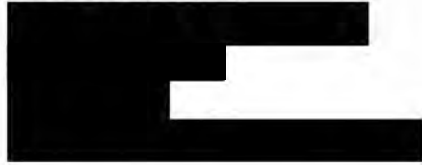


Criminal Code (Serious Vilification and Hate Crimes) Amendment Bill 2023

Submission No: 10
Submitted by: Melissa Costin
Publication: Making the submission and your name public
Attachments: See attachment
Submitter Comments:

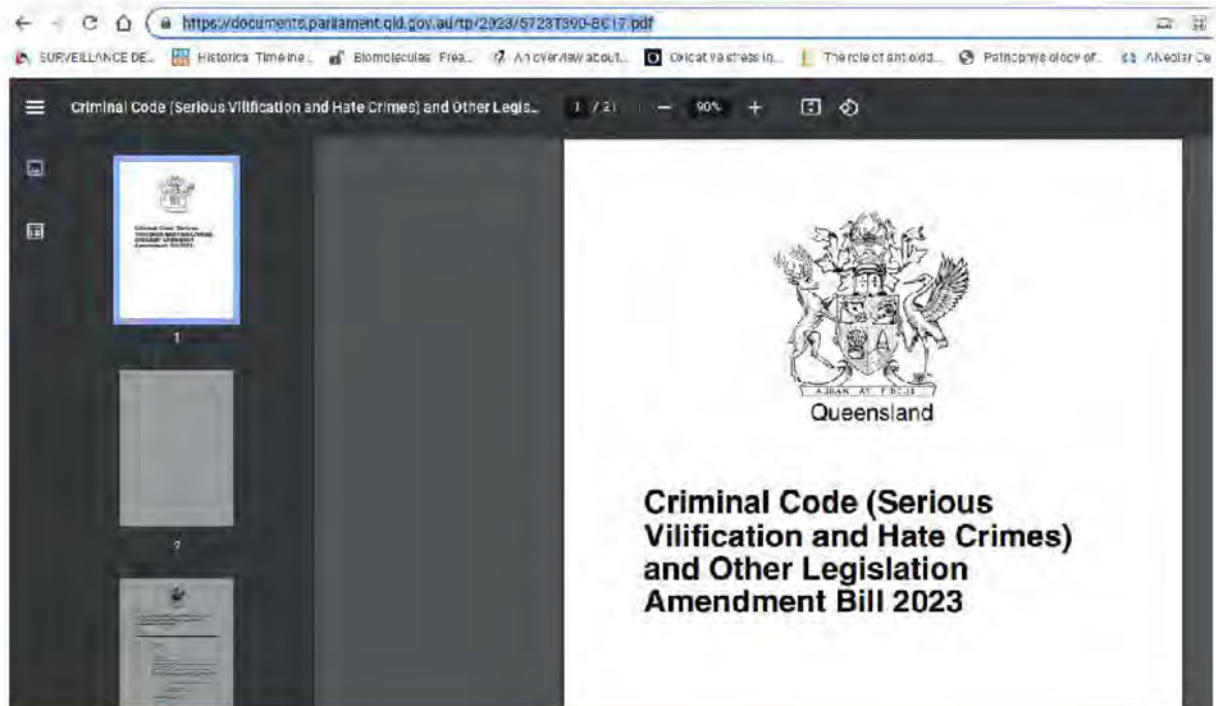
From,

Melissa D Costin,



2 May 2023,

Serious Vilification, Hate Crime Bill, Legislative amendments.



documents.parliament.qld.gov.au/tp/2023/5723T390-BC17.pdf

SURVEILLANCE DE... Historical Timeline... Biomolecules | Free... An overview about... Oxidative stress in... The role of antioxid... Pathophysiology of... Alveolar Cel

Criminal Code (Serious Vilification and Hate Crimes) and Other Legis... 10 / 21 | 90%

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11

52B Circumstances of aggravation for particular offences 18
19

(1) It is a circumstance of aggravation for a prescribed offence that the offender was wholly or partly motivated to commit the offence by hatred or serious contempt for a person or group of persons based on— 20
21
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24

(a) in relation to a person—the race, religion, sexuality, sex characteristics or gender identity of the person, or presumed race, religion, sexuality, sex characteristics or gender identity of the person; or 25
26
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Criminal Code (Serious Vilification and Hate Crimes) and Other Legislation Amendment Bill 2023
Part 3 Amendment of Criminal Code
[s 12]

(b) in relation to a group of persons—the race, religion, sexuality, sex characteristics or gender identity shared, or presumed to be shared, by the members of the group. 1
2
3
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(2) In this section— 5
prescribed offence means an offence against any 6

<https://documents.parliament.qld.gov.au/tp/2023/5723T390-BC17.pdf>

parliament.qld.gov.au/Work-of-Committees/Committees/Committee-Details?cid=0&id=4247

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30 Year Release

Ten Year Anniversary

Click [here](#) to make an online submission to the Bill.

The closing date for written submissions is 4:00pm on Tuesday, 2 May 2023.

Submissions can also made by email or post

Submissions may be emailed to: Submissions **must** include:

Email: LASC@parliament.qld.gov.au

- the author's name
- if the submission is made on behalf of an level of approval (e.g. a local branch, executive national organisation), and

at least two of the following:

- email address
- mailing address, and
- daytime telephone number.

Please ensure your submission includes the ab
be considered by the committee.

parliament.qld.gov.au/Work-of-Committees/Committees/Committee-Details?cid=0&id=4247

Historical Timeline... Biomolecules | Free... An overview about... Oxidative stress in... The role of antioxid... Pathophysiology of... Alveolar Cell Senes... Reading I

Legal Affairs and Safety Committee

The main purpose of the Bill is to implement legislative reforms as recommended by the Legal Affairs and Safety Committee's Report *Inquiry into serious vilification and hate crimes* (No.22 57th Parliament). Specifically the Bill implements recommendations 7, 8, 9 and 16 of the report.

In addition to addressing these recommendations, the Bill will amend the *Anti-Discrimination Act 1991* to increase the existing penalty for the offence **at section 131A (Vilification of serious racial, religious, sexuality or gender identity vilification).**


Further material about the bill including any written briefings from the department, responses to submissions and questions taken on notice will be available under the Related Publications tab.

CALL FOR SUBMISSIONS

The committee invites submissions addressing any aspect of the Bill, from all interested parties. Guidelines for making a submission to a parliamentary committee are available here: [Guide to making a submission](#). Please ensure your submission meets these requirements.

ide_MakingASubmission_WebVersion.pdf

1 / 1 | 100%



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Making a Submission to a Committee Inquiry

Submissions are a way for you to share your thoughts, knowledge and recommendations on issues being investigated by parliamentary committees. Submissions are important to improve a committee's awareness and understanding of relevant issues to an inquiry and may influence their recommendations to the Parliament.

What should I include in my submission?

You can find important information about the inquiry on the committee's inquiry webpage. Your submission should include your views on the issue and the reasons for these views. If the inquiry is in relation to a Bill, you should state whether or not you support the Bill and why. You may include facts, personal experience or research within your submission. If your submission is long, it might be helpful to summarise the main points as well.

How should my submission look?

You do not have to use a specific format or layout but it may be helpful to:

Greetings,

I would like to speak to the listed groups of people and people who are protected from actions partially or wholly motivated by Hate and Contempt.53B

52B Circumstances of aggravation for particular offences	18
	19
(1) It is a circumstance of aggravation for a prescribed offence that the offender was wholly or partly motivated to commit the offence by hatred or serious contempt for a person or group of persons based on—	20
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Criminal Code (Serious Vilification and Hate Crimes) and Other Legislation Amendment Bill
2023
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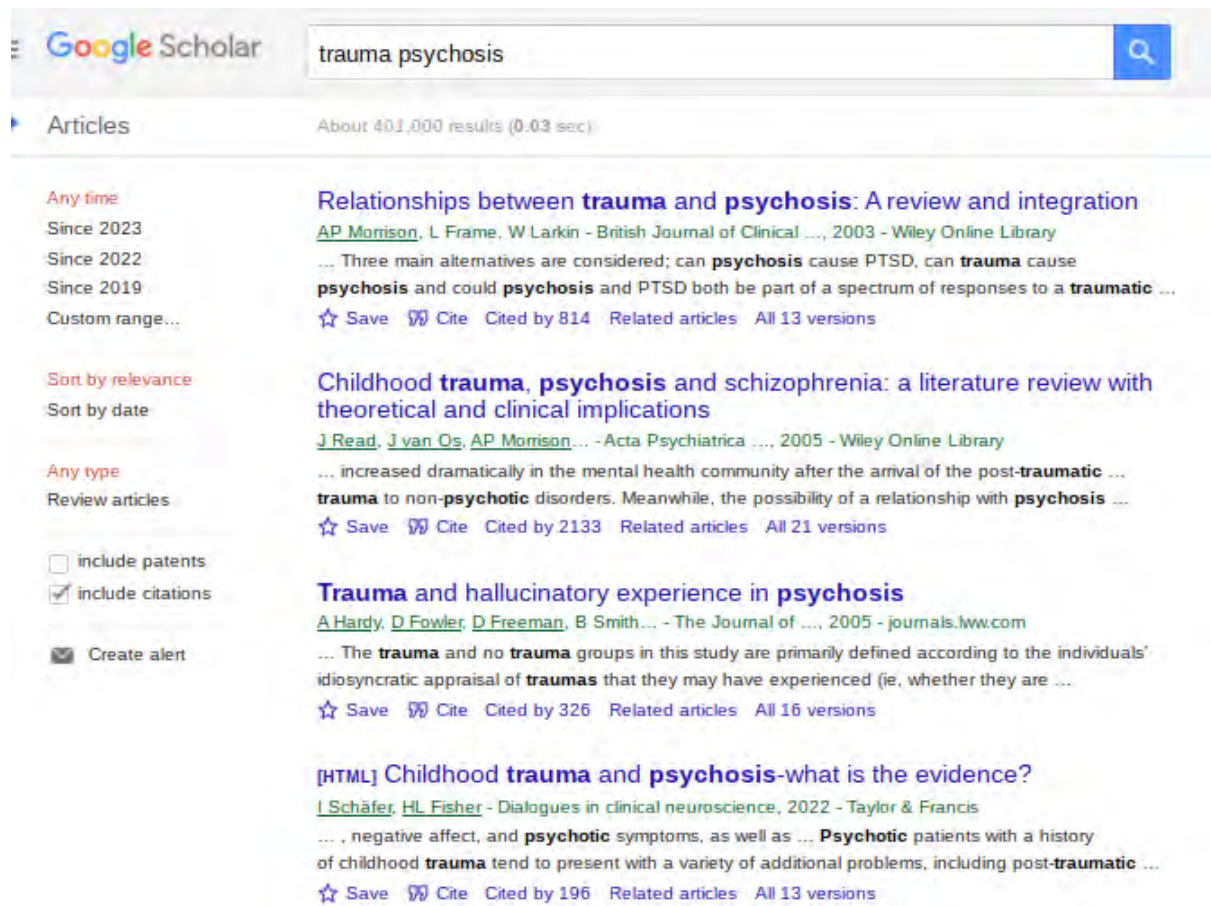
(b) in relation to a group of persons—the race, religion, sexuality, sex characteristics or gender identity shared, or presumed to be shared, by the members of the group.	1
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(2) In this section—	5

In particular I'd like to point out a shared characteristic of all people broken by hatred and vilification , that is so alled "mental illness".

Particular anxiety and depression due to fear of intimidation or violence and sadness about being not believed, helped and thus relieved of the ongoing mental torture from being targeted for vilification and hatred.

Indeed the most serious forms of mental illness are often the consequence of severe stress and psychological trauma, even psychosis.

This topic is well documented in the literature.



The screenshot shows a Google Scholar search for "trauma psychosis" with approximately 401,000 results. The search results are listed on the right, and a sidebar on the left contains filters and options.

Search Results:

- Relationships between **trauma** and **psychosis**: A review and integration**
AP Morrison, L Frame, W Larkin - British Journal of Clinical ..., 2003 - Wiley Online Library
... Three main alternatives are considered; can **psychosis** cause PTSD, can **trauma** cause **psychosis** and could **psychosis** and PTSD both be part of a spectrum of responses to a **traumatic** ...
☆ Save Cite Cited by 814 Related articles All 13 versions
- Childhood **trauma**, **psychosis** and schizophrenia: a literature review with theoretical and clinical implications**
J Read, J van Os, AP Morrison... - Acta Psychiatrica ..., 2005 - Wiley Online Library
... increased dramatically in the mental health community after the arrival of the post-**traumatic** ... **trauma** to non-**psychotic** disorders. Meanwhile, the possibility of a relationship with **psychosis** ...
☆ Save Cite Cited by 2133 Related articles All 21 versions
- Trauma and hallucinatory experience in **psychosis****
A Hardy, D Fowler, D Freeman, B Smith... - The Journal of ..., 2005 - journals.lww.com
... The **trauma** and no **trauma** groups in this study are primarily defined according to the individuals' idiosyncratic appraisal of **traumas** that they may have experienced (ie, whether they are ...
☆ Save Cite Cited by 326 Related articles All 16 versions
- [HTML] Childhood **trauma** and **psychosis**-what is the evidence?**
I Schäfer, HL Fisher - Dialogues in clinical neuroscience, 2022 - Taylor & Francis
... , negative affect, and **psychotic** symptoms, as well as ... **Psychotic** patients with a history of childhood **trauma** tend to present with a variety of additional problems, including post-**traumatic** ...
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Filters and Options (Left Sidebar):

- Any time: Since 2023, Since 2022, Since 2019, Custom range...
- Sort by relevance, Sort by date
- Any type: Review articles
- include patents
- include citations
- Create alert

Even so a victim is vilified by a system which entrenches a mental illness labels as a stigmata or mark which can consequentially used to discriminate against them as if their distress is a disease associated with being dubbed delusional, dangerous and dishonest.

Such people face slurs, such as mental, sicko, nutcase, sick in the head, crazy , psycho, schizo which exclude them from social activities and most importantly proper representation with respect to Human Rights in respect to Legal matters,

where such vilification makes a person grouped as unreliable or incapable giving evidence in their defence or more importantly against violent perpetrators.

Those perpetrators then get a free pass to persecute, intimidate, hurt and otherwise bully a victim being put in a vilified category.

My personal experience of this has been deeply destructive to my mental well being but unshakeable as if any such slur had been stamped on permanent record to be repeated and added to a whim by any government agent who wants to "gaslight" me, that is dismiss me as "crazy" rather than respond to my medical and legal needs as protected by State, Federal and International Human Rights Conventions and Legislation. From abuses such as serious violence and subsequent stalking.

Such overt (or more often occult) vilification is difficult to address, and adds to the distress of a victim especially if this empowers a particularly pro-active bully to psychologically torture a mentally broken vulnerable person into oblivion, deep depression, alcohol and drug abuse or suicide. All last ditch efforts to end the mental torture in an already scarred brain whose autonomic nervous system/ adrenergic system is constantly being triggered into fear, which is similar to synthetic adrenalin / amphetamine use on the brain and autonomic nervous system.

I won't have time to explain all who vilified me as a subhuman after I was tossed into the mentally ill category, but it is extensive, all levels and complaints departments in QPS, MNMH and State Housing as a recurrent group affecting key determinants of my mental well being by vilifying me, ie refusing to help me after I was so labelled.

Holding even one accountable would protect so many others from a fate I call a highway to hell in terms of being locked inside a concrete unit unable to even get natural light lest the perpetrator let me know they are army window watching me. Constantly trying to summon the courage to get groceries knowing there is a reasonable chance the perpetrator will be placed at the entrance to obstruct me, then yell at me and otherwise attempt to drive me out of my ground floor unit, in the delusional belief she will be allowed to take it (as I understand it).

Especially when those paid to protect and support you from such respond by echoing the "mental" hate and refuse to help you, thus acting in support of the perpetrator, with added threat of drugging you into chemical coma and keeping

you incarcerated in locked ward with other drugged, damaged and on occasions very violent people, for unknown periods of time against your will, with threats of injections and electrocutions (ECT) unless obedience ie SILENT about abuse, especially systemic abuse.

I believe that given the many inquiries and indeed Royal Commissions into the vilification of the mentally ill by the system without perceivable changes in attitude demand it, especially as mentally distressed people recovery need to be stress free ie safe, and not further traumatised ad infinitum due being vilified by fake medical labels on real human emotions which are not a disease but are real symptoms of real psychosocial distress.

I hope this Committee agrees, and even equivalent Federal legislation also includes traumatised people in protection from vilification with mental illness related slurs and outright hate speech.

Improving access to protection via justice allows for real healing and recovery instead of the living "hell on earth" which is being constantly targeted by a violent perpetrator and having cried for help met with hate speech or categorisation by citing another claiming the same unjustly.

I fear paranoia to make a person sound schizophrenic versus terrified "out of their mind" as in my case.

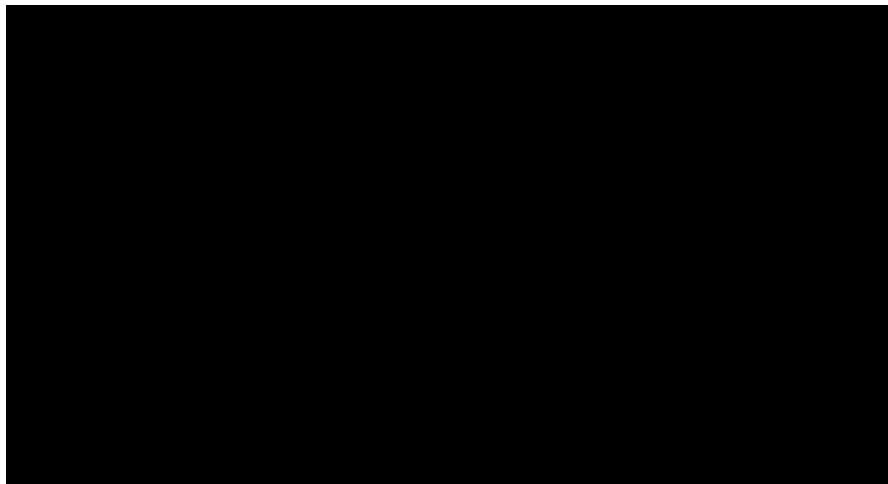
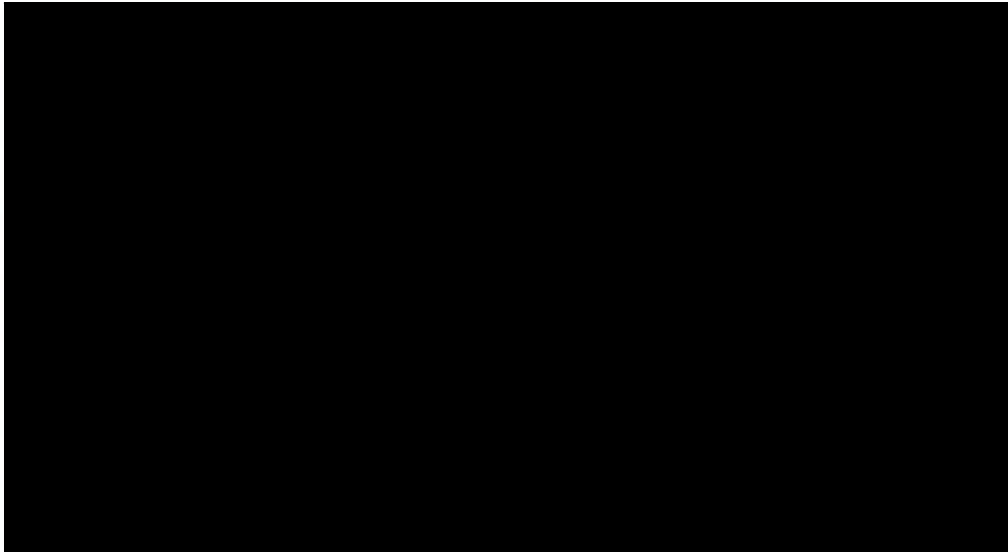
Sincerely,

