those whose abuse history is unknown ($3,289). Thus, sexual abuse histories have both significant direct and indirect effects on cost of care, a cost trajectory pattern that is very similar to that found for clients whose abuse histories are unknown. Persons with histories of physical abuse, on the other hand, have significantly lower care costs than those with no known abuse by an average of $10,370 for the index year.

If one looks at the path of influence of both gender and age on cost of care, we can understand why the abuse coefficients are larger in Model 2 than in Model 1. We noted earlier that women in this sample of clients are significantly older than men, which accounts for the positive correlation between age and gender in the model (coded "1" for women and "0" for men). Although gender is positively related to having a reported history of physical or sexual abuse, age is not. In fact, older clients are significantly less likely than younger clients to have a reported history of physical or sexual abuse, but more likely to have abuse histories that are unknown.

A second important finding in this model is the direct path between gender and cost of care with the negative coefficient of –2.989 associated with it. What this coefficient tells us is that the cost of care for women is significantly lower than the cost of care for men by $2,989 for the index year, once we have controlled for the cost-inflating effects of sexual abuse histories for women. Thus, although we find no significant difference in the cost of care for men and women overall, these findings suggest support for our hypothesis that the pathways to higher mental health care costs for men and women may be different.

Model 3: Abuse Histories, Course, and Cost of Care, Controlling for Gender, Age, and Medicaid Status

We turn now to our final model, Model 3 presented in Figure 13.4, which includes four measures of what we referred to earlier as our course-of-care constructs: (1) number of days of inpatient care for the index year, (2) number of days of residential care for the same period, (3) number of days of nursing home care, and (4) number of outpatient hours over the course of the index year. Again, as with Model 2, we have fixed all nonsignificant paths; thus, all paths shown are significantly different from zero.

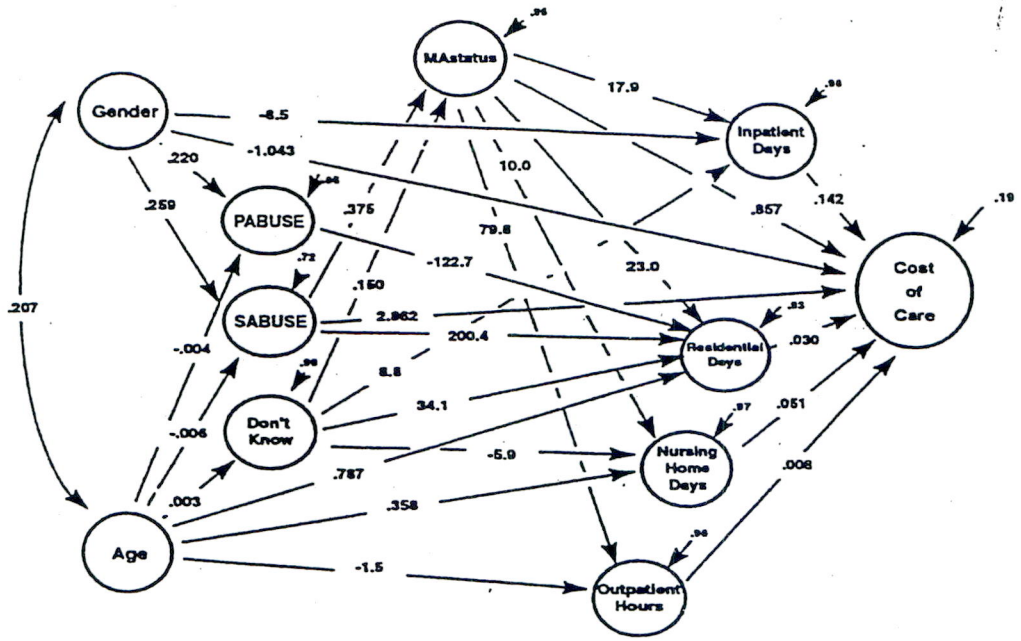

Figure 13.4. Model 3: Abuse Histories, Course, and Cost of Care, Controlling for Gender, Age, and Medicaid Status

NOTE: $\chi^2 = 19$, $df = 17$, $p = .332$. PABUSE = yes response to physical abuse question; SABUSE = yes response to sexual abuse question; MAstatus = Medicaid status.

