



Retraumatization

*Powerpoint created by Ann Jennings PhD
www.TheAnnaInstitute.Org*

Handouts

- Retraumatization Powerpoint Slides
- Retraumatization Chart
- Article: On Being Invisible in the Mental Health System.

Learning Objectives

- Definition of “Retraumatization”
- How systems of care can retraumatize consumers with histories of trauma
- Impacts of retraumatization on both consumers and on staff
- Identify examples of retraumatization in own service settings

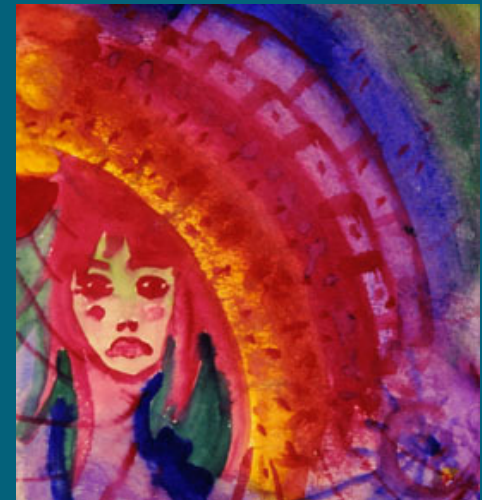
Two Basic Strategies for reducing retraumatization



- Adopt a Universal Assumption of Inclusion
- Above All Else, Do No Harm
“Primum non nocere”

What is “Retraumatization”?

- A situation, attitude, interaction, or environment that **replicates the events or dynamics of the original trauma** and triggers the overwhelming feelings and reactions associated with them
- Can be **obvious** - or not so obvious
- Is **usually unintentional**
- Is **always hurtful** - exacerbating the very symptoms that brought the person into services



Some examples from healthcare



- The Dental Office
- Emergency room at the local hospital
- The Family Doctor' Office
- Another Emergency Room example

What mental health consumers report:

- Consumers across the country report retraumatization in both institutional and community service settings.
- Psychiatric inpatient settings, where coercive practices replicate the dynamics of their original trauma, are generally experienced by consumers as the most frightening and dangerous environments (physically and emotionally)

Consumer quotes



- *“I was told that people were helping me be safe. Then they rushed me in a hallway and pinned me to the ground and lay on top of me and strapped me down and injected me against my will, and equated that over and over again with being safe. That’s the same lie I grew up with – ‘I am just doing this for your own good; you really like this.’” (LP, 2003)*
- *“I would rather die than go back to the hospital” (focus group member)*



“Somehow the idea that we are human just as they are human has to come across, or they will never treat us humanely.”

EC

South Carolina Studies on Re-traumatization “Sanctuary Trauma” and “Sanctuary Harm”

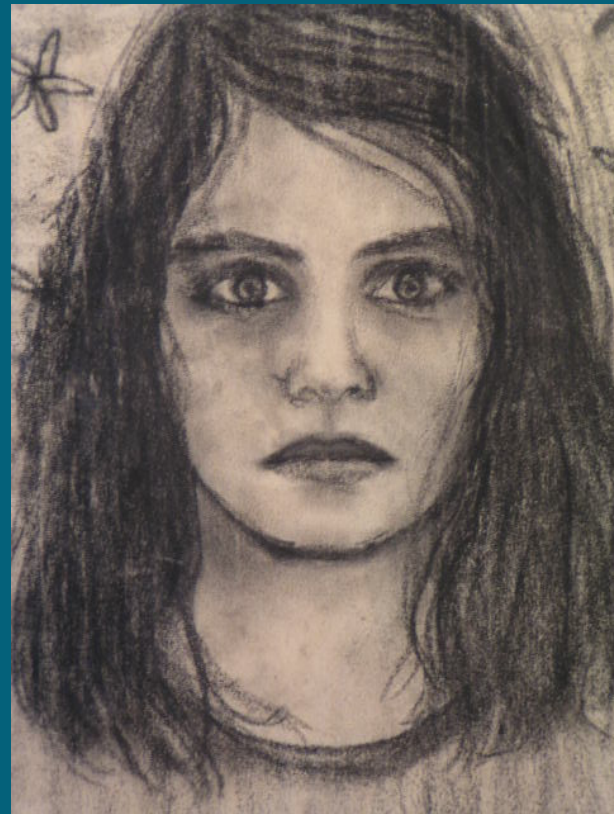
- First empirical investigations of trauma and re-traumatization within psychiatric settings
- 199 consumers self-reported and/or were interviewed. All diagnosed with serious mental illness and psychiatrically hospitalized at least once
- 87% - 99% had histories of multiple types of trauma exposures over the course of their lives.
- 47% had been physically assaulted and 33% sexually assaulted during childhood and/or as adults
- 27% met criteria for PTSD, though few (3%) were diagnosed as such.