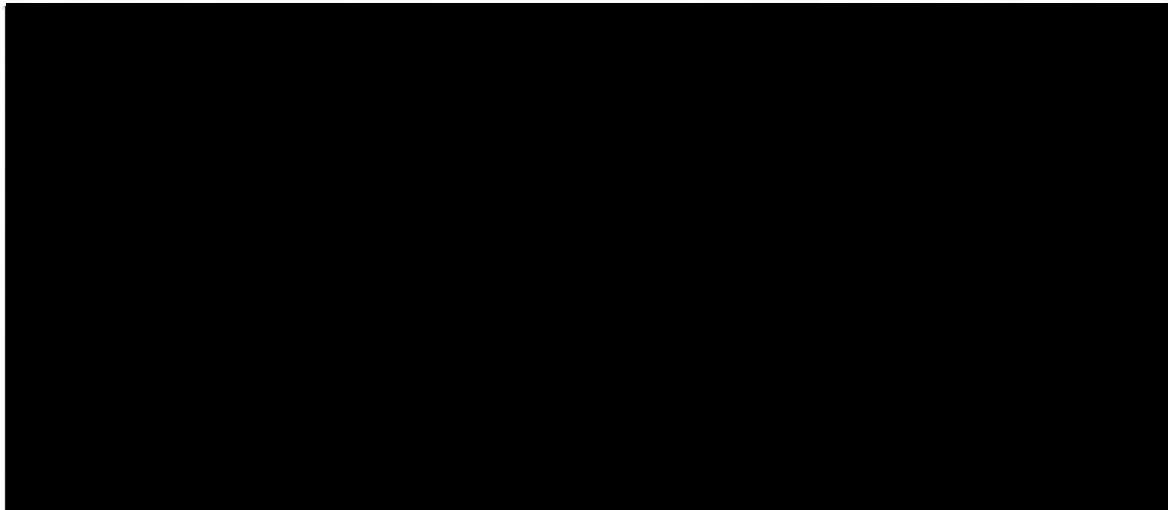
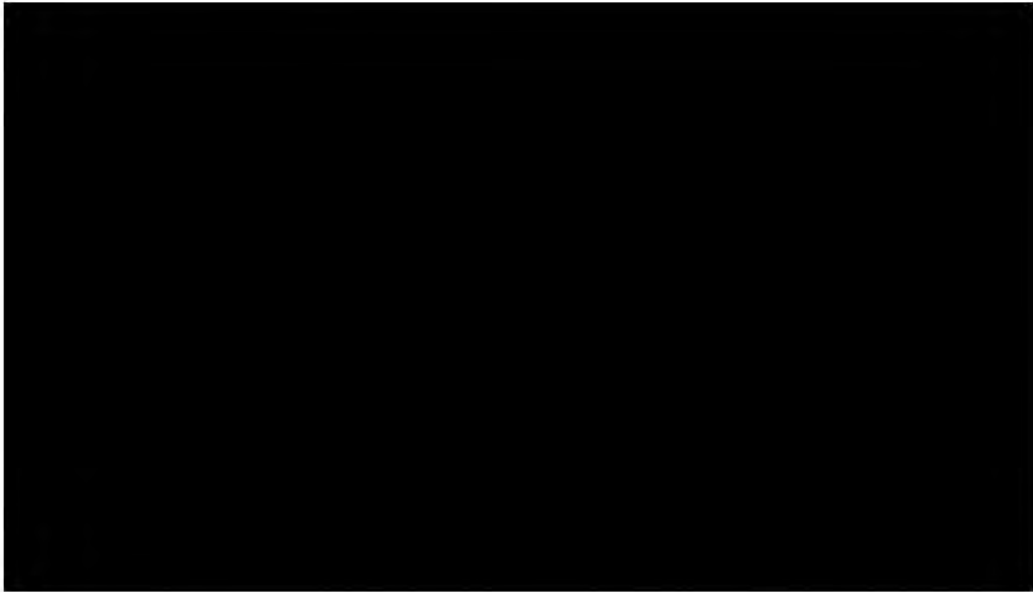
Melissa Costin MBBS UQ '93

Apologies re tech issues,

Head injury caused by being pulled by hair until my head hit ground, perpetrator admitted causing injuries at crime scene, but Police refused to accept complaint, telling me "I deserved it", which I reported to the Doctor who attended my head injuries.

I only noticed scratches on neck and abrasions on back after cleaned up for photos. I have supplied all to Police and Magistrates Court on multiple occasions.





After my complaint was ignored and much duress, I was able to get outside support after part of an inheritance allowed me to buy a car.

The CCC responded by [REDACTED] that I had not made a complaint, so in fear I did.



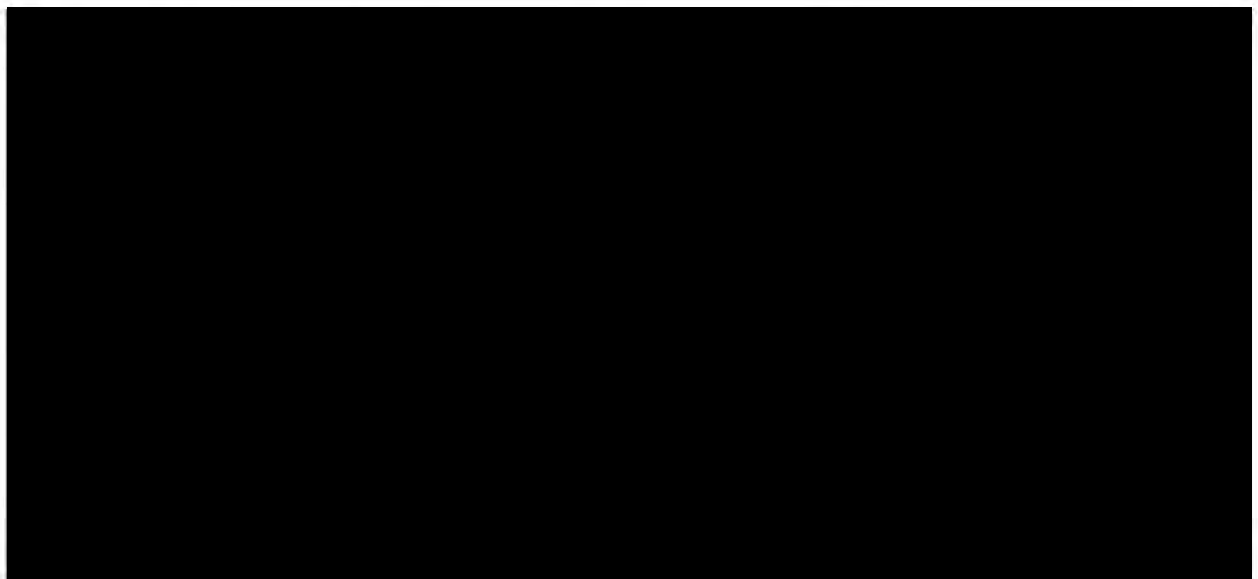
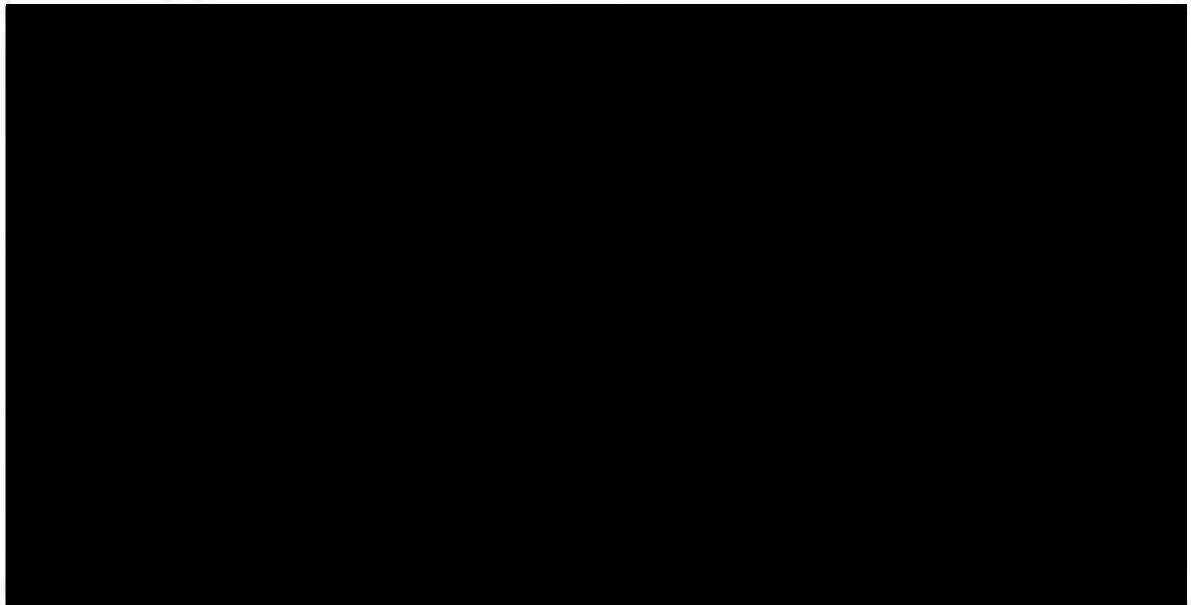
Soon after the Defendant confronted me at entrance and chased me around the grounds.

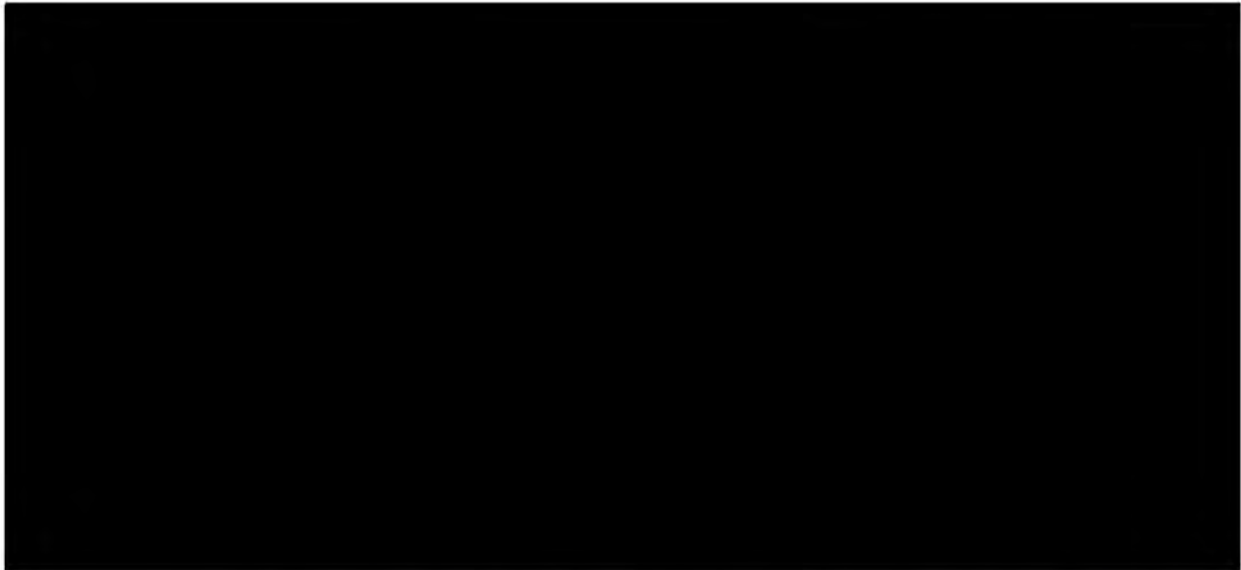


I reported this to Qpilch / New farm Neighborhood Center, and was taken against my will to RBWH psychiatry for forced incarceration and drugging as mental ill.

I was confronted by Defendant again and left to live in my vehicle for respite, off an on facing years of a "cat and mouse" game with the Defendant.

I also faced confrontations by many associates of the defendant who would wait at the letterboxes for my return trip and try and cut off my return to my unit , or turn up and park at my dining room window.

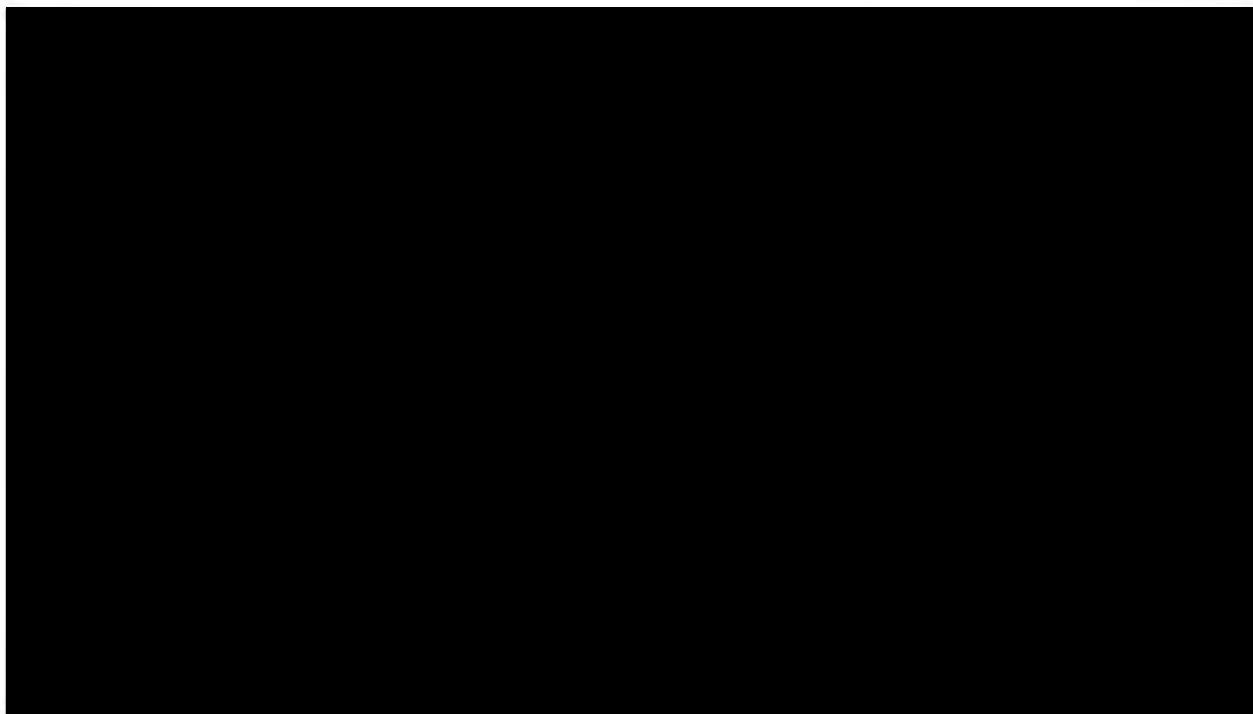




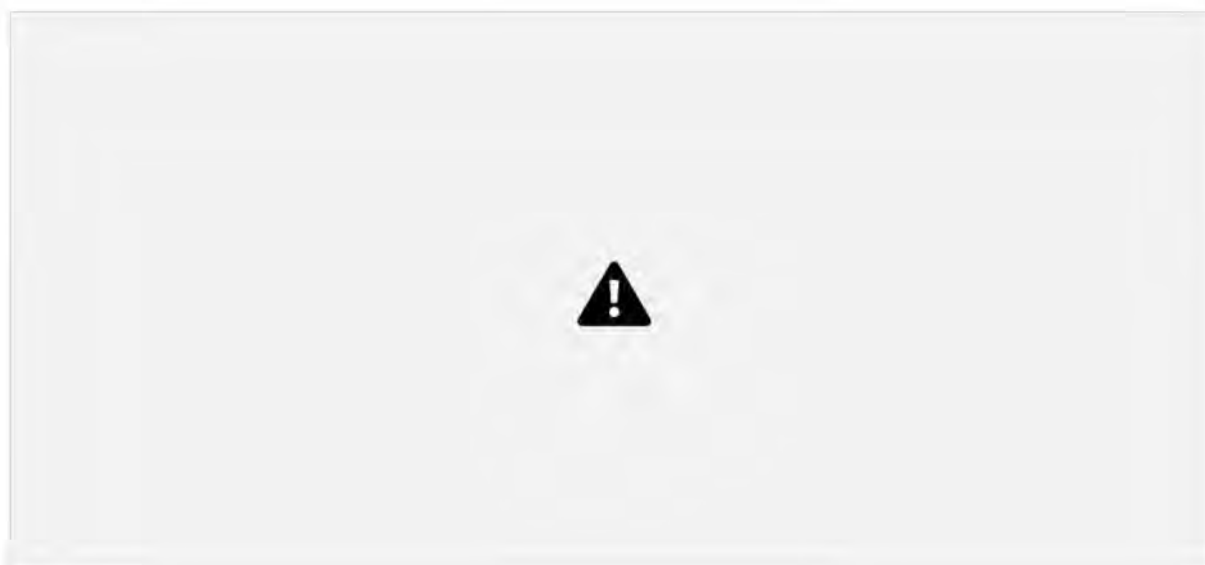
After hospitalization for chest pain for stress, I came home, and hours later heard a motorbike engine at my window and noticed the Defendant standing there with a biker, and the exit obstructed..something which triggers the limbic system, and is mentally exhausting, and contrary to Magistrate [REDACTED] directions to not "loiter" outside my unit.

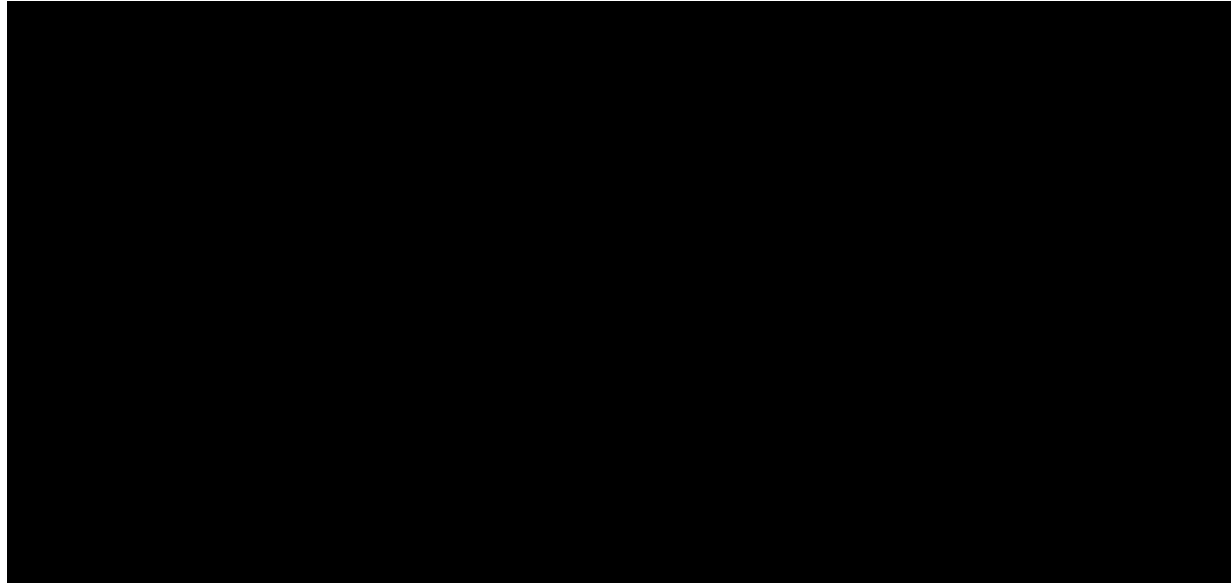


On occasions I would see the [REDACTED] at the junction of my paths to entry, pretending to be working on his car in the dark driveway instead of lit garage, as if it's another pretence to confront me by blocking the only lit entry at night (my only option).. I can't go into dark with no idea where defendant is, given their work together to block my options on occasions

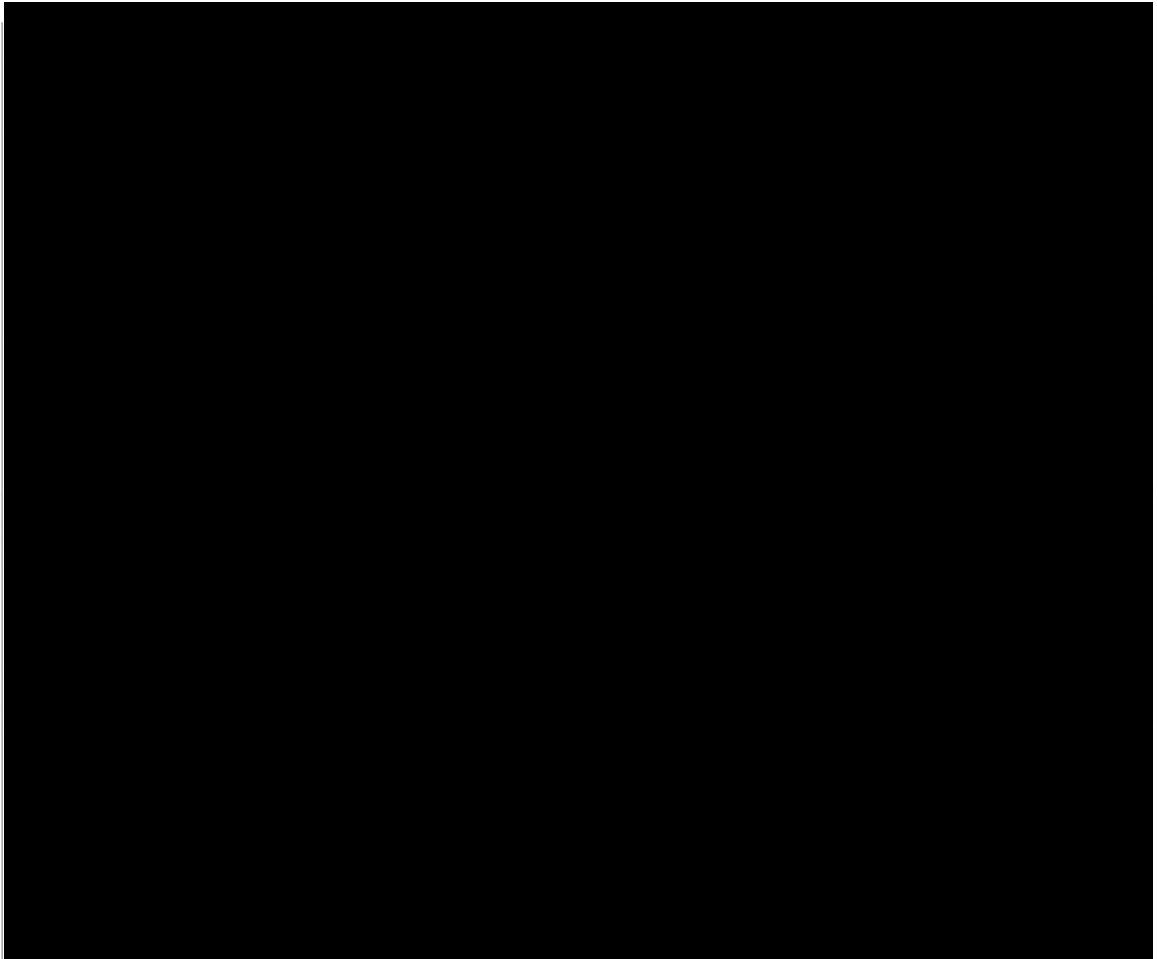


The defendant also encouraged a range of other males to park outside my window at night.