The overall goodness-of-fit statistics show that the model affords a good fit to the data. This is shown both by the χ^2 (17, N = 1,571) = 19, p = .322, and by the AGFI of .998. In short, we cannot reject the hypothesis that this is the true model underlying the observed pattern of relations among the observed data. Indeed, the addition of the course-of-care measures in the model accounts for 81 percent of the variance in cost of care, a 73 percent increase over the former model. Let us turn, then, to the substantive findings.

Earlier we hypothesized that abuse experiences are likely to increase the risk of being hospitalized in crisis situations and increase the risk of longer hospital stays, although they are unlikely to increase use of, or access to, outpatient services. Do we find support for this hypothesis? The answer, again, is a qualified yes. That is, although histories of sexual abuse are not directly linked either with outpatient hours or inpatient days, there is an indirect association, which is largely mediated by the path linking sexual abuse histories with Medicaid status (.375). Medicaid status, in turn, is associated with more inpatient days (17.9 days),

more residential days (23.0 days), more nursing home days (10.0 days), and more outpatient hours (almost 80 hours of outpatient care over the index year), as well as a higher average cost of care ($857) independent of costs associated with these four service measures.

A second path linking sexual abuse histories with a higher cost of care is through its association with residential treatment. That is, persons with histories of sexual abuse have, on average, 200 more days of residential care over the index year than persons with no known history of abuse, each day costing an average of $30. Finally, the direct path from sexual abuse histories to cost of care shows that persons with sexual abuse histories cost, on average, $2,862 per year that is over and above the two other indirect paths of association.

Indeed, if we combine these indirect and direct paths linking histories of sexual abuse with the course and cost of care, we find that clients with histories of sexual abuse use, on average, 6.7 more inpatient days, 3.8 more nursing home days, 209 more residential treatment setting days, and 30 more hours of outpatient care than do their nonabused counterparts, resulting in an average of $10,888 higher overall service costs for the index year. Thus, much of the relation between sexual abuse histories and cost of care is indirect (73.7 percent of the total effect) and mediated through the use of more restrictive, and costly, living arrangements.

Interestingly, clients whose abuse histories are unknown have cost-of-care trajectories that closely parallel those of clients with known histories of sexual abuse, with a few notable exceptions. First, the link between unknown abuse status and Medicaid status is much weaker, as shown by the path coefficient of .150. Second, although unknown abuse histories are associated with more days of residential care over the index year, the average number of days is much smaller (34.1) compared with persons with sexual abuse histories. Moreover, persons whose histories are unknown have on average 5.9 fewer days of nursing home care than their nonabused counterparts. In fact, the only association that is stronger for persons with unknown abuse histories, compared with those with sexual abuse histories, is that the former is associated with more inpatient days (8.8) compared with those with no known abuse experiences. Again, if we combine the direct and indirect paths of association with cost of care, we find that persons whose abuse histories are unknown have 11.5 more inpatient days, 37.6 more residential days, and

11.95 more outpatient hours than those with no known abuse experiences, which translates into an average higher cost of care of $2,759 for the index year.

Physical abuse histories, by contrast, seem to have precisely the opposite association with cost of care. That is, they are associated with significantly fewer days in residential settings over the course of the year (123 fewer days), which translates into $3,701 less over the index year compared to persons with no known history of abuse. Thus, despite its positive association with histories of sexual abuse, physical abuse seems to diminish clinical contact of all sorts, contrary to our initial hypothesis.

Although these findings suggest that women who are being served in public mental health programs are more likely than men to be placed in restrictive settings as part of their treatment, which is likely to drive up the cost of their care, we must qualify this claim in two ways. First, this effect is largely specific to those clients who have histories of sexual abuse, which includes disproportionate numbers of women, particularly younger women. Second, once we have controlled for this cost-inflating factor, women, in the aggregate, have significantly lower overall cost of care than do men. This is shown by two paths of influence in the model: (1) the path between gender and inpatient days (associated with a coefficient of –8.5) and (2) the path between gender and cost of care (associated with a coefficient of –1.043). These findings indicate that women, on average, have 8.5 fewer inpatient days than do men, and cost on average $1,043 less over the index year, once we have controlled for the impact of abuse histories on cost of care. Thus, although men and women do not differ in overall cost of care for mental health services, these findings suggest that pathways to higher cost of care are very different for men and women.

