

Cycles of abuse nurtured by concealment: a clinical report

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Abstract

At present, health care staff do not seem to have sufficient knowledge about their patients' abusive experiences. The aim of the present study is to analyze and discuss what the implications might be for the encounter between patients and health care professionals, when experiences of abuse are concealed. The methodology of this article is varied: a personal narrative, medical records, sociological theoretical literature and empirical evidence. From the narrative we learn that concealment of abuse was devastating for the patient. She was "treated" in vain as a correct diagnosis was not made, while abuse by her father continued. Health care staff also violated her, which she told her therapist, but her protests were not acknowledged. Ten years of treatment thus made her even more sick. This case story focuses on the mechanisms which nurture concealment of a patient's history of abuse, such as structural and symbolic violence. We also suggest ways to break "cycles of abuse". Help the patient to stop concealing also means that she/he leaves a victim role, gets in charge of the situation and takes a first step towards empowerment. In this way, health care settings can become enabling and empowering environments.

Keywords: Abuse in health care, structural violence, symbolic violence, revictimization, emotional abuse, physical abuse, sexual abuse

Introduction

'From a patient's perspective 10 years is a long time. Then I think most of all on the unnecessary suffering I had to endure. From the society's perspective it was a terrible waste of resources, as no correct diagnosis was reached and only inappropriate treatment was offered' (Annette (A), Anonymised).

Empirical studies have shown that Nordic gynecological patients who had experienced abuse did not tell their gynecologists about it, neither were they asked by the gynecologist [1]. There is no reason to assume that patients with a background of abuse are more prone to communicate abusive experiences in other health care settings. In fact, patients with an unknown story of abuse are by far the most difficult to treat well in health care; and in a way that they are not revictimized [2].

The aim of the present study was to analyze and discuss what the implications might be for the encounter between patients and health care professionals, when abuse is concealed.

The methodology of this article is varied: a personal narrative, medical records (Box 1), sociological theories, and empirical evidence. Moving epistemologically between two paradigms gives different perspectives, which we hope will enrich the reader's knowledge.

The patient's narrative

'During the last 10 years I was treated for anorexia, without getting any help at all for my real problem. The sexual abuse continued during the period I was in therapy for my eating disorder; once a month when I was on leave from the ward, and several times a week when I was treated as an out-ward patient. This went on until I married. Then I was only abused occasionally, when e.g. my father was in our house and my husband went out for a short while. The day before my marriage my father abused me by forcing me to oral, vaginal and rectal sex'.

'Only once during all those years, my therapist asked me if I had ever been sexually abused. My answer was "no". Why didn't I tell her when I suffered so much from

A was born in 1966.

From November 1992 until October 2002 A was treated for anorexia-bulimia as an inward (2–3 years) or outward psychiatric patient. She made several suicide attempts, had an unbearable anxiety, and now and then managed to gain weight only to soon lose it again. During all this period she was in therapy. A told the therapist that her father had abused her physically and emotionally since she was a small child, and was terrorizing her on the telephone all since the therapy started. Once the therapist asked if A had been abused sexually which she denied. In June 1997 A attempted suicide, and almost succeeded.

In November 1998 A got the diagnosis “Borderline Personality Disorder”, which she could not accept, as she felt that she did not fit into the diagnostic criteria. A was later treated with dialectic behavior therapy.

January 2002–May 2002 A was investigated for sexual problems at another clinic. She got several questions about the dominance her father exerted over her and about experiences of sexual abuse (SA), but dared not to tell the truth. Ten years of telephone terror of her father was, however, brought to an end.

In October 2002 A told her therapist, the sexologist and her husband for the first time that she had been sexually abused since she was 4 years old. The abuse stopped. Further investigations revealed that she suffered from Posttraumatic Stress Disorder since childhood [10]. She did not fulfil any of the criteria of Borderline Personality Disorder [11].

it? I wished I had been able to, but I dared not. Besides I did not trust her. I knew very well what would happen if I did tell anyone: my father had repeatedly told me that he then would chop me into pieces and throw the parts into the wood stove, which he had done with my pet cat. I also carried guilt and shame. Therefore I kept it a secret. The only thing I dared to talk about was that I had been emotionally and physically abused during all my life, and that my father continued to terrorise me by telephone even now. She also knew that I went home and slept there when I was on leave from the ward. How could she imagine that I chose for that?

