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Complex Trauma in Childhood, a Psychiatric Diagnosis in Adulthood:

Making meaning of a double-edged phenomenon.

Abstract

Objective: No known research explores the double-edged phenomenon of childhood trauma/adult mental health consumer. Therefore, whether receiving a psychiatric diagnosis in light of childhood trauma supports or impedes psychological wellbeing in adult life, is unknown.

Method: Interpretative Phenomenological Analysis (IPA) provided the methodological framework. Data were collected through the use of semi-structured interviews. Analysis sought thematic representation from subjective interpretations of the experienced phenomenon: childhood trauma survivor/mental health consumer.

Results: Data revealed one superordinate theme: *‘Childhood betrayal, Identity, and Worthiness’* that overarched five subordinate themes. “Legacies of doubt” that perpetuated “not good enough” delayed the development of an adult identity of worthiness in these participants. Importantly, the ‘right’ diagnosis separated ‘self’ as worthy-adult from ‘self’ as traumatised child and facilitated positive change for breaking harmful cycles, self-valuing, and increased empathy, wisdom, and patience.

Conclusions: Findings inform future research and therapeutic practice in regards to adult help seeking behaviours in light of childhood trauma, often postponed through fear of stigma associated with mental health diagnoses and services. Similarly, findings suggest that ameliorating wellbeing may be dependent on a therapeutic relationship in which accuracy or ‘right’ fit of diagnosis provides a conduit for the client to disengage from self-blame, unworthiness, and “not good enough”.

Key words: *Childhood trauma; mental health diagnosis; posttraumatic growth; complex traumatic responses; stigma, Interpretative Phenomenological Analysis.*

Introduction

Throughout the world, countless children suffer the indignity of physical, emotional, and/or sexual abuse leaving many plagued by complex traumatic distress and at risk of psychopathology in adult life (Cook, et. al., 2005; McCormack, White & Cuenca, 2016). Depending on the level of that distress, some will attract a psychiatric diagnosis. A search of the literature revealed no studies have explored the impact of receiving a mental health diagnosis in adult life associated with experiencing childhood trauma. Therefore, it is unknown whether receiving a psychiatric diagnosis in light of childhood trauma supports or impedes psychological wellbeing in adult life. As such, this phenomenological study explores the ‘lived’ experience of receiving a psychiatric diagnosis in adulthood, from distress associated with complex traumatic events in childhood. It seeks both positive and negative subjective interpretations.

Complex trauma in childhood is defined as “the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature, often within the child’s caregiving system” (van der Kolk, 2005, p.2). These events may include sexual abuse, physical abuse or neglect, emotional abuse or neglect, or the witnessing of violence within the family system (Australian Institute of Family Studies, 2013). Complex traumatic events in childhood and their potential for negative outcomes in adult life differ from ‘simple trauma’, or a single traumatic event, such as natural disaster.

Early care giving relationships underpin children’s development of representations of self, others, and the world (Cook, et. al., 2005). By repeatedly attending to a child’s needs, caregivers foster a sense of safety that allows the child to develop appropriate emotional regulation in dealing with self and the environment. In contrast, repetitive and various forms of maltreatment negatively impact a child’s developing sense of self, impairing crucial domains of development e.g. attachment, biological or physical functioning, affect regulation, dissociation,

behavioural control, cognition and self-concept (Cook, et. al., 2005; Kinniburgh, Blaustein, Spinazzola & van der Kolk, 2005; McCormack et al, 2016).

While there is no simple explanation marrying specific traumatic experiences with crucial domains of development in childhood, genetic vulnerabilities, neural development through chronic stress, the characteristics of the abuse itself, and social factors are all identified markers (Anda, et. al., 2006; Briere & Jordan, 2009; van der Kolk, 2005). In reaching adult life, ongoing distress from early life trauma may lead many to seek psychological help only to have sense making complicated by psychiatric labels such as depression, anxiety, posttraumatic stress disorder (PTSD), somatisation disorder, and borderline personality disorder (Briere & Jordan, 2009; Herman, 1992; van der Kolk, 2005).

Despite this overwhelming plethora of possible diagnoses, a number of philosophical and religious traditions, along with the humanistic, positive, and existential fields of psychology, have suggested that positive outcomes and psychological growth following adversity, is possible (Calhoun & Tedeschi, 1998; Joseph, Williams & Yule, 1993; Linley & Joseph, 2004; Seligman, Steen & Peterson, 2005; Tedeschi & Calhoun, 1995). A growing body of research recognises psychological growth as positive changes in three life domains: a) self - redefining self and limitations, b) others - increased altruism and valuing inter-personal relationships, and c) life philosophy - a greater appreciation for life and a sense of what is truly important (Frazier, Conlon & Glaser, 2001; Joseph & Linley, 2005; McCormack & Joseph, 2013; 2014; McCormack & McKellar, 2015).

