

# **IT WASN'T AN ACCIDENT**

**When So Many Were Traumatized**

**We Can't Afford To Let It Be an Accident**

**... Whether or Not People Get Trauma Informed Care**

**Considerations for more adequate and appropriate services  
for trauma survivors in healthcare in New Zealand**

**through the actions of Mental Health Support  
and Consumer Advocacy Services**

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Dunedin, October 2015**

# A PERSONAL INTRODUCTION TO

## THE EFFECTS OF TRAUMATIC INTERPERSONAL EXPERIENCES

This submission presents my personal story of difficulties arising out of Adverse Childhood Experiences – a field of substantial research interest initially brought together by Felitti, Anda and colleagues (Felitti et al., 1998, study of 17,000 members of Health Maintenance Organization members in the USA, referred to here as the ACEs Study). These forms of adversity are now known to be a major contributor to a lot of illness and distress, both mental and physical. I provide a “literature-informed consumer's” report of my experiences within the Health Care system, as a survivor of such adverse experiences, and of my adverse experiences within the Health Systems of Australia and New Zealand, as I have struggled to cope with the effects of my ACEs, difficulties and experiences I believe are shared by many in our society, so that their recovery can be speedier and more effective than mine – for many, recovery from early trauma is a lifelong process. Throughout, I shall be referring to published research. Some reference citations I provide in the bibliography, others I provide links to like **LINK** – thus, to appreciate the full import of what I'm saying, it will be beneficial if you read this whilst connected to the internet.

I shall discuss how the failure to address the relationships between abuse, trauma and adverse early experiences, in all their complexity, and the failure to address these relationships, has effects on health, illness, and general well-being. For the population as a whole this will influence the *future of health care* (Oral et al., 2015), **LINK**, and thus the overall future well-being of society. Indeed, the emphasis will be on *interpersonal relationships per se*, and the difficulties people with adverse early circumstances have with those relationships, both intimate and “therapeutic” – including things I have learned from “lived experience” arising from my former work as a “mental health clinician”, and more recently, as a “service consumer”, and in my personal life most recently.

Interpersonal trauma is not rare. In the ACEs Study (Felitti et al., 1998, who colleagues studied a community “Health Maintenance Organisation” – health insurance company), which has now become a classic of its type,

### **Of the 17,000 HMO Members:**

- **1 in 4** exposed to **2** categories – types – of Adverse Childhood Experiences (ACEs)
- **1 in 16** was exposed to **4** categories.
- **22% were sexually abused as children.**
- **66% of the women experienced abuse, violence or family strife in childhood.**
- **Women were 50% more likely than men to have experienced 5 or more ACEs**

Significant numbers of people presenting to mental health service providers have such histories:

- over 70 per cent of women presenting to Substance Abuse counselling services have been sexually, or physically abused as children, and many in adult relationships as well
- over 30 per cent of men presenting to Substance Abuse counselling services have been sexually, or physically abused as children (more likely than women to have been physically abused), and many go on to become perpetrators of intimate partner violence

- over 80 per cent of people (some would say nearly all, Dore, Mills, Murray, Teesson, & Farrugia, 2012) presenting to acute Psychiatric Service units with presenting features of substance abuse and suicidal ideation, have histories of being abused as children, and or suffered significant forms of other adversity
- Forms of abuse are rarely of a single type, with many suffering contemporaneous forms of abuse – sexual abuse, physical abuse, “betrayal trauma” etc. (Pears, Kim, & Fisher, 2008)
- Significant numbers of patients not only with Borderline Personality Disorder diagnoses, but those with other diagnoses also have such histories (Lewis & Grenyer, 2009)
- Reid has estimated that if forms of childhood adversity could be eliminated, we would see a reduction in rates of Schizophrenia / Psychosis of over 30 per cent (Varese et al., 2012)