‘A keen and skilled therapist would certainly have helped her patient to put an end to her father’s terror, but I was never offered such help. Thus both the terrorising on telephone, the abuses, and the therapy continued. A psychotherapist with experience of treating patients with eating disorders should moreover know that many of them have been victims of abuse, and should not be content with raising the question only once during ten years. Maybe I had answered “no” the second and third time she had asked, but I would certainly not have done so when the question had been posed in a good way for the fifth or sixth time. It is a special competence to be able to ask the right questions to your patient. If you ask straight and open questions you may learn much compared to if you ask closed questions when the patient can only answer “yes” or “no”, and the questions do not open up for further discussion. It was an open question that finally made me talk. I can still remember it: “it seems as if your father has much power over you. How can that be?” As a therapist you can never assume that the patient will spontaneously tell you about her abusive history, even though the memories weigh heavily on her. It will always remain the therapist’s task to help the patient dare to talk about it’.

‘I was treated both ambulant and as an intake patient for my anorexia without any success. As soon as I had gained some weight I quickly lost it again, and so the treatment went on year after year. I wonder if my therapist ever asked herself: “why does that happen again and again?” Possible explanations might have been that

the anorexia was resistant to therapy, or that there was something else behind it all and the anorexia only a symptom of a deeper problem. Instead the therapist kept explaining to me that I had stopped gaining weight too early’.

‘For my eating disorder I had a directive therapy aimed at training eating. When I started, I expressed my fear that I would start binge eating instead of starving. Things turned out exactly as I had feared and I started binge eating several days a week and got no help. My confidence in her was betrayed. Did she really think that I would stop binge eating if she took my credit card and kept it in a drawer in her desk? Probably she did, but I was clever enough to get money directly from the bank. I wish that she had understood that the reason why I binge ate was because I had unbearable anxiety and that the binge eating gave me a short release from that anxiety. I wish that she had helped me handling the anxiety in another way. All my binge eating made me feel even guiltier and increased also the shame I felt. To be honest, I had been binge eating since I was ten. . .’

‘Then once more I became a patient at the ward, to stop binge eating and to gain weight. I did stop binge eating but only succeeded to reach 48 kg. In spite of that I was kept on the ward for 1 1/2 year, like an old piece of furniture, which nobody knows what to use it for’.

‘One thing was certain with being admitted to the ward: there my father could not abuse me sexually or terrorise me over the telephone. But I could not imagine that I would be abused even at the hospital by the male staff at the ward. It took me a long time before I dared to tell my therapist. Her answer: “that’s how they are” shocked me. Thus she meant that it was all right that they came to sit at my bed and caressed my thighs, and that they approached me from behind, embraced me and whispered things in my ear. They came so close to me that I could feel that their bodies touched mine, and that their lips touched my ear. No wonder that I could not fall asleep during night, as I feared that the male nurse would enter my room. At the hospital I was convinced that it was impossible to trust anybody. I wished that my therapist had acted to stop the abuse. That was the only reason why

I had told her. But she let it go on. So I could neither trust the staff at the ward, nor my therapist’.

‘As the therapy went on I became sicker and sicker. I started to mutilate myself with a knife to get some relief for my anxiety. I told my therapist why I did so; by she never tried to find out what my anxiety was about. After one and a half year I decided to leave the ward on my own responsibility. It was one of the best things I have done in my life’.

‘I went on with my therapy, initially once a week and later more occasionally. After seven years of therapy, I suddenly got the diagnosis borderline personality disorder. I felt that the diagnosis made me sicker than I was. I did not dare to protest, although I felt that the diagnosis was wrong’.