Acknowledging the disciplines of literature, philosophy and religion, transformational experiences arising from adversity satiate historical writings. Psychological interpretation of the human experience of adversity or trauma, and recovery, is underpinned and shaped by four theoretical models of psychological adjustment to adverse threatening events, and the reduction of posttraumatic stress symptoms. Relevant features of these models include: a) a need to integrate new trauma-related information to give completion (Creamer, Burgess & Pattison,

1992; Horowitz 1982, 1986; Rachman, 1980;) b) vulnerability versus growth factors in the post-trauma phase, which lead to assimilation or accommodation of trauma-related information (Hollon & Garber, 1988; Janoff-Bulman, 1992); c) how the event is comprehended and incorporated as significant or not (Calhoun & Tedeschi, 1998, 1999; Janoff-Bulman & Frantz, 1997), and d) psychological wellbeing as opposed to subjective wellbeing (Keyes, Shmotkin, & Ryff, 2002; Linley & Joseph, 2004; Ryan & Deci, 2001). From the theories of posttraumatic stress, Joseph and Linley's (2005) organismic valuing theory of growth, based on Roger's (1964) organismic valuing process (OVP) theory, recognises that there are many possible ways in which individuals can accommodate or assimilate trauma information that may or may not lead to growth.

Importantly, these theories extrapolate processes for recovery and growth from traumatic events experienced by adults but perplex our understanding of processing and recovery from the distress of trauma experienced in childhood. Traumatic distress that chronically disrupts robust development of affect regulation, attachment patterns, autonomy, balanced world views, and other developmental competencies in childhood has the capacity to be internalised as self-blame, self-loathing and futility (van der Kolk, 2005). Furthermore, if the abuse occurs in the context of trust violation perpetrated by a significant person (or institution) on whom the child depends for survival, recovery is inescapably complicated (Freyd, 1996). Commonly referred to as betrayal trauma, perpetration of trauma by significant other in childhood is likely to be encoded in the memory of the child as traumatic amnesia or 'betrayal blindness' (Freyd, 1996). Thus, relationships are more likely to be preserved, perhaps contributing to a reduction of further abuse, and even survival for some children (Freyd, 1996). Length of exposure, lack of protective factors to offset negative outcomes in later life, and delay in purposeful processing of the trauma-related information, which is aimed at making meaning of the events, are further complications of betrayal trauma (McCormack & Sly, 2013).

Many children who suffer abuse are also witness to dysfunctional adult relationships prior to full emotional, psychological, and intellectual development. As such, the criteria suggested as necessary for psychological growth, positive social support and modelling of constructive coping skills will be likely absent impeding judicious meaning making, allocation of blame, and future interpersonal and relational ventures. The sequelae to a complex and trauma threatened childhood in which normal emotional, intellectual and psychosocial development can occur may well explain delay in help seeking and the often mis-diagnosed presentation in adult life.

Whilst professionals working within a medical model utilise diagnoses to make sense of patients' symptoms, there is the potential for many who have experienced childhood trauma to be re-victimised by having their distress labelled with a mental health diagnosis. Issues of power and trust within the therapist/client relationship must also be managed. Conversely, and despite risk of vicarious contagion for the therapist, positive change and psychological wellbeing for both client and therapist is now recognised (Joseph, 2011; McCormack & Adams, 2015).

Understanding the dual experience of survivor and mental health consumer is of critical importance, as 70% of psychiatric inpatients are reported to have experienced some form of childhood abuse (Herman, 1992). Overt discrimination is common for mental health consumers and as recognised in Link's (1987) modified labelling theory of mental illness, individuals subtly internalise cultural meanings attached to a psychiatric label and come to expect rejection and devaluation. In those who have experienced traumatic events in childhood, a psychiatric label may compound self-protective behaviours that inhibit help seeking, recovery and growth.

There appears no research dedicated to the experience of receiving a mental health diagnosis in adulthood, in the context of distress from complex traumatic events experienced in childhood. As such, this idiographic phenomenological study explores the 'lived' experience of receiving a psychiatric diagnosis in adulthood, from distress associated with experiencing

complex traumatic events in childhood. It seeks both positive and negative subjective interpretations.

Method

Participants

Following University human ethics clearance, participant recruitment was conducted via private mental health facilities and local advertisement. Advertising material outlined the study inclusion criteria: 1) 25 years of age and above; 2) a self-reported history of childhood trauma; 3) a psychiatric diagnosis received in adult life from a treating mental health specialist and related to childhood traumatic distress; and 4) not currently in crisis. This provided a small, self-selecting homogenous group, for detailed exploration, in line with IPA protocols. All consenting participants, two males and three females, were aged between 38 and 62 at the time of interview. Childhood traumatic exposure included: domestic violence; parental substance abuse; parental mental illness; physical and emotional neglect; emotional abuse, and sexual abuse. Two participants had received a diagnosis of depression, and three participants had received a diagnosis of posttraumatic stress disorder (PTSD) (See Table 1).