The formal definition of “classic” trauma (which *may* result in PTSD) relates to situations where the person has experiences which “involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others [in which] the person’s response involved intense fear, helplessness or horror” (American Psychiatric Association, 2000, 463). This mostly describes so-called “Criterion A traumas”, suitable for diagnosing responses to discrete instances of trauma; rather than the repeated, cumulative trauma characteristic of ACEs. Sad to say, the list of words given lists many, but not all, of the feelings someone who has been subjected to *interpersonal trauma* – my primary focus in this paper – may experience, shame being sometimes one of the most crippling (Taylor, 2015; van Harmelen et al., 2010; van Harmelen, Elzinga, Kievit, & Spinhoven, 2011). This “self-conscious emotion” is a particularly toxic form of self-stigmatization, additional to the professional stigmatization often heaped on trauma survivors, such as those who end up with labels like Borderline Personality Disorder, or even Bipolar Disorder (Michalak et al., 2010). When considering survivors of trauma, therefore, often it is most important, and much more useful, in order to facilitate the therapy process, overcoming the inhibiting (for some crippling) effects of these stigma processes, and remembering people have “lived with”, “adjusted to”, incorporated into their self-image, these experiences and the effects on them, “What HAPPENED to this person” rather than “What is WRONG with this person”. It is also important that therapy be conducted in such a way as it does not overtax the at times quite limited coping resources of trauma survivors, and concurrently restore to, and increase their feelings of, control over the therapy process.

In several overseas countries, there are now much better established practice guidelines for treating not only “classic” PTSD, but also for Complex PTSD. I shall refer briefly to some of these, so that the unmet needs resulting from our failure to address these issues can be more adequately understood. This material will be challenging to consider, emotionally and intellectually, but I ask for your forbearance while I present my case. I hope that after reading this, and considering the resources already available, you will assist by seeing that those who take this project forward can be more adequately resourced.

American psychiatrist and traumatologist Bessel van der Kolk estimates that, at some point in EVERYONE’S life, we are either exposed to trauma or involved with someone who is involved with trauma. So, let’s ALL try to contribute to the solution to the problem.

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## **PREAMBLE**

Please bear with me while we conduct a little exercise. Read through this list of words, and as you're reading please try to be aware of the **feelings** in your body, of your breathing, your perspiration, the feelings in your stomach; your “**behaviour**” anything you feel inclined to do; and of your **thoughts** (even if “this is terrible writing, what's this guy trying to prove?”). Try to **really** get into all the feelings and thoughts, try not to back away from them, however uncomfortable they are, but do so only for a moment if they're too distressing – if you feel like doing so, try to explore where this is coming from, and what you feel like doing as a result, all the feelings, however deep.

**List of words:** fear, tears, helpless, dirty, worthless, ashamed, powerless, taken, taken away, guilty, betrayed, hopeless, bereft, desolate, desolated, totally alone, bloody – ripped apart, mortal, fatally irrecoverably flawed

**What feelings did you have?      What thoughts did you have?**

Now think of someone you care about, whom you love, having these feelings – in a real situation

your partner – girlfriend, boyfriend, wife, husband, mother, father, son, daughter, baby

I hope this exercise does not evoke memories of any events that have happened to you but...

The words in the list can all apply at different times to someone involved in a situation where they are being abused, in a most foul manner, where every aspect of their person has been violated, most often by someone they've known, even loved and trusted, but now that is gone, and there may be no one left to trust. Then consider that these feelings have been generated, repeatedly, possibly over many different situations, varying in type, over one or several years of that loved one's life, but resulting in similar effects on that person, if not worse, how would someone feel as a result?

**Congratulations**, if you've been **truly** able to have these thoughts and feelings about someone you love, if you've been able to really empathise with someone who's had these experiences, or if you've remembered similar feelings you yourself have had in your past. If you have, again congratulate yourself, you've done something critical to the well-being of others

– **but don't forget to now go / do / think in a way that helps you recover from these feelings.**

Externalise them if you can, put them in context of place, time and circumstance, and realise that they can and will be in the past. If things like this happened to you, re-frame the overall experience in terms of the positive control you now have over your thoughts, feelings and actions, and how you're making things better for yourself, and others. Then think how lucky you are, because this is not the case for many who are survivors of adverse childhood experiences, of abuse, abandonment, betrayal, trauma – the focus of this paper.

Dorahy writes (2010, 9) “If history has a lesson, it may be that the current significance given to childhood abuse and trauma for health and mental health outcomes rests on unsolid foundations.” But what gives rise to these “unsolid foundations”. Dorahy, further on “These foundations appear dependent on society's ability to tolerate and take responsibility for adults' maltreatment of children. The ability to accept such a proposition rests in part on accepting that one of the single most pathogenic factors in the causation of mental illness, and some physical health problems, is humans themselves.” I ask you to bear the discomfort of reading this material, realizing the difference between reading it, living it – as I have to – and helping others who have lived it – it ain't easy!

