

SEXUAL EXPLOITATION OF A WOMAN WITH SCHIZOPHRENIA

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ABSTRACT

This case illustrates the sexual exploitation of women with schizophrenia. The patient was a woman with severe mental illness who was alienated from her family and who, between her many hospital admissions, lived essentially on the street. Her personal vulnerability and lack of social supports exposed her to repeated sexual and physical assaults until, at the age of 50, she was sheltered in a long-term psychiatric institution. The clinical implication is that the victimization of the severely mentally ill (men as well as women) is under-recognized. Training in self-protection is only now beginning to be included in treatment programs for schizophrenia.

Keywords: Schizophrenia; Victimization; Sexual exploitation; Violence; Women

INTRODUCTION

Numerous recent studies and reviews from around the world attest to the victimization of individuals with severe mental illness (SMI) [1-11]. The prevalence varies from report to report because of different definitions of victimization, different methods of ascertainment, and samples that differ in age, geography, severity and duration of illness, as well as co-morbidity. Although this makes for serious gaps in the evidence, the sexual exploitation of women with SMI appears to be a serious problem. As many as 40% of such women have been reported to be victims of rape [7]. Numbers differ from study to study, and the definition of sexual exploitation varies widely. Nevertheless, there is a consensus that the prevalence of sexual violence, however defined, is significantly higher in women with SMI than in other women. The causes have been variously attributed to lack of sound judgment on the part of the women (e.g. inebriation, risk taking, cognitive defect, interpersonal naiveté), financial necessity (trading

sex for food or shelter or pocket money), and lack of adequate protection (alienation from family, friendlessness, residence in dangerous neighborhoods, homelessness) [2,10].

The following case study illustrates many of these circumstances. The woman whose story this was has been deceased for a number of years. She was an only child with no known living relatives so that I was unable to obtain consent to publish although, prior to her death, the patient had repeatedly consented to the publication of other aspects of her illness. Nevertheless, to ensure confidentiality, I have changed many of the identifying details.

CASE STUDY

Carrie (not her real name) was a university student when she first came to psychiatric attention. She was the indulged, attractive, talented, only child of a wealthy family. She was the product of an elite private school education and had always done well academically, but in her sophomore year at university, her grades began to slip. At the same time, she broke off a long-standing relationship with a boyfriend. She stopped attending class and spent more and more of her time in bed. She ate very little. When she was unable to write her sophomore year-end exams, her parents brought her home and, for the first time, realized that she was very ill - emaciated, unkempt, and not making sense when she talked. She giggled to herself at times; at other times, she appeared to be very frightened. She stayed in her room all day and wandered about the house at night. She refused to see friends with whom she had grown up. She wrote feverishly in her diary, but what she wrote was not understandable to her parents. A lengthier description of her initial presentation is available in Seeman (2002) [12].

The family doctor referred her for psychiatric consultation; she was seen as suffering from a psychotic episode and was admitted to a psychiatric hospital where the diagnosis became schizophrenia. She was treated with trifluoperazine medication (10 mg. HS), and her behavior normalized. Carrie was discharged after three weeks in hospital with a follow up appointment, but in the interim she met a man who tempted her with tales of travel and she disappeared from her parents' home. Her parents traced her to another city and wired her money for rent and food until she could find a job. She had reached the age of majority and was considered cured from her illness and, therefore, free to make her own decisions.

Instead of a job, she found many men willing to look after her temporarily. She was a beautiful young woman and very attractive to men who perhaps did not realize that she was cognitively disturbed, or – and this is where exploitation enters the picture - did recognize her vulnerability and deliberately took advantage of it. At any rate, she became pregnant and came home. When the baby was born, she suffered a severe postpartum psychosis while still in hospital and was immediately transferred from obstetrics to psychiatry. She was again placed on the same antipsychotic medication, now 20 mg HS, and decided to give the baby up for adoption.

After a year of psychiatric treatment, which included weekly visits with her psychiatrist and monthly family meetings, Carrie seemed improved, but not interested in going back to university. At my suggestion, she stopped her medication because we both thought that it was responsible for her lack of motivation. This decision turned out badly. Psychotic symptoms returned in greater severity than before; she was consequently placed on long-acting depot injections of Modecate. Her symptoms, however, persisted. In 1975, this is what I wrote about her under another pseudonym, “Wilma”.

“... She is frankly deluded most of the time, sometimes hallucinates in my office, and sometimes withdraws into an angry, impenetrable mutism” [13].

Carrie’s parents divorced and neither one wanted to take responsibility for a chronically psychotic daughter. Both parents remarried and the new spouses wanted nothing to do with Carrie. She moved from boarding house to boarding house and was repeatedly evicted because she smoked in bed or let the water overflow the bathtub or screamed in the middle of the night or shouted at the other occupants of the house. She was often hospitalized, usually because of the evictions.