-Insert Table 1 here -

Procedure

Following participant recruitment, a study information letter, consent form, and trauma life event questionnaire, were distributed to consenting participants who met the selection criteria. A semi-structured interview schedule was distributed via email on the day prior to the interview, allowing for a period of pre-interview reflection (Smith, 1996). Interviews were arranged at a time and place suitable for the participants. Signed forms and questionnaire were collected prior to the interview. All interviews were digitally recorded, transcribed under pseudonyms and password protected. Each interview lasted between 60 and 90 minutes. The five cases provided the overall data set.

Validity and reliability

In considering rigor in qualitative inquiry, nomothetic considerations, reliability and validity, are regularly considered under the terms trustworthiness, credibility, and dependability. Guba and Lincoln (1981; 1982; 1989) described qualitative rigor as attending to criteria of "trustworthiness". Though still regarded as seminal and pertinent, their early research promoted a post hoc evaluation for assuring trustworthiness. More recently, researchers argue that verification in qualitative research should be a continual process of "checking, confirming, making sure, and being certain" (Morse, Barrett, Mayan, Olson, & Spiers 2008 p. 17). As such, rigor in qualitative research demands ongoing verification through a step by step endeavour to ensure reliability and validity, and thus transparency. These steps assure design quality, that is, the degree to which the investigator has chosen the most appropriate method and procedures to assure within-design consistency and analytic competence (Tashakkori & Teddlie, 2009).

Similar to nomothetic enquiry, the investigative position in qualitative research will determine the design. Importantly, interpretative qualitative research does not seek a true representation of human experience, but a representation of human sense making (Denzin & Lincoln, 2011). In fact, 'truth' or 'falsity' of an observation with respect to an external reality (a primary concern of validity) is irrelevant when seeking subjective interpretations of a phenomenon. Similarly, saturation is variably posited as part of qualitative rigor. However, in an interpretative phenomenological analysis (IPA), given that rich interview data may provide both convergent (across all interviews) and divergent (within one interview) themes, saturation is less relevant than rigorous adherence to other IPA methodological steps seeking unique richness in the data (Smith, 2011).

In IPA, investigator responsiveness adds to the rigor inclusive of theoretical considerations informing purposive sampling of a small homogenous group; adherence to skill development for funnelling down to the research question; and acquiring rich data through a double hermeneutic reiterative investigative style of interviewing (Smith, Flowers & Larkin,

2009). Through the use of a double hermeneutic, each researcher strives to make sense of the interviewee making sense of their experiences. The researcher takes an empathic 'insider perspective', reiteratively exploring as necessary seeking a comprehensive account of the phenomenon from the perspective of the participant (Smith, 1996, 2004; Smith et al., 2009).

Furthermore, inter-rater reliability is argued variably as an important method for ensuring rigor in qualitative research by some, yet unimportant by others (Armstrong, Gosling, Weissman & Marteau, 1997). In IPA auditing/analyses of the data by each researcher occurs independently and concurrently prior to robust discussion and final consensus. With a focus on the theoretic underpinnings of the research question, analysis aims to inform future research hypotheses, and theory. Thematic inclusion in the results is only assured when there is consensus by all researchers that the themes are unique, rich and substantiated by the data.

At every level, theoretical consideration allows new ideas to develop. The collecting of data and analysis is a paced and iterative interactive journey that is reliable and valid (Glaser, 1978; Smith, 1996). Protocols for this rigor carried out by each researcher in IPA include: listening to digitally recorded interviews; examining the interview transcripts; providing early notes and interpretations; and providing diagrammatic representations linking pathways from the raw data to the early independent themes underpinned by theory (IPA steps: see Table 2). It is labour intensive with authenticity and thematic representation the focus of joint discussion and final consensus between the auditors (Smith, 1996). The audit trail continues throughout the analysis and write-up of results. A small homogenous group of participants safeguard that individual interpretations are not lost in a collective or generalised rendering of experience. In seeking validity, IPA strives for credibility. In seeking reliability, IPA seeks dependability (Trochim, 2000).