## THE NATURE OF SUFFERERS CONCERNS

### PERSONAL HISTORY – Understanding Effects of Chronic, Cumulative Adversity

#### Steps to a personal formulation – Finding a new identity, a new reality

Rather than go directly into the formal signs, symptoms and diagnoses given to those still experiencing the effects of abusive or traumatic experiences I'd like to go back to an experience I had when a patient in Ashburn Clinic, Dunedin, following another bout of suicidal thinking, preoccupation, behaviour. Another male patient wanted to bring in for a visit members of an organisation he had had previous support from. A senior nurse, responsible for supervising and guiding other nursing staff there said to him, in group one day when he raised this: "Invite him here to meet us, the staff, first, so we can get to know him. You know, like you'd do in any normal family!" I later said to him: "How ridiculous was that, eh?! As if we would know what happens in a *normal* family, WE never had any *normal* family!"

I came from a family, and a background, marked by several ACEs – Adverse Childhood Experiences – verbal abuse, physical abuse, contact sexual abuse (extra familial), a battered mother, household substance abuse, household mental illness, incarcerated household members, and parental separation or divorce during the first 18 years of life (I'm listing from the ACESs Questionnaire). In general, there is agreement that adverse childhood experiences represent a risk for the development of health and social problems (Anda et al., 2010), stress in adulthood, and depression (McEwen, 2000) up to decades after their occurrence (Chapman et al., 2004). In my case, my parents split up when I was age 2, my brother 5, due to my father's alcoholism and domestic violence, my mother and brother the primary victims, my mother ending the relationship fearing my father would subject me to the same violence – but I still have memories of it, and of its effects on my brother, memories despite nearly 60 years elapsing since the events.

And that's one of the most frustrating things about having these "issues" – even those trying hard to be helpful, like the nurse at Ashburn, can be so lacking in understanding, so wide of the mark, so insulting almost in their dumb-ass comments. Over time, those making such comments, failing to check their assumptions, and their effect on those they're trying to relate to, destroy any chance of developing a "therapeutic relationship" – incidentally, several months after this discussion, my friend killed himself. And those people like him with such experiences – he had been repeatedly, viciously, raped by his father on several occasions, who have so limited experience of healing relationships, have so much difficulty in forming new healthy relationships (Dorahy et al., 2013), may yet may find it so difficult to understand "why, why me, why am I feeling this way, it was so long ago" – perhaps because of their feelings of personal shame (Taylor, 2015).

My mother was to later have at least one other violent relationship – there're few things quite as disturbing for a young children, in this society at least, as seeing his mother with a bandage over her eye, a bandage over the throat of the man she's living with – my mother had placed my brother and I into the care of my grandmother – with all of us living in the same block of flats – AND YET no one answering questions – my family was very big on "secrets", and "shaming" – I last saw my brother when I was thirteen, over a Christmas, after he got out of prison for stealing offences – my uncle went off at him, yelling at him as he stood in the street, not even on our property, my uncle yelling from the top of the stairs to the house – I've never forgiven my uncle for that. Living in a separate flat, my mother developed, or fell back into, a drinking problem of her own, separate from my father's – his having left having any involvement, financial or otherwise, with my brother and I soon after the marital separation.

When I was six, an aunt (Avis), a lesbian, came to live with and take care of my grandmother, in effect, stepping into some sort of “caregiver role” (demographically speaking) – again, little real explanation of things which were strange to a young boy. When I was even younger I once saw a photo of my grandfather, only to be told by my grandmother, without ever answering my question, saying only “He died when he was 43, and Never ask about him again” and not discussed – no else ever did say anything about him either! Normal experiences with my mother included: making chocolate crackles with her, once; dancing with her, once; being taken to school by her when I started, about age 6, my starting late due to previous chronic respiratory disorders (nearly fatal in nature – hearing a visiting GP say to my grandmother “I think you have to prepare for a future without him, only to be abused by my grandmother for “giving up” on me, and SHE wouldn't!! – another source of “trauma” – I was in Grade 8 when one day I realised I had taken another breath without “having” to think about it). My mother moved away to Brisbane, leaving my brother and me with my grandmother when I was about five years old. When I was about 11 years old, staying with my mother for a couple of weeks over Christmas, my mother told me about how my brother had “cleaned it up” when her previous partner had killed himself with a drug overdose, handling it all with the Police – he had to really struggle to do this – he had difficulty finding his glasses, both of us have had poor vision since our early childhood years. It was also around this time that my mother “tried to kill herself” – “taking a drug overdose” – or so I thought at the time, she “forced” me to give her more than one pill from a prescription bottle that said “Take NO MORE than one pill per day”. She did this when she was drunk on alcohol, and other pills I knew she had taken already. This was the last Christmas I would spend with her, I think, recognising how toxic the environment was. She appeared at my grandmother's place once, wanting to know if I wanted to live with her, saying, she would see I went to a (relatively prestigious) Christian Brothers School – I was attending a Christian Brothers school where I was already – but I felt I couldn't trust her to provide a safe “home”, so declined her offer. She died under “mysterious circumstances” the year before I left school (I was age 17, my brother would have been 22) – I think she may have killed herself, but no one wanted to tell me – supposedly she died of “Advanced Arteriosclerosis”, at the age of 38 – which is entirely possible, also, given her lengthy history of heavy use of alcohol and prescribed drugs – but really just another way of killing herself, in some ways). In more recent years, I think she might have always been suffering from some form of PTSD, arising either from her experience of domestic violence, or that she had been sexually abused by her father – fleeing the family home to “repeat the mistake”, marrying a man over twenty years older than she.