Discussion

This case story focuses the mechanisms which nurture concealment of a patient’s narrative and suggests ways to break a vicious cycle of abuse.

It is widely acknowledged that we need to privilege the voices and words of victims/survivors, and learn from their expertise. As Arthur Frank argues: “the ill person who turns illness into story transforms fate into experience”. “. . . seriously ill people . . . need to become storytellers in order to recover the voices that illness and its treatment often take away” (p. xii) [3].

Furthermore, to become a storyteller is more than promoting the healing processes. To put an end to concealment is also to stop being a victim, get in charge of the situation and take a first step towards empowerment.

Mishler suggests, “Through narratives people may be moved beyond the text to the possibilities of action. This is, to be empowered is not only to speak in one’s own voice and to tell one’s own story, but to apply the understanding arrived at to action in accord with one’s own interest” (p. 119) [4].

Cycles of abuse nurtured by concealment (Figure 1)

Why did not A mention her suffering to the therapist earlier? In the narrative A herself acknowledges this and says: “Why didn’t I tell her when I suffered so much from it? I wished I had been able to, but I dared not to. I carried guilt and shame, and besides I did not trust her”. Guilt and shame and the fear of being blamed are important for understanding why abuse remains hidden or undisclosed (Figure 1). And concealment nurtures anxiety, guilt and shame; increasing the need to conceal. As Glenn Roberts puts it “the issue is that. . . . The story cannot be spoken. The individual believes his experience to be so unacceptable to others, or risk such negative reactions, that they are held with fear and shame, concealed and hidden” (p. 19) [5]. Roberts also

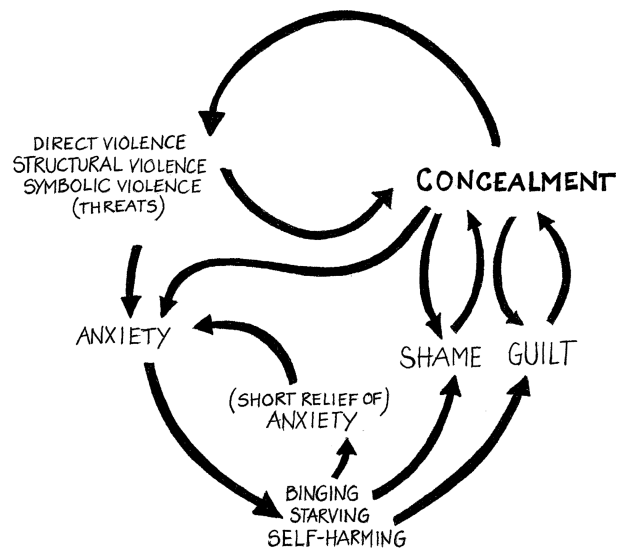


Figure 1. Cycles of abuse nurtured by concealment.

argues that “silencing” is a part of all experiences that are abusive and traumatizing. “The risk of saying them aloud seems too great, they are believed to be untellable for fear of the consequences. . .” (p. 19) [5]. Many victims have also been threatened by the perpetrator of negative consequences, if they disclose the abuse. Thus intimidation is an important part of the abuse and a means of exerting power and control over the victim. In the narrative A tells us that her father threatened her not to disclose the acts of abuse – otherwise he would “chop her into pieces and throw the parts into the wood stove”. Under these circumstances, individuals lock themselves up in a cocoon – they feel forced to hide the abuse and yet feel guilty for doing so. The anxiety from the sexual abuse led A to binge eat, starve or mutilate herself. Though this provided temporary relief, it only heightened her anxiety on a long-term basis, aggravating the shame and guilt that A experienced from her father’s abuse (Figure 1). As A says “I wish she (the therapist) had understood that the reason why I binge ate was because I had unbearable anxiety. . . all my binge eating made me feel even more guilty and increased also the shame I felt”. It is well known that children who are victims of abuse accept the guilt and shame the perpetrator tries to project on them and make it all “their own fault”. Thereby they become an accessory and their shame and guilt and the need to conceal increase even more. A was subjected to emotional abuse and sexual abuse since she was four years old. It is quite understandable that she was unable to disclose her abuse or seek professional help in a straightforward way. A did test telling, though, by all those means that she was able to use, e.g. by telling about ongoing telephone terror or self-harming behavior. But as

these signs were not acknowledged, she found it of no use to go further. Supporting A to tell her story i.e. to stop the concealment is also a key to assisting the disclosure of the ongoing cycles of abuse where each part nurtures the existence of the others.