SUMMARY AND IMPLICATIONS FOR MENTAL HEALTH SERVICES

Over the past 25 years, significant advances have been made in developing community treatment systems that reduce hospitalization

rates, thereby controlling costs for persons with schizophrenia and other serious mental illnesses. Case management programs, continuous treatment teams, day treatment, and residential alternatives have all been part of this effort.[18-21,24] This is certainly the case in the state where this study took place.[49] However, the results presented in these analyses indicate that the many services that have been developed for most persons with serious mental illness are not achieving the same outcomes for persons with serious mental illness who have a sexual abuse history.

We must, of course, acknowledge that we know little about the quality or kind of community-based care that clients with serious abuse histories are receiving within the systems of care included in the present study. Nor do we know whether clients with histories of abuse are receiving treatment that addresses their trauma experiences. Thus, an important area for further inquiry is to determine in what ways, if any, attempts are being made to address the special problems of trauma survivors within existing case management, residential, and inpatient programs.

Given the concentration of sexual abuse survivors in more restrictive living settings, it is particularly imperative that we ask: How relevant are existing treatment programs in these higher-cost settings to the special problems and needs of victims of abuse? Indeed, is the pattern of more days in restrictive settings for persons with histories of sexual abuse a function of longer stays, or more frequent entries and exits, in contrast to those with no abuse history? Finally, to what extent is a greater use of such settings for persons with abuse histories a consequence of the failure of community-based case management programs to address the special needs of abuse victims? Clearly, answers to such questions must be sought in an effort to bring down the cost, as well as improve the quality, of care.

Harris[52] has recommended modifications in community and residential treatment programs for women diagnosed with severe mental illness who also have histories of sexual abuse. These include changing the case manager's approach and relationship with the client, reevaluating the use of medications, helping clients develop ways of experiencing and controlling feelings, making efforts to develop and/or replace social networks, educating clients about sexual abuse trauma, and modifying social skills training programs. Treatment approaches that

incorporate these elements need to be designed, implemented, and evaluated to determine if inpatient and residential use, and the resulting higher cost of care, can be reduced.

Clearly, an important first step in such efforts is the need for a careful assessment of the client's abuse history, as well as revictimization experiences that may be more salient and recent in the lives of adults with serious mental illnesses. It is striking that in this sample of clients within ten community treatment systems in a state with fairly well-developed community mental health services, a third of the clients' histories of physical or sexual abuse were unknown to their case managers. Given the seriousness of symptoms that can result from histories of abuse, and the growing body of evidence documenting that substantial numbers of adults with serious mental illnesses have had such histories, it is critically important that case managers and other mental health professionals include this information in their assessment procedures. Training in assessment for histories of physical and/or sexual abuse should be incorporated into the educational programs of case managers and clinicians at all program levels.

Such assessments must be conducted for all clients, young and old, male and female, so that stereotypes about who are usual victims of abuse do not determine the trauma assessment process. For example, in the present study, patterns of service use are similar for persons with a known history of sexual abuse and for persons whose abuse history is unknown. Both have higher use of residential and inpatient care than persons with no abuse history or a history of only physical abuse. This finding raises the possibility that many of the persons in the "don't know" category may have a history of sexual abuse. Moreover, since many of the "don't knows" are older women, it may be that case managers and others do not think of older women as being sexually abused or sexually active or simply feel it would be inappropriate to ask.

Another important finding of the study that has clear implications for the assessment process is the very different effect that physical and sexual abuse histories have on service use and cost of care. That is, although persons with histories of sexual abuse often have histories of physical abuse, physical abuse appears to suppress cost of care largely through diminishing clinical contacts of all kinds. For example, persons with histories of physical abuse have significantly fewer days of inpa-

tient care and residential care than persons with histories of sexual abuse. Moreover, there was a general pattern of negative coefficients in the model linking physical abuse histories with utilization patterns, although all were not statistically significant.