Hence, from my grandmother's not talking about my grandfather, her husband, I learnt very early you don't ask about difficult things (but do your best to guess, I suppose – hardly a good way to learn “social-cognitive skills”). My grandmother thus provided very little ability to develop “mentalization” skills (Allen, Bleiberg, & Haslam-Hopwood, 2003; Oldham, 2015). But what was most disturbing, was one of my “principal caregivers”, my aunt's (Avis) always resenting my presence (somewhat understandable, given she hadn't given birth to me but ....), her making this known in a variety of ways, in a disparaging way, on many many occasions, and her style of “disciplining” me – belts, but blood blisters and bruises resulted – a form of physical abuse, apart from making me sit by her right arm when having meals, so she could belt me with her hand “attached to my strong right arm”, she said – which she did on several occasions. Of course, it didn't help that she later took on additional partners to the original one, who was kind to me, often concurrently to this woman – not an example of good, trustworthy relationship skills; and her developing drinking problems of her own. To say that we never had a trusting, safe, honest relationship would be to underestimate how bad things were – I never invited any friends home from school, never wanted to share that high risk “environment” – one of my own secrets, and things were so bad that I used to be up and out the door, to school, before she got up in the

mornings. Being the first at school I was thus vulnerable to an older student who sexually abused me on several occasions. Thus – all the building blocks for building an Anxious Attachment Style, and an enduring vulnerability to depression, and post-traumatic stress responses, not “resilience”.

Unsurprisingly, speaking non-judgementally, and for someone from my background that is very difficult to do – something my aunt, and my uncle, could never stop doing, regardless of its consequences for others – this childhood legacy has had implications for several “disorders” I’ve had over the years – one of the greatest difficulties I’ve had, which I’ve always kept to myself is the nagging question: “What’s wrong with me?” Now, decades after the experiences which caused them, much research has been done clarifying, in some small way, how these difficulties might have come about, rather than merely “labelling” them with diagnoses – a personally-developed “formulation” (Mellsoy & Clapham Howard, 2012), a self-directed form of “narrative therapy” (GoodTherapy.org, 2015). Although this has had to be done by myself – therapists, counsellors, psychologists I’ve seen have provided no support or guidance in this endeavour. More recently, however, some researcher-clinicians have been much more successful in helping patients with these concerns, initially through “psychoeducation”, and then through “skills training” (Thomaes et al., 2015). Much is said about the benefit of “therapeutic relationships” but these have rarely if even been available to me, at least in a form that has been truly therapeutic. What ways *might* be therapeutic is discussed later in this paper.

## SPECIFIC ISSUES – SELF

- **Persistent speech impairment** – mild, but, due to my starting talking “late”, and little – safer to just keep my mouth shut in a threatening environment – domestic violence? To the extent my grandmother took me to a psychologist to see if I had an intellectual impairment – but she was pleasantly surprised to see I was in fact very bright – but no one since then has ever inquired as to whether I had been referred to a mental health clinician, of any sort, when I was a child

- **Recurrent Depressive Disorder** (Chapman et al., 2004)

- **Substance Use Disorder** (Chapman et al., 2004)

? relationship between SUD and Depressive Disorder – (Cunningham & McCambridge, 2012)

- **Suicidal ideation** – (Dube et al., 2001)

- **Personality Disorder?**

In general, stigmatising – carrying the connotation of prejudice, discrimination, marginalisation, and shame. The shame and self-stigma, and sense of personal invalidation has a substantial effect on intimate relationships (Jutel, 2009; Macintosh & Johnson, 2008; Nehls, 1998).