Theory

The narrative reflects the intersections between structural, symbolic and direct violence (Box 2). We choose to discuss all three forms of violence, since we argue that they are interlinked and complex. To understand direct violence we also need to understand its relationship with structural and symbolic violence.

Structural violence

Structural violence refers to the violence and violation that arise from the unequal and exploitative relationships, which social structures sustain and nurture. It is evident when the potential development of an individual or group is held back by the conditions of a specific relationship [6]. Structural violence is a form of social injustice and leads to social suffering while the absence of structural violence is social justice [6]. There is a close relationship between structural and direct violence e.g. direct violence is assisted by social injustice and social injustice is perpetuated by direct violence.

In relation to structural violence, health care staff, who have medical knowledge, status and power, acquire legitimacy (facilitated by inequalities in the social structures) to use a certain language and vocabulary that can be disabling for patients. In our case story, structural violence disempowered the patient by firstly a wrong diagnosis, and secondly an inability to understand the patient's signals, and finally by silencing the vulnerable. The last idea is most important because it creates contexts where the patients do not speak but are spoken to. Also the fact that patients often keep silent about their suffering, allows these structures to reproduce themselves. Thus inequalities are normalized in medical interactions, which reproduce structures of domination and hierarchy. Structural violence creates an environment which enables symbolic and direct violence to

nurture (as defined in Box 2). This results in cycles of violence, which are difficult to disrupt (Figure 1).

Symbolic violence

Pierre Bourdieu defines symbolic violence as “a gentle violence, imperceptible and invisible even to its victims, exerted for the most part through the purely symbolic channels of communication and cognition (more precisely misrecognition). Moreover, when language and speech is not only a medium of communication but reflects the embedded power or a medium through which power is exercised, it constitutes symbolic violence” [7]. Symbolic violence is the exercise of domination through communication in such a way that the domination is misrecognized as such, and thereby recognized as legitimate. An example from the narrative: A tells her therapist about the abuse she is submitted to at the psychiatric ward. The therapist's answer: “that's how they are” is an example of symbolic violence which made the abuse appear as normal and routinized.

Symbolic violence can go unnoticed because it is a part of everyday life – it is “ordinary” – subtle and disguised, but nonetheless effective in its impact, and seen as legitimate.

From A's narrative we learn that she lived in a climate of fear, and was subjected to symbolic violence, through the daily life threats, the continuous fear of new direct events of violence, and her father's daily terrorizing behavior over the phone. While not explicitly using the category of symbolic violence, Liz Kelly (1988), with reference to sexual abuse, suggests that “whilst flashing and obscene phone calls are in and of themselves violating, both rely in part for their impact on the explicit or implicit threat of further assault. The link is between the generalised fear that most women experience and forms of visual and verbal violence that accentuate it” (p. 97) [8]. For many victims there is a “durable effect” exerted through the dominant social order [7: p. 172], which habituates them to perceive certain situations as threatening and to respond with fear. In our case study, the father created a climate of fear which pre-disposed A not to disclose the abuse but to blame herself for what was happening.

Box 2. Definitions.

Structural Violence: violence that is located in social and systemic structures. Structural violence is not physical abuse but inequalities inherent in social structures (class, gender and bureaucracy) that make some more vulnerable and disadvantaged than others. Inequalities located in social structures could create conditions that nurture forms of abuse. Structural violence is invisible and silent.