These findings suggest that when designing services for persons who are abuse survivors, it is essential to explore all forms of abuse in the client's history. Indeed, one of the factors that may complicate the clinical picture for some sexual abuse survivors is a mixed history of both physical and sexual abuse. Persons with such histories may be more ambivalent about using services, as well as more unpredictable in their feelings and behaviors toward service providers, than persons with a sexual abuse history only or no abuse. Alternatively, persons who have a history of physical abuse, in the absence of other abuse experiences, may be particularly reticent to reach out for help or trust the help that is offered. These observations suggest that the particular configuration of services needed, or the way in which they are offered, may be quite different for persons with different kinds or combinations of abuse experiences.

As we move toward managed care for adults with serious mental illnesses, the higher use of inpatient care for persons with a history of sexual abuse is a finding that has important fiscal implications. Rather than simply restricting access to the hospital as a response, managed care programs should review the appropriateness of the assessment and treatment being provided to persons with histories of abuse. Our findings suggest that an assessment of physical and/or sexual abuse should be required prior to the commencement of treatment. If more appropriate community treatment is provided to persons who have such histories, inpatient use may be reduced without the need for arbitrary restrictions.

In conclusion, this study documents the increased cost of care for persons with serious mental illness who have a history of sexual abuse. Advocates, survivors, policymakers, treatment providers, and researchers must now join together to demand that treatment programs designed to meet the special needs of abuse survivors be developed, implemented, and evaluated. Failure to do so is costly in both human and financial resources and is a form of systematic discrimination against women that must be addressed.

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What Can Happen to Abused Children When They Grow Up?

Some Statistics from the Research

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Childhood abuse can lead in adult years to:

SERIOUS MENTAL HEALTH PROBLEMS

- Childhood abuse can result in shame, flashbacks, nightmares, depression, alcohol and drug use, feelings of humiliation and unworthiness, ugliness and profound terror.

  (Harris, 1997; Carmen, 1995; Herman, 1992; Janoff-Bulman & Frieze, 1983; van der Kolk, 1987; Brown & Finkelhor, 1986; Rimsza & Berg, 1988)

- As high as 81% of men and women in psychiatric hospitals have experienced major physical and/or sexual abuse. 67% of these men and women were abused as children.

  (Jacobson and Richardson, 1987)

- 74% of Maine's Augusta Mental Health Institute patients, interviewed as class members, report histories of sexual and physical abuse trauma.

  (DMHMRSAS, 1998)

- 50 to 70% of all women and a substantial number of men treated in psychiatric settings of all kinds have histories of sexual or physical abuse, or both.

  (Carmen, Rieker, and Mills, 1984; Bryer et al., 1987; Craine et al., 1988)

- Adults abused during childhood are:
  - more that twice as likely to have at least one lifetime psychiatric diagnosis
  - almost three times as likely to have an affective disorder
  - almost three times as likely to have an anxiety disorder
  - almost 2 1/2 times as likely to have phobias
  - over 10 times as likely to have a panic disorder
  - almost 4 times as likely to have an antisocial personality disorder

  (Los Angeles Epidemiologic Catchment Area Study (Stein et al1988)

- 97% of mentally ill homeless women have experienced severe physical and/or sexual abuse. 87% experienced this abuse both as children and as adults.

  (Goodman, Johnson, Dutton & Harris. (1997) Prevalence and Impact of Sexual and Physical Abuse. In Harris and Landis (Eds), *Sexual Abuse in the Lives of Women Diagnosed With Serious Mental Illness*)

SUICIDE AND SELF-INJURY

- There is a highly significant relationship between childhood sexual abuse and various forms of self harm later in life, i.e. suicide attempts, cutting, and self starving particularly.

  (van der Kolk, Perry, and Herman 1991)

- For adults and adolescents with childhood abuse histories, the risk of suicide is increased 4 - 12-fold.

  (American Journal of Preventive Medicine, 1998)

- Most self mutilators have childhood histories of physical or sexual abuse. 40% of persons who self-injure are men.

  (Graff, Mallin, 1967; Pattison, Kahan, 1983; Briere, 1988; Conterio, 1998; Strong, 1998)

Childhood abuse can lead in adult years to:

ALCOHOL AND DRUG ABUSE

- 75% of women in treatment programs for drug and alcohol abuse report having been sexually abused . (SAMHSA, 1994; US Public Health Service)
- Teenagers with alcohol problems are 21 times more likely to have been sexually-abused than those without such problems.
- 71% to 90% of adolescent and teenage girls and 23% to 42% of adolescent and teenage boys in inpatient substance abuse treatment reported histories of childhood sexual abuse.

