Section 13. Trauma & Social Trust 2

This document is one of 24 sections that make up the proposal to form TRISI. The other sections can be found at:
http://www.ptgrr.com/trisi/about/trisi

Reference: Brian Rogers. Trauma & Resilience-Informed Solutions Institute of Southern Africa – Proposal of a Trauma-Activist; PTG-RR; Sep 2015/7

This proposal is a living discussion platform. The answers do not lie in one person’s mind. Its objective is to attract enabling-capital which includes intellectual contribution and financial support. Should you wish to participate, please visit the TRISI webpage. Furthermore, it is not in any way intended to presume scientific validity. The style, or method, is argumentative and documentary. It lacks academic skills which include the traditional representation of sources. Full acknowledgement is given at the point of disclosure so that the reader can identify the source and seek its original in order to explore further.

Section 13. Social Trust 2

1. Moral Injury
2. Betrayal Trauma
   - Institutional Trauma
3. Soul Repair
4. Stigma
   - Stigma and Mental Health
   - Stigma and Trauma
   - Stigma and HIV/AIDS
   - Stigma and Substance Abuse
5. Victim, Survivor Thriver

“The path of growth and maturity is steep and hard to go on alone. It doesn’t mean you can’t go on it by yourself but who will be there to pick you up when you fall? And you will surely fall.”
Reb Buxton

“A honeycomb is a mass of hexagonal wax cells built by honey bees in their nests to contain their larvae and stores of honey and pollen.”
Wikipedia

Those who come up with the best ideas are those who are comfortable with the fact that, sometimes, you know, just before you know why.
John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009
Note: This section, like all the others is prepared in such a way that the experts in their fields primarily tell the story. The sources are clearly displayed and the reader can seek them out for further interrogation of the subject matter.

This is not a section that has leant itself to interest by the South African Research community, with the exception of Stigma and HIV/AIDS, where they have done a splendid job of understanding the dynamics of Stigma. This is a great pity as the Trauma nomenclatures of Betrayal and Moral Injury are in every modern history book. It may well be that the very failure to deal with these constructs that are at the very heart of our Stigma issues in this country and the underlying cause of the highly destructive “Victim Mentality” we see in our everyday lives in this country. Failure to address these Trauma concepts in the future will hamstring any attempts to deal with Community and Cultural Trauma.

**Moral Injury**

‘The foundation of recovery from psychological and moral injury is safety, sobriety, and self-care, mutually supported by a circle of peers.’ Jonathan Shay, M.D., Ph.D. Veteran Psychiatrist to Veterans;

‘The concept of Moral Injury was introduced by Jonathan Shay. It refers to an injury to an individual's moral conscience resulting from an act of moral transgression which produces profound emotional shame. The concept of moral injury emphasizes the psychological, cultural, and spiritual aspects of trauma.’

“Like those who spoke out against the Witch Trials in 1692, it is Dr Shay’s voice and the voices of others speaking out against injustice that have changed the way that both the public and the military treat a group of citizens, in this case American troops who suffer from PTSD, both while in active duty and after. Through his work, Dr Shay has helped make it possible for those who serve in the military and others in the path of war with PTSD to be offered treatment so that they have an opportunity to lead a full life.” SALEM

‘The term moral injury has recently begun to circulate in the literature on psychological trauma. It has been used in two related, but distinct, senses; differing mainly in the “who” of moral agency.’

‘Moral injury is present when there has been

(a) a betrayal of “what’s right”;
(b) either by a person in legitimate authority (my definition), or by one’s self—“I did it” (Litz, Maguen, Nash, et al.);
(c) in a high stakes situation.

Both forms of moral injury impair the capacity for trust and elevate despair, suicidality, and interpersonal violence.

They deteriorate character. Clinical challenges in working with moral injury include coping with -
[1] being made witness to atrocities and depravity through repeated exposure to trauma narratives,
[2] characteristic assignment of survivor’s transference roles to clinicians, and
[3] the clinicians’ countertransference emotions and judgments of self and others. A trustworthy clinical community and, particularly, a well-functioning clinical team provide protection for clinicians and are a major factor in successful outcomes with morally injured combat veterans.’

The following extracts are courtesy of two interviews that can be viewed on YouTube.

Jonathan Shay - ‘Moral Injury’ http://www.youtube.com/watch?v=X8kCgLJSpQ
Jonathan Shay Moral Wounds of War: http://www.youtube.com/watch?v=BJWzyZun27g&noredirect=1

‘One category of psychological injury — moral injury — has recently lit up both in military professional circles and in the clinical literature.’

‘My current most precise (and narrow) definition has three parts: moral injury is present when (1) there has been a
betrayal of what’s right (2) by someone who holds legitimate authority (3) in a high-stakes situation. When all three are present, moral injury is present and the body codes it in much the same way as it codes physical attack.’

‘When the term ‘moral injury’ has recently surfaced in the psychological research literature, it has been used somewhat differently: ‘Potentially morally injurious events, such as perpetrating, failing to prevent, or bearing witness to acts that transgress deeply-held moral beliefs and expectations may be deleterious in the long-term, emotionally, psychologically, behaviourally, spiritually, and socially.’ The cited clinician-researchers have shown an elevated risk of domestic violence and suicide, if moral injury is present. Our two meanings of ‘moral injury’ differ mainly in whether leadership malpractice is part of the definition. The view of the above researchers could be paraphrased as what happens (1) when someone ‘betrays what’s right,’ (2) the violator is the self (3) in a high-stakes situation.

I have focused where the betrayer of what’s right holds legitimate authority. Moral injury in my meaning can lead to moral injury in the above clinician-researchers’ meaning. Both forms can occur in the same person. An example would be for a soldier or marine to be ordered to murder civilians or disarmed, unresisting prisoners (likely a moral injury in my sense), and then, feeling compelled to carry it out, to incur moral injury in their sense. Our junior enlisted fighters do not want to know themselves to be murderers. And moral injury in my sense can lead to it in their sense. They both exist and are both destroyers of human flourishing.’

‘What does leadership-malpractice add to the elements visible in betrayal of what’s right by the self in a high-stakes situation? Primarily, it destroys the capacity for social trust in the mental and social worlds of the service member or veteran. I regard this as a kind of wound contamination in the mind, preventing healing, and leaking toxins.’

‘The clinician researchers also note the impairment of trust in patients with their version of moral injury. Further, they note that such patients do not experience physiological activation when they are reminded of the events related to the moral injury in their sense, differing from PTSD in this regard. My observation has been that moral injury in my sense, which hinges on leader malpractice, does involve physiological activation — the body codes moral injury as physical attack.’


‘The need for trust, Dr Shay argues, comes from human prehistory. Without claws, wings or other natural weapons, human ancestors survived by watching one another’s backs. As a result, Dr Shay argues, the need for trust is part of human biology. Trust makes us feel safe; feeling safe is good for our mental and physical health.

That sums up Shay’s views – that PTSD is usually the product of a betrayal of trust. That it is not confined to war and combat. That rape and abuse is an example of the betrayal. Trust is most betrayed when authority is discovered to be in it for itself. Sums up most of corporate and political leadership today and often the power in family’s too.’

Syracuse University; The Moral Injury Project; http://moralinjuryproject.syr.edu/about-moral-injury/

‘Moral injury can lead to serious distress, depression and suicidality. Moral injury can take the life of those suffering from it, both metaphorically and literally. Moral injury debilitates people, preventing them from living full, healthy lives.

The effects of moral injury go beyond the individual, impinging on the family system and the larger community. Moral injury must be brought forward into the community for a shared process of healing.’

‘EXAMPLES OF MORAL INJURY IN WAR

- Using deadly force in combat and causing the harm or death of civilians, knowingly but without alternatives, or accidentally
- Giving orders in combat that result in the injury or death of a fellow service member
- Failing to provide medical aid to an injured civilian or service member
- Returning home from deployment and hearing of the executions of cooperating local nationals
- Failing to report knowledge of a sexual assault or rape committed against oneself, a fellow service member, or civilians
- Following orders that were illegal, immoral, and/or against the Rules of Engagement (ROE) or Geneva Convention
- A change in belief about the necessity or justification for war, during or after one’s service

**Brock, Rita Nakashima and Lettini, Gabriella** Soul Repair 2012, Beach Press.

‘Moral injury is not PTSD. Many books on veteran healing confuse and conflate them into one thing. It is possible though, to have moral injury without PTSD.’

**Syracuse University; The Moral Injury Project;** http://moralinjuryproject.syr.edu/about-moral-injury/

‘Traumatic brain injury (TBI) and post-traumatic stress disorder (PTS or PTSD) became household terms over the last decade thanks to the maturation of attitudes about the costs of war; moral injury is now the object of growing focus by researchers and academics in the same manner.

Moral injury does not, by its nature, present itself immediately. Some will experience questions of moral injury days after an incident; for many others, difficulties will not surface for years. An experience with potential for moral injury is typically realized after a change in personal moral codes or belief systems.’

‘Moral injury must be acknowledged in the same way that we acknowledge the physical and mental costs of traumas experienced in war and other place of danger. Moral injury is subjective and personal. Research on moral injury is younger than research on PTSD – the definitions, ideas and practices we’re working with are both experimental and varied.

Trauma of a type and severity that cause PTSD are likely to cause moral injury, too. This does not mean treating PTSD will “treat” moral injury, nor vice versa. We favor the tenet that “treatment” of moral injury must be defined by the individual according to their beliefs and needs. Outlets for acknowledging and confronting moral injury include talk therapy, religious dialogue, art, writing, discussion & talking circles, spiritual gatherings, and more. Therapists, counselors, social workers, and clergy are often at the front lines of addressing moral injury; however, the larger community can also take part. Consider that moral injury affects, and is affected by the moral codes across a community. In the case of military veterans, moral injury stems in part from feelings of isolation from civilian society. Moral injury, then, is a burden carried by very few, until the “outsiders” become aware of, and interested in sharing it. Listening and witnessing to moral injury outside the confines of a clinical setting can be a way to break the silence that so often surrounds moral injury.’

**Thomas Gibbons-Neff; Why distinguishing a moral injury from PTSD is important.** Special to the Washington Post

‘Moral injury is as timeless as war — going back to when Ajax thrust himself upon his sword on the shores of Troy. Unlike post-traumatic stress, which is a result of a fear-conditioned response, moral injury is a feeling of existential disorientation that manifests as intense guilt.’

‘Moral injury makes its mark by creating a flawed sense of who you were when you were in harm’s way. This is the second self. Deployed veterans, morally injured or not, have this second-self formed in war — one who can tell incoming from outgoing artillery and whose first reaction to an arterial bleed is to kneel into their best friend’s pressure point.’