- Insert Table 2 here -

Analytic strategy

Philosophic underpinnings and analysis

Unlike Grounded Theory or Discourse Analysis, interpretative phenomenological paradigms such as IPA sit within a critical realism perspective of the world concerned with how individuals socially construct and interpret their world (Blaikie, 2000). IPA (Smith & Osborn, 2008), as an idiographic method, incorporates theories and philosophies that compliment its realist stance, and allows researchers to unfold the idiosyncratic nature of each participant's narrative and meaning making. In particular, symbolic interactionism which posits that meaning can only be fully understood through the dynamic process of interpretation, underpins IPA's relational interaction between the researcher and the participant (Smith, 1996). This is consolidated by a 'double hermeneutic' as the researcher strives to understand and interpret the reflexive process that is the participant making meaning of his/her experience (Smith, 1996).

Author's perspective

Interpretative analysis is also intersubjective thus the investigator is positioned relative to their own biases and presuppositions which need to be stated. The greatest threat to credibility in qualitative research is the investigators' inability to remain open to the data, sensitive and creative in their social enquiry, and adhere to the rigorous steps of the chosen method informed by philosophical underpinnings (Schwandt, 2015). The first author's research is in complex trauma, at the interface of trauma and psychological growth, and she has worked as a trauma therapist/clinician for over 25 years. The second author is a clinical psychologist working in public mental health and therapeutically supporting survivors of childhood trauma. The authors challenged each other's interpretation throughout the investigation rigorously questioning the impact of prior experiences and knowledge on the credibility of final results.

Results

One superordinate theme: *Childhood betrayal, Identity, and Worthiness* overarches five subordinate themes: *Legacies; The label; Putting the jigsaw together; Stigma; and Better than good enough self* (see Table 3). These themes reveal that complex traumatic events in

childhood for these participants insidiously impacts adult mental wellbeing. Early adult life turmoil precipitates a search for meaning wherein a diagnostic label is one possible explanation for the plethora of emotional and psychological responses they have grown to accept as emanating from self. Help-seeking provided a conduit to externalise shame and blame and bring meaning to adult life. Initially a psychiatric label was felt as stigmatising yet provided externalising validation.

The themes explain the multiple layers of betrayal from experiencing childhood trauma inclusive of legacies of doubt and “not good enough”. However, juxtaposed with self-doubt were growthful domains of hope, determination to break harmful cycles, valuing self, empathy, wisdom and accepting patience. Importantly, the “right” diagnosis was the essential key that gave meaning to years of unexplainable distress which in turn allowed them to embrace self-value, and an adult identity as separate to that of traumatised child (See Notations).

-Insert Table 3 here -

Legacies

Making sense of childhood abuse was a navigational quagmire for these participants inhibiting a separate adult identity from that of traumatised child. This legacy was almost wholly perceived as negative and persisted in dominating the individual’s identity for many years. The therapeutic relationship was described as instrumental in bringing synchronicity to interpreted experience where outcomes could be viewed as both positive and negative.

However, for many years, purposeful rumination was confounded by the implausible inaction of *witnessing* adults and their unwillingness to interject, defend or question abusive actions. Unable to understand the acquiescence of those who could have protected them, they sensed the abuse was therefore condoned creating a cognitive pathway to self-blame and internalised shame:

I had so much shame ... because it was never discussed. People would witness events but nobody ever said 'that's not right' ... when other people condone it around you, there's this sense of shame.

Instrumental in defining the young 'self' shame emerged in numerous acts of self-sabotage, maintaining self-doubt and personal identity as "not worthy":

I feel like I've made the wrong choices because I've always self-sabotaged. Because you've got this little voice inside of you saying you're not worthy. You're not worthy.

Early attempts at adult relationships, were fraught with disjoint and barriers.

Underpinning these efforts was the belief that relational patterns played out in childhood would be repeated in adult life. Victim status was always in the wings:

In all men I see reflections of my father, which is quite Freudian and horrid ... I think that 'oh you're just gonna think the same things about me that he did'.

A coherent sense of self was evasive inhibiting confident self-protective choices, trapping them in patterns of deferment to others:

Relationships ... I just couldn't sustain them. I was giving all my power away ... you've been pushed down as a child. It's just instant. You give it away automatically, so you're never, ever, living your life.

Participants felt 'stuck' within these patterns 'peaking and troughing; peaking and troughing'. They had no sense of how to take the helm in their own lives or engage with a purposeful adult life:

I feel like it's been an endurance race and I've been running on the spot, while all my peers and friends have just run past me.

"Not good enough" was deeply felt and remembered with a sense of desperation.

Overwhelmed, a desire to survive was palpable even within the interviews. They mused on their earlier lack of capacity to change the situation alone. Fear added to that desperation and became the motivator for action to seek professional help:

I made an ultimatum [when first entering therapy] ... I said, 'I don't want to be a statistic ... please don't let me be another statistic ... You either help me, or I don't know what's going to happen'. I wasn't trying to threaten, I was just saying this ... is how much I'm hurting.