  (Study of patients at a Maine facility, 1988)
- HMO Adult members who had experienced multiple childhood exposures to abuse and violence had a 4 -12-fold increased risk of alcoholism and drug abuse, and a 2 - 4-fold increase in smoking.

  (American J. of Preventive Medicine (ISSN: 0749-3797),1998)
- Adults abused during childhood are more than twice as likely than those not abused during childhood to have a higher prevalence of substance abuse

  (Los Angeles Epidemiologic Catchment Area Study (Stein et al., 1988))
- Women with lifelong histories of multiple substance abuse are 16 times as likely as women without, to have been exposed as children to familial violence and personal physical abuse. They are 7.5 times as likely as women without, to have been sexually abused as children.
- 55% of Augusta Mental Health Institute class members with a dual diagnosis of mental illness & substance abuse report histories of physical and/or sexual abuse.

  (DMHMRSAS, 1998)

DELINQUENCY, VIOLENCE AND CRIMINAL BEHAVIOR

- Among juvenile girls identified as delinquent by court, over 75% have been sexually abused - and in attempting to mitigate that abuse by running away, they are often labeled as delinquent . (Calhoun and colleagues (1993)
- 80% of children in the juvenile justice system have suffered severe childhood abuse.
- 80% of women in prison and jails have been victims of sexual and physical abuse. These women are far more likely to be abused while in prison.

  (National Women's Law Center: "An End To Silence: Smith, Brenda. April 1998)
- Todays victims are tomorrow's perpetrators. Reenactment of victimization is a major cause of violence in society. Numerous studies have documented that many violent criminals were physically or sexually abused as children

  (e.g., Groth, 1979; Seghorn, Boucher, & Prentky, 1987)
- Almost all murderers and sex offenders have histories of childhood abuse. The majority of women and men in the criminal justice system were abused as children.

  (National Commission to Prevent Child Abuse)

Childhood abuse can lead in adult years to:

SERIOUS MEDICAL PROBLEMS

- Medical impacts of violence and abuse include: Head trauma, brain injury, sexually transmitted diseases, unwanted pregnancy, HIV infection, physical disabilities (back injury, orthopedic, neck etc.)

(Prescott, Women Emerging in the Wake of Violence, 1998

- Children who had experienced multiple exposures to abuse and violence compared to those who had not, had experienced multiple (50 or more) sexual intercourse partners and sexually transmitted disease; had poor self-rated health, a higher rate of physical inactivity and severe obesity.

(American Journal of Preventive Medicine
ISSN: 0749-3797, v. 14, no. 4, pp.245-258, 1998)

- Adverse childhood exposures showed a relationship with the presence of adult diseases, including
  - Ischemic heart disease,
  - Cancer,
  - Chronic lung disease,
  - Skeletal fractures, and
  - Liver disease.

(American Journal of Preventive Medicine
ISSN: 0749-3797, v. 14, no. 4, pp.245-258, 1998)

- Research is revealing a history of severe and prolonged childhood sexual abuse to underlie damage to the brain structure, resulting in impaired memory, dissociation, and symptoms of PTSD.

(Briere)

DEVELOPMENTAL OR PHYSICAL DISABILITIES

- Violence is a significant causal factor in 10% - 25% of all developmental disabilities.

(Sobsey, D. (1994; Valenti-Hein & Schwartz, 1995)

- 3% - 6% of all children will have some degree of permanent disability as a result of abuse.

(Sobsey, D. (1994; Valenti-Hein & Schwartz, 1995)

- Between 20% - 50% of abused children suffer mild to severe brain damage.

(Rose and Hardman, 1981; in Sobsey)

Childhood abuse can lead in adult years to:

SEVERE SOCIAL PROBLEMS

Homelessness:

- 70% of women living on the streets or in shelters report abuse in childhood.
(Goodman, 1991)

Prostitution:

- Victims of child sexual abuse are at high risk of becoming prostitutes.
(Vindelhor and Browne, 1984; Silbert and Pines, 1981; Prescott)

Welfare:

- Recent surveys find more than 40% of women on welfare with multiple persistent problems in leaving the rolls, were sexually abused as children.
(Jason DeParle. November 28, 1999. Life After Welfare. *The New York Times)*

Truancy, Running Away, Risky Sexual Behavior:

- Childhood abuse has been correlated with increased adolescent and young adult truancy, running away, substance use/abuse, risky sexual behavior, eating disorders, low self-esteem, prostitution, and violence to self or others.
Prescott

REVICTIMIZATION

Predators look for weak or vulnerable people. Having been abused as a child - especially having been sexually abused, makes one vulnerable to being revictimized.