‘But moral injury makes it hard to transition from memory to the present; it confuses the old self and the new. If the injury is severe enough, it can be almost impossible to see yourself in the present. Instead, you see the person who was capable of making the wrong decision when, years later, you know you could have made a different one.’

‘To understand moral injury and address its effects, we need to recognize that it exists. If we don’t, if we continue to categorize moral injury under the same umbrella we have for centuries, those who have borne our wars will have to carry their own wounded.’
‘The experience is not new. Shay says the concept of moral injury comes right out of the “Iliad” and thousands of years of war. But it’s not an established condition.’

‘Shay says lobbying for these changes has been “a lonely pursuit.” But that’s beginning to change as a growing number of researchers are focusing on moral injury. “Shay started the ball rolling, using literature to raise the consciousness of care providers and families,” said Brett Litz, a clinical psychologist with the VA’s health care program in Boston and a professor at Boston University. Now, Litz and colleagues are attempting to build out the science.’

‘Brett Litz and colleagues can be credited for major developments in the psychological perspective on moral injury. They define moral injury as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.” Litz and colleagues focus on the cognitive, behavioral, and emotional aspects of moral injury in a preliminary conceptual model. This model posits that cognitive dissonance occurs after a perceived moral transgression resulting in stable internal global attributions of blame, followed by the experience of shame, guilt, or anxiety, causing the individual to withdraw from others. The result is increased risk of suicide due to demoralization, self-harming, and self-handicapping behaviours.’

‘More specifically, moral injury has been defined as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009). Various acts of commission or omission may set the stage for the development of moral injury. Betrayal on either a personal or an organizational level can also act as a precipitant. On a conceptual level, moral injury is different from long-established post-deployment mental health problems. For example, whereas PTSD is a mental disorder that requires a diagnosis, moral injury is a dimensional problem. There is no threshold for establishing the presence of moral injury; rather, at a given point in time, a Veteran may have none, or have mild to extreme manifestations. Furthermore, transgression is not necessary for a PTSD diagnosis nor does PTSD sufficiently capture moral injury, or the shame, guilt, and self-handicapping behaviors that often accompany moral injury.’

‘“Litz et al. (2009) provide a comprehensive review, complete with working definitions, prior research in related areas, a preliminary conceptual model, and intervention suggestions. The conceptual model posits that individuals who struggle with transgressions of moral, spiritual, or religious beliefs are haunted by dissonance and internal conflicts. In this framework, harmful beliefs and attributions cause guilt, shame, and self-condemnation. Forgiveness is also an important mediator of outcome. The moral injury framework posed by Litz et al. suggests that although moral injury is manifested as PTSD-like symptoms (e.g., intrusions, avoidance, numbing), other outcomes are unique and include shame, guilt, demoralization, self-handicapping behaviors (e.g., self-sabotaging relationships), and self-harm (e.g., parasuicidal behaviors). This framework highlights the importance of thinking in a multi- or interdisciplinary fashion about helping repair the moral wounds of war. Litz et al. argue that existing PTSD treatment frameworks may not sufficiently target moral injury.’

‘Self-harm might arise because you feel unforgivable and damned and you may feel at a very deep level that you deserve to suffer,” Litz said. “So how is someone going to behave if they feel that they deserve to suffer? They may abuse drugs, they may drive dangerously, some may not even care whether they live or die.’

‘If you feel undeserving and unforgivable, you may take one step forward in your relationships and your workplace and then three steps back,” Litz said. “You may feel guilty if you feel good.’

‘Moral injury is perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations. This may entail participating in or witnessing inhumane or cruel actions, failing to prevent the immoral acts of others, as well as engaging in subtle acts or experiencing reactions that, upon reflection, transgress a moral code.’

‘What are morals?
The majority of individuals have a strong moral code that they use to effectively navigate through their lives. Morals are defined as the personal and shared familial, cultural, societal, and legal rules for social behavior, either tacit or explicit.’

‘Are there unique emotions related to moral beliefs?
Moral emotions, both self-focused and other-focused, serve to maintain a moral code. Morality-related emotions are driven by expectations of others’ responses to perceived transgression. Embarrassment may encourage adherence to broadly or locally accepted moral standards by prompting individuals to act in conciliatory ways so as to win approval or inclusion (e.g., Keltner, 1995). Positive emotions such as self-oriented pride and other-oriented gratitude also shape moral behaviors.’

‘The effect of shame on social behavior and connection
Shame is fundamentally related to expected negative evaluation by valued others. It is, therefore, not surprising that individuals respond to shame with a desire to hide or withdraw. The non-verbal and verbal communication behaviors related to shame in interpersonal contexts function to inhibit interaction and communication with others (Izard, 1977; Keltner & Harker, 1998).’

‘Self-forgiveness
A good deal of research has shown that interpersonal forgiveness, that is, forgiving others who have transgressed, helps people adapt and recover from various social harms. Less studied, but no less important from the vantage point of preventing wrongdoing and helping transgressors, is the process of self-forgiveness, which is a means of obviating self-condemnation and shame and a vehicle for corrective action.’

Laura K Kerr, PhD “Soul Repair” and Veterans of Trauma; Trauma’s Labyrinth | Journey of the Wounded Healer
‘This definition of moral injury (Brett Litz, et al) is similar to the idea of betrayal trauma, which is a likely outcome of early childhood abuse. Although young children may lack the cognitive capacity to reflect on how abuse affects their moral beliefs, they nevertheless can have a felt sense that abuse degrades their sense of self. Furthermore, the child must often dissociate feelings of betrayal when the person who betrayed their humanity is a caregiver they depend on for survival. Researchers Robyn L. Gobin and Jennifer J. Freyd give the following explanation of betrayal trauma:

“Betrayal trauma theory posits that interpersonal violations such as childhood sexual or physical abuse perpetrated by individuals who victims care for, depend on, or trust will be processed and remembered differently than violations perpetrated by individuals with whom victims do not have such a close connection. A violation perpetrated by someone significant is characterized as a trauma high in betrayal and is remembered less than traumas low in betrayal .... Because the victim views the perpetrator as the key to his or her physical and psychological survival, he or she finds it advantageous to remain interpersonally and emotionally connected to the perpetrator.... Thus, the child may become “blind” to the betrayal and fail to identify the experience as abusive. Such betrayal blindness or unawareness of abuse has adaptive value in that it maintains the attachment between child and caregiver such that the child can continue trusting and depending on the caregiver (Freyd, 2003). [Gobin, Robyn L., & Freyd, Jennifer J. (2009). “Betrayal and Revictimization: Preliminary Findings.” Psychological Trauma: Theory, Research, Practice, and Policy, 1(3), 242-257.’

Dinah Shelton; Remedies in International Human Rights Law; Oxford University Press
‘Moral damages are widely recognised. Nearly all legal systems accept claims for non-pecuniary injury such as harm to reputation, dignity, and other wrongs for which monetary value must be presumed as it cannot be assessed. Compensation for such non-pecuniary harm is sometimes is sometimes assessed as a separate claim independent of pecuniary losses while in other states the amount of moral damages is directly linked to the amount of pecuniary injury or otherwise limited to a maximum mount. In some states, statutory scale of damages may be introduced for certain types of harm and states often specify the types of actions or injuries for which moral damages are recoverable or they define the term moral injury.

The law of damages in South Africa, which was heavily influenced by Roman Dutch Law allows for vindictive damages, nominal damages, and special or sentimental damages. High damage awards are justified because they can force the state to internalise the cost of its wrongful conduct and deter such behaviour when the expected costs would exceed the expected benefits.’
‘While law and morality are obviously related, it’s important to understand that they are definitely not the same thing. Once we understand that, we will come one step closer to building the kind of society we all want, but can’t seem to achieve,’ Professor Rossouw comments.

‘Once we have understood this distinction between legality and morality, we still have to confront another challenge: developing a moral code that is widely accepted as a basis for behaviour, and thus is something that can act as a yardstick for behaviour. Our problem is that morality tends to emanate from amongst others, religious and cultural systems, and we have a plethora of both in our country,’ Professor Rossouw says.

One positive is that most of the world’s great religions share many basic moral tenets—Christianity, Judaism, Hinduism and Islam are all well represented in South Africa. This “universal morality” could be combined with African philosophies, like Ubuntu, to create a moral code that all South Africans could use to self-regulate their actions.’

‘This is an important public discussion that needs to occur, because without a fairly broad consensus, people will not appropriate the moral code into the way they live and act, and actions will continue to be judged on their strict legality and nothing more,’” he argues. “We also need strong examples of moral leadership, where people act in terms of their morality rather than waiting to see if they can slip in under the law.

“The way in which the former SARS Commissioner, Oupa Magashula, resigned in the wake of a scandal was not properly celebrated for the moral courage displayed in resigning. Mr Magashula could have hung on and fought a lengthy court battle, and maybe even have been exonerated, but he seems to have decided that, questions of legality aside, he should take responsibility for the morality of his actions. By contrast, Travelgate saw parliamentarians demonstrating a lack of moral leadership by sheltering behind the defense of legality.’

There are no adequate words to describe the behavior of a PTSD driven adrenaline junkie, using alcohol and success to self medicate. Nothing makes sense, and on the rare occasions it does the other shoe soon drops.

Dirk will put substance to the warning given by an early career counselor, in particular that he will develop a pattern of not completing anything he starts. He does not complete his bachelors degree. Even he is eventually unable to explain away his resume as following the computer industry up its promotional ladder.

What starts as a sexual tryst on a business trip while engaged to Terry, progresses to infidelity while married to Julie, and then to out-of-control sexual debauchery. Dirk turns to Zambia, with crazy plans to open an alluvial tin mine as a cover for smuggling emeralds. Unfortunately his endeavors do not have the happy ending of a Wilbur Smith novel.

South Africa bomb a southern terrorist base in Zambia and Dirk is lucky to escape with his life.

Dirk and Julie move to England, but the marriage is doomed by his undiagnosed and untreated alcoholism. He abandons the marriage and his children, unable to face admitting that he has acquired a viral STD, refusing to settle down, and having becoming involved in an affair with his sales assistant Joe.

Dirk remains one job ahead of his next firing, eventually landing the one job still available to people like him. He builds his own company called InSite Computer Technology. Circumstances intervene, and his contentious outspoken character is perfectly suited to Microsoft, who need someone to rock their customers boat, and who they can blame for the "not British" directness much needed to stall their big customers from turning to Lotus Notes.