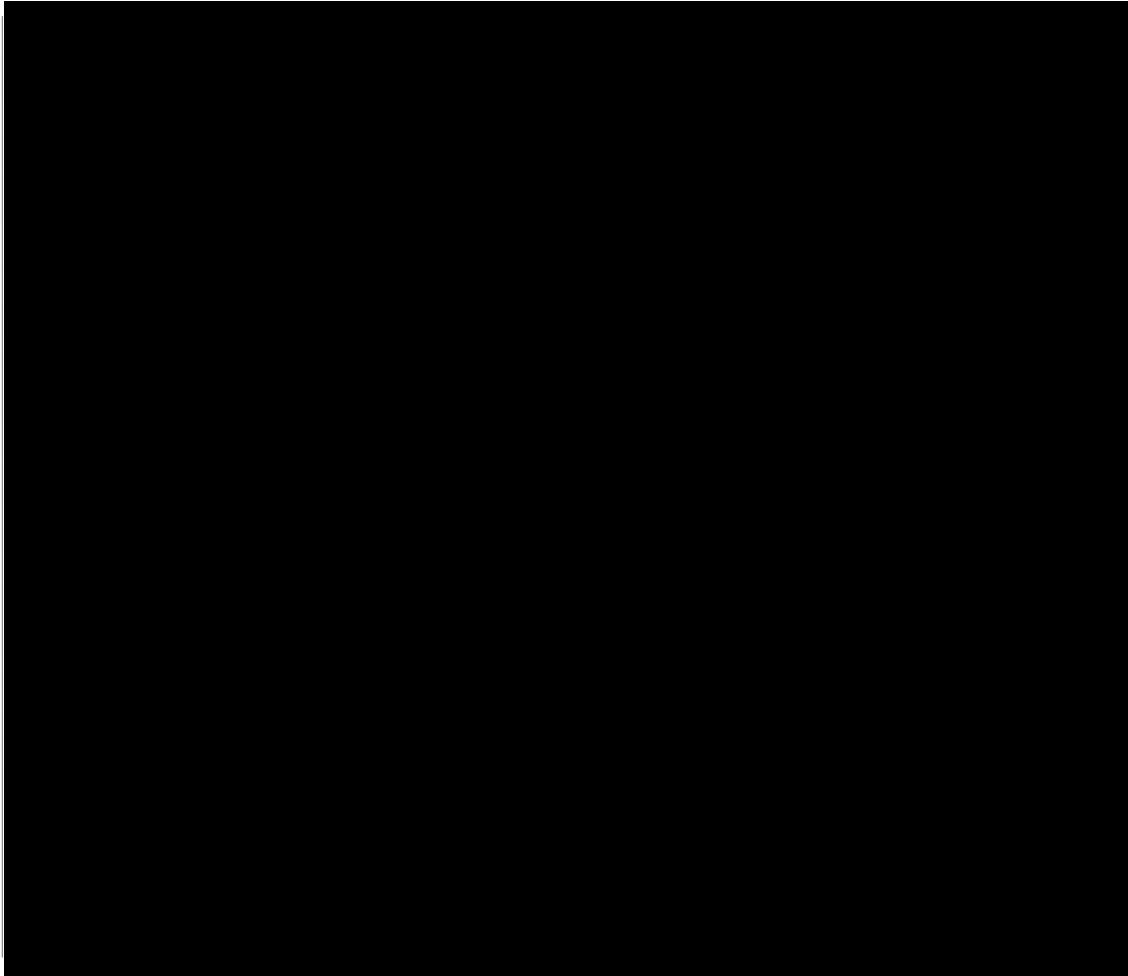


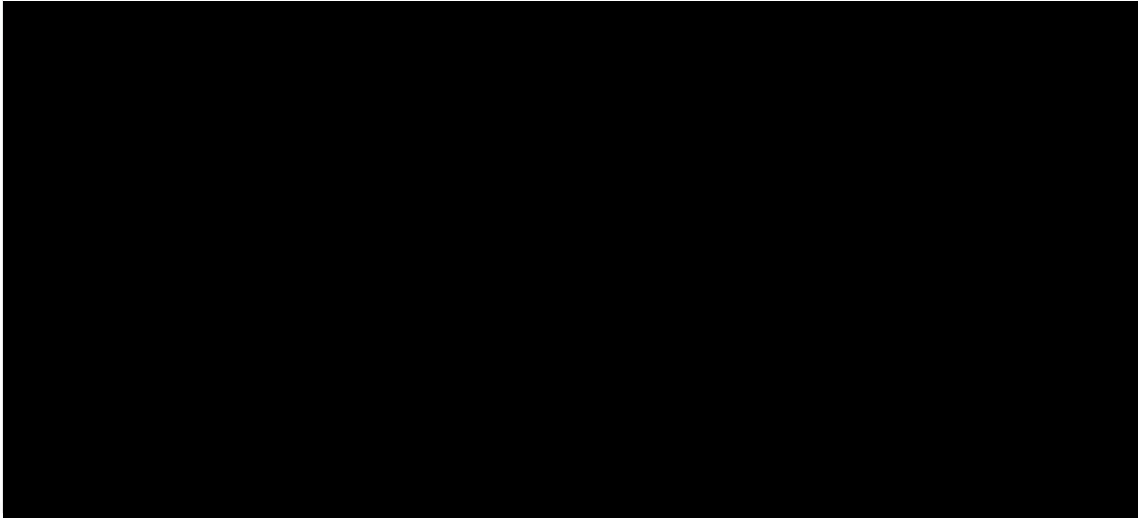


While also continuing to bang her broom on my door and metal rails outside my door, demonstrating she had no fear of me, and any suggestion otherwise is a blatant deception, yet her mischaracterisation of me to authorities goes on relentlessly.

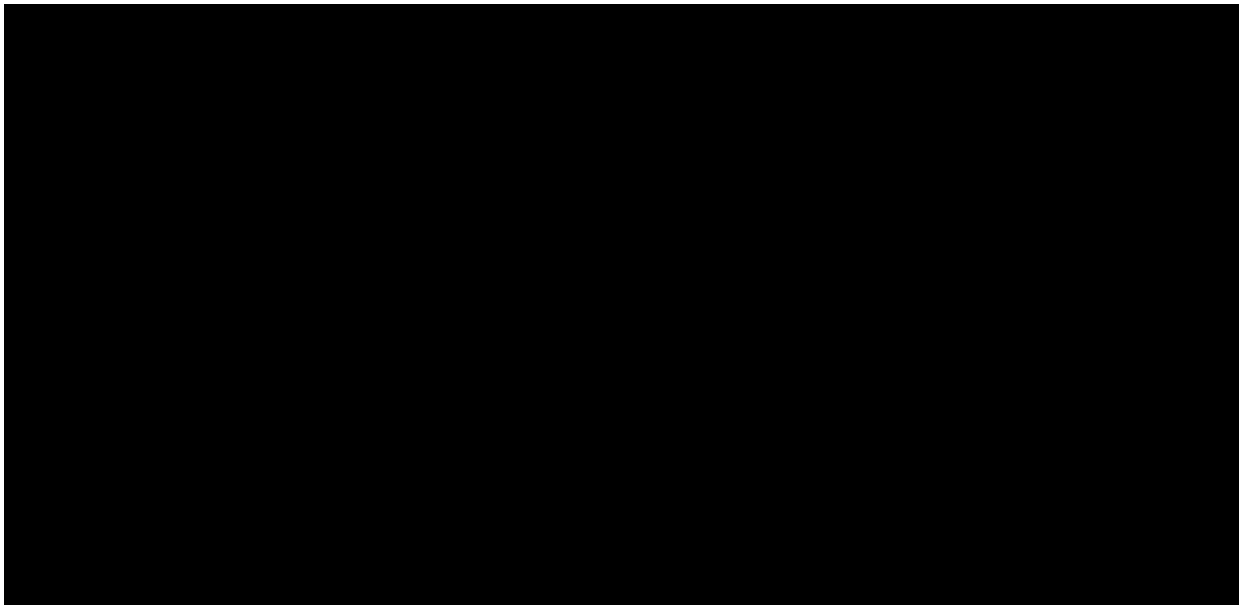


Borrowing the vehicle usually used by her [REDACTED] to wait at letterboxes, until I decide to go past
, at which point the defendant enters the vehicle and reverses at me.

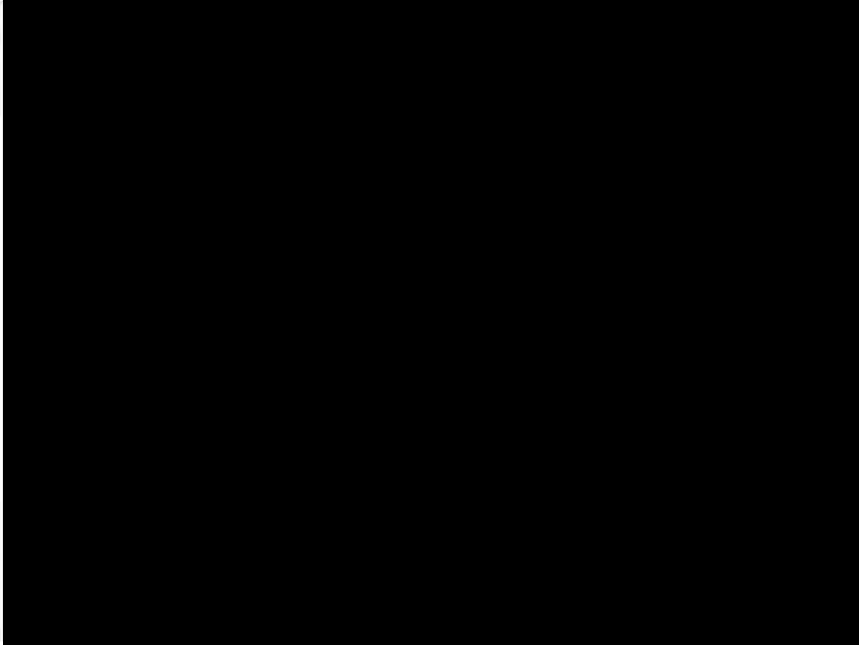




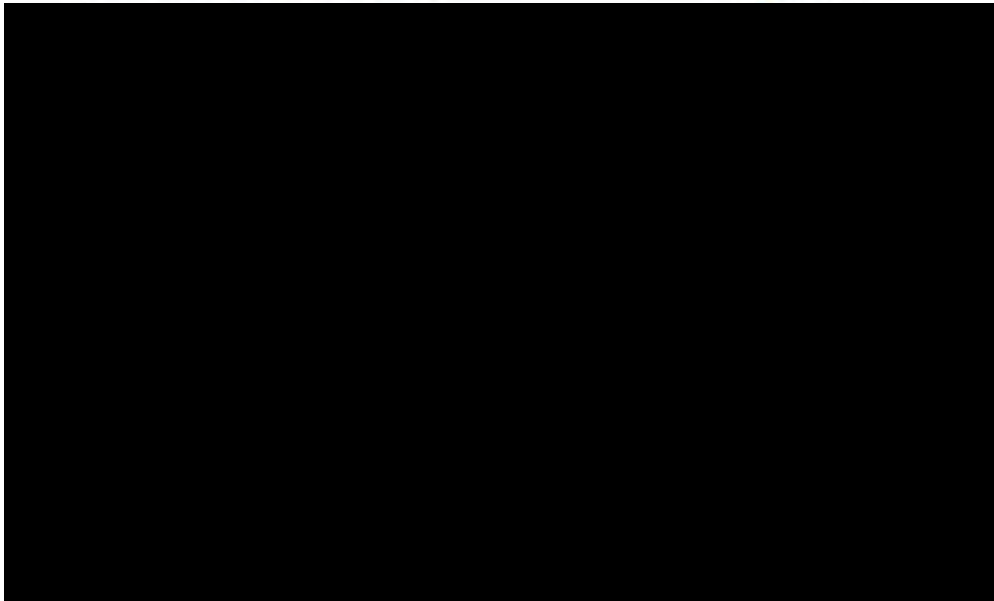
Back at my window, so I can never forget the attack, never feel safe, or recover.



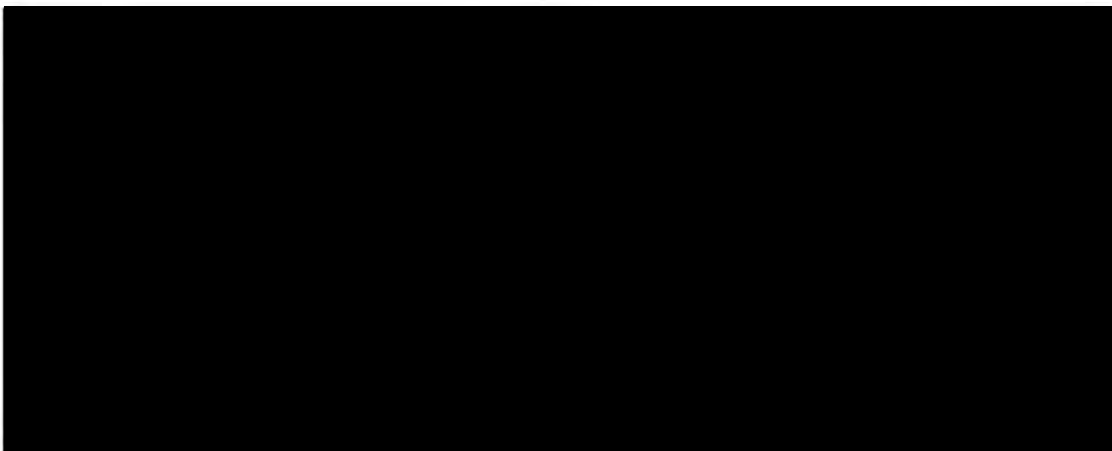
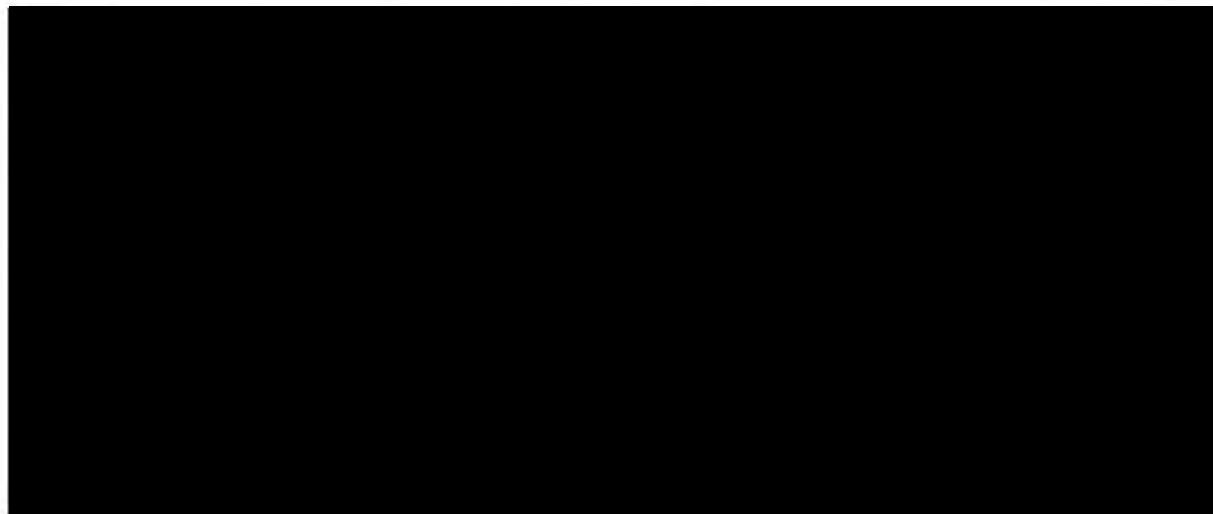
I seek help with candidate and attend a forum.



I come home from a bike ride to get groceries and see the [REDACTED] parked at my alternative entrance, blocking that, again pretending to work on his vehicle.



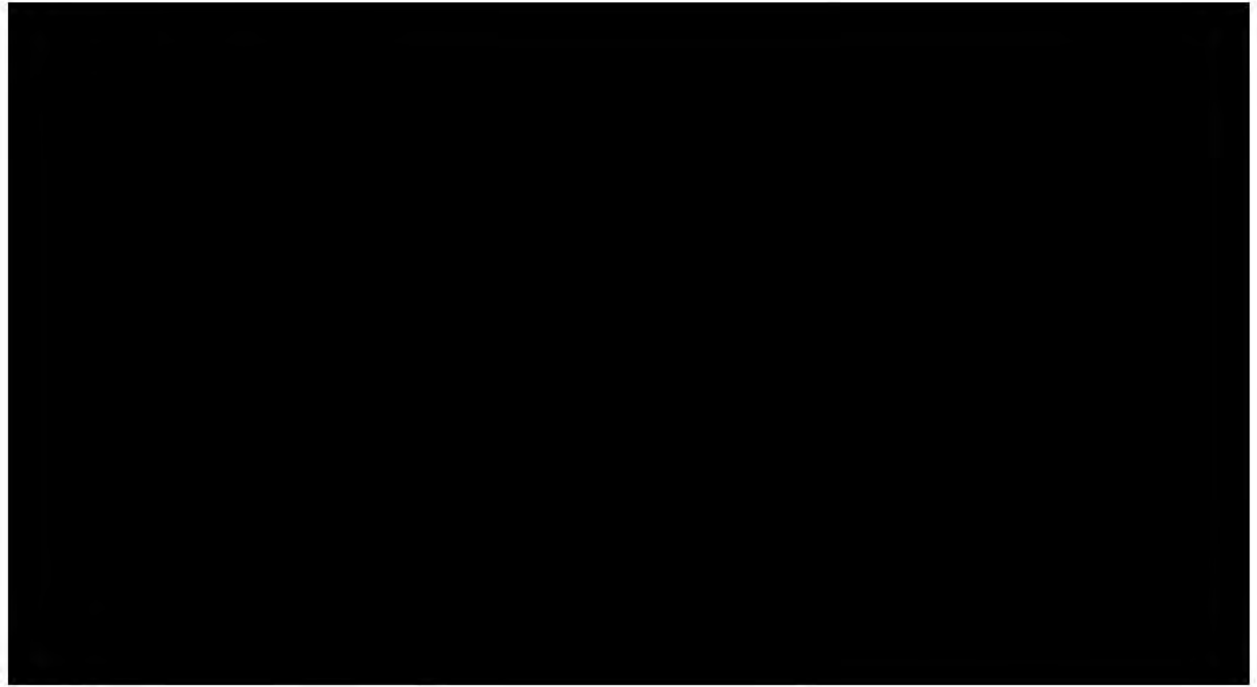
The defendant pretends to clean the door handle, making me wait and very nervous, she acts like she can't hear me, when i speak, and as I raise my voice films me and claims I am harassing her, when I just asked to get inside.