- Women who are sexually abused during childhood were 2.4 times more likely to be revictimized as adults as women who were not sexually abused.
(J.Clinical Psychology, 60: 167-173, 1992)
- 68% of women with childhood history of incest reported incidents of rape or attempted rape after age 14 compared to 38% of a random sample.
- Girls who experience violence in childhood are 3 to 4 times as likely to be victims of rape.
- Childhood sexual assaults are associated with increased risk of adult assaults of both a physical and sexual nature, whereas childhood physical assaults, by contrast, were not related to adult victimization experiences.
(Newman, Greenley, Sweeney, Van Dien, 1998)
- Twice as many women with a history of incest as women without such a history are victims of domestic violence . (Prescott)
- 4 times as many women with a history of incest as women without such a history reported unwanted sexual advances by an unrelated authority figure.
(Prescott)

COMMUNITY RETRAUMATIZATION

"With abuse, you suffer loss of soul, loss of self and loss of meaning"
"In the system, you must fight every day, every minute, to keep from feeling worthless - to keep your spirit alive" K.W. (Survivor)

Based on information contributed by survivor trauma advisory groups

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- **Environmental Insults and Insensitivities - Re-convey Messages of Worthlessness and Inferiority**
- **Denial, Discreditation, Ignoring, Minimizing or Silencing of Abuse - Re-enacts Past Trauma**
- **Exerting Power and Control Over Client - Replicates Power Imbalance of Original Trauma**
- **Not Accommodating the Vulnerabilities of the Trauma Survivor - is Revictimizing and Retraumatizing**
- **Housing Without Privacy, Control and Safety - Reenacts Abuse Environment and Is Retraumatizing**
- **Repression of Emotions - Hinders Recovery and Replicates the Abuse Mandate of Silence**
- **Being Pathologized and Blamed - Replicates the Abuse By Making It "Your Fault"**
- **Failure to Listen, Take Seriously, Learn From Survivors - Conveys Worthlessness, Replicates Abuse**
- **Using Diagnosis as Labeling, - Shames and Stigmatizes, Replicates Abuse**
- **Misdiagnosis Invalidating Experience Of Survivor - Leads To Maltreatment and Is Retraumatizing**
- **Lack of Mental Health Professionals Who Understand Your Experience and Can Help You - Leaves You Alone and Desperate As You Were As A Child**
- **Being Treated As If You Aren't Intelligent, As If You Don't Have a Brain - Conveys Inferiority and Replicates Abuse**
- **Using Helpful Techniques and Theories In Hurtful Ways - Replicates Childhood Abuse**

- **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**

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

- **Lack Of Privacy and Violation Of Confidentiality - Replicates Childhood Abuse**

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

- **Professionals Who Have Not Dealt With Their Own Childhood Abuse - May Be Hurtful**

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

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

- **12-Step Programs Are Sometimes Shaming and Retraumatizing For Both Male and Female Abuse Survivors - May Replicate Abuse**

- **Medical Procedures With No Understanding of Trauma - Can Be Retraumatizing**

- **Poverty**

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

COMMUNITY RETRAUMATIZATION

"With abuse, you suffer loss of soul, loss of self and loss of meaning"
"In the system, you must fight every day, every minute, to keep from feeling worthless - to keep your spirit alive"

Environmental Insults and Insensitivities - Re-convey Messages of Worthlessness and Inferiority

- Different bathrooms for clients and staff
- Professional has cup of coffee, does not offer one to client
- Keeping people waiting, sometimes for hours, or all night at ERs
- Assuming individual is willing to ride all day to get to clinic
- Humiliating and lengthy process of trying to get social security entitlements and other financial assistance- forcing person to live with no income, no housing, and to have to go to a shelter

Denial, Discreditation, Ignoring, Minimizing or Silencing of Abuse - Re-enacts Past Trauma

- "Professionals don't want to hear about or deal with sexual abuse"

- Casting doubt on the validity and seeking to discredit what the survivor says about her/his memories and experience of abuse is extremely traumatizing - and is exact replication of a most painful part of original childhood abuse experience.