– Narcissistic – diagnosis given to me while I was at Ashburn Clinic – but note this is not consistent with new research evidence on the contributors to Narcissism (Brummelman et al., 2015), and likely to have been more as a result of my challenging the administrators' views, their views clearly a relic of past psychoanalytic theories, invalidated by recent research – yet another example of punishing stigmatisation by psychiatrists – attempted invalidation of me and my opinions, both professionally and personally  
– “Avoidant PD traits”, at least in *my* opinion, arising in part from my history of anxious

attachment (Eikenæs, Pedersen, & Wilberg, 2015), and my particular pattern of skills, interests and coping styles

– as such, diagnoses, particularly those of Personality Disorder are “unhelpful”, but when used may best be addressed through a practical, therapeutic, focus on dysfunctional coping styles (Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010)

- **Employment difficulties / disability** – often linked to difficulties handling stress (Joensuu et al., 2015) and depression
- **Adult Health Problems** – Diabetes, together with High Blood Pressure (Winning, Glymour, McCormick, Gilsanz, & Kubzansky, 2015)
- **Emotion Dysregulation** – varying between over-regulation (emotionally, behaviourally, and “creatively” restricted – essential when living under the threat of violence and being thrown out of “home” to an even more toxic environment; to under-regulation – potentially overwhelming bursts of feelings of dread, panic, depression, sadness – this remains a problem, and has in some ways been THE most troubling of all.
- **Impaired Self-Regulation** – perhaps the substance abuse, aggravated by continuing sense that I would die young, and hence difficulty saving or planning life activities (“for the future” – what future??)

All of these difficulties, which plagued me so much for so long, “Why me?”, only recently identified as being “natural consequences” of chronic early childhood stress, rather than “character disorder”. Perhaps most significantly, I have never been diagnosed as suffering from any stress-related disorders; despite, in my opinion often presenting, in the past, as having symptoms of these. Given my childhood background, I think these stress disorders would have been pretty common sense diagnoses to make, even back then, but that was a long time ago, perhaps, maybe, before these diagnoses became “acceptable”, or even potentially able to be given diagnoses. This brings us to the next section of this paper – the “formal diagnosis” of stress disorders, in particular Post-traumatic Stress Disorder, with formal criteria; and Complex Trauma, Developmental Trauma Disorder, or some such “informally recognised” disorders. Criteria for the diagnosis of this disorder have been formally arrived at for ICD-11 (Elklit, Hyland, & Shevlin, 2014) What the foregoing diagnoses demonstrate, more than anything, is how totally NON-explanatory the diagnoses I was previously given are when removed from the context that gave rise to the behaviours and problems alluded to, and how incredibly UN-helpful, shaming, and stigmatising I have experienced the diagnostic labels to be, as a result.

What I have provided in the foregoing is of course not “the full story”, in some ways it's a bit like scraping a fingernail over a bit of a surface of the tip of an iceberg, you've got some idea of what it feels like, but no real idea of what it really *is* even now in many ways. In some ways my account is quite “self-serving” – I haven't written about how incredibly grateful I am for the undoubted love and care my grandmother provided for me; the gratitude I have for my aunt in providing the material assistance, support and relative stability my early life enjoyed; the wonderful ability of my mother to be able to share and discuss some things with me that no one else ever could, or at least did; how bad some of my own behaviour was; how unbelievably lucky and grateful I am that my mother pulled me out of her disastrous marriage to my father. I also haven't written about all the other problems my brother had – more a classic case of “Developmental Trauma Disorder” (see my uploaded copy of van der Kolk's wonderful article from Psychiatric Annals, 2005 [LINK](#)). From all these people – my mother, my grandmother (a former maternal and child welfare nurse), my aunt