One inside the defendant stands at my window continuing to yell at me about reporting me to QPS and Housing, and I file a Peace and good Behaviour Application, in lieu of Police wasting my time filing and ignoring me as previously seems to have happened.



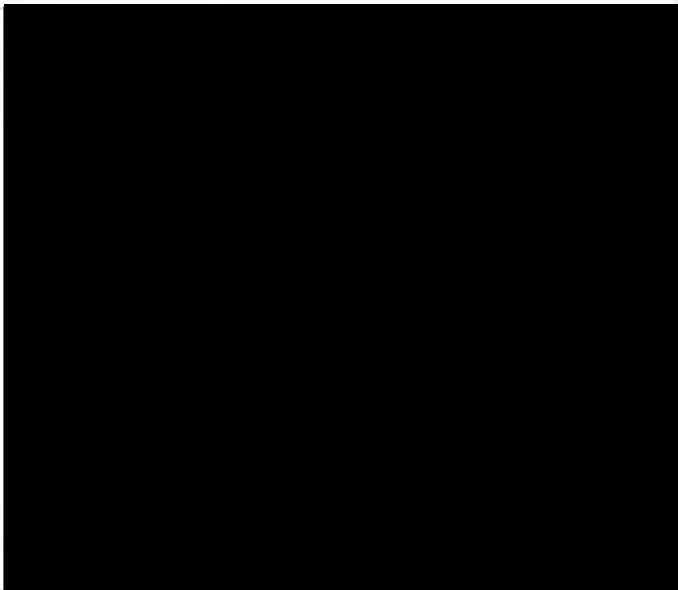
As i return from Filing, I see the defendant coming towards me in the stairwell as I fumble nervously for my keys.



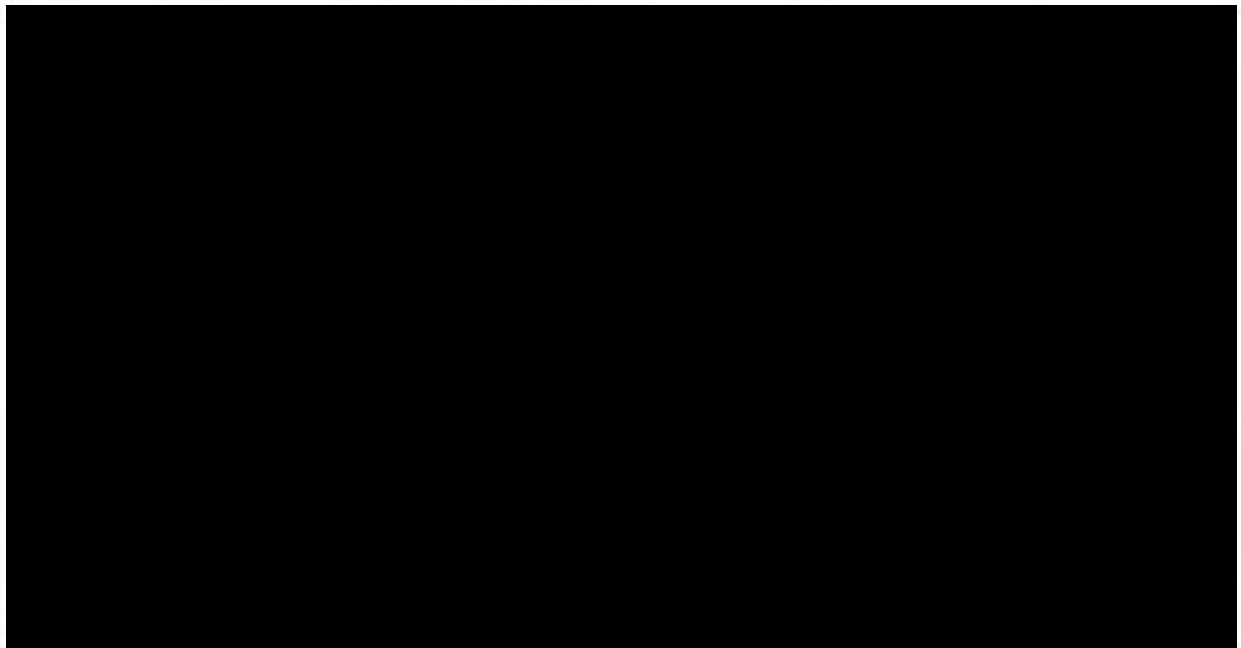
The Police attend while I am locked up against my will drugged with valium, lithium, zyrex, epilium, and aripiprazole, under an ITO which I have to fight off at MHRT.

ITO is revoked and my claims of having PTSD thus using legal safe and effective treatment in prescribed cannabis is endorsed by accepting my actions over [REDACTED] MNMH.

I return from groceries, to see the defendant in her [REDACTED] car waiting, and reversing out and driving at me at entry, i have to leap out of way.. Something I might not have noticed under heavy sedation, which is a serious safety issue, in predator situation as I am in.



Another obstruction, the red car arrives from behind as i enter the driveway, the defendant is in the gap between vehicles with 2 associates.

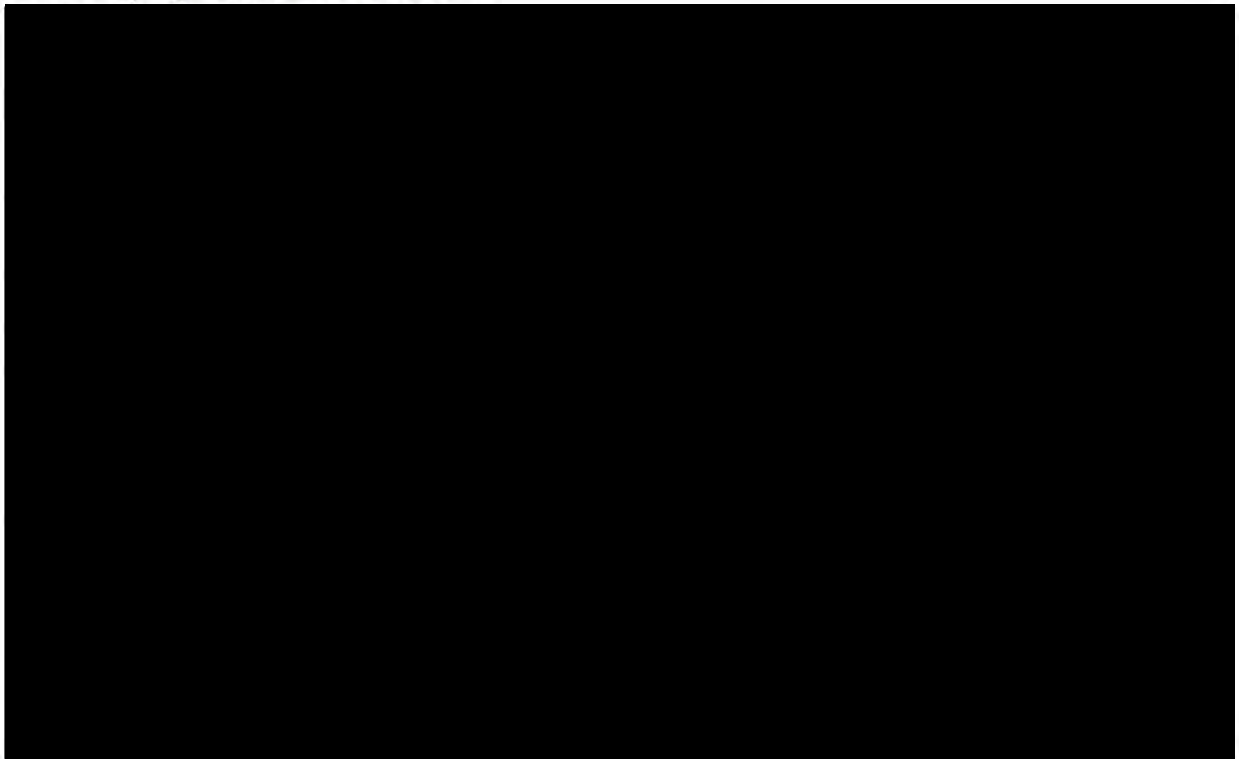


Defendant at my window again, calling me sick in head with gestures again.

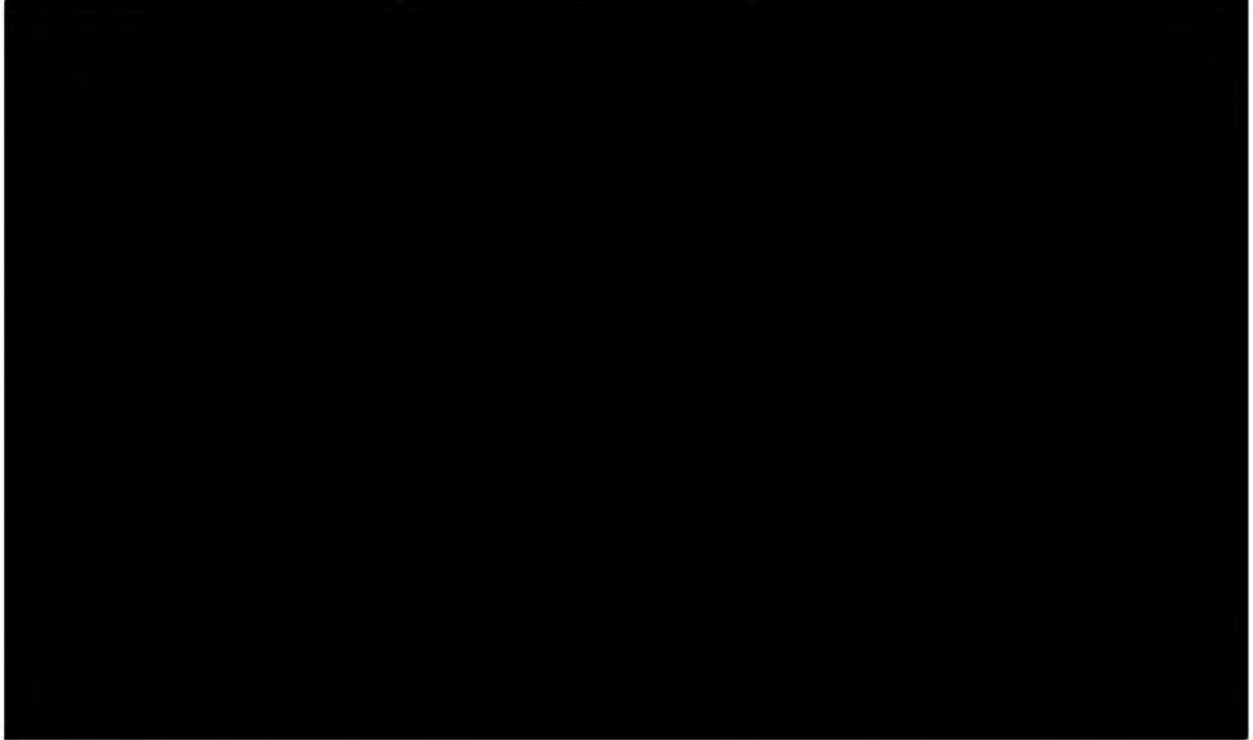


Waiting for me at letterboxes, trying to cut in front of me

I have to jump side fence to avoid her.

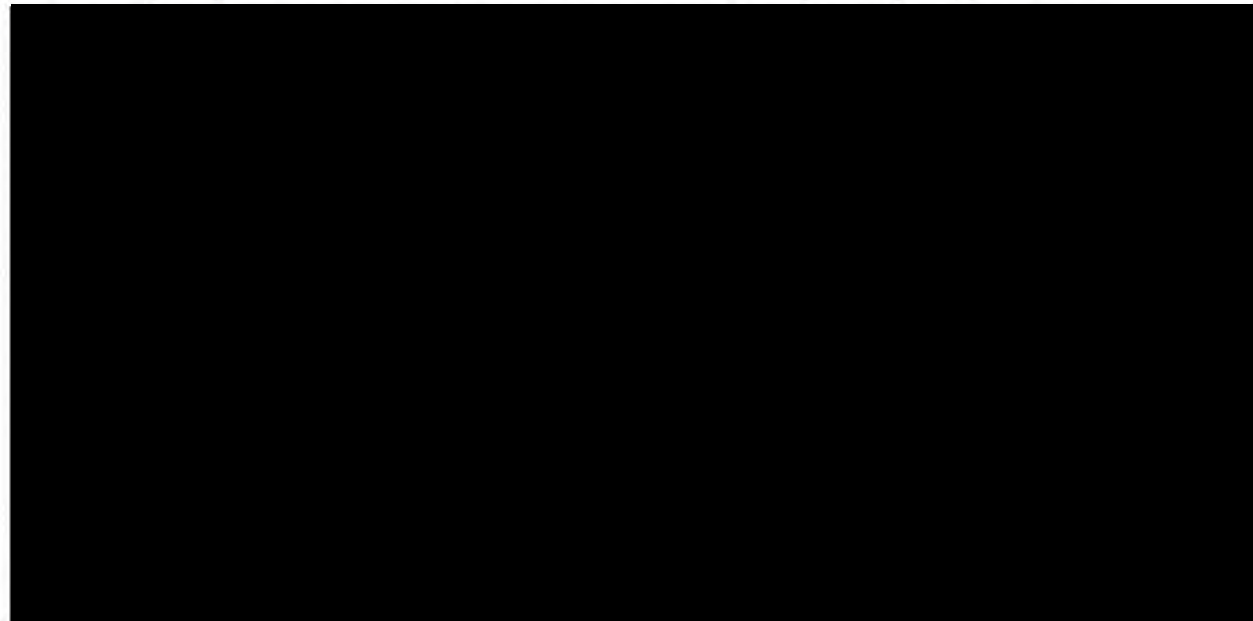


At garage again just as I happen to be getting home, obviously watching me, and stresses me, triggers memories of being rushed and grabbed by throat, every time she's between me and safety, inside and barricaded.



Standing over me at balcony

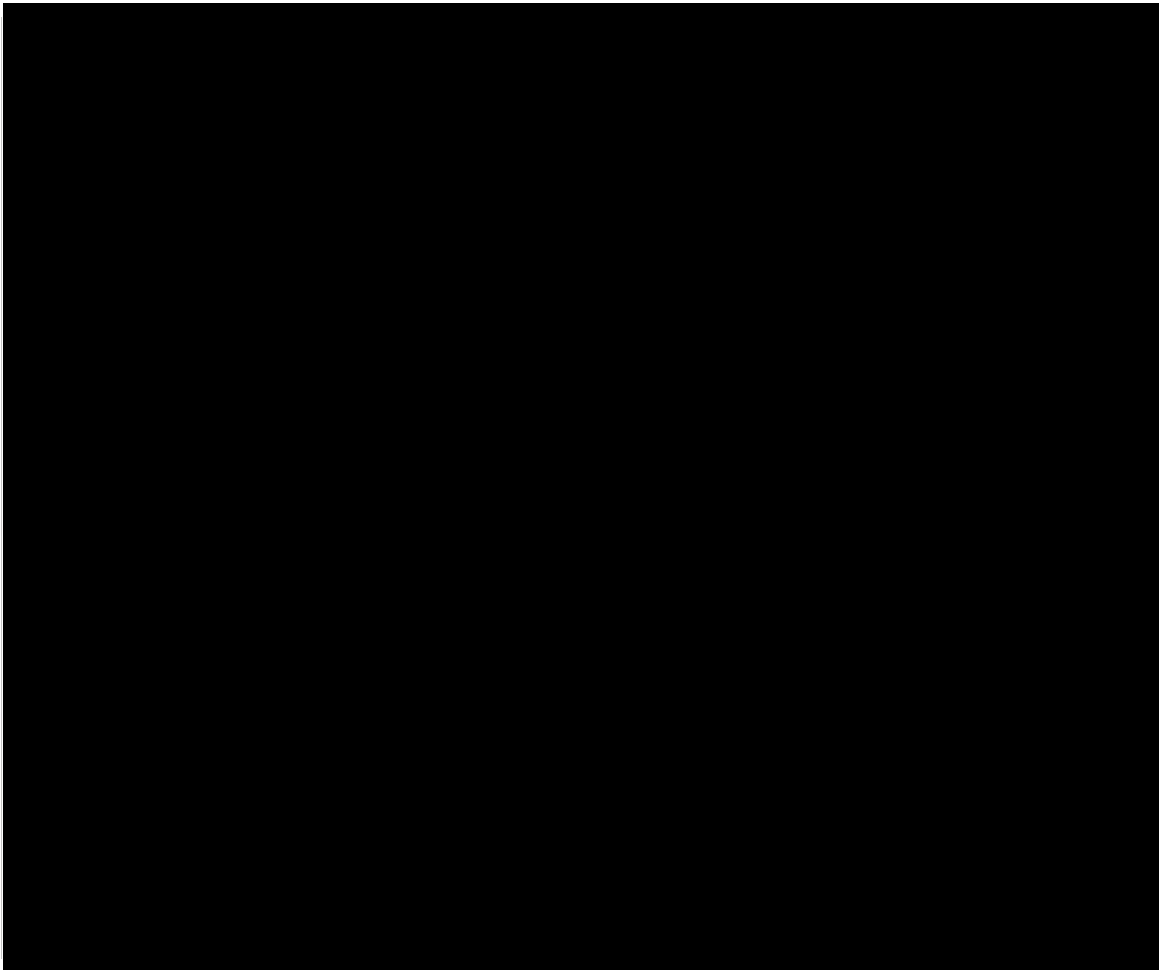
Another regular place to watch me, and leave me fearing things being dropped on me



More provocations, banging on my door, giving me a gesture and wanting to "fight" me again.