- Failure to initiate discussion of sexual abuse sends message that such abuse does not occur or does not matter, confirms persons belief in the need to deny the reality of the experience, and maintains guilt and isolation of person.

- Conceptualizing recollections of abuse as psychosis, characterological manipulations, or oedipal fantasies colludes with the family's denial of the occurrence and impact of abuse, or with the victims sense of guilt and defectiveness.

- Results in misdiagnosis, misinterpretation and maltreatment
  - fragmented memories and logical anger and fear get viewed as insanity
  - accommodations developed to deal with the abuse and with the systems failure to address it, are labeled dissociative, psychotic, affectively disordered, inappropriately distrustful, etc. and are seen as pathology

Exerting Power and Control Over Client - Replicates Power Imbalance of Original Trauma

- Exerting your will onto client in any way - "for their own good" - unless he or she has given you explicit permission in advance to do so. (ie. advance directive in case of emergency)

- Any behavior which does not demonstrate respect for the client's wishes and which deprives her or him control over the interactions: e.g.:
  - -not asking permission before making a home visit.
  - -arranging to ride in a car, or attend a recreational activity uninvited
  - -forming treatment plans which impose perceptions and desires of others on client

- Foisting services on unwilling clients - risk creating atmosphere like that in which a controlling adult asks a vulnerable child to do something that the child knows she does not want to do, in effect replicating the very dynamics of the trauma itself.

- Insistence on being "in charge". Because abusers use power to threaten and intimidate victims, clients are wary of worker who has lots invested in being in charge. For some, any relationship in which a power imbalance exists may be reminiscent of the abuse relationship.

- Not recognizing the power imbalance inherent in staff/client relationship, especially between psychiatrist and client.

- A contract should be a two-way agreement. the way it is done, you do all the contracting - and they make no contract with you regarding what they will and will not do.

- Language of oppression: replicates abuse
  - My - that was an angry feeling
  - Remember, you've already lived through the worst
  - Nobody can hurt you now
  - Use of rhetoric, jargon
    - the therapeutic "milieu"
    - your behavior is inappropriate
    - your affect is not appropriate
    - your affect is blunted
  - The therapeutic "we":
    - How are "we" feeling today?
    - We're going to have a nice bath now
    - We're going to eat something now
    - We won't have any negativity
    - My, we're in a hostile mode today
    - Shall we join the group?

- Withholding services

Not Accommodating the Vulnerabilities of the Trauma Survivor - is Revictimizing and Retraumatizing

- Placing perpetrators and victims in same groups, day programs, group homes, etc.
  Person stuck in same day program group as person she had protection order against. She protested and was rejected from group.
- This is often as important for the perpetrators (who are frequently survivors of childhood sexual abuse themselves) as it is for the victims
- Insensitivity to gender issues:
  eg. Assigning male case manager to victim of male perpetrator (unless given permission)
  eg. Assigning woman therapist when perpetrator was female or where woman is perceived as failed protector and target for rage.
- Involving family members without clients explicit willingness and permission

Housing Without Privacy, Control and Safety - Reenacts Abuse Environment and Is Retraumatizing

- Lack of secure, private sleeping space problem for survivor whose bedroom was violated by intruders in the past.
- Rules mandating when and where people sleep imposed by residential staff create a problem for survivor who learned only safe time to sleep is during the day, and that beds are unsafe places in which to sleep
- Housing in marginal neighborhoods where break-ins, rapes, and murders occur.

Repression of Emotions - Hinders Recovery and Replicates the Abuse Mandate of Silence

- Expressing any intense feeling is viewed as dangerous behavior or "disruptive to the therapeutic milieu" - you are punished usually by take-down and being involuntarily committed
- Medicating any sign of powerful affect in person - causes affective numbing and contributes to survivors belief that her feelings are bad and dangerous and should not be felt.
- Prohibiting and punishing clients feeling fully and expressing powerful emotions of anger, pain, and sadness - is destructive of the process essential for recovery.
- Ascribing guilt and wrongness for emotions -
  -"oh you shouldn't feel that way..."
  -"its about time you got over it..."
- When person is in pain, trying to "fix" it, turn it off, make it go away.
- Unwillingness to just "be with" person in distress - be a witness. The essence of survivor is being alone with no witness.