Study Findings

- Nearly half (47%) experienced “**Sanctuary Trauma**” – events that met DSM IV criteria for extreme traumatic stressor leading to PTSD symptoms
- 91% experienced “**Sanctuary Harm**” – events involving highly insensitive, inappropriate, neglectful or abusive actions by (often a small minority of) staff, which produced or exacerbated symptoms from prior trauma.

Those especially vulnerable....

- Consumers with lifelong histories of multiple traumas
- Consumers with sexual abuse histories



Retraumatization from Sanctuary Trauma



- Being **physically assaulted** by staff or other patients (31%)
- Being **sexually assaulted** by staff or other patients (8.5%)
- **Witnessing** others being physically or sexually assaulted (63%)

Retraumatization from Sanctuary Harm

- Being placed in seclusion (60%)
- Being around other persons who were very disturbed, violent or frightening (56%)
- Being handcuffed and placed in a police car (65%)
- Being taken down or witnessing other people being taken down (47%)
- Being put in restraints (33%)
- Being strip searched





- Not having adequate privacy for bathing, dressing, or using toilet
- Having police or security guard outside seclusion room with no explanation
- Medication or commitment being used as a threat or punishment (20%)
- Being forced to take medication against one's will
- Use by staff of derogatory names toward the consumer or toward other patients – badgering or bullying them in some verbal way. (23%)

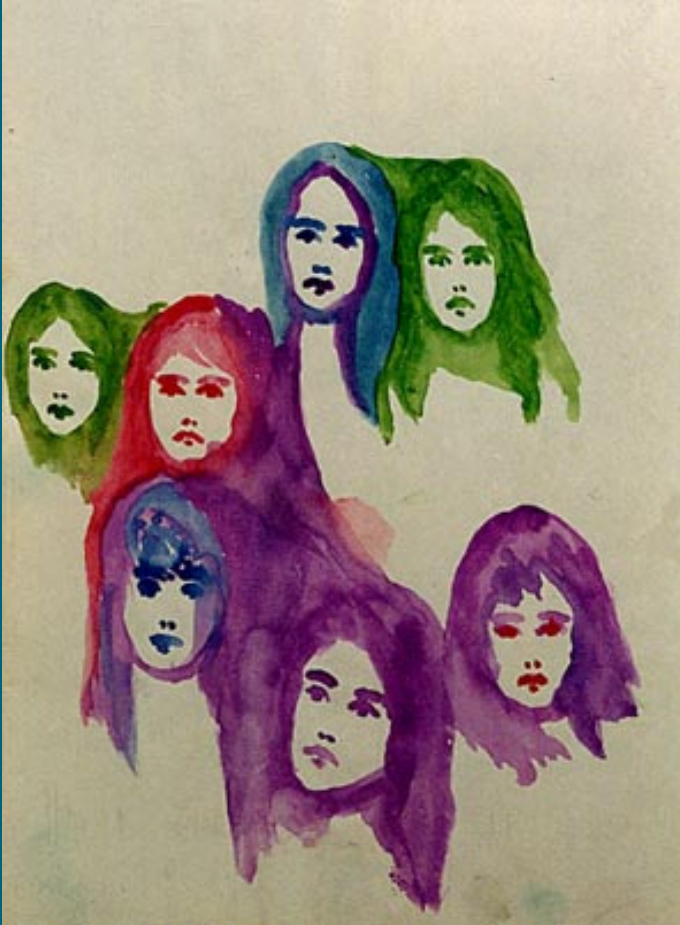
Impacts of Retraumatization on Consumers