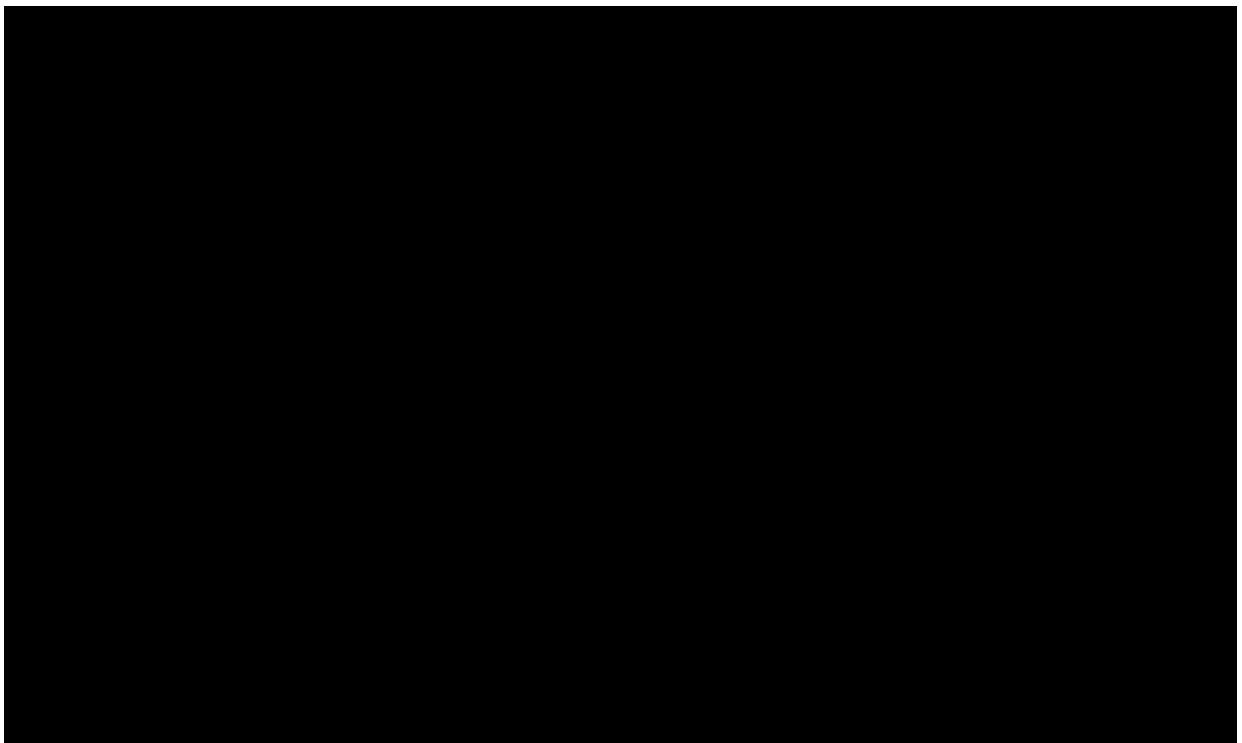
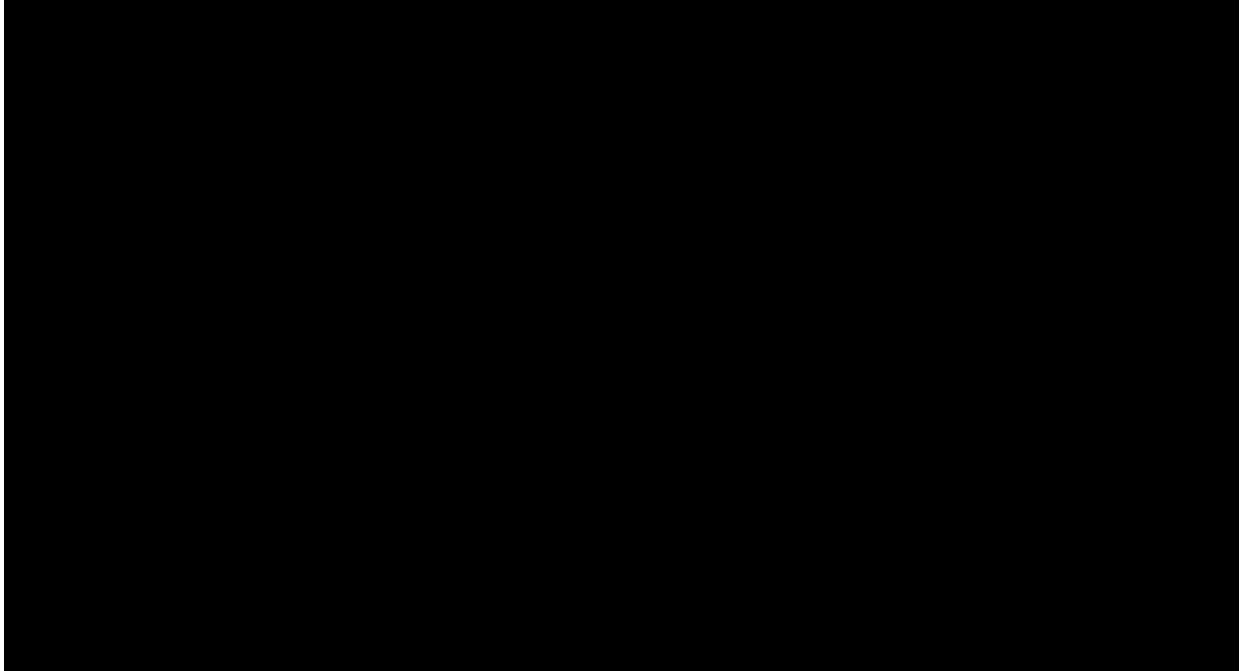
Usually accompanied by calls of [REDACTED]

While the defendant says this is the name of her cat, to me there is an abbreviated double meaning wrt coward which fits other behaviour of defendant and adding to my anxiety and depression, fear and hopelessness.



The day the Defendant was ordered by magistrate to file a defence, again mocking me claiming she can't hear me, as I ask for a written reply.

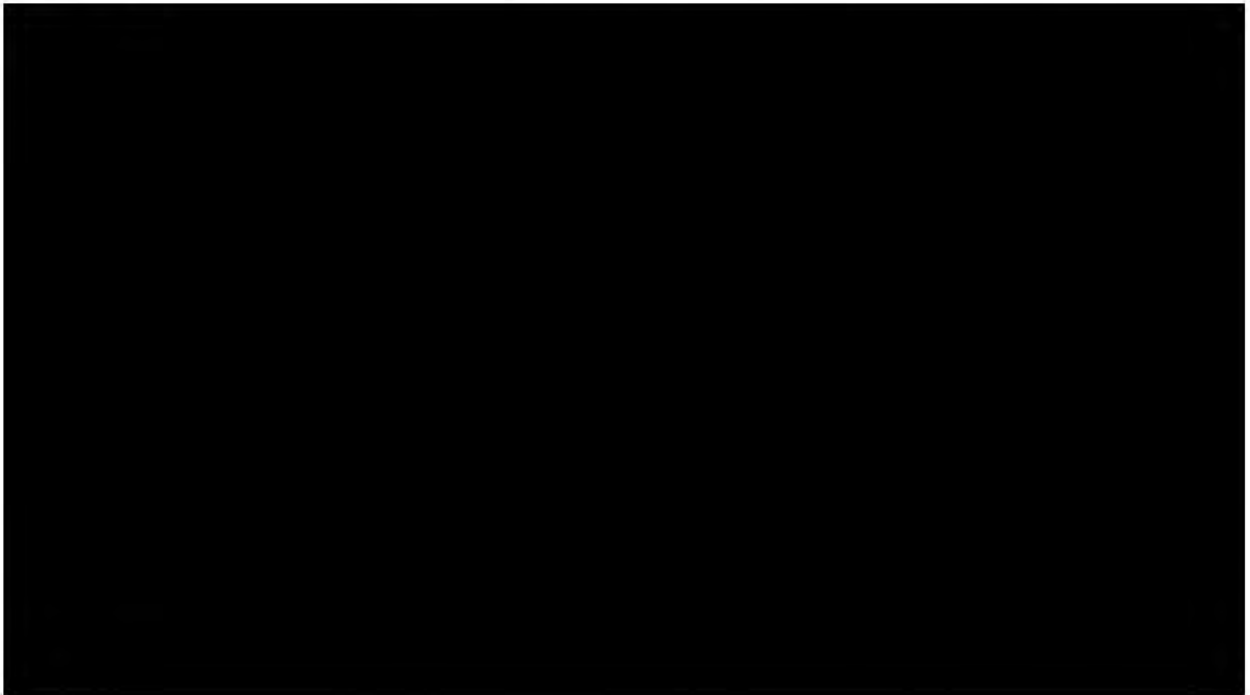
I film a 10 minute tirade of abuse re contents, then the same claims to magistrate never to have received the same in lieu of replying to contents.

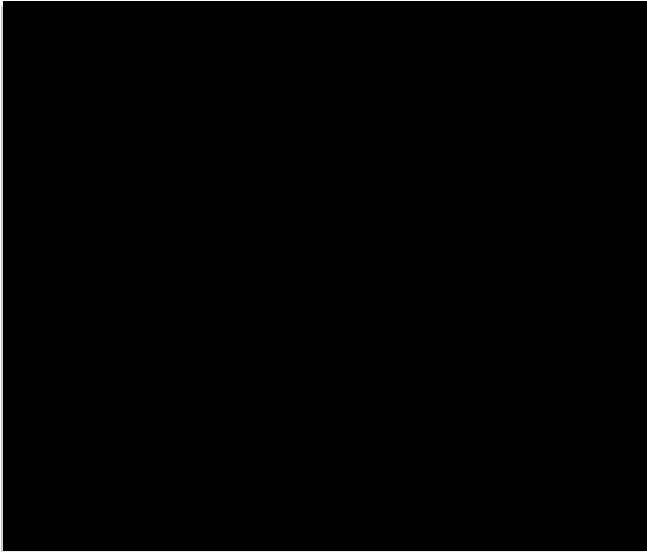




Leading up to hearing, bangs balconies above me, as is usual in back yard if i try to garden to relax, usually she ceases before I can capture it, so this is an escalation.

I have turned around here after I was alerted to her position after banging and falling debris from ?rugs?

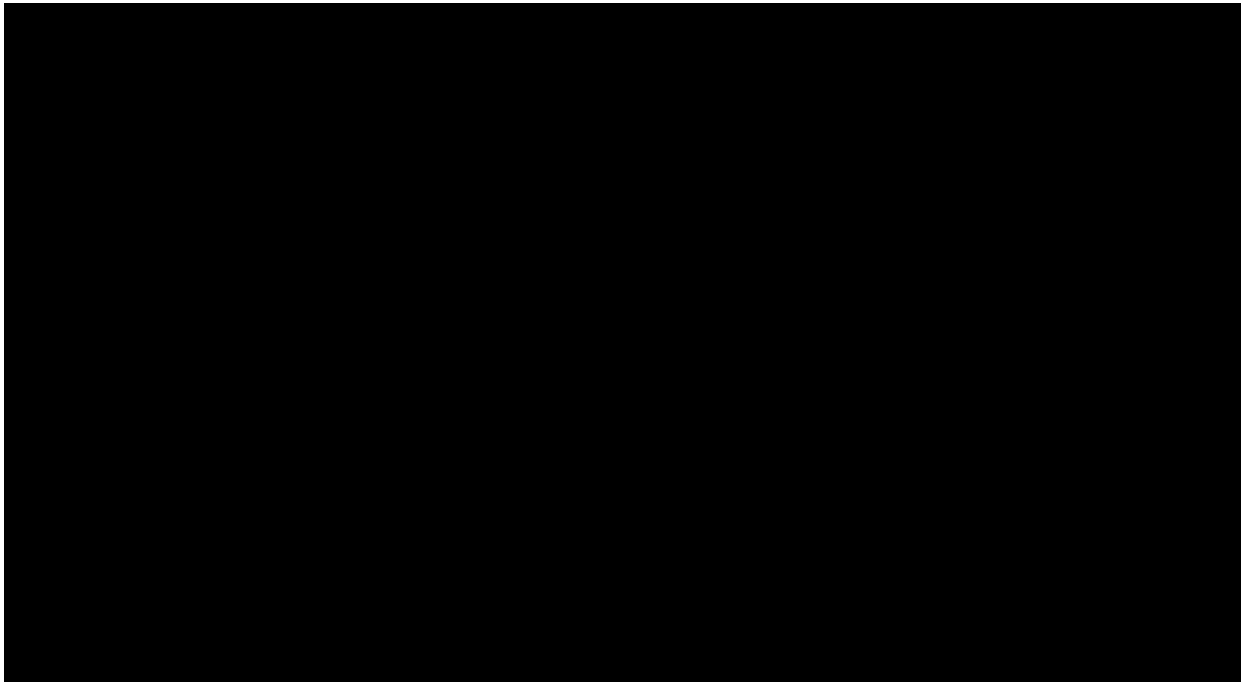


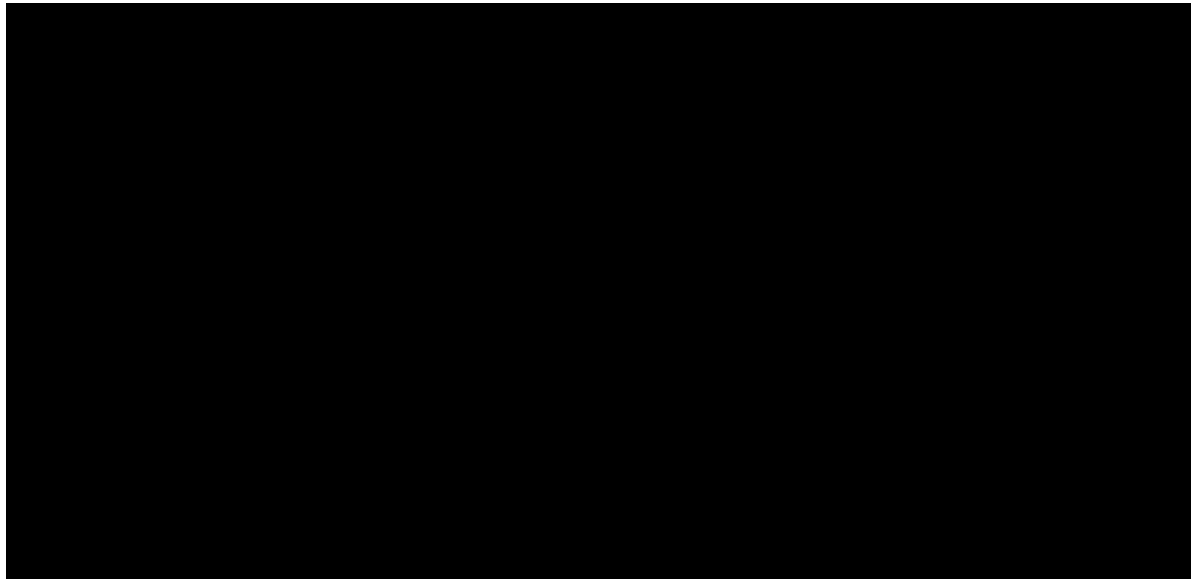


I have a long slow hearing where my mind goes blank in stress, and I'm not given any orders but referred back to Police despite insisting they won't help.

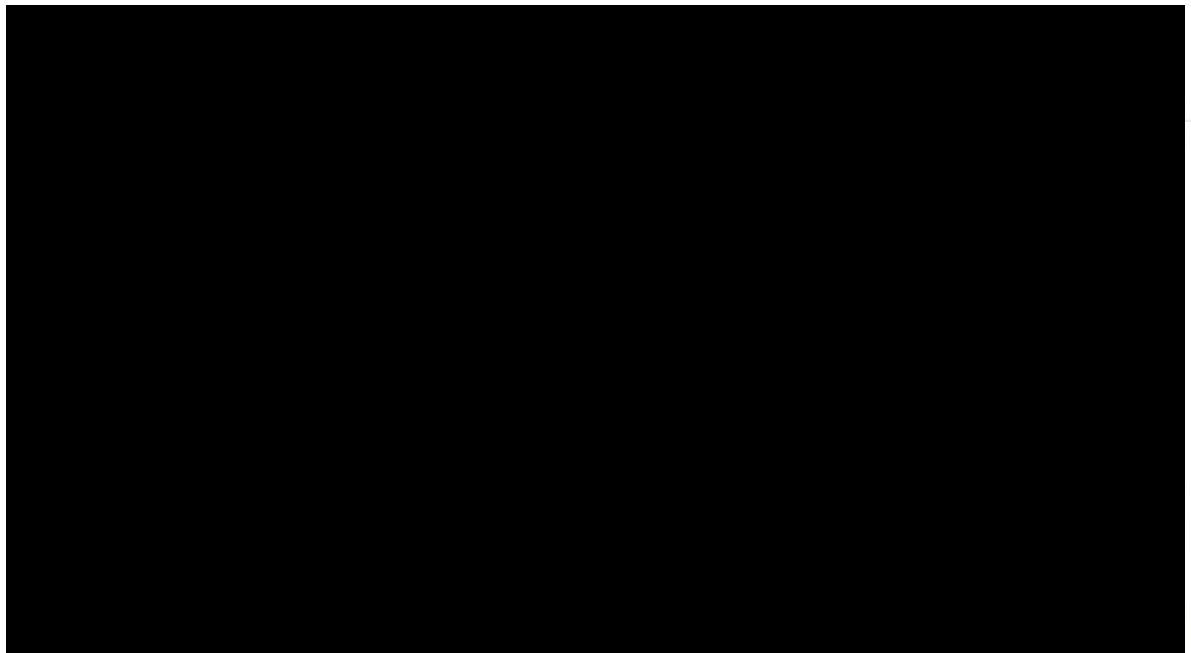
I got the impression that a conversation with [REDACTED] who I had hoped would support my position re how stressful this is for me, but I don't think he did.

Same day of hearing, ie 2 hours after being told to stay away from my unit, back at the door banging her broom claiming she is just "cleaning".

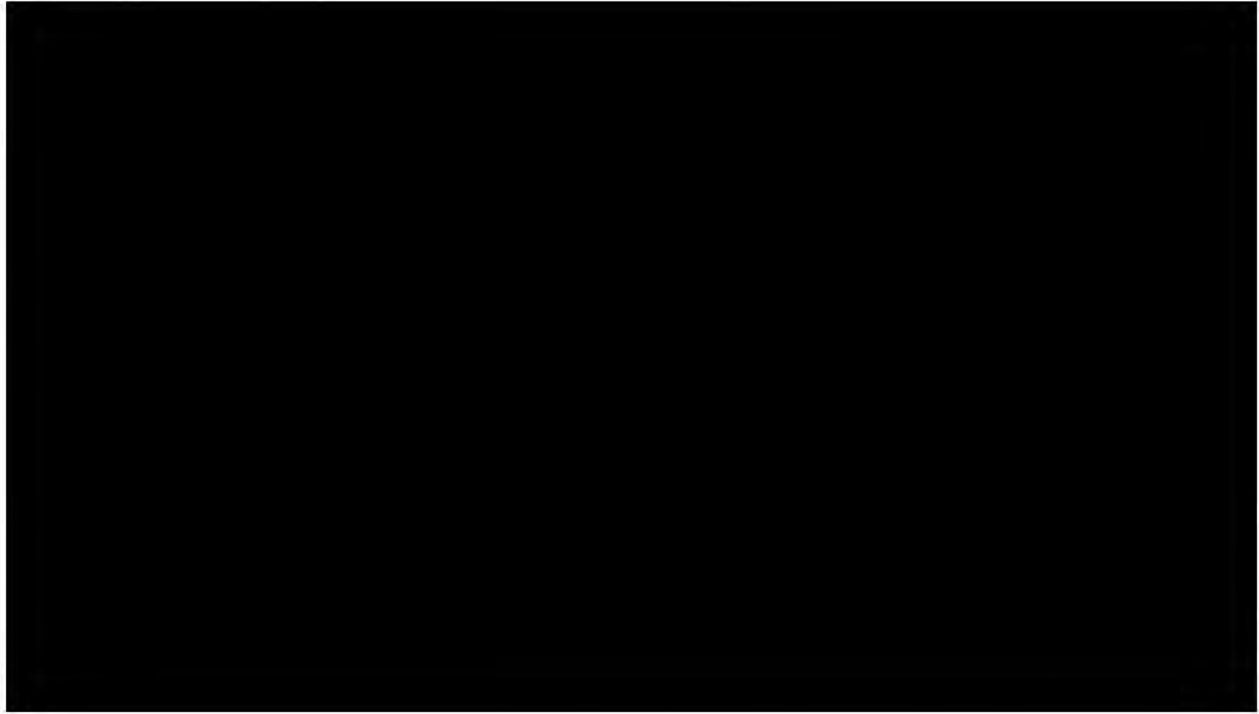




I attend Royal Commission into Violence Against People With A disability in Their Homes, involving some from earlier Forum hoping for help.

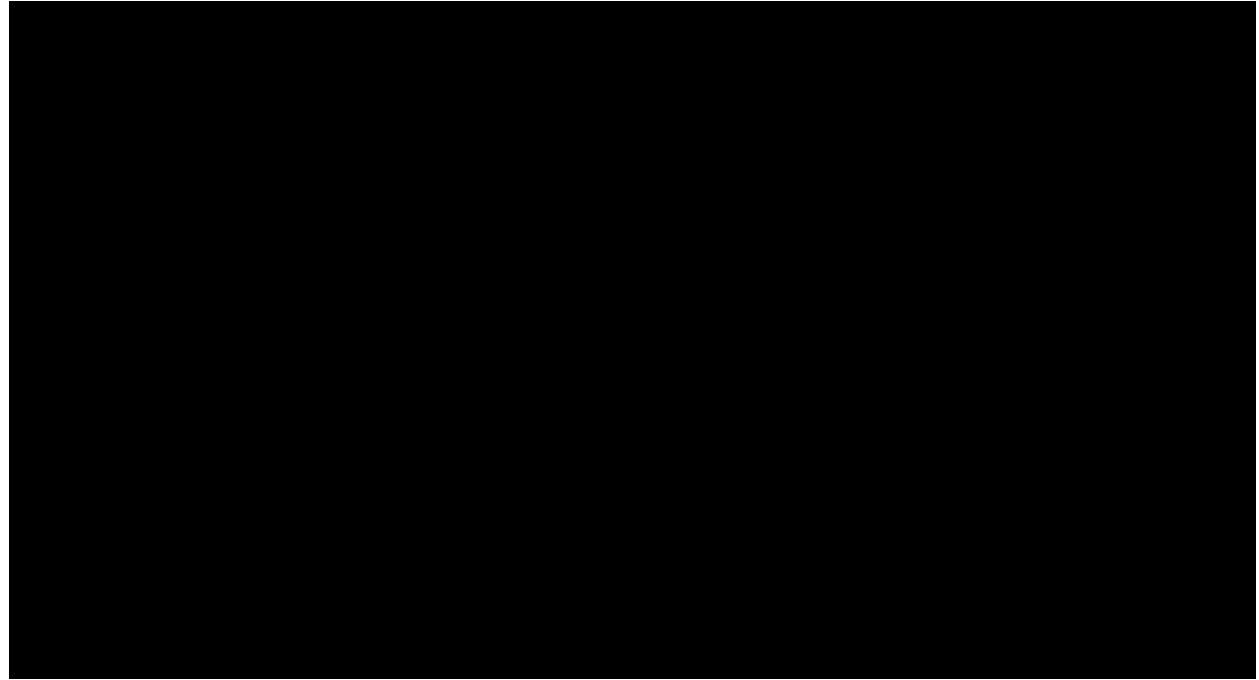


I live in fear waiting for this and help as defendant's relatives freely park outside while I live trapped inside.