Being Pathologized and Blamed - Replicates the Abuse By Making It "Your Fault"

- Everything gets interpreted as "symptoms" of "mental illness", rather than as normal and creative responses to abnormal circumstances, like being raped at age 2
- Fragmented memories and understandable anger and fear of survivors get viewed as insanity
- Accommodations and skills developed by survivors to cope with the traumatic impact of the abuse, are pathologized and labeled dissociative, psychotic, affectively disordered, inappropriately distrustful, etc.
- "It hurts to hear myself talked about in pathological terms and to know I'm not seen as me, but as a disorder, a pathology."
- Attempts to struggle against hurtful power imbalances are interpreted as pathological and punished. eg:
  - "Case manager came to my house uninvited. I asked him to leave and he wouldn't, so I slammed the door. I got labeled "violent"."
- When you are trying to get help, you are said to be "playing angles" and "manipulating", eg:
  - being told "Its a game, cut it out"
  - being told, "We're not going to put up with the game plan"
  - "My arms were all cut up, and I had no sense of how or why it happened. I was labeled "borderline" and said to be playing games"
  - "I asked the same questions of two different staff members and was said to be manipulating"
- Staff commonly share client's trauma through countertransference, including feelings of anger, guilt, helplessness, fear, even dissociation. Often the client is blamed for these feelings and called manipulative.
- Telling the truth gets you punished.
  - "If I say I don't remember doing something, I'm accused of lying, manipulating, or of not being safe, so they lock me up"
- Calling a client "noncompliant", "treatment-resistant" etc. rather than taking responsibility for failing to better help him or her, or for not knowing what to do or how to understand.

- Accusing clients of "splitting" staff rather than staff taking responsibility for splitting themselves. Most of what passes for "splitting" is simply the person asking different people for what she/he wants, hoping for an alternative answer or an ally.

- "Your history follows you no matter what you do in the present. I only got assaultive one time and that was when they tore the head off my stuffed doll that I had had for a lifetime. Now providers tell me I'm dangerous and I terrify people. My history follows me"

- "It hurts to read my records and see how I'm described- like some evil thing"

- It tears down your self-esteem. I fight all the time to keep from feeling worthless.

Failure to Listen, Take Seriously, Learn From Survivors - Conveys Worthlessness, Replicates the Abuse

- We know what works for us and what we need, but no one will listen or take us seriously.

- Providers don't trust or respect what I've learned works from my experience.

- Providers won't do what I and my therapist tell them I need, because they say it "perpetuates the disorder", "encourages negative coping", and is "counter-productive toward therapy". They use jargon that makes no sense.

- Professionals look to others for information when I have the experience and I am there and can answer their questions with the most authority. Like I have nothing to offer.

- When you are physically ill or have a physical complaint, you are discounted, your statements are not taken at face value. Everything is made psychological and open to the interpretation of hidden messages, like making reality other than what it is. I would have an allergy and break into hives, and its viewed as psychological

- My reports when there are uncomfortable side effects of medication, are ignored

- I spent months at Sheppard Pratt Hospital and learned the medications that worked for me so I could still work on the trauma. The psychiatrist back home refused to give them to me. He would not respect what I told him worked for me

Using Diagnosis as Labeling, - Shames and Stigmatizes, Replicates Abuse

- Problem with diagnosis, is it stamps you forever. With the labels, you lose credibility

- Having your identity taken away from you by being labeled "a schizophrenic", "a borderline" - hurts

- Being deprived of hope by being called "chronic" - hurts

- Clients are "named" - given diagnosis, marked as having behaved a certain way at one point. Once "named", 15 years can go be and client is still "named" and treated the same way. We need to educate people that situations and individuals can change

- Professionals have a "compulsive labeling disorder" (CLD). They should continually check in with themselves regarding how they are thinking about the people they are supposed to be helping.

- Providers can't get past "borderline" stigma. The ER won't treat because you're "borderline". We can't help you because you're borderline. You can be suicidal and have overdosed, and you can't get help because you're "borderline".