In between hospitalizations and brief stays in boarding homes and shelters, Carrie lived on the street, with her ever-diminishing belongings crammed into plastic bags. Anyone passing her on the street would have judged her unwell - unkempt, talking to herself, sometimes laughing, sometimes shouting. However, she was still young and still attractive, so men frequently accosted her. She consented to sex in return for shelter or, eventually, even in exchange for a cigarette. When she came for psychiatric appointments, she very frequently showed signs of assault – bruises, missing teeth, a broken hip bone on one occasion. She was readmitted to hospital every time she came to the Emergency Room, again discharged to a boarding home but again, in a short time, evicted. Much effort went into attempts to keep her safe. She was registered in a day program, which meant she could spend time in the clinic rather than on the street, but she rarely attended. A nurse and an occupational therapist were assigned to help her with daily activities. They tried, unsuccessfully, to interest her in a sheltered workshop program. A social worker tried to re-engage her family. This, too, failed. New medications were tried, but Carrie was treatment-resistant. Despite repeated efforts, her itinerant life continued for many years until she was permanently hospitalized in long-term care at the age of fifty.

DISCUSSION

Treatment-resistant psychosis, such as suffered by patients like Carrie, and victimization have been shown to be interconnected throughout the life course [14]. Victimization can take place not only on the street but also in homeless shelters, [15] in psychiatric hospitals, [2,16] in boarding homes [17] in prisons [18]. It can happen in the context of family life, women with SMI being frequent victims of domestic abuse [11,19,20]. It is more common in the context of substance abuse, but Carrie was not a drinker nor a drug user. It occurs, as in Carrie’s case, when there are no guardians, no concerned relatives or close friends to provide guidance and protection [21]. It happens because women with SMI are usually poor and lacking sound judgment; as a consequence, they become easy prey [22,23]. Sexual exploitation is associated with assault and sexually transmitted disease [24,25] and unwanted pregnancy [26].

Some women report that their disclosures about being assaulted are not taken seriously [27]. They report being discredited and disbelieved and blamed by professionals when they described their victimization [28]. Most often, they are not given the opportunity, during psychiatric visits, to even bring up the subject of victimization [11]. Because the plight of these patients is becoming better recognized, clinical programs are being instituted to protect SMI service users and to teach them how to stay safe on the street [29,30]. Thus far, the programs reported in the literature mainly address protection against non-sexual assaults. For instance, SOS training [29] targets emotion

regulation skills, assertiveness and conflict resolution skills, and skills that enhance personal safety and reduce vulnerability to attack. BEATVIC [30] is an experience-based approach that combines body awareness exercises with physical activity. Patients learn to recognize their own emotional and behavioral reactions to different social situations and are given the opportunity of practicing new body postures and new behaviors.

Such programs need to be evaluated for effectiveness and to eventually become part of comprehensive care of severely mentally ill persons, women and men.

CONCLUSION

Clinical experience suggests that the patient story presented here is not atypical of the lives of women with severe mental illness. Greater awareness and more programs such as the ones described above will lead to improved protection.

REFERENCES

1. [Bengtsson-Tops A, Ehliasson K. Victimization in individuals suffering from psychosis: A Swedish cross-sectional study. J Psychiatr Ment Health Nurs, 2012. 19: p. 23–30.](#)
2. [de Mooij LD, Kikkert M, Lommerse NM, Peen J, Meijwaard SC, et al; Victimization in adults with severe mental illness: prevalence and risk factors. Br J Psychiatry, 2015. 207: p. 515–22.](#)
3. [de Waal MM, Dekker JJM, Kikkert MJ, Kleinhesselink MD, Goudriaan AE. Gender differences in characteristics of physical and sexual victimization in patients with dual diagnosis: a cross-sectional study. BMC Psychiatry, 2017. 17: p. 270.](#)
4. [Dekker JJM, Theunissen J, Van R, Peen J, Durkoop P, Kikkert M. Victimization of patients with severe psychiatric disorders: prevalence, risk factors, protective factors and consequences for mental health. A longitudinal study. BMC Public Health, 2010. 10: p. 687.](#)
5. [Kamperman AM, Henrichs J, Bogaerts S, Lesaffre EM, Wierdsma AI, et al; Criminal victimisation in people with severe mental illness: a multi-site prevalence and incidence survey in the Netherlands. PLoS ONE, 2014. 9: e91029.](#)
6. [Khalifeh H, Johnson S, Howard LM, Borschmann R, Osborn D, et al; Violent and non-violent crime against adults with severe mental illness. Br J Psychiatry, 2015. 206: p. 275-282.](#)
7. [Khalifeh H, Oram S, Osborn D, Howard LM, Johnson S. Recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis. Int Rev Psychiatry, 2016. 28: p. 433-451.](#)
8. [Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, et al; Domestic and sexual violence against patients with severe mental illness. Psychol Med, 2015. 45: p. 875–886.](#)
9. [Latalova K, Kamaradova D, Prasko J. Violent victimization of adult patients with severe mental illness: a systematic review. Neuropsychiatr Dis Treat, 2014. 10: p. 1925–1939.](#)
10. Nunes de Oliveira H, Machado CJ, Crosland Guimaraes MD. Factors associated with self-report of sexual violence against men and women with mental disorder in Brazil. Soc Psychiatry Psychiatr Epidemiol, 2012. 47: p. 1567–1579.