Insite is saved from Dirk's financial mismanagement, when Verity, a Silicon Valley public company needs his relationship with Microsoft, aquires them. In a rare moment of financial prudence, Dirk uses the money to provide for his daughters education and to secure the family home in Coventry.

Dirk moves to Silicon Valley, where his alcoholism follows him. Three engagements and numerous partners later Dirk has lost all sense of relational integrity with the opposite sex. A close friend is defined as anyone who will drink with him in the bar. Verity tolerate his behavior as they do not want to lose his inside knowledge to the competition.

Verity's value rises with the financial boom, and Dirk's worth in close accord. His daughters live a dual life of American opulence when visiting, and conservative middle-class for the rest of the year with their mother.
The only common denominator in the chaos he brings to all those who engage with him, is a systemic lowering of the moral standards by which he conducts himself.

**Betrayal Trauma**

Freyd, J.J. (2014). *What is a Betrayal Trauma? What is Betrayal Trauma Theory?* [http://pages.uoregon.edu/dynamic/jjf/defineBT.html](http://pages.uoregon.edu/dynamic/jjf/defineBT.html).

‘The traditional assumption in trauma research has been that fear is at the core of responses to trauma. Freyd (2001) notes that traumatic events differ orthogonally in degree of fear and betrayal, depending on the context and characteristics of the event. Research suggests that the distinction between fear and betrayal may be important to posttraumatic outcomes. For example, DePrince (2001) found that self-reported betrayal predicted PTSD and dissociative symptoms above and beyond self-reported fear in a community sample of individuals who reported a history of childhood sexual abuse.’

‘Betrayal Trauma:’ The phrase "betrayal trauma" can be used to refer to a kind of trauma independent of the reaction to the trauma. From Freyd (2008): *Betrayal trauma occurs when the people or institutions on which a person depends for survival significantly violate that person’s trust or well-being: Childhood physical, emotional, or sexual abuse perpetrated by a caregiver are examples of betrayal trauma.’

‘Betrayal Trauma Theory:’ From Sivers, Schooler, & Freyd (2002): *A theory that predicts that the degree to which a negative event represents a betrayal by a trusted needed other will influence the way in which that events is processed and remembered.’

‘What is betrayal blindness?’ Betrayal blindness is the unawareness, not-knowing, and forgetting exhibited by people towards betrayal (Freyd, 1996, 1999). This blindness may extend to betrayals that are not traditionally considered "traumas,” such as adultery, inequities in the workplace and society, etc. Victims, perpetrators, and witnesses may display betrayal blindness in order to preserve relationships, institutions, and social systems upon which they depend.’

‘From this talk - Freyd, J.J. Memory repression, dissociative states, and other cognitive control processes involved in adult sequelae of childhood trauma. Invited paper given at the Second Annual Conference on A Psychodynamics - Cognitive Science Interface, Langley Porter Psychiatric Institute, University of California, San Francisco, August 21-22, 1991:

"I propose that the core issue is betrayal -- a betrayal of trust that produces conflict between external reality and a necessary system of social dependence. Of course, a particular event may be simultaneously a betrayal trauma and life threatening. Rape is such an event. Perhaps most childhood traumas are such events." Betrayal trauma theory was introduced: "The psychic pain involved in detecting betrayal, as in detecting a cheater, is an evolved, adaptive, motivator for changing social alliances. In general it is not to our survival or reproductive advantage to go back for further interaction to those who have betrayed us. However, if the person who has betrayed us is someone we need to continue interacting with despite the betrayal, then it is not to our advantage to respond to the betrayal in the normal way. Instead we essentially need to ignore the betrayal....If the betrayed person is a child and the betrayer is a parent, it is especially essential the child does not stop behaving in such a way that will inspire attachment. For the child to withdraw from a caregiver he is dependent on would further threaten his life, both physically and mentally. Thus the trauma of child abuse by the very nature of it requires that information about the abuse be blocked from mental mechanisms that control attachment and attachment behavior. One does not need to posit any particular avoidance of psychic pain per se here -- instead what is of functional significance is the control of social behavior."’
‘Is gender a factor? It appears that men experience more non-betrayal traumas than do women, while women experience more betrayal traumas than do men. These effects may be substantial (Goldberg & Freyd, 2006; Freyd & Goldberg, 2004) and of significant impact on the lives of men and women (DePrince & Freyd, 2002b). To the extent that betrayal traumas are potent for some sorts of psychological impact and non-betrayals potent for other impacts (e.g. Freyd, 1999), these gender differences would imply some very non-subtle socialization factors operating as a function of gender.’

‘Is betrayal trauma related to Stockholm syndrome? In cases where Stockholm syndrome has occurred, the captive is in a situation where the captor has stripped nearly all forms of independence and gained control of the victim’s life, as well as basic needs for survival. Some experts say that the hostage regresses to, perhaps, a state of infancy; the captive must cry for food, remain silent, and exist in an extreme state of dependence. In contrast, the perpetrator serves as a mother figure protecting her child from a threatening outside world, including law enforcement’s deadly weapons. The victim then begins a struggle for survival, both relying on and identifying with the captor.” (Fabrique, Romano, Vecchi, & Van Hasselt, 2007) ’

Christina Gamache Martin, Lisa DeMarni Cromer, Anne P. DePrince, Jennifer J. Freyd; The Role of Cumulative Trauma, Betrayal, and Appraisals in Understanding Trauma Symptomatology; Psychol Trauma. 2013 March 1; 5(2): 110–118. doi:10.1037/a0025686.

‘Poor psychological outcomes are common among trauma survivors, yet not all survivors experience adverse sequelae. The current study examined links between cumulative trauma exposure as a function of the level of betrayal (measured by the relational closeness of the survivor and the perpetrator), trauma appraisals, gender, and trauma symptoms.’

‘The trauma survivor’s relationship to the perpetrator is an established predictor of trauma-related psychopathology, with interfamilial or interpersonal traumas being associated with more negative psychological outcomes than extra-familial or non-interpersonal traumas (Cromer & Smyth, 2010; Freyd, Klest, & Allard, 2005; Lawyer, Ruggiero, Resnick, Kilpatrick, & Saunders, 2006). Betrayal trauma theory (Freyd, 1996) offers one possible explanation to account for these differences. Founded in attachment theory, betrayal trauma theory proposes that trauma that is perpetrated by a trusted or depended upon other (i.e., a high betrayal trauma) is more psychologically damaging than trauma perpetrated by a non-close other, or non-interpersonal traumas. The concurrent states of dependence and abuse are at odds with one another, creating a conflict for the victim between the need to stay engaged in a relationship and the need to defend oneself. According to betrayal trauma theory, betrayal awareness is suppressed when survival and attachment are at stake. In order to obtain basic needs (e.g., food, shelter, or attachment), the victim will attempt to maintain a relationship with the perpetrator, potentially resulting in unawareness of the trauma and/or self-blame. This puts victims at long-term risk for mental health problems.’

ROBYN LATRICE GOBIN; TRAUMA, TRUST, AND BETRAYAL AWARENESS; DISSERTATION; September 2012

‘Women and men who experience early interpersonal violence are at increased risk for subsequent victimization. Little is known about the mechanisms by which early trauma increases vulnerability for revictimization. According to Betrayal Trauma Theory, harm perpetrated by close others early in life may impair the ability to accurately decipher trust and identify betrayal, thus increasing risk for future violation. Dissociation, a state of cognitive, emotional, and experiential disconnectedness, is theorized to facilitate impaired betrayal awareness, and peritraumatic dissociation (i.e., dissociation at the time of a traumatic event) has been linked to revictimization. These findings provide a solid foundation for future research aimed at understanding the ways high betrayal trauma impacts social and emotional functioning, and thus, increases risk for future victimization. Deficits in trust and betrayal awareness appear to contribute to revictimization risk. Intervention efforts for survivors of high betrayal trauma should aim to repair trust and betrayal awareness.

It is important to mention that much controversy exists in the research community about: the distinction between “normal” psychological distress related to life events and PTSD as a mental health pathology; and whether or not the prevalence of PTSD can be effectively measured in population-level studies. According to authors critical of the current Western psychiatric categorization of PTSD, diagnosis of this condition and development of related interventions should be re-evaluated using a more critical lens (Summerfield, 2001, 2004; Wakefield, 2007).’
Jennifer Hardnek; Surviving intimate partner violence: Exploring denial of abuse using Betrayal Trauma Theory; Department of Psychology, University of Cape Town

‘Intimate partner violence (IPV) is one of the most salient social problems attributed to the high rate of societal violence in post-apartheid South Africa. My study is based on interviews with women from lower socio-economic areas around Cape Town who have lived under the victimisation of repeated violent abuse by their partners for many years before making a decision to divorce or separate with their partners... The study reports that at the core of the experience of living with IPV is the mechanism of denial, which is employed for a range of reasons mainly in order to minimise, and thus to endure the impact of IPV. This is because the woman feels powerless to change the situation or lives with the hope that things will change. This psychological dimension brings back trauma theory into the analysis of IPV. It is suggested that the concept of “betrayal trauma” could be usefully applied to understand the common pattern of denial among the participants in the study.’

Cyril K Adonis; Exploring interpersonal issues and challenges confronting ex-combatant fathers and their sons in post-apartheid South Africa; South African Journal of Psychology 2014, Vol. 44(1) 60–72 © The Author(s) 2014

‘... no one wants to remember what we did for them . . . They only want to pay attention to us when they think we are a security risk . . . It’s hard to socialise with anyone but a comrade. People don’t understand you . . . Our children will spit on the graves of the stupid fathers who went to war, stupid war, and got nothing in return . . .

Nell and Shapiro (2012, p. 27).

The quotation above captures the plight of many ex-combatants who had engaged in armed resistance against the apartheid state since the 1960s, at a huge cost to them and their families (Gear, 2002).’

‘Thus, ex-combatants were expected to abandon their militarised past and identities, yet they were confronted with a context where there were and still are few opportunities for them to build alternative identities (Gear, 2002). Van der Merwe and Lamb (2007) have attributed the failure of the DDR programme to poor planning, coordination, and implementation of effective programmes. Furthermore, despite the availability of state funding, spending had been sporadic, difficult to access, and politically selective (Nell & Shapiro, 2012). In addition to this, Cock (2004) claims that an independent audit report in 2000 uncovered misuse or possible misappropriation of some R300 million earmarked for the retraining of ex-combatants.’