A slow rising of consciousness brought recognition that rejection by others triggered an effortful desire to self-validate through achievement and success. This was a consciousness breakthrough from a reactive attempt at remedying not being "good enough":

I always felt I couldn't be good enough. I wasn't good enough. I wasn't good enough to be told I was loved ... and as a result of that I tried a lot harder I suppose ... I just had to be better to be good enough.

The label

Thematically, participants' fears and difficulties, associated with the concept of receiving a psychiatric diagnosis, are interpreted as a need to overcome or integrate the label in order to begin to 'own' and experience its benefits. While participants expressed relief at receiving a "*the right*" diagnostic label as it offered an explanation for their distressing emotions and behaviours, there was fear associated with "*being*" the label and what this meant for their relationships and sense of self.

A diagnosis separated these participants conceptually from others who did not have a label. Questions arose about core strength and character:

It's ... a weakness of self or mind ... Weakness of character. Because you should be able to overcome it ... these things shouldn't lead to a label ... I should have been able to overcome these obstacles.

and whether they were personally flawed:

Why did I come out of that experience with it [the diagnosis], whereas other people could get through that experience and not get it?

While a diagnosis served as a useful descriptor of symptoms and could be intellectualised, being a recipient of a psychiatric 'label' was 'resented' and heralded

systemic neediness – *“no-one wants a label. It’s like, far out, I’m in the mental health system”*.

These participants were unwilling to join the fraternity of ‘mental health’ users, identifying their symptoms as arising from a direct response to an adverse environment forced on them as children:

I don’t see myself as someone with a mental health [diagnosis] ... It’s because of a traumatic childhood that was out of my control. I wasn’t born that way.

Personal biases of what it means to have mental health needs invaded their consciousness disputing cognitions of belonging:

I would still say that I definitely have this stigmatism of wanting to divide myself from other people with mental health [diagnoses], which is completely non-intellectual. I don’t want to be lumped into that group.

A label did allow these participants to provide a context for their distress and create a new narrative of their trauma history acknowledging it as only one part of their life story, not their entire identity:

One of the things that’s come out of it, is that slowly I’m able to put this into part of my narrative, as being in the past.

Putting the jigsaw together

Having experienced invalidation of their experiences throughout childhood, and despite inner disparity, seeking and receiving the right diagnosis served to acknowledge the severity of their trauma history and the indelible imprint of childhood abuse and trauma:

No, that wasn’t the right diagnosis ... What the PTSD [diagnosis] allowed me to tap into was that this is real. What had happened was a traumatic experience.

As they struggled to integrate baffling current distress responses when threat was no longer a daily encounter, an undesirable badge of recognition, a diagnosis, gradually brought a rational and believable explanation. It gave credence and comfort to their childhood memories:

I was relieved ... it meant that how I was feeling was of value ... I had thought I was insane ... that I was mad ... I thought 'I'm going to have to commit myself'.

Reframing childhood histories as potentially life-threatening abnormal events, where highly distressing responses were the correct response, allowed a transformation from 'me' as the source of the problem, to 'me' as a survivor of horrific childhood events:

There wasn't something wrong with me as such, I was a product of my early environment ... people who experience similar things have similar results. This is actually something quite typical of humans if they go through that.

Once the right diagnosis was experienced, a tangible framework of psychological healing was able to replace the "*muddy pond*" of distressing emotions, confused thoughts and repeated dysfunctional patterns of behaviour - "I could put it in a box and say 'that's what's wrong with me'". The diagnosis "put the jigsaw together":

I changed therapists, the diagnosis didn't feel right ... Having a name to put to that gave me something to attack. It gave me something to work with ... a tangible framework of something I could manage.

Stigma

Despite benefits from receiving a diagnosis, a diagnosis negatively set these participants apart from others. Fearful of being labelled "*a crazy person*", the judgement and stigma surrounding mental ill-health was difficult to reconcile and kept them protective:

I feel like I'm a better person because I've got a diagnosis. I'm glad I've got a diagnosis, but then do I go and spruik it (spread the information) out to people? No, because people are so quick to judge.

They recognised that others' biases prevented the metamorphosis they had experienced keeping participants positioned as cautious, sometimes vulnerable, engendering frustration:

People were unnecessarily looking out for me when I was ok ... They suddenly saw me as someone ... who was perhaps vulnerable or unable to cope. And I resented that ... There was a mis-match between how I saw myself and how they saw me. And it was irritating. I didn't feel like someone who wasn't coping.

These participants questioned their deservedness of a diagnosis feeling stigmatised even amongst those with the same diagnosis, those who seemed more ‘worthy’ of the diagnosis, having lived through *“An earthquake, a bomb, a war or combat”*

If they were in the Bosnian war, or a Sudanese child, they’ve seen their family slaughtered, horrific ... They’re both traumas, they’re both things that shouldn’t have happened, so why would one be more legitimate than the other?