Symbolic Violence: a subtle but effective exercise of power which is embedded in terms, language and symbol systems. Symbolic violence serves to conceal the use of symbolic power. Symbolic power is reproduced by language and communication which often constitutes symbolic violence. One example is threats.

Direct Violence: violence perpetuated by human beings against other forms of life and nature e.g. physical and sexual abuse.

Symbolic violence is perhaps the most difficult to pin down, because it is enacted through the discursive plane, that is through language. Though it may not cause physical harm to e.g. patients, it disempowers them by undermining their integrity as individuals. Loosing integrity and self-esteem leads to social suffering. Both structural violence and symbolic violence may not be necessarily tangible, but their operations become evident through their “effect” on people.

Empirical evidence

Female patients who have experienced childhood abuse run a greater risk of experiencing abuse in health care (AHC) as adults than female patients without such a background [9]. Is it because they are more vulnerable towards the structural/symbolic violence within health care?

At present, health care staff does not seem to learn about their patients’ abusive experiences. In a Nordic sample of gynecology patients ($n = 3641$) almost none of the women with a background of abuse had told their gynecologist about these experiences at their latest consultation [1].

The undisclosed abuse may not only lead to a wrong diagnosis, as in this case story, but also implies a risk of maltreatment and AHC. The fact that A’s history of ongoing abuse is not disclosed, is the probable reason why the correct diagnosis Posttraumatic Stress Disorder was not recognized. In this case study, the diagnosis Borderline Personality Disorder was instead added to A’s diagnosis of anorexia-bulimia, which A perceived as another violation.

When a patient does not get a correct diagnosis, it is probable that she/he goes on seeking help in health care. She/he will then be exposed to more meetings with health care staff, increasing the risk of being revictimised. Another risk is that she/he gets a diagnosis of somatizing disorder or “functional complaints” and is more or less neglected by a staff, who feels helpless as to how to handle such problems. This may also be perceived as a personal violation.

Moving forward – what can be learnt?

Patients with a background of abuse often first tell that part of their story which is the easiest to disclose. This is a sort of “testing strategy”: if the staff manages the test well – i.e. listens – more parts of the story may be told later. Health care staff should be aware of this phenomenon, and keep in mind that even when they have got a “story”, they may not have heard of the worst and most shameful parts. A told her therapist about physical and emotional abuse, which might have been the least difficult parts to disclose, while the most shameful parts were kept a secret. This dilemma may be handled by repeating questions

about abuse, patiently just wait for a continued story and acting towards the patient as if she/he has suffered from the most traumatic abuse you could ever imagine. If the patient’s story is half told it is also half concealed and “cycles of abuse” remain.

The staff should make it clear by all possible sources of communication that they know about the problem of abuse and that they move with the possibility that abuse could be involved in the actual problem. One example is given by A, when she narrates that she still remembers the question that made her talk: “It seems as if your father has much power over you. How can that be?” These patients also scan the sphere in the meeting for markers if the staff is trustworthy and brave enough to dare to listen. They do not only listen to verbal communication, but use all their senses in this scanning process, which is of vital importance for them since they have learnt that disclosure of abuse may be fatal. Victims of abuse need help and support to be able to stop concealing which is a main key to break the “cycles of abuse”.

Conclusion

Helping a patient to stop concealing her story of abuse is a main key to break “cycles of abuse”.

This case story shows how important it is to incorporate the patients’ “voice”: to create an environment where they can speak, to listen to the silence and understand that it may conceal a narrative, and to ask different and open questions about abusive experiences. In this way, health care settings can become enabling and empowering environments.

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Current knowledge on this subject

Several studies have shown that patients seldom spontaneously talk about experiences of abuse, and health care staff rarely asks such questions. At present, health care staff do not seem to have sufficient knowledge about their patients' abusive experiences.

What this study adds

This study analyses and discusses what the implications might be for the encounter between patients and health care professionals, when experiences of abuse are concealed. Moreover, a theoretical basis is presented for the understanding of the mechanisms which nurture concealment of a patient's narrative and suggests ways to break a vicious circle of abuse.