Avis (a nursing administrator), her partner Betty (a nurse educator), I've had wonderful examples of professionalism, hard work, compassion and generosity for others. Also from my grandmother I learnt the value of hearing and valuing other's life stories – in my first year of working at the old Wolston Park Hospital [LINK](#) , which at the time had many very chronic patients (20++ years in hospital) I was sitting in one day on an activity, and came to be seated beside someone obviously in their retirement years. I asked him what he'd done for work (men being men!) and he said the railways. I grew up near a railway and so started sharing the old stories of steam trains, shunting noises et cetera. A nurse later said: “Cor! You're game, he can get really angry and aggressive”. Yet, he and I had gotten on very well and I'd been sorry our conversation had to come to an end when the activity did! In many other ways, I've been incredibly fortunate in my life, doing the ways I've been able, seeing the sights I have, and so forth. In some technical sense I might have an appreciable ACEs Score reflective of childhood adversity, but it is nowhere near as high as my brother's would be if it was worked out; it is nowhere near as high as that of many children even in our own society, let alone in many overseas countries. It is nowhere near as high as that of children in Australia's immigration detention centres, of their fathers in such centres if they're from New Zealand! But, in other respects, back in my day at least, the “warning signs” were never really picked up on and steps were not taken to make sure that some of my, and my brother's, problems could be prevented. Not long ago, we've had the first report from our current Children's Commissioner (Office of the New Zealand Children's Commissioner, 2015). Anyone with the slightest knowledge of criminal justice and mental health can see the red flags and warning signs all over that document – some of those who have left CYFS care in the past, some who are leaving its care now, will come knocking on the doors of our mental hospitals, and our prisons, and some will go straight to the morgue, some by their own hand, some by others, some they will put in the morgue, long before their natural lives should be over – their “mental health problems” will not be identified and understood until it's too late. And this has to be said of many of those in our prisons – the recent news item in Dunedin's The Star newspaper clearly points to this – more than 70 per cent of those who end up in youth correctional facilities have their own “high ACEs Scores”, and many will progress on to adult prisons, all without being “understood”, supported and help – Dostoevsky reminded us “The degree of civilization in a society can be judged by entering its prisons “ – we're not doing well in having a civilized society!! Compared to them I am both incredibly, and undeservedly, lucky.

If you have been able to read all this, I thank you for your time and patience. I hope I have demonstrated in some small it is crucially important that diagnosis not be separated from the “context” surrounding an individual's “presentation” and the events in their life, both in the present, and in the past.

## **WHAT'S TO BE DONE? HOW CAN YOU HELP?**

Given that you are members of Consumer Advisor services / peer support services within the Health System in New Zealand, I'd appreciate your assistance in the following, directed at the Ministry of Health, service professionals, agency intake / counselling / support staff, so that:

- Since existing systems of care do not even inquire into presenting patients' histories of adverse early experiences (Dore et al., 2012) clearly we need to educate all involved – service providers, service administrators, clients and patients themselves – about the high incidence, severity, and long lasting effects of such forms of adversity. Initial assessments, and assessments throughout the course of a person's contact with a service (trauma

survivors both choose not to tell, and are often not able to tell, important details of their experiences to treatment and support staff – it needs to be left to the individual consumer when, and if, they relate “their story” to others) across all aspects of health care – physical, mental, substance abuse, individual / family / whanau – should comprehensively cover inquiry into ALL aspects of patients early, and ongoing, experiences of adversity, interpersonal attachment, and neglect / abuse / trauma. These effects can include substantially elevated risks of suicide (Dube et al., 2001).

- Consumers' need and demand for all aspects of their care to be understood and “useful” to them, needs to be appreciated and pushed to the Ministry of Health, and District Health Boards, with a need to emphasise “formulations”, seeing presenting problems in life context, what has happened to people, rather than what is “wrong” with people, as framed in diagnoses (Mellsop & Clapham Howard, 2012; Moeke-Maxwell, Wells, & Mellsop, 2008)
- Consumers' need and demand for more say, and control over, therapeutic processes needs to be pushed with the Ministry of Health, and District Health Boards – see Appendices attached to this submission – this is part of therapy “process”, or “style”, the current Medical Model needs to be replaced by a more truly Bio-, Psycho-, Social approach to assessment, intervention, care, and ongoing (even lifelong) recovery support (Read, Dillon, & Lampshire, 2013) [LINK](#)
- Currently, we do not, in this country, have any accepted Practice Guidelines for the treatment of PTSD and Complex Trauma. International standards DO exist, however, and these should be pushed with the Ministry of Health, through the various District Health Boards – therapy content – see Appendices.
- Services, especially in the areas of mental health, substance use counselling, suicide prevention, women's services, services for those in secure care (those in Correctional Centres, and secure mental health care often have much higher rates of prior, and ongoing, traumatization than the general community, Berry, Ford, Jellicoe-Jones, & Haddock, 2013). And family support / therapy need to be structured along Trauma Informed Care lines (see Appendices). Such services need to be prioritised on the basis of need, and thus prioritised overall in health budgets.
- Peer support has been demonstrated in various areas of mental health, and can have a substantial transformative effect on ensuring existing services are more Trauma Informed – see the discussion about Zero Suicide and Trauma Informed Care [LINK](#) for practical examples.
- Peers need to be encouraged, supported, and where necessary trained, to play an active role in the development, operation and evaluation of services for trauma survivors.
- Many staff may feel uncomfortable about asking about such experiences, so we need to identify readily available resources able to be used with staff. Such resources include:
  - webinars about the links between adverse childhood experience and later physical and mental distress, impaired functioning, and how these may be improved upon – a good resource for recordings of these include my own website [LINK](#) I have several more videos already uploaded to various cloud stores, and will be uploading individual links to these as time permits – I am currently re-developing the site to make it suitable for portable devices, and thus able to “rate better” in Google Searches
  - Professor John Read (Read, Hammersley, & Rudegear, 2007), formerly of Canterbury University, Christchurch, has written an article “*Why, when and how to ask about childhood abuse*” which should prove valuable in guiding staff about how to inquire into patients / clients / consumers early experiences which could be of concern to them [LINK](#) I know of additional materials, links to which I shall post via my website.
  - Aces Connection [LINK](#) is a valuable website for those interested in learning how to do more in this area, and its existence and opening to new members needs to be promoted.