Without visible wounds, without an opportunity to narrate the experiences of a child living in daily fear, finding the words to explain the invisible scars remained shamefully elusive:

Psychological and emotional abuse is not something people recognise very well. They just think if you didn’t get a smack across the head and you haven’t got a big bruise, then what’s wrong?

Better than good enough self

The benefits construed by the experience of having received a diagnosis were one link in the chain of progress from solely negative outcomes, to psychological growth that emerged in these participants. Now able to acknowledge their trauma responses as ‘normal’, redefining what is important in life as adults brought hope, determination to break harmful cycles, valuing self, empathy, wisdom and patience:

I’ve won lots of things. I’d like to think wisdom’s one of them. I’ve won patience. I’ve won empathy. I’ve won the ability to let myself cry.

Each day was able to be absorbed and identified as momentary experiences. The preciousness of being safe in the moment with freedom from guilt seemed to allow the innocence of the child to re-emerge.

I see life now as a series of moments. Beautiful moments with people ... And I cherish that. That has really helped me ... to find the little things in life.

The distress of a traumatic childhood conversely leveraged gratitude at having had the opportunity to *“live a full life”*:

I think I've been a lot luckier ... because I've experienced a lot more things. Whether they were good or bad or whatever, it's certainly been full. So if I cark it (die) tomorrow, at least I've lived a life!

For these participants, distress was juxtaposed with recognition of “*strength and courage*” to overcome difficulties, facilitating hope:

There is hope. It doesn't have to end in tragedy every single time. There is absolute hope.

Whilst still fragile, learning to acknowledge one's own inherent value and worth allowed the adult to recommit to the child in the present, with compassion and acceptance:

I actually love myself. I actually think I'm important and of value. And things I say are important and valuable. I am being kinder to myself.

Growth out of adversity was facilitated by conscious efforts to attain help, motivated by a desperate determination to rescue the adult from the childhood trauma, and by placing blame within the historical context, distinctly separate from ‘self’:

Being able to reposition how I thought about myself, how I thought about my parents, how I thought about others and what I was capable of was the life changing thing ... it was probably the first time that I genuinely believed in myself. I genuinely cared for myself.

Discussion

This study revealed one superordinate theme: *Childhood betrayal, Identity, and Worthiness*; overarching five subordinate themes. “Legacies of doubt” that perpetuated “not good enough” delayed the development of worthiness in these participants as they floundered to make sense of their adult identity in the aftermath of childhood trauma. Importantly, the ‘right’ diagnosis separated ‘self’ as worthy-adult from ‘self’ as traumatised child and facilitated positive change for breaking harmful cycles, self-valuing, and increased empathy, wisdom, and patience.

A diagnosis that accurately characterised these participants' difficulties allowed them to separate their adult identity from that of traumatised child. Psychological wellbeing could now be nurtured through redefining meaning of their early childhood experiences. In amongst the

legacies of doubt and believing themselves undeserving, hope, empathy, wisdom and patience, a determination to break harmful inter-generational cycles, and a sense of beginning to value themselves, slowly developed. Despite benefits, the negative consequences of societal stigma created a bittersweet outcome for the *label*.

Childhood trauma leaves invisible scars, often for a lifetime (Briere & Jordan, 2009; Cook, et. al., 2005; Herman, 1992; Kinniburgh, Blaustein, Spinazzola & van der Kolk, 2005; van der Kolk, 2005). The participants in this study, some of whom were many decades away from childhood, still spoke of deep pain associated with their incredibly difficult experiences. Living in environments characterised by violence, unpredictability and disregard for their needs, these children grew up with fear ever present. As eloquently described by Herman (1992, p. 96), the child in a traumatic environment “must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness”. Childhood is the preparation ground for the development of self-regulation, self-soothing, the ability to be in relationship with others, the formation of identity and the maintenance of hope and meaning (Cook, et. al., 2005; Kinniburgh, Blaustein, Spinazzola & van der Kolk, 2005), which is thwarted when the child exists in an environment which respects none of this. These participants clearly described the internal chaos of the child living within environments of terror. It left a living legacy that did not cease through virtue of reaching adulthood.

In the aftermath of childhood trauma, these participants characteristically struggled to form a coherent sense of self, which left them vulnerable to difficulties forming and maintaining healthy relationships, in managing emotions, and in identifying and enacting values. Their representations of self, others, and the world were seriously impacted, as attachment theory would predict (Cook, et. al., 2005), resulting in the self-blame and self-loathing (van der Kolk, 2005) described by these participants. Living a satisfying life seemed out of their reach.

