Clinical Practice

Victimization and Trauma

by Holly Ramsey-Klawsnik, Ph.D.*

Individuals who have been victimized can develop a broad range of psychosocial responses. Many factors influence the response a victim may experience, including precrisis personality and functioning and the nature and extent of the victimization. Severe trauma, as well as long-term trauma, can result in a "shutting down" response. Personality, affect, will, confidence, self-esteem, spontaneity all may "shut down" somewhat or become "flattened." Fear, passivity, depression, lack of confidence, and pessimism can invade the severely victimized individual. This is particularly likely when trauma is recurrent.

Child Abuse, Maternal Neglect

Many years ago, I evaluated a young child. Three-and-a-half-year-old Katie had been removed from her mother due to sadistic, multifaceted abuse by the mother's boyfriend and maternal neglect. The court that had placed the child in state custody referred her to me for a clinical evaluation. This beautiful little child was brought to my office by her foster mother and I was expected to conduct the evaluation over the course of several weeks. My task was then to write a detailed report for the court on the child's psychosocial functioning. I needed to interview her and collect information about her abuse experiences and the aftermath. The court needed this information to inform further decision-making about her custody. At that time, I frequently evaluated children and was accustomed to interviewing traumatized children and using play therapy techniques to help build rapport, collect information, and assess functioning. The behavior of this child was striking: She did not speak, she did not play, she simply stared at me with terror in her eyes for two entire 90-minute sessions. This, despite the fact that she was seen in a well-equipped child play therapy room complete with dollhouse and dolls, toy stove and pots and pans, numerous furry animal puppets, art supplies, and other child-appealing materials. Most children loved the play therapy room and enjoyed the child-friendly atmosphere and the undivided attention of an adult willing to play. Katie would not play or speak, so I played and gently spoke to her about the toys and the play. I cooked pretend hamburgers on the toy stove and baked a pretend cake. When offered a piece of the confection, Katie continued to simply stare at me with big eyes filled with fear.

The foster mother reported that Katie experienced severe nightmares and bedwetting, never cried, did not play, and kept largely to herself. This childcare expert noticed that during trips to the supermarket Katie became particularly frightened when men approached the grocery cart in which she sat. She evidenced her fear not by crying, but simply by clinging to her foster mother and making her body rigid.

As I prepared for my third meeting with Katie, I racked my brain for techniques to calm her fears, help her feel safe with me, and encourage her to speak and play. I felt desperate because the court was relying upon me to extract needed information from the child for an upcoming hearing. My allotted evaluation time would soon run out.

Fortuitous Accident. As Katie entered my office for her third session, a fortuitous accident occurred. Our cat, Butterfly, who was not normally allowed in the office, happened to be there that day. While he was not supposed to be in the entrance way and waiting room, someone had left the wrong door open and he darted by as Katie stepped in the door. Katie whispered her first words to me, "Can I please see your kitty cat?"

Inside I jumped for joy! She spoke! She can talk! I knew enough to contain my excitement on the outside and spoke slowly and gently to Katie, "Yes, I think Butterfly can come into the play room." Butterfly, a skittish cat by nature, was particularly leery around young children. In the play therapy room, he promptly hid deep under a table. I gently coached him out while explaining to my young client that Butterfly was frightened. I told Katie that he was afraid he would be hurt, but "We have rules here. No one is allowed to hurt cats and no one is allowed to hurt children. Animals and children are safe here. We will be very gentle with Butterfly so he will not be afraid." Katie made eye contact with me for the first time and nodded her little head. She gently stroked Butterfly and softly offered to make me a hamburger and a cake on the toy stove.

Therapy Cat. Over time, details of Katie's severe abuse slowly unfolded. The court extended the evaluation period and then appointed me to do ongoing child therapy. Each week, Katie would step into my office and quietly ask, "Can Butterfly come?" He became a therapy cat and was expert at his job. Many, many weeks later Katie, while playing house with the dolls, had the man doll hold the head of the little girl under the water in the bathtub. Katie coughed and coughed and told me that she used to think she was going to die when her mother's boyfriend did this to her.

Elder Abuse

Following years of work with victimized children and the professionals serving them, I was "pressed into service" by the Massachusetts Elder Protective Services Program to work with elderly victims and PS staff. My practice expanded to serve people who were elderly and adults with disabilities. Long after working with Katie, I met Mrs. D., the 62-year-old subject of an abuse report. My task was to conduct a clinical evaluation, the results of which would inform the investigation outcome. Referral information indicated that Mrs. D. was electively mute, clinically depressed,

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and the victim of ongoing domestic violence by her husband of 40 years. I met with Mrs. D. at her adult day program to avoid asking her about an allegedly abusive marriage in the presence of her husband. I found this very thin and withdrawn woman silent and immobile in a chair apart from others at the program. During an attempted interview, she did not speak; she merely nodded and shook her head. She denied any problem at home or with her husband. She did give me permission to continue her evaluation and to speak with her son, Roberto, who had made the abuse report.

Son's Abuse Report. Roberto related with upset a history of severe, multifaceted abuse under the coercive control of Mr. D. He reported that throughout his childhood, he repeatedly observed his mother physically and sexually assaulted by his father. During the attacks, Roberto sometimes ran to his mother and attempted to protect her. He was inevitably beaten as a result. Other times, he hid under his bed and covered his ears to block his mother's screams. His punishment was severe pangs of guilt for days following these episodes.