- Decrease or loss of trust
- Higher rates of self-injury
- Significantly less willingness to engage in any treatment
- Increase of intrusive memories, nightmares and flashbacks
- Reexperiencing of symptoms and emotions from previous trauma – when extreme may take on delusional intensity
- Increase in chronicity of stress with greater risk for psychiatric morbidity, e.g. PTSD, chronic depression

- Higher distress rates – for longer periods of time after discharge
- Increased symptom relapse and re-hospitalization



Impacts on Staff



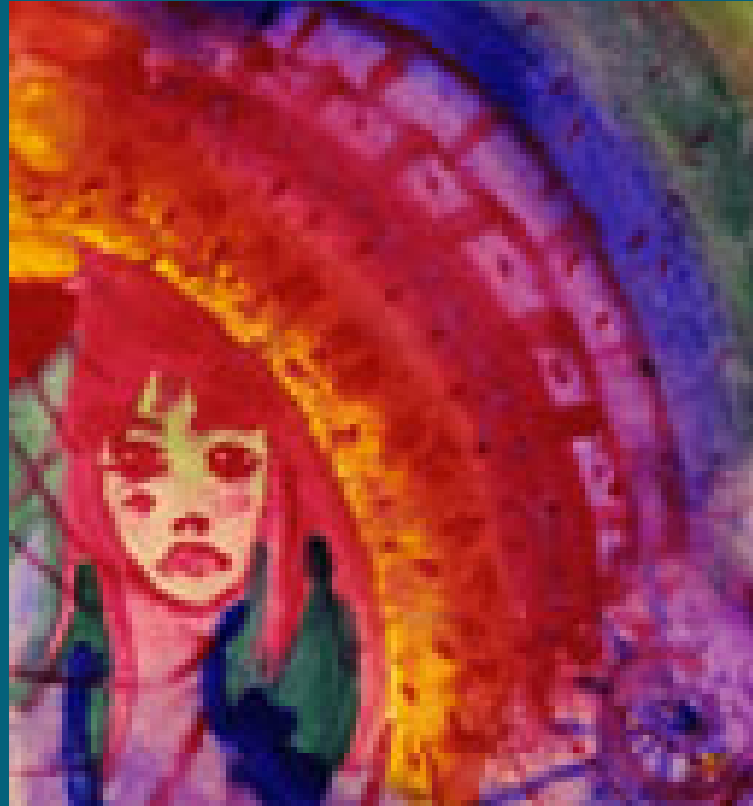
- Higher rates of staff assault and injury
- Need to accommodate longer hospital stays
- Significantly less treatment compliance
- High rates of consumer complaints
- Significantly more difficult to develop trust
- Increased level of stress and secondary trauma experienced by staff
- Higher rates of staff turnover and low morale
- Increased rate of staff absence and illnesses

Staff quote:

“One of the things that doesn’t get talked about very much is the trauma of the staff. We talk about the trauma paradigm for our clients or people in recovery. But not very often in my 20 years of work in the field of mental health have I heard much about what happens to us, the workers. And I think that’s an area where we need to do some work. I’ve seen some pretty traumatic things from when I first started 20 years ago. Some of those things still haunt me that I’ve seen.”

Female direct care staff
Jorgenson et al, 2006

Retraumatization Chart



Seeing the Patterns

Child's Experiences Replicated in Services

- Unseen & Unheard
- Trapped
- Sexually Violated
- Isolated
- Blamed & Shamed
- Controlled, Powerless
- Unprotected & Vulnerable
- Threatened
- No Privacy or Boundaries
- Objectified
- Crazy-making
- Betrayed

The information in the following case example is expressed repeatedly by consumers across the country who are diagnosed with a serious mental illness, have histories of severe childhood and ongoing trauma and have experienced both inpatient and community services

Childhood Trauma

Re-trauma in Service Systems

Unseen and Unheard

- Child's psychiatrist, pediatrician, mental health staff did not inquire about or see signs of sexual abuse. Child misdiagnosed. No treatment or misguided treatment.
- Child's attempts to communicate abuse were unheard, disbelieved, ignored, misunderstood. Silenced.
- Not screened or assessed for trauma. Trauma impacts not identified. Client misdiagnosed. Treatment misguided - sometimes harmful.
- Reports of past and current abuse ignored, disbelieved, discredited. Interpreted as delusional. Deemed inappropriate to talk about. Silenced.