‘Combat experience has also left many of them emotionally distressed, which has been further compounded by their frustration at not being understood by their families, their communities, and society at large (Abrahams, 2006). They are saddled with the stigmatisation of having fought for the struggle but not having anything to show for it (Nell & Shapiro, 2012). This has rendered many ex-combatants vulnerable to what can be referred to as social exclusion,...’

‘This, coupled with economic marginalisation, has served to further make ex-combatants vulnerable to other social ills such as criminality, domestic violence, suicide, and drug and alcohol abuse (Nell & Shapiro, 2012).’

‘Furthermore, on being requested to reflect on the direct personal impact that combat experience had on their lives, participants in Abraham’s (2006) study reported nightmares, poor concentration, feelings of anger, violent behaviour, aggression, paranoia, vengeful thoughts, blaming, and difficulty in taking on social roles such as mother, father, or breadwinner.’

‘According to Abrahams (2006), as well as Gear (2002), the failure of the DDR programme, including the lack of psychosocial support to deal with combat-related post-traumatic stress disorder (PTSD) has compromised the emotional, psychological, and social well-being of many ex-combatants.’

‘Although we are accustomed to think of silence as the absence of sound, it functions in families in ways that are much more complex (Danielli, 1998). ‘Family members know more than they are told, intuit more than they see, and register more than they hear’ (Weingarten, 2004, p. 51). The implication of this is that combat experience can impact on the emotional, psychological, and social well-being of not only ex-combatants but also on their children, particularly their sons due to identification with the same-sex parent (Goertz, 1998).’
‘The effects of combat on the children of ex-combatants have received significant international scholarly attention, particularly in the United States (e.g. Glenn et al., 2002; Rosenheck & Fontana, 1998). In South Africa, research of this nature is lacking. This is unfortunate given the precarious situation ex-combatants and their families face.’

‘The results of the study support conclusions from international research that has documented impaired family relations among military veterans. In terms of this, these families are typically characterised by increased levels of conflict and violence, decreased levels of self-disclosure, sociability, affection, intimacy, and cohesion (Carroll, Rueger, Foy, & Donahoe, 1985).’

‘Finally, the results also support previous research which highlights the fact that ex-combatants are likely to have been traumatised given their experiences of physical and psychological torture (Gear, 2002). One father was the sole survivor of a bomb blast in which three of his comrades died, while another was thrown from the fourth floor of the police station where he was detained. While ex-combatants have recognised the need for them to get psychosocial support, many have not received any (Cock, 2004; Mashike, 2004). In some cases, this is because of a lack of awareness of the availability of support services. while in others, they have been reluctant to access services because of fear of stigmatisation (Abrahams, 2006).’

**Institutional Betrayal**

Freyd, J.J. (2014). *What is a Betrayal Trauma? What is Betrayal Trauma Theory?* [http://pages.uoregon.edu/dynamic/jjf/defineBT.html](http://pages.uoregon.edu/dynamic/jjf/defineBT.html).

‘The term "Institutional Betrayal" refers to wrongdoings perpetrated by an institution upon individuals dependent on that institution, including failure to prevent or respond supportively to wrongdoings by individuals (e.g. sexual assault) committed within the context of the institution. The term "Institutional Betrayal" as connected with Betrayal Trauma Theory is discussed in more detail in various publications, including in a section starting on page 201 of Platt, Barton, & Freyd (2009) and in a 2013 research report (Smith & Freyd, 2013). Institutional betrayal is a core focus of the book *Blind to Betrayal*, by Freyd and Birrell, 2013. Currently the most definitive exploration of institutional betrayal is presented in the *American Psychologist* (Smith & Freyd, 2014).’

Carly Parnitzke Smith and Jennifer J. Freyd University of Oregon; **Institutional Betrayal**; September 2014; *American Psychologist*

‘A college freshman reports a sexual assault and is met with harassment and insensitive investigative practices leading to her suicide. Former grade school students, now grown, come forward to report childhood abuse perpetrated by clergy, coaches, and teachers—first in trickles and then in waves, exposing multiple perpetrators with decades of unfettered access to victims. Members of the armed services elect to stay quiet about sexual harassment and assault during their military service or risk their careers by speaking up. A Jewish academic struggles to find a name for the systematic destruction of his people in Nazi Germany during the Holocaust. These seemingly disparate experiences have in common trusted and powerful institutions (schools, churches, military, government) acting in ways that visit harm upon those dependent on them for safety and wellbeing. This is institutional betrayal.”¹⁶²

Recent public focus on systemic violence suggests that this willingness to be aware of institutional wrongdoing is growing.’

‘Institutional betrayal is associated with complex outcomes similar to those associated with interpersonal betrayal. When measured directly, the exacerbative effects of institutional betrayal on psychological well-being are clear and consistent with betrayal trauma theory: higher rates of dissociation (see Figure 1), anxiety, sexual dysfunction, and other trauma-related outcomes (Smith & Freyd, 2013). When institutional betrayal is not measured directly, it is possible to infer its effects by comparing experiences likely to be high in institutional betrayal to experiences less likely to include this type of betrayal.’

**Institutional Characteristics**

Examination of those settings in which traumatic events are *more likely* to transpire can help increase understanding of institutional-level policies, practices, and cultures that can serve to condone, hide, or normalize trauma. Those institutions most often associated with egregious and/or frequent allegations of abuse have several characteristics in common. ’
Membership Requirements
Clearly defined group identities with inflexible requirements for membership often precede institutional betrayal.

Prestige
When institutions or their leaders enjoy an elevated role within the community or society, their potential to perpetrate or facilitate abuse can be obscured.

Priorities
Institutional betrayal may remain unchecked when performance or reputation is valued over, or divorced from, the well-being of members.

‘Barriers to Change
When these institutional actions come to light, they almost always deliver a blow to the institutional reputation, quite counter to the risk management intent. Yet many institutions continue to operate in this manner due to at least three barriers to change.’

‘The first is a lack of language around the issues that continually arise (e.g., child abuse in religious organizations) only to be apparently seen for the first time, each time. This is beginning to shift as terms such as professional perpetrators (Sullivan & Beech, 2002), secondary victimization (Campbell & Raja, 2005), institutional abuse (Carr et al., 2010; McDonald et al., 2012), and institutional betrayal (Smith & Freyd, 2013) enter the literature and allow for connections across occurrences and institutions.’

Lemkin also noted both American and European citizens’ abilities to “live in a twilight between knowing and not knowing” about the genocide occurring across Europe (Power, 2007, p. 35). This “not knowing” is a second common barrier to recognition of institutional and systemic factors in our understanding of trauma. This pattern emerges in workplaces where sexual harassment is common and apparently condoned (Fitzgerald et al., 1997), in schools where abuse is “common knowledge” but unaddressed (Wolfe et al., 2003), and in churches where clergy are reassigned or moved to a new parish after allegations of abuse surface but are otherwise not reprimanded (Dale & Alpert, 2007). Yet this barrier (i.e., maintaining unawareness of injustices around us) is a very human quality, particularly if this knowledge would be threatening to our well-being (Freyd & Birrell, 2013). Not knowing at a societal level is evidenced in the seemingly cyclical nature of social awareness of issues of trauma more generally.

‘A third barrier to incorporating systemic factors into our understanding of trauma arises from a system’s own experiences of trauma. Bloom and Farragher (2010) explained that organizations themselves can be subjected to “cultural trauma” (e.g., punitive policies, sudden loss, accusation of wrongdoing) in much the same as individuals.’

Soul Repair
Syracuse University; The Moral Injury Project; http://moralinjuryproject.syr.edu/about-moral-injury/

‘In the context of a soul, with respect to the diversity of beliefs, including religion, held by those involved with Moral Injury, consider this perspective:

Moral injury is damage to the soul of the individual. War is one of, but not the only thing that can cause this damage. Abuse, rape, and violence cause the same type of damage. “Soul repair” and “soul wound” are terms already in use by researchers and institutions in the United States who are exploring moral injury and paths to recovery.’
‘What will it take to heal our moral injury and repair South Africa’s soul?

Such repair is not the work of government alone, but a work of all of us who are determined to reclaim our humanity.

Whatever else is required, an absolute essential is to bring back the spirit of ubuntu and compassion from exile – back to the centre of our national discourse. His Holiness the Dalai Lama declares that “compassion and love are not mere luxuries. As a source of both inner and external peace, they are fundamental to the continual survival of our species.”

So, let us not sentimentalise compassion. It is not “the religious soft option” – it is the only option. It may be the ultimate realpolitik because without a return to compassion, all other attempts to deal with our moral injury will fail…”

Edward Tick, Ph.D, War and the Soul; Quest Books

…I learned that PTSD is not best understood or treated as a stress disorder, as it is now characterised. Rather it is best understood as an identity disorder and soul wound, affecting the personality at the deepest levels.’

‘Our goal is not just to awaken the soul; that is what childhood, religious and secular education is meant to do. Rather our goal is to grow the soul large enough, to help it become wise and strong enough, so that it can surround the dominating wound we call trauma. When we do this, PTSD can evaporate and we can have people like Mr Tiger (Sic.), devoted to the peaceful cultivation of the earth and to international friendship and reconciliation.’

David Hartman, Diane Zimberoff; Soul Migrations: Traumatic and Spiritual; Journal of Heart-Centered Therapies, 2006, Vol. 9, No. 1, pp. 3-96

‘Just as the human being comes apart at death, with the body dying and decaying while “the breath of life” persists, we suggest that a person comes apart in a similar way at other crucial junctures of life, such as moments of excruciating shame and delirious orgasmic experience, insurmountable trauma and ecstatic spiritual experience. The abused child, like shipwreck survivors in an overcrowded lifeboat, must sacrifice some aspects of the self in order to preserve others. The more overwhelming the assault, the more essential and closer to the core is that aspect that must be sacrificed. Inner resources such as innocence, trust, spontaneity, courage, and self-esteem were lost, stolen, or abandoned in those early traumatic moments, leaving an immense empty space. The psychic energy cast off through dissociation and splitting, the sacrificed aspects of self, do not simply disappear into thin air, but rather continues in split off form as a primitively organized alternative self. Retrieving these inner resources in age regression to those traumatic events reunites the sacrificial alternative self with the immanent embodied person, strengthening the fabric of the soul’s energetic field.