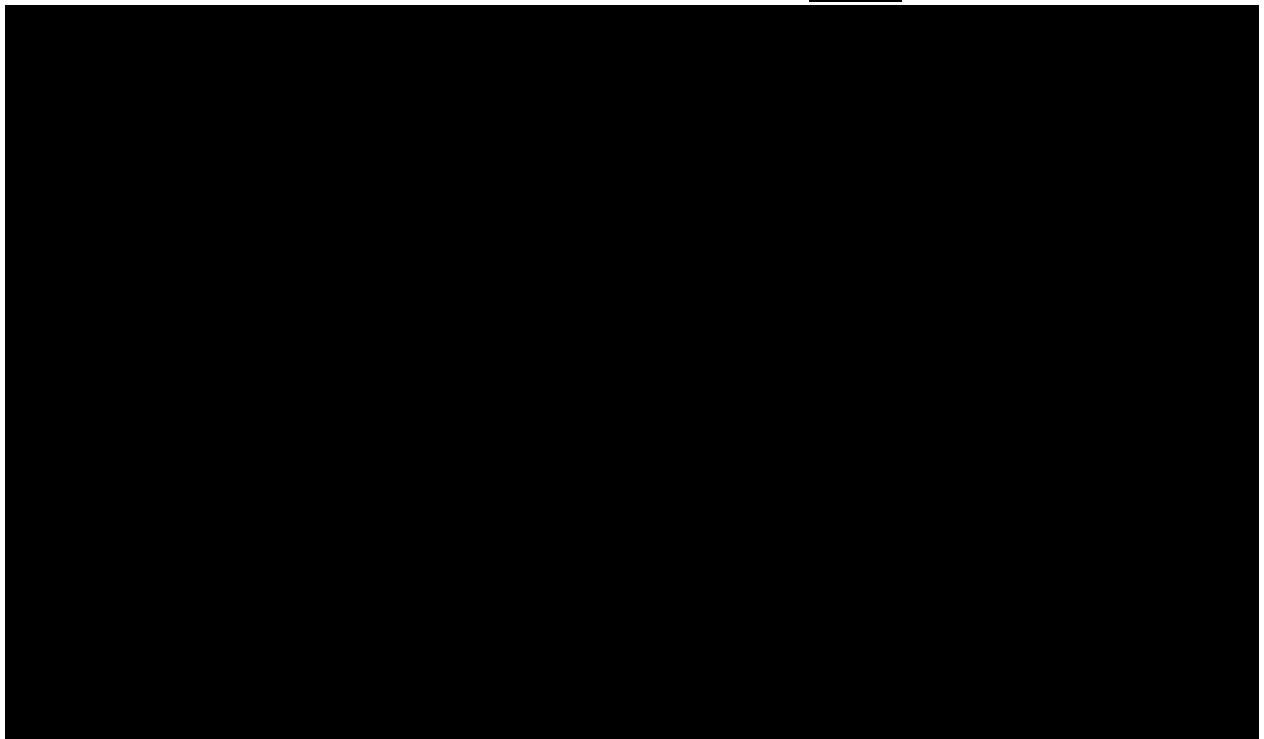


Even answering door to postman is complicated by defendant pushing past so I face her instead of parcel.





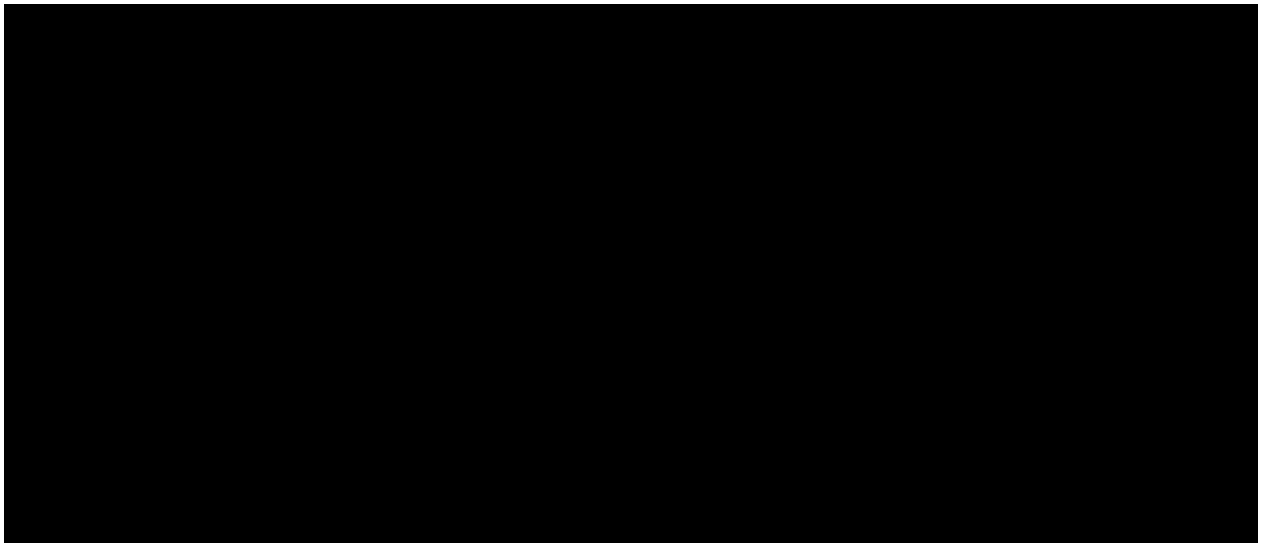
The obstruction by visitors to defendant continue to trap me and no one cares re no parking letters and signs are ignored, nor the directions by Magistrate [REDACTED]

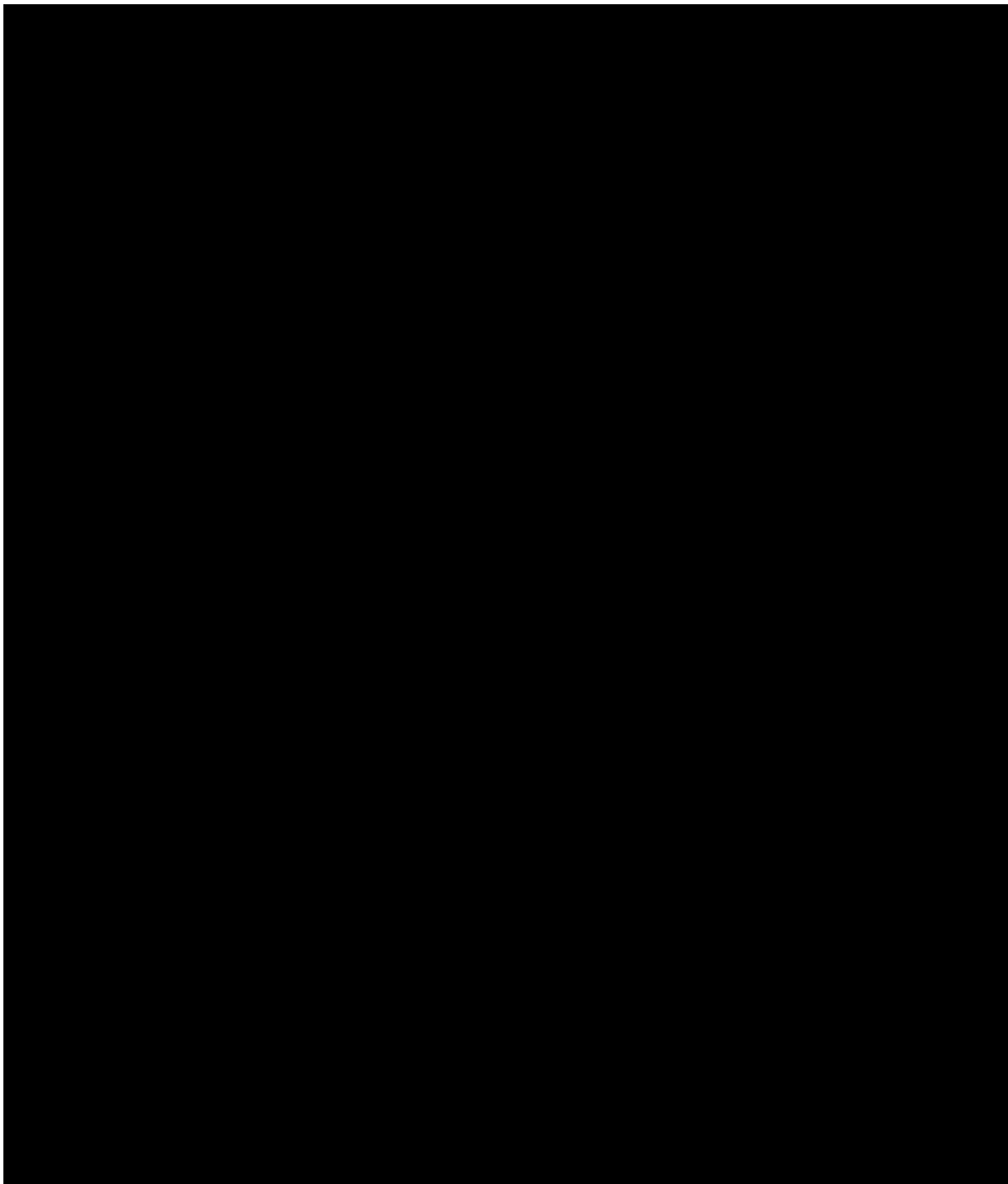


Apparently watching my social media the defendant literally ambushes me from low hanging branches as I return from groceries, mocks my attempts to get justice yet again as she stands above me..after I deviated to avoid her being yet again waiting along my direct path home.

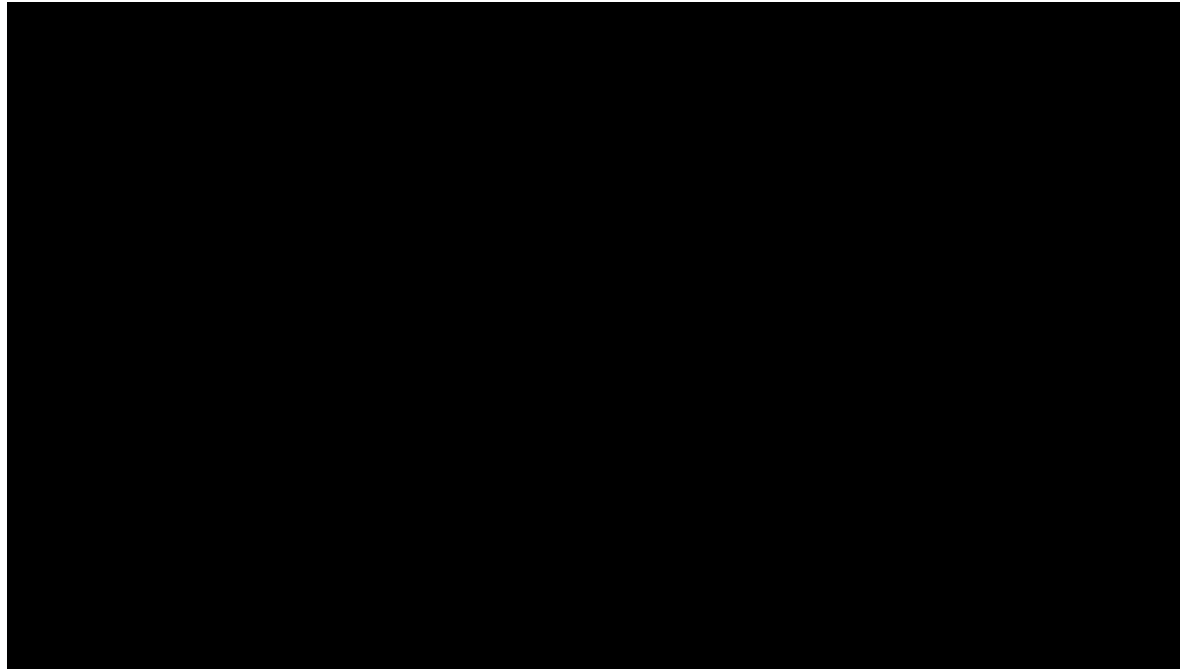


Back at my window pretending to be sweeping.





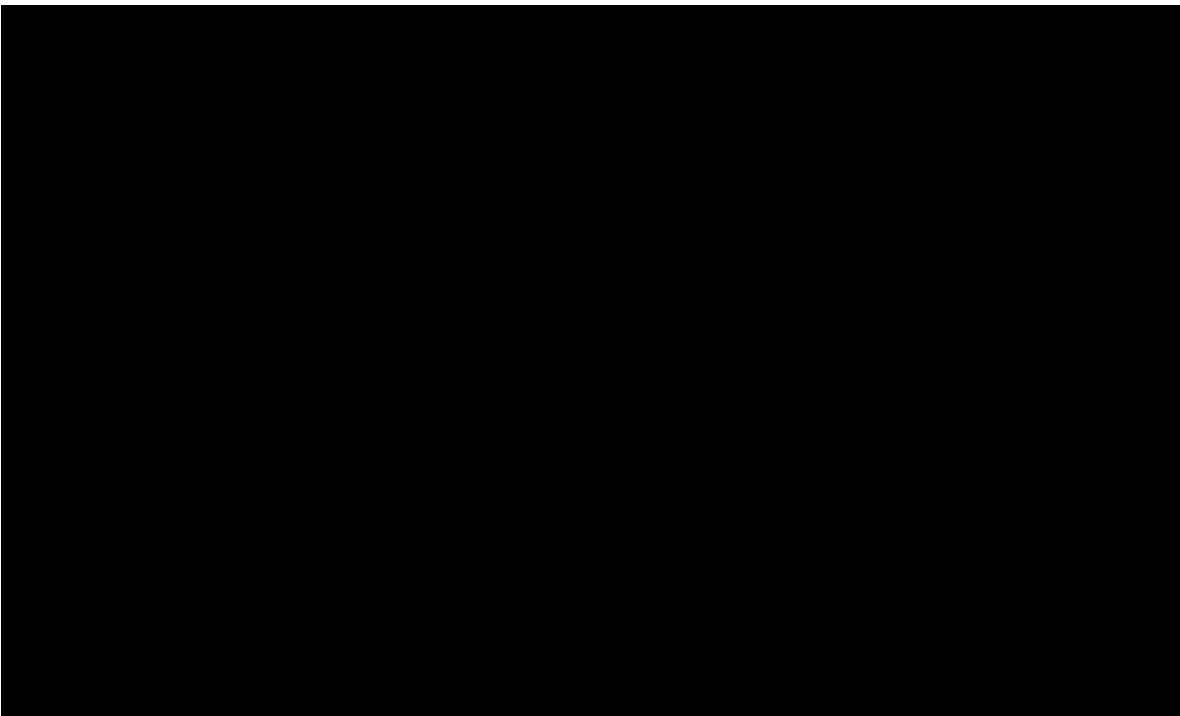
Having fun with cat, and lingering, despite being told such was unacceptable by Magistrate, and claiming she is in fear of me as a person labelled mentally ill.

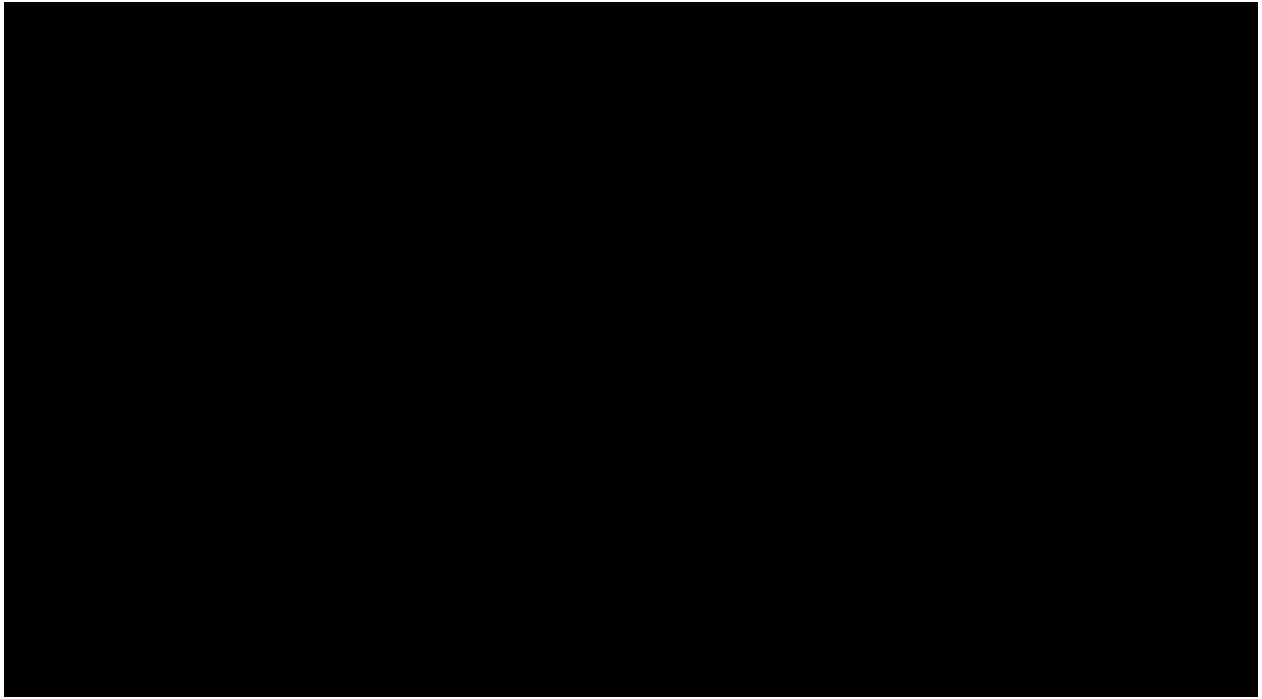


Doubling down the watchers with [REDACTED] who I have footage of standing over me while loudly talking about buying a gun while looking directly at me.

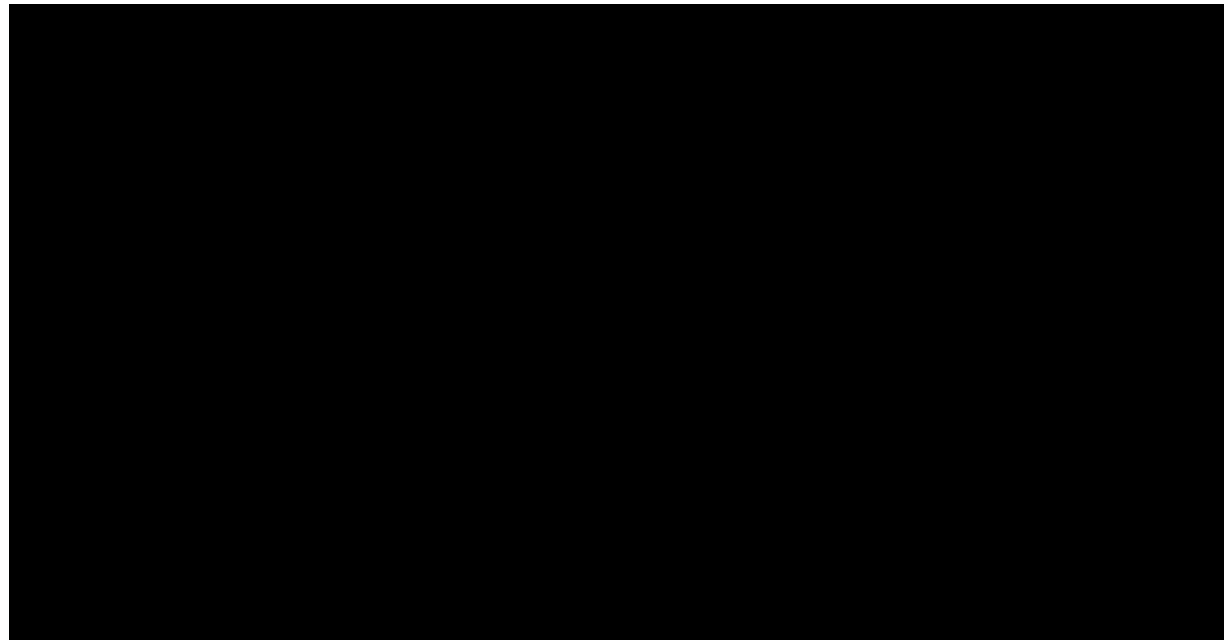
He turned up very regularly this year parking outside my unit and being on balcony above me, after befriending new resident about his old unit..