Participants' identity as individuals, with their own thoughts, desires, feelings and values was seriously impeded, in turn negatively impacting on their ability to be in relationships with others. Though they saw themselves as successful in relation to education and employment, their ability to form solid and reciprocal relationships with others was questioned by self. Muller, Lemieux and Sicoli (2001) describe a working model of self which identifies an individual's perception of self and self-worth as occurring in the context of relationships, with negative sense of self and perceived negative views of others towards them, being significant risk factors for psychopathology. Unsurprisingly then, for these participants whose self developed within environments of fear, psychopathology was an outcome in adulthood.

For those participants exposed to direct physical, psychological and sexual abuse, and to serious neglect by a perpetrator, the impact of the shame was disclosed as the most painful element of the abuse. While those charged with protecting them ignored their needs or blatantly humiliated them, their core identity became one of "inner badness" and they adopted a "false self" in an attempt to avoid the expected pain from powerful others (Harvey, et. al., 2005).

McNally (2005) points out that trauma victims are very capable of remembering their trauma experiences, though they may go for long periods of time not thinking about the distressing experiences to simply get on with life. However, the remembered fear of domestic violence emerged as a common thread in these narratives ever present to sabotage the adult lives of all five participants in either violence against the mother, or inter-parental conflict. Inclusive of this was the ever present threat of death and injury in childhood for three of these participants. Similar to other studies this appeared to impact on vulnerability to low self-esteem, distress, depression and posttraumatic stress in adult life (Levendosky & Graham-Bermann, 2001). Any form of abuse, and the vicarious effects on spouses, are recognised as psychological burdens on exposed children (McCormack, Hagger & Joseph, 2011; McCormack & Sly, 2013) often resulting in poor attachment, emotional dysregulation, and an difficulty disengaging from violent relationships in their own adult life (McCormack & Sly,

2013). In addition, parentification, that is, children having responsibility for care and protection of a caregiver and often siblings, confers greater risk of poor outcomes in adulthood (Hooper, DeCoster, White & Voltz, 2011).

As experienced by these participants, early exposure to stigma from family, friends, services, and the wider community, shamed and isolated them from the broader society. The ‘innate’ knowing that something was sabotaging their lives emerged as the catalyst for seeking psychological help in these participants. Complicating this desire for help, participants remembered the fear of being judged and spoke of the negative cultural stereotypes of mental illness, which then became relevant to them when they received a diagnosis. These internalised stereotypes influenced how they expected to be treated (Link, 1987) which was mirrored in self-judgement based on social perceptions that those with mental illness are somehow ‘less than’. Unable to justify their struggle, their trauma for many years was held internally, rather than visible.

Despite the stigma of a psychiatric diagnosis, all five participants readily identified the diagnosis as precipitating meaning making of their childhood trauma and their responses to those traumatic events. Whereas the adult identity had been constructed around a negative sense of self, having a name for the set of difficulties they were experiencing eventually allowed those responses to be externalised and no longer held as core disabilities. Externalising allows a sense of ‘personal agency’ to move to the fore allowing new individual narrative to materialise (Besley, 2002). Thus, seeing these difficulties as symptoms rather than as identity allowed room for an alternate sense of self to emerge.

Participants recalled that a new and novel view of self emerged when a diagnosis felt ‘right’. Redundant shame and blame were able to be redefined when the oppression of a mental health diagnosis was reframed as not of their own making. The participants identified that it was in feeling ‘right’ about the diagnosis that allowed a move towards growth in view of self, experience of others, and in life philosophy (Frazier, Conlon & Glaser, 2001; Joseph &

Linley, 2005; McCormack & Joseph, 2013, 2014; McCormack & McKellar, 2015). This sanctioned confidence to engage more effectively in relationships as someone deserving of positive support in adult life, place greater trust and value in relationships, and embrace a greater appreciation of life. Four even took responsibility to move positive change forward through adult careers in child protection or child education. Similarly, though a therapeutic relationship can offer challenges of power and authority for many trauma clients, engaging with the diagnosis and the potential for psychological growth was facilitated by therapists who empathically offered validation that empowered the client.

Given the large numbers of children exposed to complex trauma, and the likelihood that many of these children will go on to experience mental health difficulties in adult life, there is a high probability that most therapists will have the opportunity to work closely with adult survivors of complex trauma from childhood. A sensitively broached diagnosis, given upon clear understanding of the individual's history, has the potential to assist in the move towards psychological growth.

Limitations

Inherent in any qualitative study are several limitations. The themes described by these five participants are particular to them and therefore cannot be generalised nor can they offer cause and effect as in nomothetic studies. Given participants are reflecting on distressing experiences from childhood, there may be biases related to recall and memory. Further studies may wish to explore the trajectory of time, the impact of diagnosis on positive change, and the manner in which a diagnosis is given in relation to early childhood trauma. A mental health diagnosis which does not encompass the psychosocial history of childhood may leave the adult shamed and guilty, unable to draw positives and psychological growth from externalising their trauma narrative. Therapist biases, therapeutic style, and therapeutic relationship are worthy areas of future research in complex childhood trauma (McCormack & Adams, 2015).