There are currently only 9 people in New Zealand who are members but I am hoping to soon bring some “community” to their activities, through setting up our own closed Facebook group **ACEsNZ**, to facilitate collective efforts and mutual education and support – those interested should contact me via [ACEsConnect.NZ@gmail.com](mailto:ACEsConnect.NZ@gmail.com)

If you have suggestions as to how this work can proceed, or proceed better, I would be most receptive and welcoming of them.

### ***In Closing***

American psychiatrist and traumatologist Bessel van der Kolk estimates that, at some point in EVERYONE’S life, we are either exposed to trauma or involved with someone who is involved with trauma. So, let's ALL try to contribute to the solution to the problem.

### **We Can't Afford To Let It Be an Accident**

### **... Whether or Not People Get Trauma Informed Care**

***"Life's unfairness is not irrevocable; we can help balance the scales for others, if not for ourselves." Hubert H. Humphrey***

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## APPENDICES

### Five Essentials of Effective Trauma Therapy

If I had ever been given the opportunity to take part in effective therapy for my own experience of trauma, I believe it would have had these components, taken from the work of Mary Jo Barrett

– see my website for a relevant video [LINK](#)

– and here for an extended written discussion [LINK](#)

1. a recognition and acceptance, by the therapist and the client that "You have suffered, but things can change for the better"
2. Skills building -- such skills might include:
  1. mindfulness skills -- making room to pause and make choices
  2. communication skills
  3. parenting skills
  4. cognitive behavioural skills
  5. an acknowledgement that coping required skills (even some "symptoms") which can still be used
  6. integration skills -- integrating cognitive, spiritual, and bodily (sensorimotor, sensing and soothing type) functions
3. a strength orientation -- an understanding of how symptoms **have** worked in the past as coping skills -- and thus therapy involves a loss, of symptoms, but has benefits as well
4. the recognition by the client that during therapy "I felt safe" -- as the therapy was well structured and explained to the client whenever requested by the client, with the therapist regularly checking on the client's understanding and acceptance of therapy processes; and as a result, therapy was predictable, had known boundaries, goals, structure -- this feeling of safety is essential for change to occur, The therapist needs to say "You tell me how to act", and act in a collaborative, elaborative way.
5. therapy must involve the creation of "workable realities" -- requiring the therapist to know at all times what they're doing; the client is confident that the therapy is evidence-based; and involves the creation of a workable future, in a concrete, defined way, and not just positive thinking



## **PRACTICE GUIDELINES FOR THE TREATMENT OF TRAUMA**

Also see my website, which will continue to be updated to show these details [LINK](#)

In particular, the details about the  
New Haven Competency Conference – Consensus Statement [LINK](#)

It will be noted that in a system of Trauma Informed Care (detailed in next section), it is incumbent upon professionals that they remain informed about current and ongoing developments in their areas of practice.