Throughout her marriage, Mrs. D. had not been allowed to drive, manage money, hold a job, or socialize. Roberto spoke about his father's "strict rules" and frequent "spankings" with belts for any perceived violation of his harsh rules and expectations. Roberto explained that his mother worked hard cooking, walking to the store to buy groceries, cleaning, doing laundry, and trying to anticipate the moods and demands of his father. She often hid childhood problems such as poor report cards from Mr. D. in order to protect her boys from beatings.

There were now five adult sons in the family; three had moved out of the area and maintained no contact with their parents. Roberto remained near his family, but struggled with serious mental illness and was unable to visit his parents due to intense anxiety experienced in the presence of his father. One son remained in the family home, at the age of 40 unable to work, move out, or create an independent life. Roberto had filed the report under investigation after learning from his brother of a recent episode of marital rape.

Collateral Data. Roberto gave me permission to share his statements with his mother. He expressed grave concern for her and wanted her to receive intervention services. He was gaining strength from his mental health treatment. He found that he had improved considerably after moving out of the family home at age 28 and discontinuing contact with his father. The unfortunate consequence of this was that he was now unable to see his mother. He gave me a message for her as we concluded our meeting, "Please tell my mother that I love her and miss her. Please tell her that I want her to be safe."

I continued my evaluation of Mrs. D. Collateral data indicated that she had experienced a mental health breakdown during menopause, resulting in hospitalization for clinical depression. This occurred just after her youngest child, Roberto, turned 18. For the previous 14 years, Mrs. D. had experienced repeated mental health hospitalizations, many psychotropic medications, and even recurrent ECT treatments. She remained deeply depressed, electively mute, incapable of normal daily activity. Two prior reports alleging abuse of Mrs. D. by her husband had been quickly and superficially investigated. Mrs. D. had not revealed any abuse and the reports were unsubstantiated.

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Son's Pivotal Involvement. Upon meeting with Mrs. D. for my second interview (also at her day program) she remained silent and passive. Giving her Roberto's message brought her first eye contact with me and even a small display of positive affect. She gave me permission to interview her, and answered my questions nonverbally by nodding for yes and shaking her head slightly for no. The fact that Roberto had given me an extensive family history and consent to discuss his statements with his mother was pivotal in the evaluation. I carefully shared some of what Roberto had disclosed, and asked Mrs. D. if her son had helped me to understand accurately what had occurred during his childhood. My client nodded affirmation. Through a slow and laborious process of several additional meetings, Mrs. D. confirmed a long history of domestic violence including marital rape, physical abuse by her husband, and childhood abuse of her boys. She indicated that physical abuse no longer occurred, but sexual abuse was still a problem.

Mrs. D. was offered a broad range of intervention services, including legal assistance, help in arranging a separation or divorce, in-home help, and extended time at her day program. She expressed fear at the suggestion of a divorce, separation, or legal intervention of any type. She did agree to meet regularly with a female therapist trained and experienced in counseling domestic violence victims. This service was arranged at her day program, thereby eliminating the opportunity for Mr. D. to sabotage the counseling.

Aftermath of Trauma

Over many years of evaluating and treating people who have experienced severe and long-term victimization, I have been struck by the similarity in the aftermath of trauma among victims. The young, the old, people with disabilities, those without disabilities—all experience profound psychosocial consequences of endured human cruelty. It was striking to observe the "shutting down" process of constriction of affect, speech, personality, and normal behavior in victims as different as Katie and Mrs. D. Working with them and others has taught me a profound lesson: Severely traumatized individuals move very slowly. They tend to disclose their abuse slowly over time as trust is built with a reliable and safe person. They are open to life-changes that might make them safer typically only in small steps. This is perhaps to be expected given the abuse sequelae of pessimism, anxiety, fear, and lack of confidence. I have also learned that a victim's fear of the offender often generalizes to others, including would-be helpers.

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Must Move Quickly

It is an unfortunate irony that professionals working with and for abuse victims need to move quickly, when those we want to help can only move slowly. Regardless of role—APS investigator, police officer, long-term care surveyor, Sexual Assault Nurse Examiner, victim witness advocate, prosecutor, court-appointed evaluator—we have limited time and service capacity. We want victims to tell us what happened, meet standards that we set for determining credibility, accept our intervention, and do it all quickly—on our timetable. This is an inherent problem in the system our society has created to deal with interpersonal violence. Whatever we can each do in our own role to slow our process to that which the victim can tolerate—rather than expect the victim to accommodate to our timetable—will not only better serve the individual victim, but also help to create a more just and safe society.

Postscript

During Katie's two-year therapy her mother married her boyfriend, despite his brutalization of the child and his arrest for organized drug crimes. The mother's parental rights were terminated because she steadfastly refused to believe, protect, or nurture her child. Katie was subsequently raised by two kind and responsible adults. Mrs. D. came to trust and speak with her counselor and eventually accepted additional services designed to minimize her dependence upon and vulnerability to her husband. Visits were arranged between Mrs. D. and Roberto at the day program. ■