He'd arrive the small part of day when I could get sunshine usually, which again I found stressful.

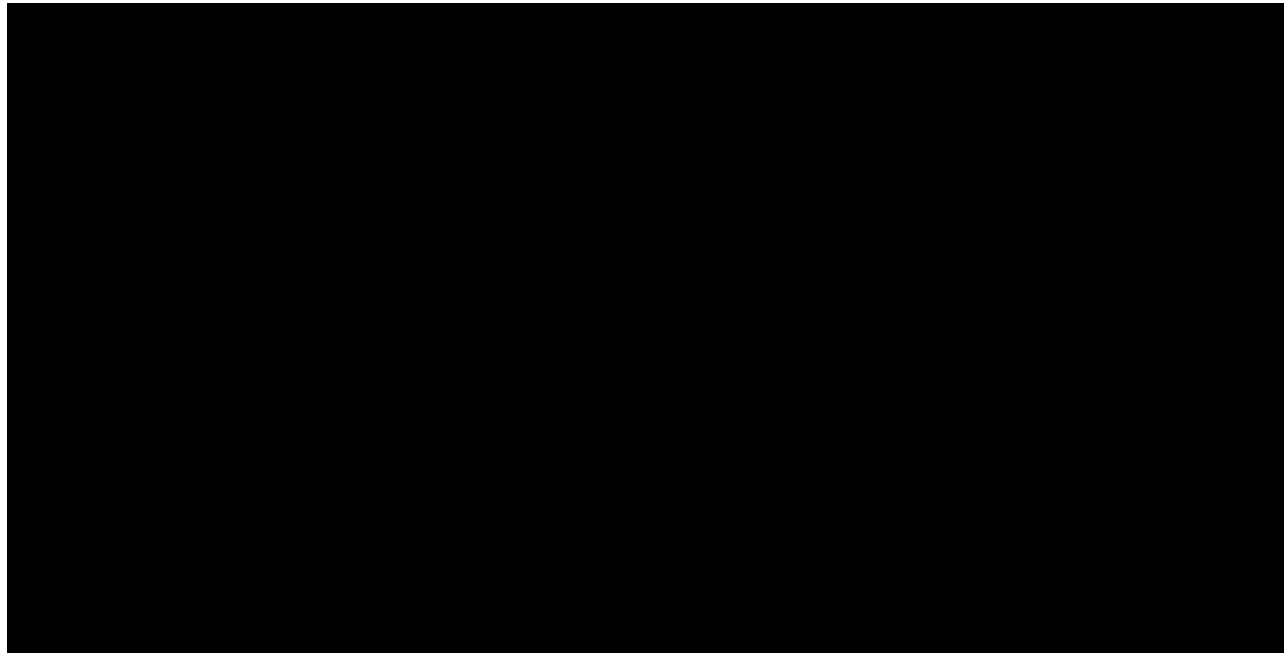




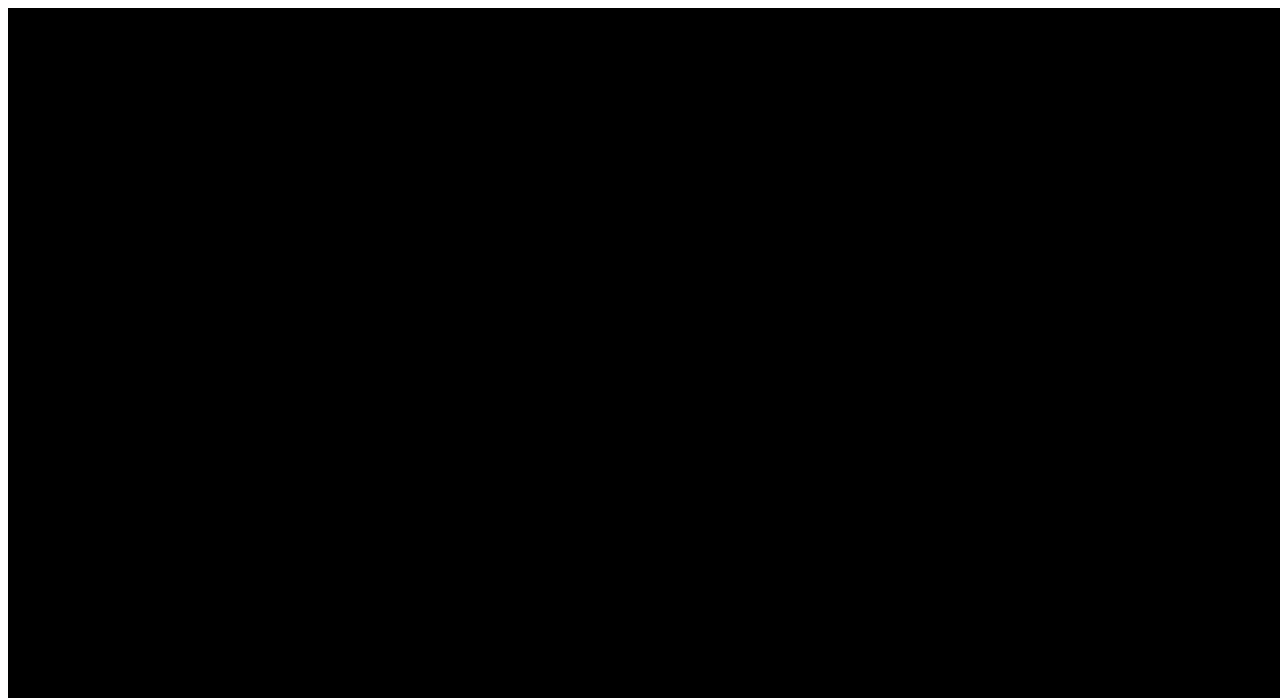
Unable to be sure of my safety getting inside on a saturday night after the defendant seemed to be waiting for the last bus, ie my usual time, even inside I would be approached, yelled at, had a glass smashed against my screened window in direction of my face.



Followed by another stranger, male associate giving me medical advice about my mental health.

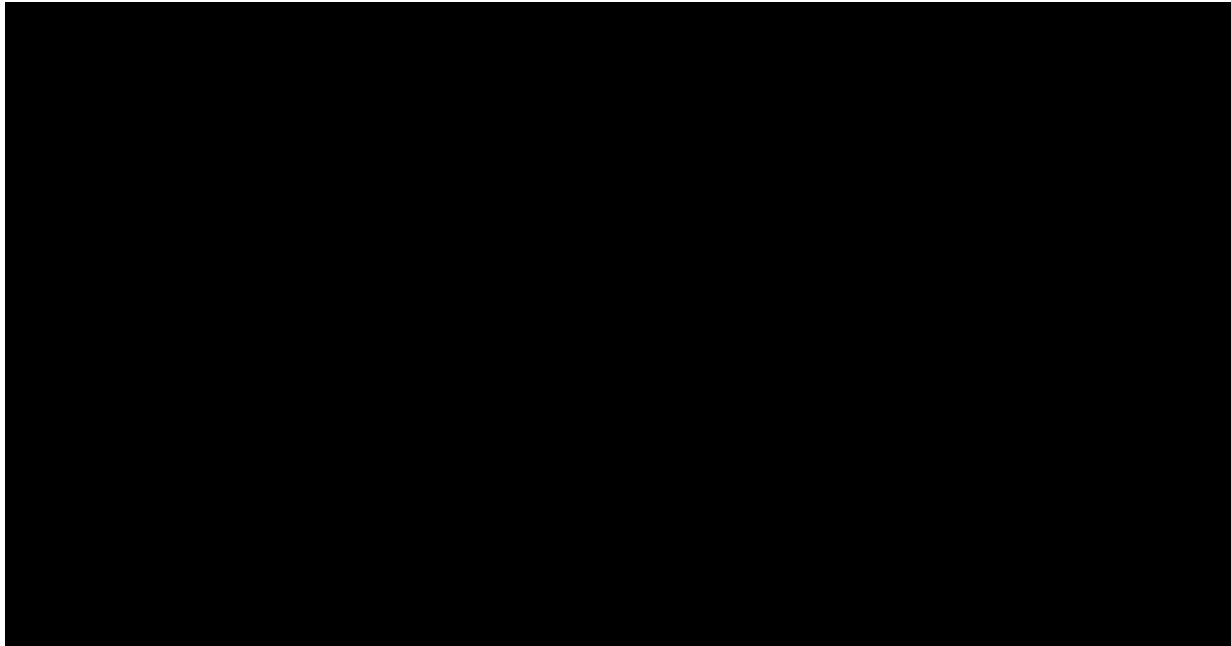


While waiting for QPS, the defendant comes bck bangs my window, kicks my door and drunkenly calls me out for a fight calling me weak etc .

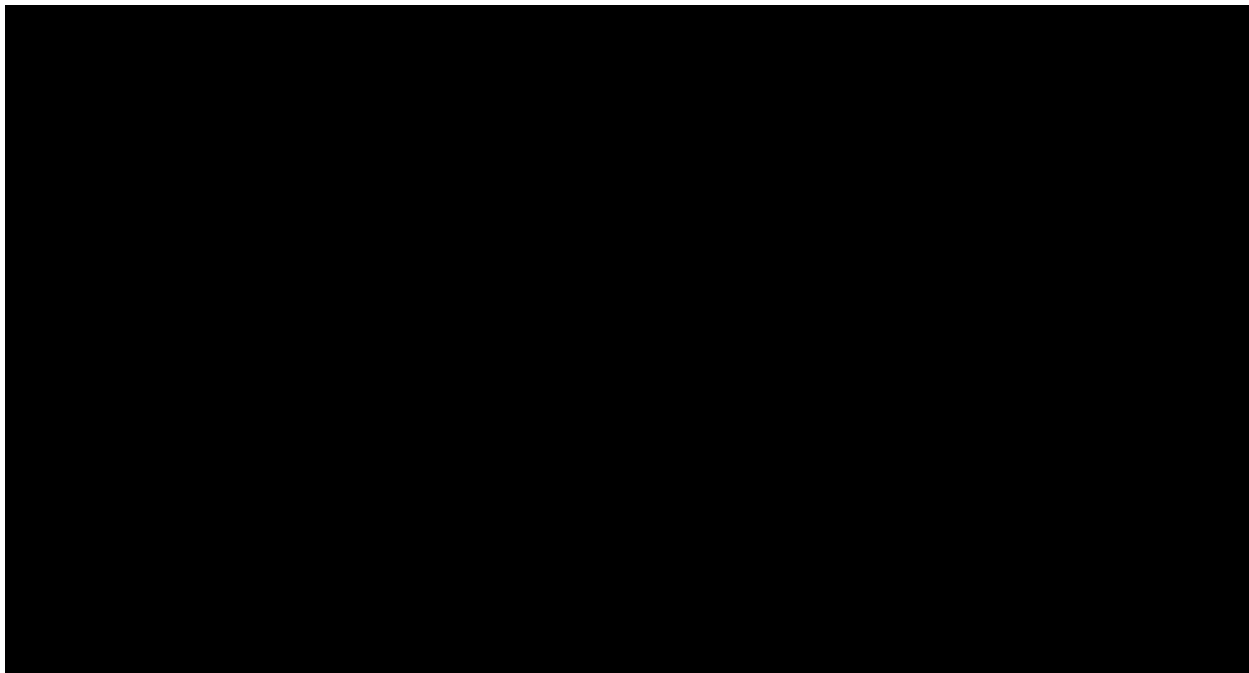


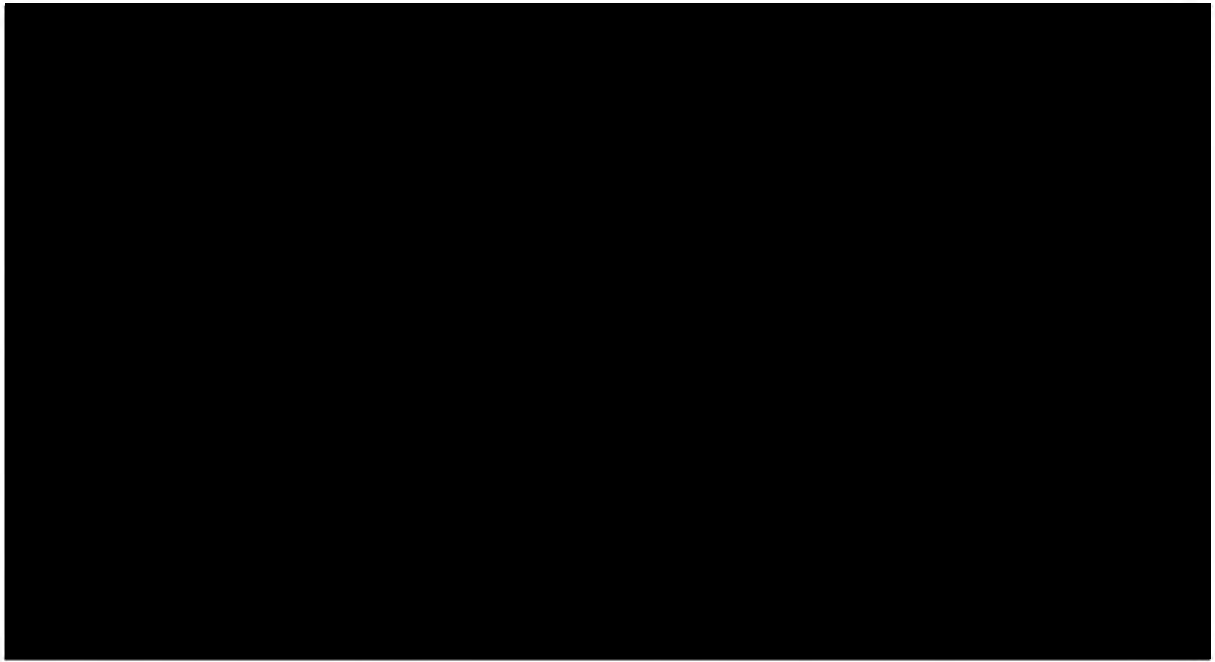
The Police attend don't help me, despite many statements, nor do DRC legals, despite promises of protection from retaliation.

DRC support try to hypnotise me as therapy while seriously unsafe/targetted by violent attacker and many associuates.



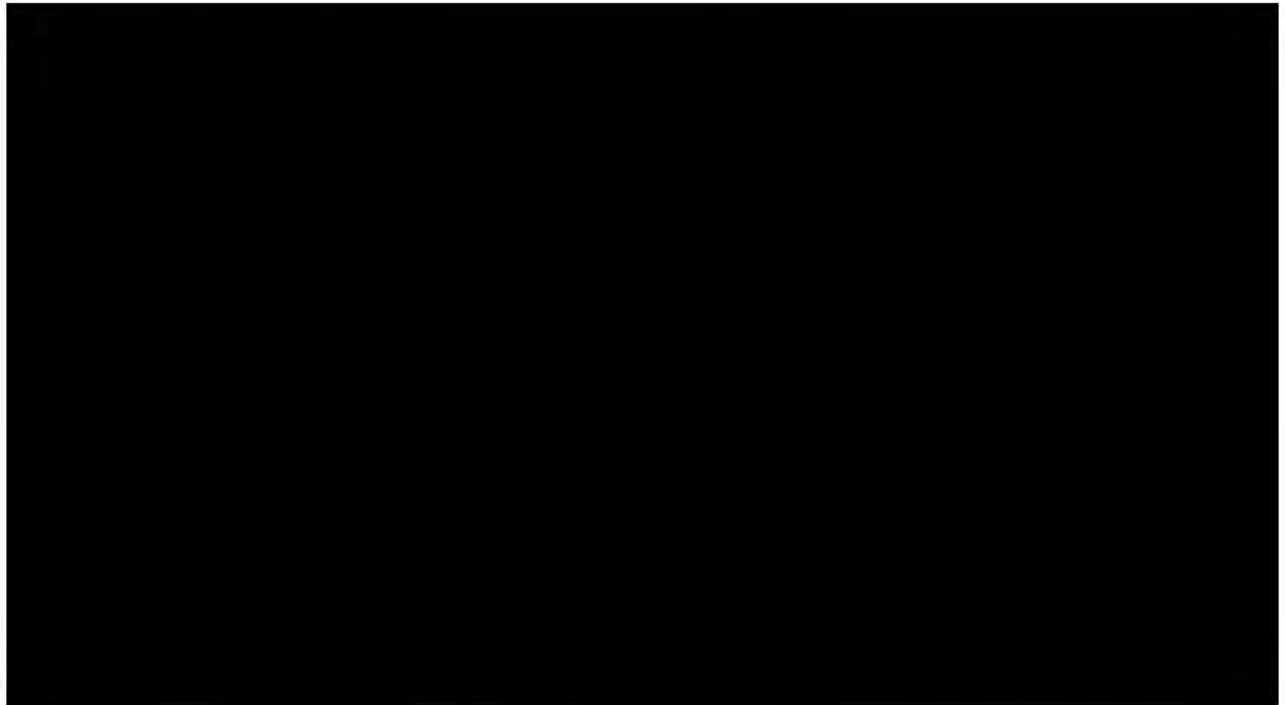
The defendant borrows another car, parks it at my alternative entry and tries to block my front and side entry as she chases me across the grounds and I try to get safe inside.





When this fails, the defendant engages 2 other people with a vehicle, chairs and other property to obstruct the front entry, while gaining access to side via garage of unit █.