Summary

These participants experienced extensive psychological wounds from abuse in childhood. Those who should have protected them, including the wider societal network in which they lived, failed them. Many first world countries are currently conducting commissions into the horrors experienced by children in institutionalised care, and future traumas perpetrated on social media are yet to be unearthed. Ironically, had these participants as children not been exposed to violence, neglect and abuse from their caregivers, associated mental health difficulties in adult life would be redundant. Factors impacting adult wellbeing inclusive of medium of abuse, age of trauma, longevity of trauma, perpetrator relationship, precipitating events that encouraged/discouraged psychological help seeking in adult life, and power factors in the client/clinician relationship, are all worthy of future research.

A diagnosis that felt 'right' provided the basis for a therapeutic relationship that successfully externalised the distress of childhood abuse within the context of others' actions, and was able to validate and create opportunities for psychological growth in these participants. Therapists can play a vital role in providing the space for alternate and self-reparative narratives to emerge within therapy. Given that symptoms of various disorders are co-occurring, success of the therapeutic alliance will be impacted by the client's perception of accuracy in the diagnosis. The alternative outcome may diminish the client's faith in mental health support and opportunities for wellbeing, placing the client at risk of re-victimisation and heightening potential for further stigma.

The legacy of childhood trauma has powerful tentacles. As powerfully put by Perry, Pollard, Blaichley, Baker and Vigilante (1995):

"Adults generally presume (childhood) resilience ... Children are not resilient, children are malleable ... elements of their true emotional, behavioural, cognitive and social potential are diminished – some percentage of their capacity is lost, a piece of the child is lost forever."

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Data Extract Notations:

[...] indicates editorial elision where non-relevant material has been omitted

[-] indicates pauses in speech by participant

Table 1.
Participant Demographics

Pseudonym	Age	Gender	Diagnosis
William	41	Male	Major Depressive Disorder
Samantha	38	Female	Posttraumatic Stress Disorder
Frini	46	Female	Posttraumatic Stress Disorder
Peta	42	Female	Posttraumatic Stress Disorder
Lawrence	62	Male	Major Depressive Disorder

Table 2.
Steps of Interpretative Phenomenological Analysis Process

Process	
Step 1:	Immersion in each interview data set through repeated listening and reading of the recordings and transcribed verbatim transcript from which initial impressions and observations are recorded;
Step 2:	Creation of a comprehensive set of initial notes primarily noting significant content, language and concepts that appear embedded in the transcript;
Step 3:	Thematic emergence that concisely captures the essence of the transcript and guides further analysis;
Step 4:	Establishing connections between emergent themes and identified clusters of themes in each individual case.
Final	These four steps are repeated for each transcript independently by each researcher before a final coming together for robust discussion and consideration of overall data sets for rich verbatim extracts for each theme. Examination of sets of themes for convergent and divergent themes across all transcripts. Five subordinate themes emerged. Discussion between authors ensure identified themes are supported by the data. Superordinate theme identified. Linking of relevant theory to identified themes.

Table 3.
Five Subordinate Themes Overarched by One Superordinate Theme - 'Childhood betrayal, Identity, and Worthiness'.

Theme	Description
Legacies	Pain and confusion due to childhood betrayal continuing into adult life
The label	Resentment and questioning of self and the system
Putting the jigsaw together	Validation and transformation of self as the diagnosis externalises the source of the problem
Stigma	Fear and judgement from self and others
Better than good enough self	The diagnosis feels 'right'. Positively redefining views of self, relationships and life

Appendix 1

The semi-structured interview schedule is as follows:

We are interested in how you have made sense of receiving a psychiatric diagnosis in adult life as a consequence of distress experienced as a result of childhood trauma. We are interested in both your positive and negative interpretations.

1. In general, can you describe your experiences around early life trauma and how this has led to medical intervention over your lifetime so far?
2. How do you make sense of being given a psychiatric diagnosis in relation to your distress from childhood trauma?
3. How do you feel you as a person have changed because of this dual experience?
4. What about this experience in particular has impacted on you either positively or negatively?
5. How do you make sense of the human dynamics and path that you have been caught up in as a child which are not of your own choosing?
6. Any psychological, philosophical, existential thoughts that have altered or become part of your thinking because of these experiences?
7. How you see your life going forward from these experiences?
8. What has changed in your feelings, thoughts, relationships, goals because of your childhood trauma and the consequential diagnosis?