What we are proposing here is a profound level of splitting in that what is split is neither consciousness nor ego nor self, but rather one’s essential spiritual identity, what we are calling one’s soul.’
A major difference between care and cure is that cure implies the end of trouble. If you are cured you don’t have to worry about whatever was bothering you any longer. But care has a sense of ongoing attention. There is no end. Conflicts may never be fully resolved. Your character will never change radically, although it may go through some interesting transformations. Awareness can change, of course, but problems may persist and never go away. Our work in psychology would change remarkably if we thought about it as an ongoing change rather than a quest for a cure.” Thomas Moore, Care of the Soul

Stigma

Nel van Beelen, Managing editor, Exchange on HIV/AIDS, sexuality and gender; Challenging Stigma;

‘In ancient times, a ‘stigma’ was the mark made in the flesh (burning/cutting) of a slave or criminal. Since the Canadian sociologist Goffman in 1963 defined stigma as “an attribute that is deeply discrediting within a particular social interaction” and “a deviation from the attributes considered normal and acceptable by society,” many other definitions have been proposed, bringing attention to different aspects and causes of stigma. This illustrates the complex interactions and factors leading to stigmatization.’

Patrick Corrigan; How Stigma Interferes With Mental Health Care; University of Chicago

‘Stigma as a social–cognitive construct is only one of several stigma-related factors that undermine obtaining mental health care when in need. Services researchers have examined other interpersonal, economic, and policy factors that also mitigate service use. One manifestation of these factors is structural stigma; namely, economic and political pressures on the culture, rather than psychological influences on the individual, that yield discrimination and undermine care access (Corrigan et al., in press; Link & Phelan, 2001). Rather than stereotypes, prejudice, and discrimination, the products of these forces are social and institutional structures that rob people of opportunities.'
Structural stigma develops during historical epochs that can be centuries long rather than the few years that might describe an individual’s developmental period.’

Centre for the Study of AIDS (CSA), University of Pretoria; SIYAM’KELA Stigma Project: Measuring HIV and AIDS related Stigma in South Africa - From indicators to action

‘Stigma has existed throughout history, usually based on a fear of disease and difference. In essence it is a form of social control, layered onto other forms of discrimination around race, class, gender, sexual orientation, disability and age.’

‘Anti-stigma work should challenge individual attitudes and beliefs but it should also address the social processes which perpetuate stigma. To do this a multi-level, multi-sectorial and holistic approach needs to be adopted. Based on good evidence and research, it should empower individuals and communities to sustain any stigma reduction strategy, utilise a gender focus and be rights based.’

David Pilgrim, Paul Corry; Strategic Review of Anti-Stigma Approach in Scotland: Final Report; University of Liverpool

‘Stigma and discrimination is often contextualised, from the viewpoint of those experiencing it, as a civil or human rights issue; the ending of which would be a good in itself to be shared by society as a whole. Domains of discrimination that could be reached by a broad campaign focused on ending the scourge of discrimination itself would be missed by efforts concentrated through issue-specific initiatives. In this context, it would not be enough to have better access to a service or an improved sense of acceptance. What would be required, ultimately, would be the ending of discrimination itself so that each and every person could enjoy human dignity and respect in the round.

Patricia Geiling Blum PhD Janet Vlavianos; Healing Stigma through Trauma Informed Approaches

‘Defining Stigma

- Stereotypes - attitudes about groups of people, which help to quickly categorize and make decisions about people.
- Prejudice defined as the acceptance of the stereotype.
- Discrimination is the behaviour that results from the prejudice (Corrigan and Lundin 2001)

Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental health issues.’

‘Stigma is Distinguished into Public Stigma and Self-Stigma

Self-Stigma

1. “negative beliefs about the self”;
2. self-prejudice, which results in low self-esteem and low self-efficacy;
3. a self-imposed discrimination, which presents as failure to apply for a job or apartment or to initiate a conversation

Public Stigma

- negative beliefs that persons with mental health issues are dangerous and incompetent;
- prejudice, which is the acceptance of the belief and the emotional reaction; and
- discrimination, which is the response to prejudice (Corrigan, 2005).

Approaches to Mitigate and Eliminate Public Stigma

- Exposure which is direct or indirect contact with individuals experiencing mental health issues
- Education, which can be provided in a Public Campaign or local forums
- Political Action (Corrigan & Gelb, 2006).

How Trauma Informed Approaches Overlap with Stigma Elimination Approaches

- Education on the impact and prevalence of trauma and self-stigma.
- Recognize and validate the signs and symptoms of Trauma and self-stigma.
- Provide emotional support/validation for Trauma and self-stigma
- Share your experience – tell your story – this may be the same story for many individuals
• Responds by fully integrating knowledge about self-stigma and trauma informed approaches into policies, procedures, practices, and settings.
• Community education on impact and prevalence of trauma - which can be provided to mass audiences
• Political action to prevent trauma in all forms
• Exposure – telling your story (Corrigan & Gelb, 2006).

The Anti-Stigma Project; Stigma: Language Matters; http://www.onourownmd.org/projects/the-anti-stigma-project

‘Consider This... DON’T focus on a disability. Focus instead on issues that affect the quality of life for everyone, e.g., accessible transportation, housing, affordable health care, etc. DON’T portray successful persons with disabilities as superhumans. This carries expectations for others and is patronizing to those who make various achievements. DON’T sensationalize a disability. This means not using terms such as "afflicted with," "suffers from," "victim of," and so on. DON’T use generic labels such as "the retarded," "our mentally ill," etc. DON’T use psychiatric diagnoses as metaphors for other situations, e.g. a "schizophrenic situation." This is not only stigmatizing, but inaccurate. DO put people first, not their disabilities. Say, for example, "person with schizophrenia" rather than "schizophrenic." DO emphasize abilities, not limitations. Terms that are condescending must be avoided.’

Stigma and Mental Health

Mental Health Foundation; What are Mental Health Problems? http://www.mentalhealth.org.uk/help-information/an-introduction-to-mental-health/what-are-mental-health-problems/

‘Many people who live with a mental health problem or are developing one try to keep their feelings hidden because they are afraid of other people’s reactions. And many people feel troubled without having a diagnosed, or diagnosable, mental health problem - although that doesn’t mean they aren’t struggling to cope with daily life.’


‘In 2006, the Sainsbury Centre for Mental Health commented that a more tolerant and understanding society ‘would bring about the biggest improvement in the lives of people with mental health problems’ (Sainsbury Centre for Mental Health, 2006, p.12). The British Psychological Society Division of Clinical Psychology has stated that it aspires to a society that regards discrimination against people with mental health problems being ‘as unacceptable as racism or sexism’ (British Psychological Society, 2000, p.7).’

Patrick Corrigan; How Stigma Interferes With Mental Health Care; University of Chicago

‘Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun. One of the reasons for this disconnect is stigma; namely, to avoid the label of mental illness and the harm it brings, people decide not to seek or fully participate in care.

‘Although the quality and effectiveness of mental health treatments and services have improved greatly over the past 50 years, many people who might benefit from these services choose not to obtain them or do not fully adhere to treatment regimens once they are begun. Stigma is one of several reasons why people make such choices; namely, social–cognitive processes motivate people to avoid the label of mental illness that results when people are associated with mental health care.’

‘Research has suggested that people with concealable stigmas (people who are gay, of minority faith-based communities, or with mental illness) decide to avoid this harm by hiding their stigma and staying in the closet (Corrigan & Matthews, 2003). Alternatively, they may opt to avoid the stigma all together by denying their group status and by not seeking the institutions that mark them (i.e., mental health care). This kind of label avoidance is perhaps the most significant way in which stigma impedes care seeking.’

‘People may also avoid the stigma of mental illness because of stigma’s potential effects on one’s sense of self. Living
in a culture steeped in stigmatizing images, persons with mental illness may accept these notions and suffer diminished self-esteem, self-efficacy, and confidence in one’s future (Corrigan, 1998; Holmes & River, 1998). Research shows that people with mental illness often internalize stigmatizing ideas that are widely endorsed within society and believe that they are less valued because of their psychiatric disorder (Link, 1987; Link & Phelan, 2001).

‘What is presented as self-stigma here is clearly influenced by public stigma. Hence, the two constructs, and their impact on care seeking, are best understood in interaction.’

WHO /Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health; Investing in MENTAL HEALTH; 2003

‘Violations also occur outside institutions: the stigma of mental illness. In both low- and high-income countries, there is a long history of people with mental disorders being stigmatized along with their families. This is manifested by stereotyping, fear, embarrassment, anger, and rejection or avoidance. The myths and misconceptions associated with mental disorders negatively affect the day-to-day lives of sufferers, leading to discrimination and the denial of even the most basic human rights. All over the world, people with mental disorders face unfair denial of employment and educational opportunities, and discrimination in health insurance and housing policies. In certain countries, mental disorders can be grounds for denying people the right to vote and to membership of professional associations. In others, a marriage can be annulled if the woman has suffered from a mental disorder. Such stigma and discrimination can, in turn, affect a person’s ability to gain access to appropriate care, recover from his or her illness and integrate into society.’

Minister’s Advisory Group on the 10-Year Mental Health and Addictions Strategy; Respect, Recovery, Resilience: Recommendations for Ontario’s Mental Health and Addictions Strategy; December 2010

‘Goal #2: Stop stigma and discrimination

Change attitudes. The stigma that people with mental illnesses and addictions experience – in housing, the workplace, the health system, the justice system and other human services, the media and from family and friends – affects their health.

Stigma is both a cause and effect of mental illnesses and addictions. It isolates people, and eats at the health of individuals, families and our communities. It is also one of the main barriers to seeking care and following treatment plans. (Public Health Agency of Canada, 2002) It keeps people with mental illnesses and addictions from asking for help, and it threatens their recovery and their ability to gain or regain their place in their communities.

Stigma helps explain why parents wait so long to bring their children’s mental health issues to the attention of health care providers. For seniors, the stigma associated with loss of mental functioning often prevents them from accessing services, leaving them in unnecessary and dangerous isolation. Stigma and misperceptions also explains the “not in my backyard” reaction of many members of the public to having mental health and addictions services in their neighbourhoods.