Unseen and Unheard

- School psychologist evaluation suspected some kind of trauma. Did not inquire or discuss with child or parents
- Abuse occurred at pre-verbal age. No one saw the signs of sexual abuse expressed in child's artwork, play, hyperactivity, behaviors, body movements
- Only two psychologists saw trauma as core treatment issue. Their reports ignored by hospitals and community MH service providers
- One art therapist saw sexual abuse trauma in client's artwork. Her insights ignored. No one else linked the art, behaviors or symptoms to unaddressed childhood trauma.

Childhood Trauma

Re-trauma in Service Systems

Trapped

- Child was trapped by perpetrator, unable to escape his abuse
- Child dependent on family, caregivers.
- Client unable to escape abuse in locked facilities, residences.. Outpatient commitment feels like a trap. Vulnerable to involuntary commitment. Trapped by MH diagnosis. Mandated counseling
- Client kept dependent on system. Strengths, talents, competencies not nurtured. No education provided. No skill development to live and work in community. Cyclical nature of unaddressed trauma can affect ability to stay employed at any job.

Sexually Violated

- Abuser stripped child, pulled t-shirt over head to hide face.
- Child stripped by abuser/rapist to “with nothing on below”
- Child tied up, held down, arms and hands bound
- Client stripped of clothing when searched, secluded or restrained, often by or in presence of male attendants.
- To inject medication, patient’s pants pulled down, exposing buttocks and thighs, often by male attendants
- “Take-down”, “restraint” – arms and legs shackled to bed

Sexually Violated

- Abuser blindfolded child with her t-shirt pulled over her head
- Abuser forced child's legs apart
- Abuser was "examining and putting things in me" (Abuse included torture and rape)
- Cloth thrown over patient's face if she spat or screamed while strapped down
- Forced four-point restraints in spread-eagle position
- Medication injected into body against patient's will.

Childhood Trauma

Re-trauma in Service Systems

Isolated

- Child was taken by abuser to places hidden from others
- Child isolated in her experience, “Why just me?” Belief she alone was singled out. Is different from all others. Child thought she was only one in the world to be sexually violated
- Separated from community in locked facilities. Forced, often by male attendants, into seclusion room. In community, isolated from others by living conditions, effects of meds, stigma
- No inquiry or discussion with clients about their childhood or adult trauma experiences. No one talks openly or educates clients about prevalence and impacts of trauma. Client is left isolated and alone with the experience, just as a child.

Blamed and Shamed

- Child was left with a feeling of being “bad” and thought of herself as a “bad seed”, defective in a fundamental way
- Child acting out because of her trauma, became the “difficult to handle” child
- Clients stigmatized as deficient, mentally ill, defective. Their brains are thought of as diseased. Attitudes, practices and ugly environments convey low regard for clients, tear down self-worth
- Clients with trauma-based behaviors are often seen as “noncompliant,” “treatment-resistant,” manipulative, attention seeking, difficult-to-handle.

Blamed and Shamed

- Child was blamed, spanked, confined to her room – for her anger, screams, cries.
- Cause of child's "bad" or unusual behaviors placed within child. Seen as due to something inherently wrong with the child. Child blamed for behaviors. Impact of environmental factors (e.g. trauma) not recognized or considered.
- Clients rage, terror, screams, result in medication, restraint, involuntary commitment, loss of privileges, seclusion, expulsion from services
- Cause of client's emotions and behaviors placed within the person of the client and his/her inherent defectiveness or "mental illness". Impact of environmental factors (e.g. childhood traumas) not recognized or given import.