11. [Oram S, Khalifeh H, Howard LM. Violence against women and mental health. *Lancet Psychiatry*. 2016. 4: p. 159-170.](#)
12. Seeman MV. Schizophrenia: two sides of the mirror. *Queen's Quart*, 2002.109: p. 191-205.
13. Seeman MV. Therapist-induced speech disorders. *Psychotherapy: Theory, Research, Practice*, 1975. 12: p. 175-178.
14. [Honings S, Drukker M, ten Have M, de Graaf R, van Dorsselaer S, van Os J. The interplay of psychosis and victimisation across the life course: a prospective study in the general population. *Soc Psychiatry Psychiatr Epidemiol*, 2017. 52: p. 1363–1374.](#)
15. Wenzel SL, Leake BD, Gelberg L. Risk factors for major violence among homeless women. *J Interpers Violence*, 2001. 16: p. 739-752.
16. [Frueh BC, Knapp RG, Cusack KJ, Grubaugh AL, Sauvageot J, et al; Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatr Serv*, 2005.56: p.1123–1133.](#)
17. [Schomerus G, Heider D, Angermeyer MC, Bebbington PE, Azorin J-M, Brugha T, Toumi M. Urban residence, victimhood and the appraisal of personal safety in people with schizophrenia: results from the European Schizophrenia Cohort \(EuroSC\). *Psychol Med*, 2007. 38: p. 591–7.](#)
18. [Wolff N, Blitz CL, Shi J. Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatr Serv*, 2007. 58: p. 1087-1094.](#)
19. [Brownridge DA. Partner violence against women with disabilities. Prevalence, risk, and explanations. *Violence Against Women*. 2006.12: p. 805–822.](#)
20. Howard LM, Trevillion K, Agnew-Davies R. Domestic violence and mental health. *Int Rev Psychiatry*, 2010. 22: p. 525–534.
21. Teasdale B. Mental disorder and violent victimization. *Crim Just Behav*, 2009. 36: p. 513-35.
22. [Wenzel SL, Tucker JS, Elliott MN, Marshall GN, Williamson SL. Physical violence against impoverished women: A longitudinal analysis of risk and protective factors. *Women's Health Issues*. 2004. 14: p. 144–154.](#)
23. [Wenzel SL, Tucker JS, Hambarsoomian K, Elliott MN. Toward a more comprehensive understanding of violence against impoverished women. *J Interpers Violenc*, 2006. 21: p. 820-839.](#)
24. [Newman JM, Turnbull A, Berman BA, Rodrigues S, Serper MR. Impact of traumatic and violent victimization experiences in individuals with schizophrenia and schizoaffective disorder. *J Nerv Ment Dis*, 2010. 198: p. 708-714.](#)
25. [King C, Feldman J, Waithaka Y, Aban I, Hu J, Zhang S, Hook E 3rd, Bachmann LH. Sexual risk behaviors and sexually transmitted infection prevalence in an outpatient psychiatry clinic. *Sex Transm Dis*, 2008. 35: p. 877-82.](#)
26. [du Toit E, Jordaan E, Niehaus D, Koen L, Leppanen J. Risk factors for unplanned pregnancy in women with mental illness living in a developing country. *Arch Womens Ment Health*, 2017.](#)
27. [Chandra PS, Deepthivarma S, Carey MP, Carey KB, Shalianant MP. A cry from the darkness: Women with severe mental illness reveal their experiences with sexual coercion. *Psychiatry*, 2003.66: p. 323–34.](#)

28. Koskela SA, Pettit B, Drennan VM. The experiences of people with mental health problems who are victims of crime with the police in England: a qualitative study. Preprint accessed online, Dec. 6, 2017.
29. [de Waal MM, Kikkert MJ, Blankers M, Dekker JJM, Goudriaan AE. Self-wise, Other-wise, Streetwise \(SOS\) training: a novel intervention to reduce victimization in dual diagnosis psychiatric patients with substance use disorders: protocol for a randomized controlled trial. BMC Psychiatry, 2015. 15: p. 267.](#)
30. [Van der Stouwe ECD, de Vries B, Aleman A, Arends J, Waarheid C, et al; BEATVIC, a body-oriented resilience training with elements of kickboxing for individuals with a psychotic disorder: study protocol of a multi-center RCT. BMC Psychiatry, 2016. 16: p. 227.](#)