As a group, health professionals are no less susceptible to discriminatory beliefs than the general population. Many people with mental health and addiction problems report experiencing stigma when they try to use the health care system and other public services. A recent study of resident physicians in a range of specialties showed that education and work experience had little effect on their attitudes towards people with mental illnesses and/or addictions. What does make a difference is personal experience: the doctors with the most positive attitudes were those who had family members with a psychiatric illness. (Carol et al., 2008)

For many people, the stigma of mental illness and addictions is exacerbated by other forms of discrimination, including racism, ageism, and homophobia. Stigma and discrimination is a particular issue for people seeking health care services and for people who have contact with the justice system. Workplace policies and practices that do not accommodate people with mental illness or addiction lead to structural discrimination in employment. Discrimination against people with a mental illness or addiction also limits their ability to access affordable housing and be part of the wider community. (CMHA website, 2010)’

SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH (SAFMH); http://www.safmh.org/index.php/who-we-are/what-we-do/human-rights#sthash.WVmMjBVI.dpuf

‘Despite the advancements in human rights focussed legislation, progress made in medical science in terms of diagnosing and treating mental disorders and improved understanding of mental disorders in general, we are still
stuck with stigma and related discrimination, and this fact is clearly acknowledged by our Government. Stigma involves elements of ignorance, attitude and behaviour where negative responses are directed at a certain group of society – persons with mental disorders are one of the most vulnerable among all the marginalised groups of society. Stigma and related discrimination has a huge impact on a person’s life, and causes severe disabling effects, even more so than the symptoms of their mental disorder. It creates barriers that prevent mental health care users from accessing and enjoying their Constitutional rights.

Human rights related issues affect persons with psychosocial and intellectual disabilities severely as they form part of the marginalised groups of society and have to deal with the impact of stigma and discrimination attached to these disabilities, that frequently lead to human rights violations. A large number of those experiencing human rights violations don’t report it, some don’t know where to report it and others who do report it often find that their case ends up unresolved.

**SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH (SAFMH);**
http://www.safmh.org/index.php/who-we-are/what-we-do/advocacy#sthash.VI1r0CZW.dpuf

‘Outside of the mental health field and within communities, persons with psychosocial and intellectual disabilities must be empowered to participate at all levels of their lives. Prevalence rates of stigma attached to these disabilities are very high (not just in SA, but worldwide), which creates barriers in accessing and enjoying all rights enshrined in the South African Constitution’s Bill of Rights and other relevant policies and legislation such as the UN Convention on the Rights of Persons with Disabilities. Persons affected by these “invisible” disabilities however play a crucial role in breaking down these barriers through being empowered and actively engaging with the public and private sectors, and expressing their concerns, needs, challenges and working together to overcome these. Because of their personal experiences, these individuals are also a key source of awareness on mental health, with direct access to and in-depth knowledge about specific communities across South Africa.’

David McDaid; *Countering the stigmatisation and discrimination of people with mental health problems in Europe; European Commission*

‘Stigma and prejudice contribute to the fundamental abuse of human rights that sadly continue to be seen in some of the outdated large psychiatric institutions and social care homes that remain the mainstay of mental health systems in some Member States. This abuse manifests itself in many ways; even where community based care dominates, as in much of western Europe, individuals can be just as neglected and isolated within their communities as they were previously in institutions.’

‘Stigma can also reduce the willingness of public policymakers to invest in mental health. Some public surveys have indicated that mental health is seen as a low priority when it comes to determining how to allocate health system funds. Several studies have also reported that the general public may believe that people with mental health problems cannot be treated within the health care system and instead should make use of complementary and alternative medicines.’

‘To this day the stigmatisation of people with mental health problems can lead to people being discriminated against in daily life, being denied access to goods and services or being treated unfairly. It is seen right across the globe regardless of differences in culture and context.

Why is this? Perhaps because negative attitudes to mental illness are firmly entrenched in individuals early in life: children are, for instance, exposed early to television programmes with ‘crazy, loony’ characters, ‘stereotypical, blatantly negative and served as objects of amusement, derision or fear’. Certainly by adolescence these views are well developed. In one survey 250 terms were used by 400 fourteen year olds in schools in England to describe mental illness; not one of these terms expressed people with mental health problems in a positive light while 116 were highly derogatory.

But what perhaps singles out the stigmatisation of people with mental health problems, from other potentially marginalised groups, e.g. women, ethnic minorities and people with disfigurements or physical disabilities, is the lack of voice that they often have in fighting against discrimination. They are among the most marginalised of groups within society: often service user organisations are poorly funded and reluctant to take any funding from industry. Stigma, discrimination and social exclusion do not end with people with mental health problems; there are also substantial impacts on family, friends and other individuals who come into contact with people with mental health problems, such as social workers and psychiatrists.’
Stigma plays a major role in the persistent suffering, disability and economic loss associated with mental illnesses. Persons with mental illnesses are often victimized for their illnesses and face unfair discrimination, such as difficulties accessing housing, employment, and other societal roles. They are often mistreated by their family and friends, as well as in the community. Loss of family and/or peer support, loss of employment and lack of access to mental health services (either because of limited access to services or because of the stigma towards seeking mental health care) can worsen their mental illness. It can also place these individuals at increased risk of substance abuse and criminal activities. Many of these individuals consequently end up in the criminal justice system instead of being treated in mental health services. Other factors such as poverty also compound the detrimental effects of stigma on individuals with mental illnesses.’

‘The success of any anti-stigma intervention relies heavily on the content and mode of the intervention as well as the selection of an appropriate measure and method to evaluate its impact. One cannot assume that increasing awareness about mental illnesses will lead to change in attitudes and behaviour. Educational programmes in other areas have often shown little effect in changing behaviour. For example, programmes to educate adolescents to practice

In order to properly assess stigma-reduction interventions, a better understanding of the complex manifestation of stigma in the South African context must first be gained. Strategies to optimize the impact of such interventions can then be developed and evaluated. Promotion of such research and subsequent dissemination would make a scientific contribution locally and internationally, allow for stronger evidence-based policy, and inform future planning of anti-stigma campaigns in South Africa and elsewhere.’

Jayasree Kalathil; Beth Collier, Renuka Bhakta, Odete Daniel, Doreen Joseph, Premila Trivedi; Recovery and resilience: African, African-Caribbean and South Asian women’s narratives of recovering from mental distress; Survivor Research. User-led perspectives in Mental Health

‘The treatment of “the mentally ill” has historically centred on the individual and, as histories of psychiatry have shown, there has been an element of blame attached to the individual seen as insane or mad, including a lack of will or self-control or a sense of morality (Foucault 1965, Mack 1975, Wirth-Cauchon 2001). A bio-medical explanation, based on genetics or chemical imbalance, externalises the responsibility for distress and to a certain extent allows people to free themselves of the blame. Groups as diverse as the National Alliance of the Mentally Ill (NAMI) in the US to NGOs and user/carer groups in India have used the bio-medical model as a weapon to fight against stigma and discrimination of mental health issues in society, for example, through arguing that it was “an illness like any other” (Sayce 2000).’

‘However, it has been suggested that bio-medical models create their own stigmas based on assumptions about difference, disorder and dangerousness, both within their own communities and families and in the wider society (Prins, et al. 1993, Taha and Cherti 2005, Fitzgibbon 2007, Corrigan 2007). Psychiatry has a history of pathologising both black communities and women (along with other “non-normative” groups like homosexuals) based on definitions of deviance and disorder in opposition to the definitions of ‘normalcy’ and ‘reason’ of Europeans (Metzl 2010, Wirth-Cauchon 2001, Showalter 1987).’

HEALTHY AGING AND DEPRESSION; Overcoming Stigma: Double Trouble: Stigma and Depression

‘Older adults who experience depression must deal with double trouble, according to Patrick Corrigan, professor of psychiatry at the Illinois Institute of Technology and principal investigator of the Chicago Consortium for Stigma Research. One challenge, of course, is the burden of depression itself, which affects a significant number of older men and women (see sidebar, left). But another is stigma — the widely held, but false, perception that people who have depression and other mental problems are dangerous, incompetent, or weak. These stereotypes persist in books, film, and television and thus in the hearts and minds of the public.

There are three types of stigma:

1. **Public stigma** occurs when health care providers, employers, and the general public develop and sustain negative stereotypes about people with mental illness.
2. **Self-stigma** occurs when individuals with mental illness apply negative stereotypes to themselves.

3. **Institutional stigma** occurs when assumptions about persons with depression are translated into public policy and funding decisions that discriminate against people with mental illness.

*The American Nurse; Overcoming stigma; Education and advocacy can make a difference in mental health care and services*
(The American Psychiatric Nurses Association (APNA), American Nurses Association (ANA))

‘Every nurse is a mental health nurse, but it takes skills, training, and specialization to become a psychiatric nurse,” Moller explained.

That said, she added, “[non-psychiatric specialty] nurses need to get rid of their fear of working with patients with psychiatric disorders, and one way is through education.’

APNA President-elect Marlene Nadler-Moodie, MSN, APRN, PMHCN-BC, agreed, noting that, “general nurses do tend to feel like working with patients with mental illness is out of their scope of understanding. But the more they learn, the more comfortable they will be.”

“All nurses also need to understand trauma-informed care,” Moller said. (This involves being aware that a medical procedure or hospital stay can trigger earlier trauma, such as childhood abuse.)

They further must understand the role stigma plays, and that mental illness is “as real and valid” as any medical condition, Farley-Toombs said. “And they need to embrace the idea that people with mental illness are working toward recovery and can live meaningful lives.”

*Substance Abuse and Mental Health Services Administration. Developing a Stigma Reduction Initiative. SAMHSA Pub No. SMA-4176. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2006.*

‘Certainly, stigma is one of the more formidable obstacles to a transformed mental health system. Stigma and discrimination against people with mental illnesses leads others to avoid living, socializing or working with, renting to, or employing people with mental illnesses. It leads to low self-esteem and hopelessness. And it deters the public from seeking and wanting to pay for care. Worst of all, it often causes people with mental illnesses to become so embarrassed or ashamed that they conceal symptoms—and avoid seeking the very treatment, services, and supports they need and deserve.’

‘A key to successful communications is addressing your audiences in language with which they are comfortable and with a message they are ready to hear. One example you will notice in virtually all the educational materials developed for the EBI is the reference to “mental health problems,” instead of “mental illnesses.” This was a conscious decision based on considerable testing among target audiences, especially the general public. While targeted audiences responded to “mental health problems” favorably and felt the term covered a wide range of conditions, the term “mental illnesses” came across as frightening; audiences felt that it connoted the potential for violence. Certainly, the public’s reaction to the term “mental illnesses” points out the need for stigma reduction initiatives. Yet a key to effective social marketing is to move audiences up the continuum from rejection to acceptance, and because stigma reduction efforts are at their infancy, it was clear that audiences were not ready to accept the term “mental illnesses,” and the use of the term might have led them to reject the overall message of the EBI.’

‘Mounting a stigma reduction initiative requires a significant investment, in terms of both human and financial resources. It is a full-time job, especially in the early planning stages. It is hard work. Yet it is also gratifying. As the ugly veil of stigma gives way to compassion and acceptance, one realizes the reward is worth the hard work.’
Post-traumatic stress disorder (PTSD) was unheard of when Erving Goffman published Stigma in 1963.