Childhood Trauma

Re-trauma in Service Systems

Controlled/Powerless

- Perpetrator had absolute power/control over child
- Pleas to stop violation were ignored. Perpetrator ignored child's cries of pain and continued to hurt her
- Child's expressions of intense feelings, especially anger directed at parents, were often punished and suppressed.
- Institutional staff and psychiatry have great power/control over patients. Community providers control referrals, treatments, services, entitlements. Can initiate involuntary commitment. Can force medication.
- Pleas and cries to stop abusive treatment, restraint, seclusion, overmedication – commonly ignored
- Intense feelings, especially anger at staff, suppressed, not allowed expression, punished by coercion or expulsion

Childhood Trauma

Re-trauma in Service Systems

Unprotected/Vulnerable to Harm

- Child defenseless against perpetrator abuse. Attempts to tell were unheard or ignored. There was no safe place for child, even in her own home or room.
- Secrecy: Those who knew of abuse did not tell. Priority was to protect self, family relationships, reputations.
- Child, once sexually violated, was vulnerable to other sexual abusers
- As patient often defenseless against staff or patient abuse. Reports deemed not credible. Policies fail to effectively protect clients. Can be difficult to dismiss abusive staff.
- Secretiveness replicates family's. Priority is to protect institution, jobs, reputations. Patient reports of abuse not reported up line.
- People with SMI and unaddressed trauma histories significantly more vulnerable to rape, physical violence - in facilities and in community

Childhood Trauma

Re-trauma in Service Systems

Threatened

- As a child, constant threat of being sexually abused . Threat pervaded child's life
- As mental patient, constant threat of being stripped, thrown into seclusion, restrained, overmedicated, loss of privilege.
- In community, threat of involuntary commitment for behaviors to cope with trauma such as self injury, suicidality, acting out of dissociation, etc.
- Perpetrator retaliation if abuse revealed
- Reporting of staff abuse by client is retaliated against

No Privacy/Boundaries

- Child's privacy rights and emotional and physical boundaries were grossly violated by perpetrator. Body, room and home were entered against her will. She felt exposed and vulnerable to harm at any time
- Appropriate right to privacy is often violated in psychiatric hospital setting, residential programs, prisons, jails.
- Touching and body contact without permission often occurs

Childhood Trauma

Re-trauma in Service Systems

Objectified

- Child was viewed and treated by perpetrator solely as an object for his use
- Child was not seen or experienced as whole person capable of experiencing hurt
- Perpetrator was not capable of feeling empathy for child and what child was experiencing and feeling as a result of his abuse of her
- Clients objectified. Viewed as diagnosis or symptom: a “borderline”, a “schizophrenic”, a “depressive”, a bulimic, a cutter – to be managed or treated.
- Clients often seen only in their role as “sick” individuals - with symptoms to be managed. Clients personal history and lived experiences of trauma not viewed as core to their distress.
- Providers ability to be empathic limited by narrow view of client which excludes client’s history of violence and abuse and the pain they feel as a result.

Childhood Trauma

Re-trauma in Service Systems

Crazy Making

- Appropriate anger at sexual abuse seen as something wrong with child. Abuse continued, unaddressed.
- Child's appropriate fear of threat of being abused was misunderstood and considered unreasonable.
- Sexual abuse of child unseen or silenced. Message: "You did not experience what you experienced".
- Appropriate anger at hurtful institutional and community mental health practices judged pathological. Practices were continued.
- Appropriate fear of abusive and threatening practices and behaviors, labeled "paranoid" by those producing the fear.
- Denial of sexual abuse and its impacts. Message to client, "You did not experience what you experienced".

Childhood Trauma

Re-trauma in Service Systems

Betrayed

- Child was violated by trusted caretakers and relative
- Disciplinary interventions were “for her own good”.
- Child’s family relationships fragmented by separation, divorce, abandonment, substance abuse, etc. Connections broken. Child learns not to trust or depend on others as trustworthy.
- Patients and clients trust was violated by helping professionals and psychiatric settings
- Hurtful or unwanted interventions presented as for the good of the patient or the client
- Relationships of trust arbitrarily disrupted based on needs of system, shift changes, staff turnover, limits of insurance coverage. No continuity of care or caregiver. Ability to trust is further compromised.



Antidotes to Retraumatization

Safety

Trustworthiness

Choice

Collaboration

Empowerment