A number of evidence-based therapies for PTSD have been developed and evaluated through comprehensive research trials. Much less comprehensively evaluated have been psychotherapies for Complex PTSD. Two reasons for this might be that there has been a belief that many such patients suffer from Personality Disorders, and are thus much less resistant to treatment than those whose trauma can be tied to specific incidents; and that until recently there has not been an accepted diagnosis for Complex Trauma. However, with the October 1<sup>st</sup> 2015 introduction into the American insurance / treatment such of the requirement to use ICD criteria, this can be expected to change somewhat – ICD-11 criteria include a diagnosis for Complex Trauma , and ICD-11 is scheduled for introduction in 2018 – a variety of dates are given, 2018 is given on the UN WHO website [LINK](#) In the meantime, for insurance criteria, treatment providers should be consistent with their systems – a combination of ICD-10 and DSM criteria was accepted for a time; now providers need to use ICD-10 criteria – the diagnostic codes for ICD-11 are already contained in the DSM-5 manual).

Pharmacological interventions, particularly selective serotonin re-uptake inhibitors, are frequently prescribed for PTSD; however, recent research indicates that only about 50 per cent of patients derive significant benefit from these. Also, many patients stop taking them due to their side-effects.

### **Evidence-based psychotherapies for PTSD (review Schnyder by et al (2015))**

- Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy
- Cognitive Therapy for PTSD
- Narrative Exposure Therapy
- Prolonged Exposure Therapy
- Brief Eclectic Psychotherapy for PTSD
- Cognitive Processing Therapy
- EMDR Therapy

A number of “adjunct treatments” such as Mindfulness Skills Training may be used in conjunction with these, but their value as standalone treatments is still open to review.

One of the most important elements in helping a trauma survivor is the social acceptance and emotional validation of the legitimacy of their response – the typical “medical model” response, searching for internal constitutional vulnerability factors, can easily work against this process, resulting in re-traumatization of the patient, and with re-traumatization (cumulative trauma) being quite common, such an approach can actually work against the patient's recovery.

A big issue, and potential problem, with the selection of treatments is the question of how acceptable the treatment is to the patient. For example, trauma-focused treatments for PTSD have been widely disseminated in the United States Veterans Health Administration and have been found to be highly effective for those who complete the treatments. However, several studies have consistently shown (e.g., (Hundt et al., 2015; Mott et al., 2012; Mott, Koucky, & Teng, 2015) that fewer than 10% of veterans with PTSD do so. Although systems factors may in part explain this slow uptake, it allows consideration of whether the treatments are meeting patient needs and how to deliver treatments that better engage patients.

Psychoeducation is an integral part of skills training and meaning making. It also involves the transmission of basic information such as that trauma is common, its effects are well recognized, and effective interventions are available. Acknowledgement of the reality of trauma, its psychological impact, and the identification of the possibility of recovery provides a sense of support and hope, well-known factors in recovery from and protection against future traumas.

### **Treatment for Complex PTSD**

Although selective serotonin-reuptake inhibitors are sometimes used for some of the PTSD symptoms suffered by those with Complex PTSD, there are less data showing that pharmacological interventions can be effective with the more personal-level difficulties of CPTSD. Again, while there are a variety of different validated treatments for PTSD, when considering treatments for Complex PTSD, this is not the case, and existing treatments usually address one or another of the symptom clusters:

- (1) affective dysregulation,
- (2) negative self-concepts, and
- (3) interpersonal problems.

Thomaes et al. (2015) argue that treatment guidelines for PTSD patients cannot be applied directly and automatically to Complex PTSD because there is no scientific evidence to justify such a step. They note that the neurobiological profile of PTSD differs from that of complex PTSD. Thus, over a succession of studies, most reported in English-language papers, though the latest is not. Their program primarily targets emotion regulation difficulties. However, they do note that their treatment groups did not screen out those with personality disorders, and that there were no differences in participant attrition rate or treatment related to personality disorder. Thus, this treatment should definitely be investigated further.

EMDR therapy has also been modified, very recently in order to treat Complex PTSD [LINK](#)

## PRINCIPLES OF TRAUMA INFORMED CARE

### What is meant by *Trauma Informed Care*?

It is useful to start addressing this question by considering the following definition of trauma – one of the best I've come across:

***Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.***

Substance Abuse and Mental Health Services Administration (SAMHSA)  
(United States)

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach [LINK](#)  
July 2014

### What's an organization that is trauma informed like?

***A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.***

### **SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH**

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

These are explained in more detail in the full SAMHSA document

[LINK](#)

### **TRAUMA INFORMED CARE**

- Aims to avoid re-victimisation
- Appreciates many problem behaviours began as understandable attempts to cope
- Strives to maximise choices for the survivor and control over the healing process
- Seeks to be culturally competent
- Understands each survivor in the context of life experiences and cultural background

**(Noll Alvarez and Sloan, 2012)**