“PTSD is a stigma of mental health, what Goffman would call a “discreditable” identity, a “blemish of individual character” that marks its bearer tainted and undesirable. For the sufferer, it means managing a discrepancy in differences between the virtual identity (what is seen by others, including on Facebook) and the actual identity (the hurt self, the symptoms of the trauma). In turn, this creates tension for the person with PTSD because they have to control information about their failing in social interactions, there is a great fear of being found out and seen as not normal. Social life is a constant question of whether or not to disclose potentially discrediting information: “To display or not to display, to tell or not to tell, to let on or not to let on, to lie or not to lie.”

“For the “normals,” (the unafflicted, those who do not depart negatively from society’s expectations) people suffering a stigma are inferior and not fully human and because of this, they act discriminatory and cruel; which ultimately, lessen life chances of the stigmatized. Everyday life is tough for a person with a mental health disorder like PTSD. It means living a life feeling slightly apart from others and fully aware of not possessing the “right” attributes but having to make a show of being well adjusted anyway, so as not to upset the normals.”

“So, who is a normal? A normal is most likely White or light-skinned, middle or upper class, contained in body and spirit and a person who is thought of as “friendly” or “honest” (regardless of whether they actually are). They are an ideal and they are everywhere. They are on our TV’s, in our movies and magazines, on the boxes of products we purchase to improve ourselves. The constant cultural message is “you’re not good enough, buy this.” There is a sense, I think, that being “normal” might be equated with being “perfect.”

Many individuals who seek treatment in behavioral health settings have histories of trauma, but they often don’t recognize the significant effects of trauma in their lives; either they don’t draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether. Likewise, treatment providers may not ask questions that elicit a client’s history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program’s clinical orientation, or their agency’s directives.

‘Because of their abuse experiences, most adult survivors [of child abuse] feel stigmatized and experience people as dangerous and not to be trusted. Attending parties or other social gatherings can evoke anxiety, insecurities and concerns over not being ”good enough.” Fear of rejection is also a common concern for survivors. And, because they were usually harmed by adults whom they trusted, survivors tend to carry their fear of being harmed by others into the present.

Many survivors end up living in isolation because it feels safer and less threatening to them. The role of the recluse, employed during childhood to avoid the abuse, becomes in adult life a means of protecting oneself against hurt. Sometimes the threat is real; other times it is imagined. When survivors do venture out into the world and attempt to establish contact with others, they may be tremendously sensitive about how they are treated. Survivors may experience joking or teasing — intended as lighthearted banter appropriate to the social situation — as critical or hostile and at their expense.

Much of survivors’ difficulties in social situations have to do with never having learned how to communicate. Others may have ignored or invalidated survivors’ childhood opinions and perceptions, and left them wondering how to relate to people. If you expect rejection, criticism and humiliation, it is hard to learn to speak with conviction, listen with interest and telegraph your receptivity to others via body language and non-verbal cues.”
Stigma and HIV/Aids

Fareed Abdullah, Chief Executive Officer, South African National AIDS Council; The People Living With HIV Stigma Index: South Africa 2014; SUMMARY REPORT; MAY 2015

‘When the National Strategic Plan was being written, activists of the people living with HIV (PLHIV) sector wisely demanded that the reduction of stigma and discrimination becomes one of the five main goals of the HIV response. This report shows that they were right.

South Africa has made good progress in dealing with HIV related stigma and the levels of stigma are relatively low when analysing instances of stigma independently of each other. When composite scores of external and internal scores are analysed the report shows that there is still a moderate level of stigma affecting about one-third of PLHIV who took part in the study. Unsurprisingly, the report shows that internalized stigma is still a major challenge in South Africa with more than 40% of PLHIV expressing feelings of internalized stigma.

For many years, subjective views have dominated the discourse on the levels of stigma and discrimination in the country. This report provides an objective view that will serve as a baseline for future comparisons.’

Centre for the Study of AIDS (CSA), University of Pretoria; SIYAM’KELA Stigma Project: Measuring HIV and AIDS related Stigma in South Africa - From indicators to action

‘HIV and AIDS-related stigma continues to be a major challenge for all those affected by, and working in, the HIV and AIDS epidemic. Stigma has an impact on prevention, testing, treatment and care, and hampers the efforts of government and civil society. Primarily a negative attitude towards people living with HIV/AIDS (PLHA), stigma can also be attached to people merely suspected of being HIV positive, or those close to a person living with HIV/AIDS, such as a partner, family member or caregiver. When this negative attitude turns into acts which result in unjustified treatment, we call this discrimination. Sometimes stigma can be internalised, resulting in feelings of shame and self-blame, and a range of self-protective behaviours, including the inability to disclose HIV status.’


‘Stigmatisation of persons with physical disabilities is well-documented (Bagenstos 2000; McMaugh 2011; Tyrrell et al. 2010; Wang & Dovidio 2011). According to Bagenstos, society has historically discriminated against persons with disabilities based on their ‘abnormal’ appearance. In this study, therapists identified that stigmatisation of persons with disabilities made it very difficult for these patients to obtain transport to attend therapy. The prejudice against persons with disabilities in this study also seemed to be largely related to the fact that they looked different and as a result the cultural belief that a person was ‘bewitched’.’

Nel van Beelen, Managing editor, Exchange on HIV/AIDS, sexuality and gender; Challenging Stigma;

‘Stigma not only affects the quality of life of PLWH and their access to quality treatment and care, but also fuels an invisible internal fire, causing further spread of the virus. When people know that they will encounter stigma and discrimination, they will be less motivated to go for testing and disclose their HIV status. A study in South Africa showed the association between fear of stigma and non-disclosure to sexual partners. It also showed that non-disclosure is closely related to behaviours that support the transmission of HIV. Often, due to stigma, the delay in time between knowing one’s HIV-positive status and the time of disclosure (to sexual partners) can be months up to years, while during this time episode unprotected sex is not unusual.’

‘Many indicators have been developed to investigate different levels and aspects of HIV-related stigma. A lot of them have been summarized in a publication of the International Federation of the Red Cross and Red Crescent Societies (IFRC), GNP+ and UNAIDS.4 They can be used in epidemiological surveys (e.g. the percent of respondents expressing accepting attitudes towards PLWH), but can also be used to measure the existence and decrease of stigma as the result of concerted actions or a single project or programme.’
**Examples of indicators**

<table>
<thead>
<tr>
<th>Measuring</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>The percent of respondents expressing accepting attitudes towards PLWH</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Number of PLWH who report cases of others who distance themselves from them physically</td>
</tr>
<tr>
<td>Rejection</td>
<td>Number of people who feel that PLWH would not be welcomed in their homes</td>
</tr>
<tr>
<td>Moral judgment</td>
<td>Number of people who use the concept of blame to inform their response to PLWH</td>
</tr>
<tr>
<td>Abuse</td>
<td>Number of PLWH who have been physically abused as a result of their HIV status</td>
</tr>
<tr>
<td>Pre-existing stigma</td>
<td>Number of cases of discrimination against MSM in the public/private health systems</td>
</tr>
<tr>
<td>Internal stigma: self-exclusion</td>
<td>Number of PLWH who choose not to apply for a job because of their fear of being exposed as HIV-positive</td>
</tr>
<tr>
<td>Stigmatization in health care</td>
<td>Mechanisms in place to identify PLWH in the health system / Number of health centres with anti-discrimination workplace policies</td>
</tr>
<tr>
<td>Stigmatization by media</td>
<td>Number of media reports discussing the rights of PLWH</td>
</tr>
</tbody>
</table>

‘Being confronted with many possible indicators linked to stigma, it is crucial in the selection and use of these indicators to be totally clear what is the main purpose of measuring these indicators and which ones are most useful in a specific context. The most suitable indicators should be defined before starting any stigma-related activity and these indicators should be evaluated after the end of the project.’

Sr Silke-Andrea Mallmann; *Building Resilience in Children Affected by HIV/AIDS*; CPS Catholic AIDS; Catholic AIDS Action, Namibia

‘Children are severely affected by the stigma (HIV/AIDS). Research in Africa by the British organisation Save the Children showed the seriousness of the effects.

- Orphans were discriminated against by members of their extended families after the death of their parents. They were expected to work harder than other children in the family. They were often the last to receive food and/or to have their school fees paid. Some orphans were isolated from the other family members because it was believed that they were infectious and would transmit HIV/AIDS.

- Orphans of school-going age and children with infected parents reported that other children teased them and called them names. Sometimes the teasing led to physical bullying. They weren’t allowed to play with other children. Many children said that they would rather stay at home than go to school. The children wanted teachers to protect them from the teasing and to respect their privacy. Older children and adolescents said that gossip about people’s HIV/AIDS status by members of the community was common. Many adolescents felt hurt by the gossip and felt that their sense of self-worth was affected. Infected parents felt the same way. They said that it was hard to support their children who were being teased when they were being gossiped about as well.

- Some families keep the HIV-status of a family member secret. In order to hide in order to protect the secret, children and adults draw back from their friends and other social contacts. Some children make up stories about their parents and family. Children may start living in this fantasy world in order to cope with what is actually happening at home. Children between the ages of five and eight may not be able to distinguish between their fantasy world and the real world.

Older children make up stories about their parents because they feel ashamed and because they don’t want to be different from their friends. Some children worry that teachers or other authorities will find out that something is not “normal” at home and they are afraid of having to answer questions. Forced secrecy can be a great burden on children because they have to control what they say, what they do and how they express what they feel.

The secrecy and stigma still attached to HIV/AIDS makes it even more difficult for children to deal with the disease and death of their parents. It is a sad fact that people still think of “AIDS orphans” differently from children who have been orphaned because their parents died of other diseases or were killed in car accidents.

The children themselves cannot change this. They need committed adults, religious groups and organisations, and institutions that are willing to stand up to support these children and fight for their rights. This will eventually erase the stigma that is attached to HIV/AIDS.’
'The attitudes of caregivers and teachers play a role in encouraging normal responses in children. There is a danger in labelling children affected by HIV/AIDS as “orphans and vulnerable children” because the term “vulnerable” sometimes makes us see them as victims. Seeing them only as victims suggests that they are dependant, helpless and unable to survive. This is wrong. They need our support and assistance, but these children are in fact survivors!

Stigma and Substance Abuse


‘Addicted people typically experience a profound compulsion to use substances of abuse. They generally experience a loss of control over the amount of substance used or the amount of time they intended to use the substance. Addicted people typically engage in continued use of substances of abuse despite a multitude of biological, psychological, social, and spiritual adverse consequences. Addicted people frequently experience gut-wrenching episodes of relapse.

