidence that, when trauma is recognized and responded to therapeutically, actual recovery is possible for persons with histories of hospitalization and use of the most expensive services of the system. Resources for "re-tooling" the mental health system to effectively address trauma are to be found in the forces pushing the field to change. Institutions, agencies, and systems that ignore the opportunities presented by the new trauma paradigm do their clients an injustice.

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APPENDIX F

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