As if that’s not enough, addicted people also experience stigma in many areas of their lives and through all phases of active addiction, treatment, and recovery. Although the sting of addiction-related stigma can be felt most strongly and frequently by addicted people, it is also experienced by their family and friends, co-workers, and employers. Even substance abuse treatment providers experience addiction-related stigma.’

‘Recovery is a paradox. During treatment and early phases of recovery, saying the words “I am an addict” is a powerful way to help people understand that their lives have become unmanageable and that they need help. However, during later phases of recovery, the same phrase can prompt some people to define themselves solely by their addiction. The challenge for addicted people, their families, and those who treat them is to recognize that while self-identifying as an addicted person can be liberating, viewing oneself only as an addicted person can be self-limiting.’

‘Stigma erodes confidence that substance-related disorders are valid and treatable health conditions. It leads people to avoid socializing, employing, working with, renting to, or living near persons who have substance-related problems or histories.

- Stigma deters the public from wanting to pay for treatment, reducing access to resources and opportunities for treatment and social services.
- Stigma stops people from seeking help for fear that the confidentiality of their diagnosis or treatment will be broken. It gives insurers—in both the public and private sectors—tacit permission to restrict coverage for treatment services in ways that would not be tolerated for other illnesses.
- Stigma stops people from seeking treatment because of the fear that they will not be treated with respect or dignity within the treatment system.
- Powerful and pervasive, stigma prevents people from acknowledging their substance abuse problems, much less disclosing them to others.
- An inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation, and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society.
- Stigma results in:
  - Prejudice and discrimination
  - Fear and shame
  - Distrust and disgrace
  - Stereotyping and rejection
  - Anger and frustration
  - Avoidance of treatment and inadequate coverage
  - Ostracism and denial of rights’
Victim, Survivor, Thriver

“If it’s never our fault, we can’t take responsibility for it. If we can’t take responsibility for it, we’ll always be its victim.” Richard Bach


‘One problem is, there are elements of our culture that glorify frailty, says Washington, D.C. psychiatrist Steven Wolin, M.D. There is a whole industry that would turn you into a victim by having you dwell on the traumas in your life. In reality you have considerable capacity for strength, although you might not be wholly aware of it. Sometimes it is easier to be a victim; talking about how other people make you do what you do removes the obligation to change. And sympathy can feel sweet; talk of resilience can make some feel that no one is really appreciating exactly how much they have suffered.

Most people mistakenly operate on what Wolin calls "the damage model," a false belief about the way disease is transmitted. It basically says that if your family is having trouble, the chances are high that you will suffer lasting emotional disturbances. It's a prophecy of doom.’

Victim

victim [vɪktɪm]

noun: victim; plural noun: victims

1. a person harmed, injured, or killed as a result of a crime, accident, or other event or action.
   "victims of domestic violence"
   synonyms: sufferer, injured party, casualty, injured person, wounded person; More
   antonyms: attacker, assailant
2. a person who is tricked or duped.
   "the victim of a hoax"
   synonyms: dupe, easy target, easy prey, fair game, sitting target, everybody's fool, stooge, gull, fool, Aunt Sally;
3. a person who has come to feel helpless and passive in the face of misfortune or ill-treatment.
   "I saw myself as a victim"
4. a living creature killed as a religious sacrifice.
   "sacrificial victims for the ritual festivals"
   synonyms: sacrifice, offering, burnt offering, scapegoat
   “he offered himself as a sacrificial victim”.

‘The psychological profile of victimisation includes a pervasive sense of passivity, loss of control, pessimism negative thinking and strong feelings of guilt, shame blame and depression. All this can lead to haplessness and despair.’

‘Being a victim is a great excuse for not questioning difficult life issues. We can remain passive and not take responsibility for our actions. We can take refuge in victimhood to accuse others of the behaviour for which we are really responsible. This is particularly tempting because blaming others for life’s wrong scan have a cathartic effect. We should never underestimate the sense of relief that comes with shifting the responsibility for our misery onto someone or something else. Resorting to this tactic is a relatively low risk proposition. We don’t have to take any chances.'
Assuming martyrdom is also a highly effective cover for our own aggressive inclinations. The blame game combines helplessness with self-protection. As the world is perceived as a dangerous place where nasty things can happen, people suffering from the victim syndrome strike out in this surreptitious way in order to defend themselves against the inevitable aggression of others.

There are advantages to treading water in a sea of misery. Misery loves company, meaning that people who are miserable find solace in others who share their feelings. People with a victim mindset attract others. The feeling we are not alone creates a sense of solidarity, support and interconnectedness. Perhaps we are also nurturing a secret desire for the ‘white knight to materialize and help us out of our misery.

‘Victims of childhood abuse may become victimizers, victims or both. The pain and rage from the abuse and betrayal may turn inward, becoming self-destructive or turn outward toward others manifested in passive-aggressive behaviours.’


‘Seven steps to breaking out of victimhood

1. Know the benefits of a victim mentality.
   • Attention and validation.
   • You don’t have to take risks.
   • Don’t have to take the sometimes heavy responsibility.
   • It makes you feel right.
2. Be ok with not being the victim.
3. Take responsibility for your life.
4. Gratitude.
5. Forgive.
6. Turn your focus outward and help someone out.
7. Give yourself a break.’

Susan Omilian; What Is A Thriver? the THRIVERZONE. http://thriverzone.com/what-is-a-thriver/

‘Neuroscience has confirmed that trauma is experienced in the midbrain and lower brain, sometimes referred to as the “feeling” brain or the “survival” brain. Reason and logic, the ability to make sense of what has happened and act accordingly, simply are not accessible in trauma (Shore, A., 2001; Levine, P., & Kline, N., 2008; Ford, J., et. al., 2006; Perry, B., 2009; Brendtro, L., Mitchell, M., McCall, H., 2009). For this reason, we must direct our efforts at helping children with the experiences they are having, with the way they now see themselves, others and the world around them as a result of their exposure to trauma. We must engage them in experiences that allow them to “rework” their traumatic experiences and memories in ways that now allow them to see themselves as survivors and thrivers, others as helpful and supportive rather than threatening and unsafe, and life as promising rather than continually painful. Using talk therapy alone does not access that part of the brain where traumatized children are living and experiencing life.’

Survivor

survivor [səˈvaɪvər]
noun: survivor; plural noun: survivors

1. a person who survives, especially a person remaining alive after an event in which others have died.
   "he was the sole survivor of the massacre"
2. the remainder of a group of people or things.
   "a survivor from last year’s team"
3. a person who copes well with difficulties in their life.
   "she is a born survivor"
I was riveted, moved, and deeply inspired by Cheryl’s core message – namely that it is our many unique facets of imperfection that reveal our true magnificence. Without our imperfections, the flip side — perfection, beauty, and magnificence — are impossible to see and appreciate. So many people today strive tirelessly to hide their flaws and foibles – to pretend at perfection, and to shun vulnerability at all cost. But here is Cheryl — who as a teenager endured some of the most harrowing forms of abuse at the hands of two male strangers on her first day in a foreign country — telling us so bravely and confidently that there is magnificence in imperfection (and embracing her own imperfect life experiences to the fullest).

Cheryl’s take on the 8 most important resilience behaviours are: (Abbreviated)

1. Know that exacting revenge won’t bring peace.
2. Understand that sometimes your thoughts are not your friends.
3. Control what you can.
4. Help others.
5. Seize responsibility.
6. Don’t become a survivor.
   Move out of victimhood and straight through the role of survivor without stopping.
   Understand that being a survivor and being a victim are opposite sides of the same coin; both are predicated upon dragging around the past. Do not condemn yourself to being a survivor; keep moving and put the difficulties of the past behind you.
7. Understand that there’s no getting back to like it was before.
8. Finally, embrace wabi-sabi.

Wabi-sabi represents a powerful Japanese aesthetic centred on the acceptance of transience and imperfection.

‘Without dismissing the reality, enormity and severity of the trauma that commercially sexually exploited/domestically trafficked girls and young women experience, it is vital for the field to begin to address not only the myriad practical, physical and psychological needs but to also address the need for positive youth development programming, leadership development and the creation of authentic leadership opportunities for girls and young women as they move from victim to survivor.’

1. Survivors need the opportunity to grow and learn in a supportive environment
2. Survivors need the opportunity to develop knowledge & skills
3. Survivors need the opportunity to build their confidence/self-esteem
4. Survivors need the opportunity to discover their own strength & resilience
5. Survivors need the opportunity to impact others & make a difference

Thriver

“Surviving is barely getting by. Thriving. That’s fighting…”

Jillian Michaels

thrive [thrəhɪv]

verb (used without object), thrived or throve, thrived or thriven

[thriv-uh n] (Show IPA), thriving.

1. to prosper; be fortunate or successful.
2. to grow or develop vigorously; flourish:
‘From the time I started articulating my thoughts on the stages of SURVIVOR/FIGHTER/THRIVER I wanted an easy label to cover all a patient’s life. I wanted to categorize their entire life as either surviving their life, fighting for what they want, or thriving in their life. That would have been much easier for me to deal with as a psychotherapist but life rarely offers simplistic answers to difficult problems. That is when I relented and gave into the complexity and embraced the idea that a person could very well be thriving in several areas of their life while simply surviving in others.’

“What is fear? Fear is the worst of the worst case scenario. If our fear is loneliness, our greatest fear is living a solitary life and dying alone. If our greatest fear is futility, failure and meaninglessness lurk around every corner. If our greatest fear is our own power, beauty, and strength, we will do anything to destroy what is good and lovely about ourselves and elevate our failings to validate the lie.”

“Psychotherapy is about facing your fears. This involves confronting negative thoughts and beliefs about yourself. It is also about confronting immaturity, bad habits, and our dark, shadow-self with its bizarre and perverse imaginations. Our fears form throughout life starting from a very young age and are rooted in both the rational and irrational. If left unchallenged in our conscious or unconscious mind, they can take on epic proportions as we age.

The unforgiving messages generated by our fears permeate the depths of our heart, mind, soul and inevitably influence our day-to-day decisions. They emerge from the dark corners of our psyche at the most inconvenient times whispering the same vicious lies coated in a veneer of truth. These half-truths prevent us from embracing our lives and celebrating our individuality. In short, they zap our vitality by choking us with shame, discouragement, and yes, more fear. In this downward spiral our fear perpetuates more fear. If this is the atmosphere in which all that prevents us from thriving originates, it is no surprise then that this unholy space is not easily accessible nor prone to change without intense, intentional effort.’