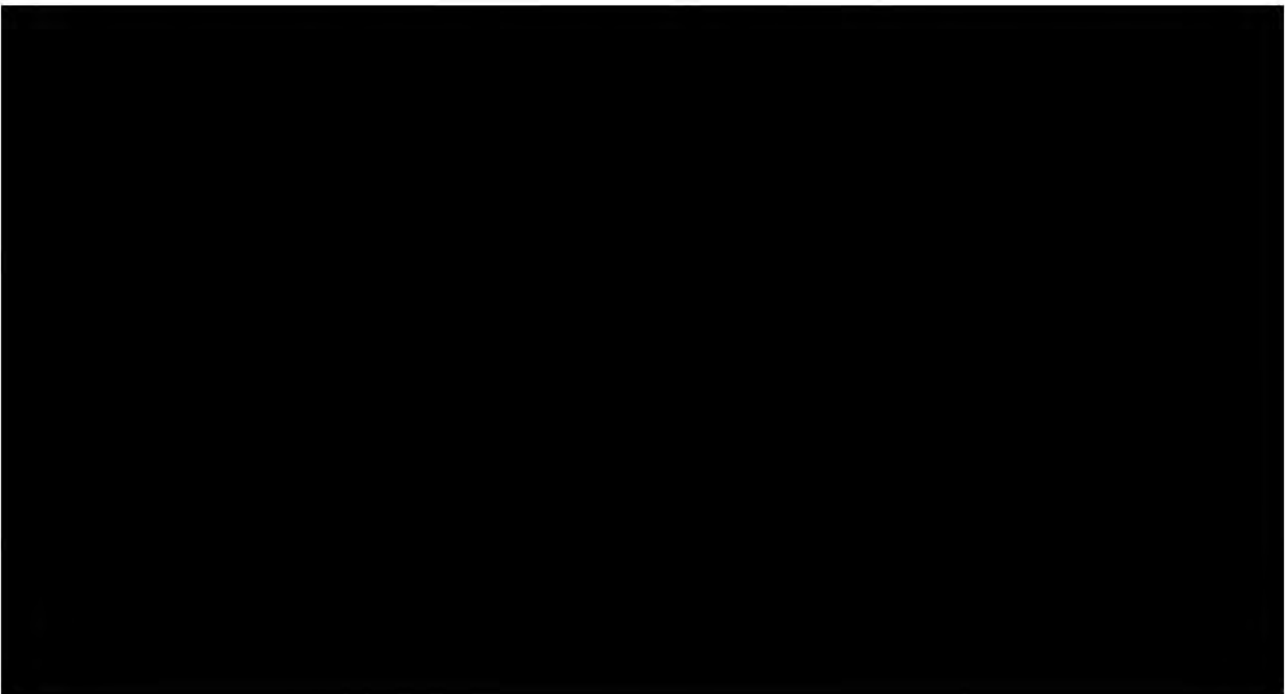


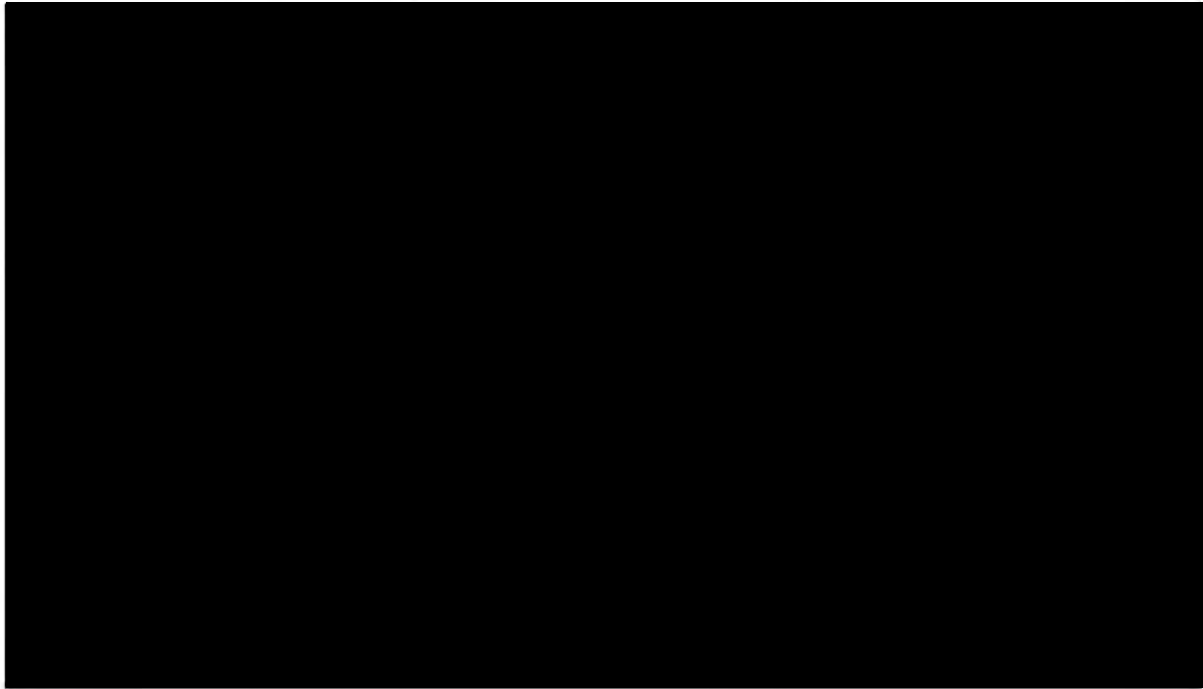


Once inside the defendant with 2 balconies, entertains the same outside her garage while watching my window to see if I call anybody for help (as previously)

This is close to 9 year anniversary of violent assault.

Another episode of targeted harassment as I try to get inside, unsure where the other 2 people who just moved in are, so I am stuck under her to scared to enter the stairwell or side path.



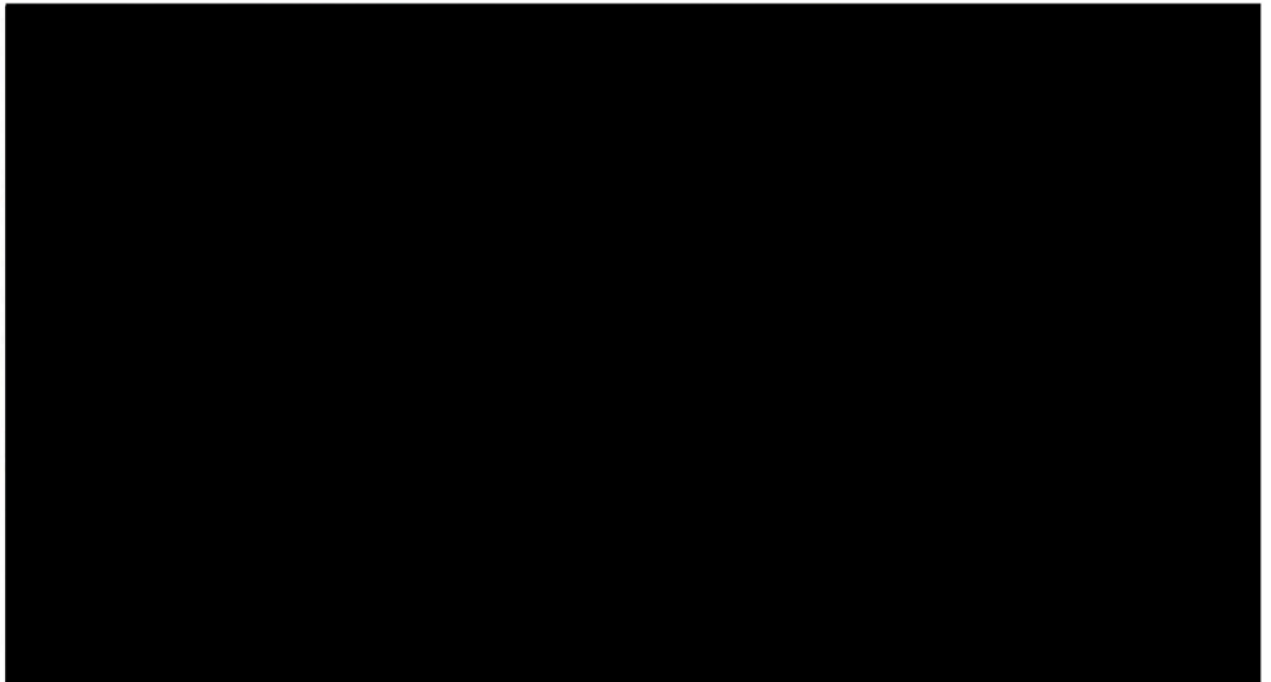
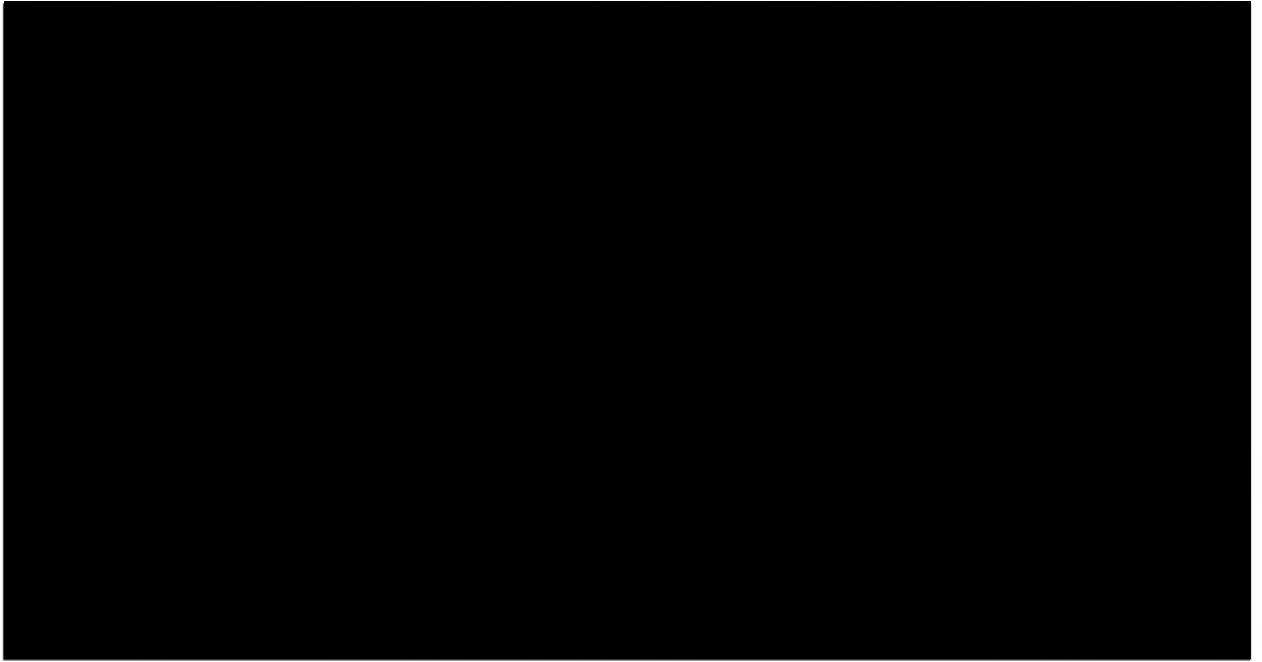


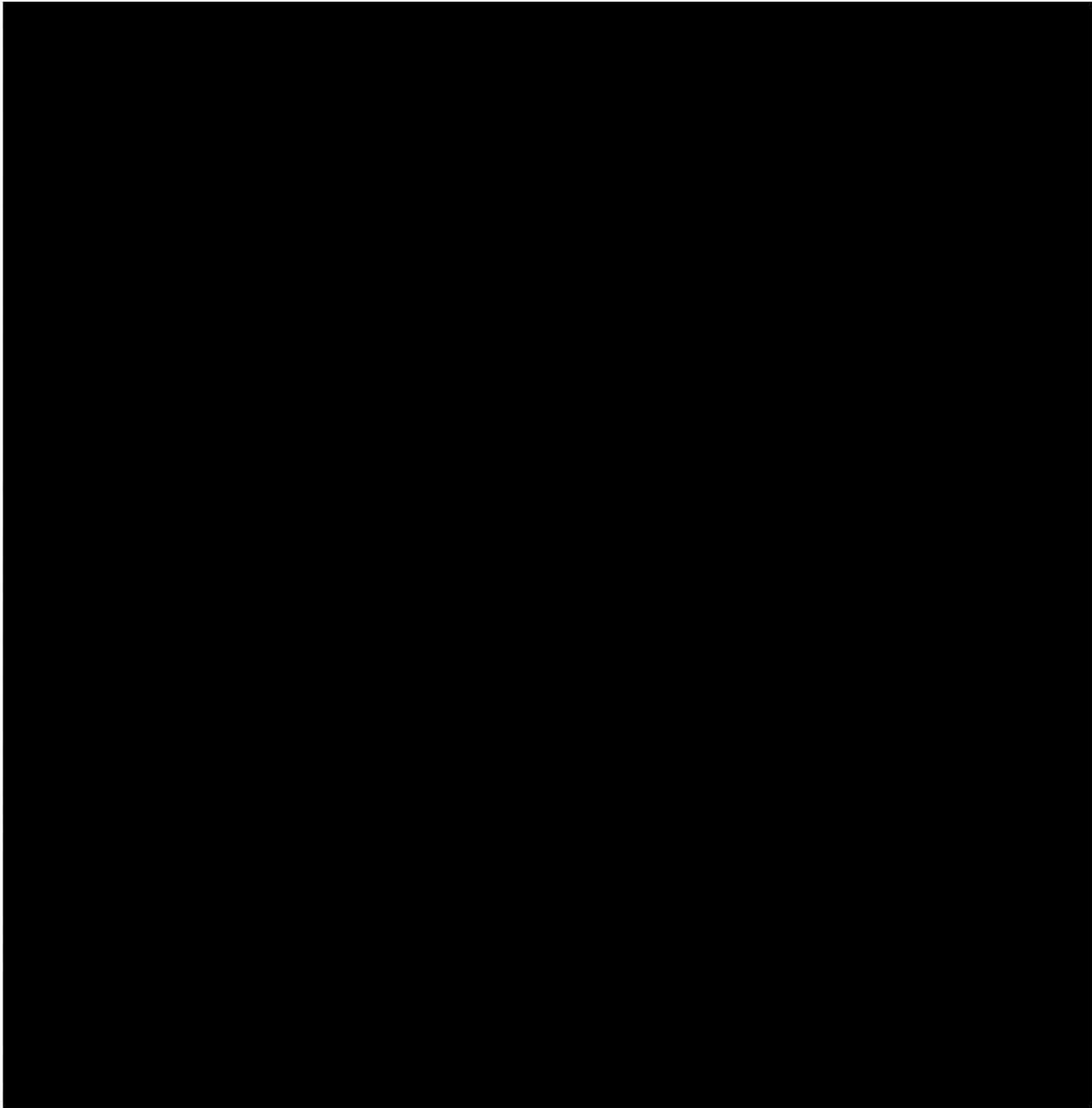
I report this formally, no action, accept more loitering outside for my return from grocery shopping, this time she started as a show behind the bin fence before going to letterboxes to block me.

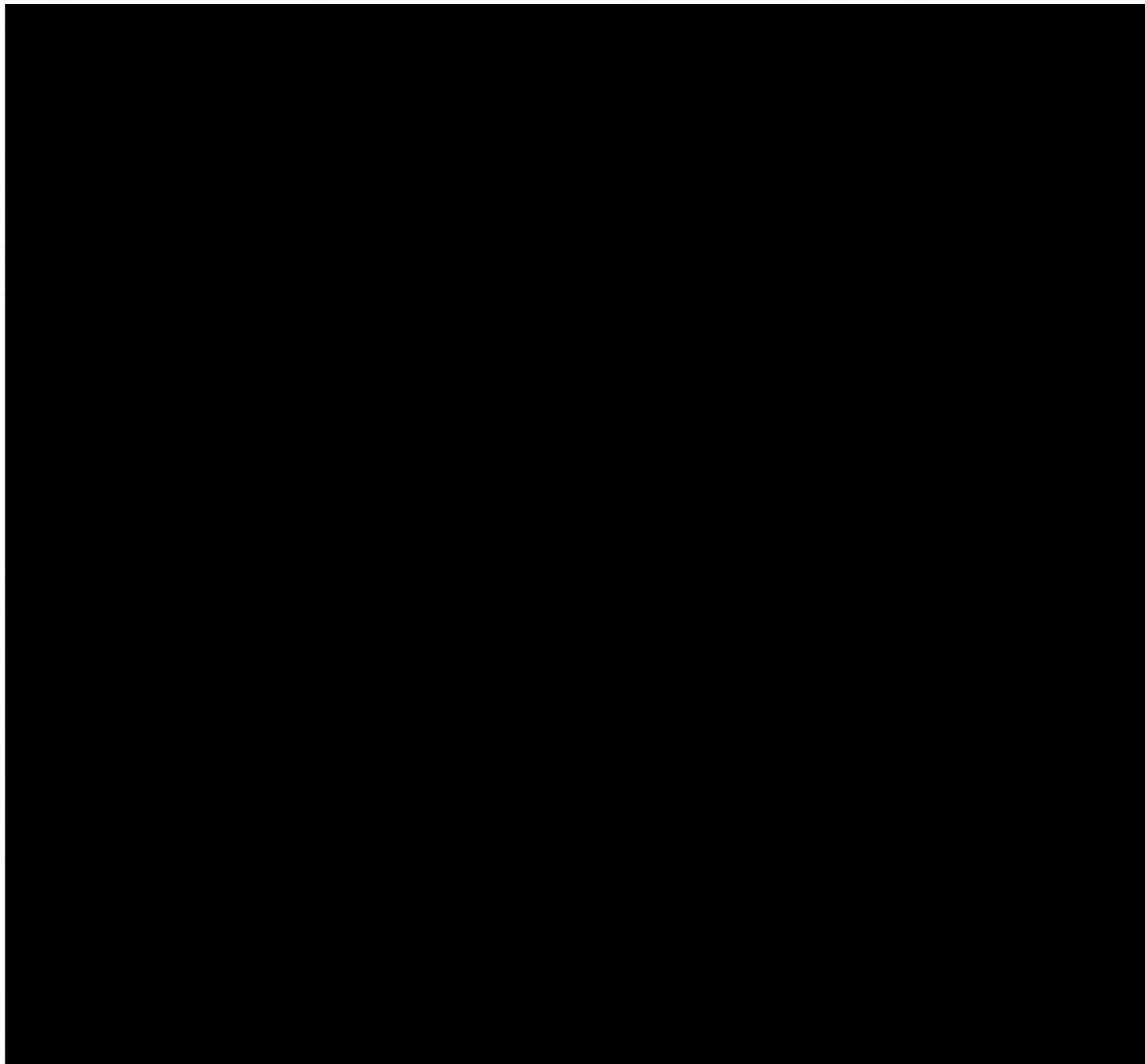


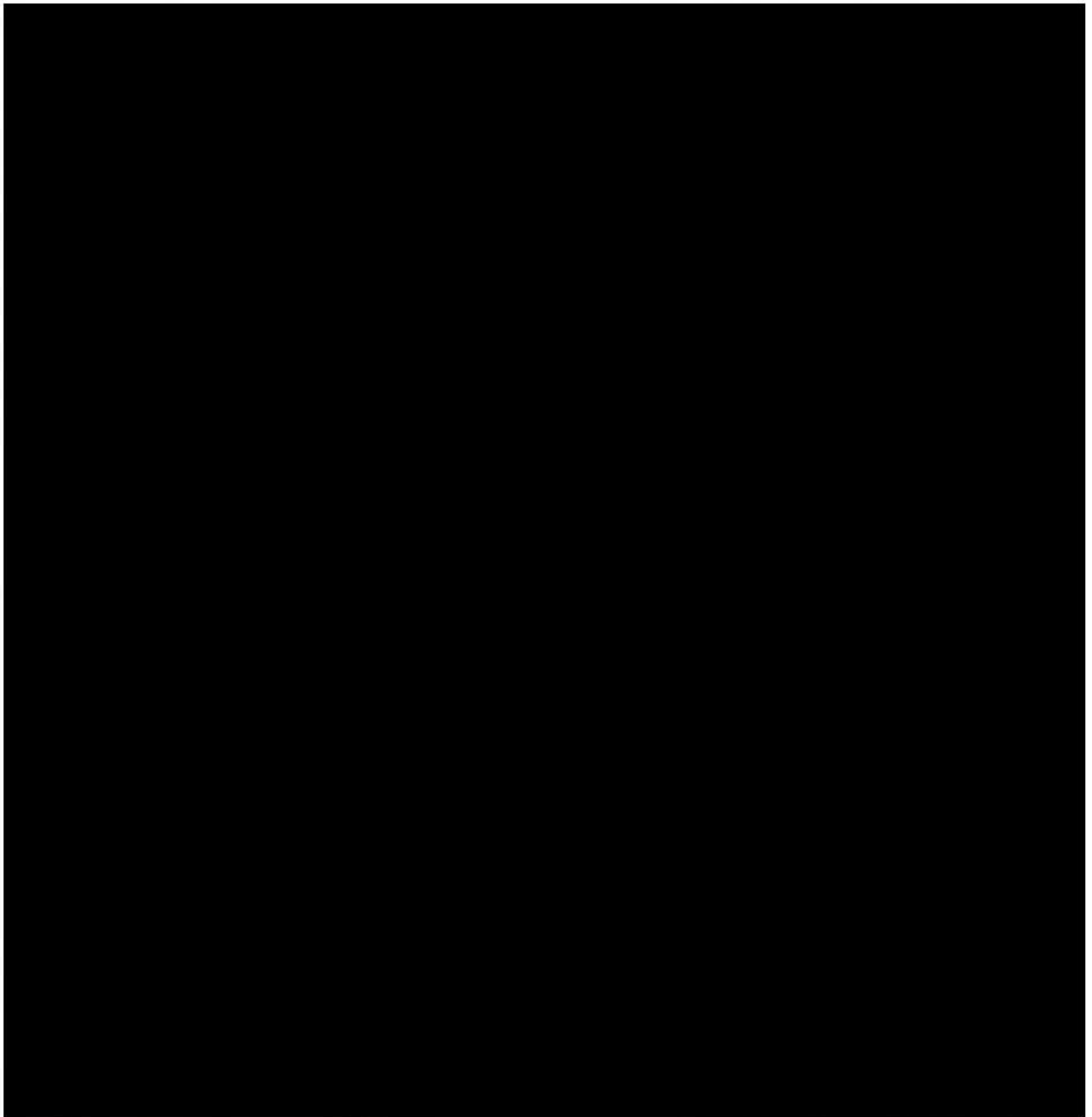
Another aggressive confrontation after noticing her just outside the other door, which I use as an alternative.

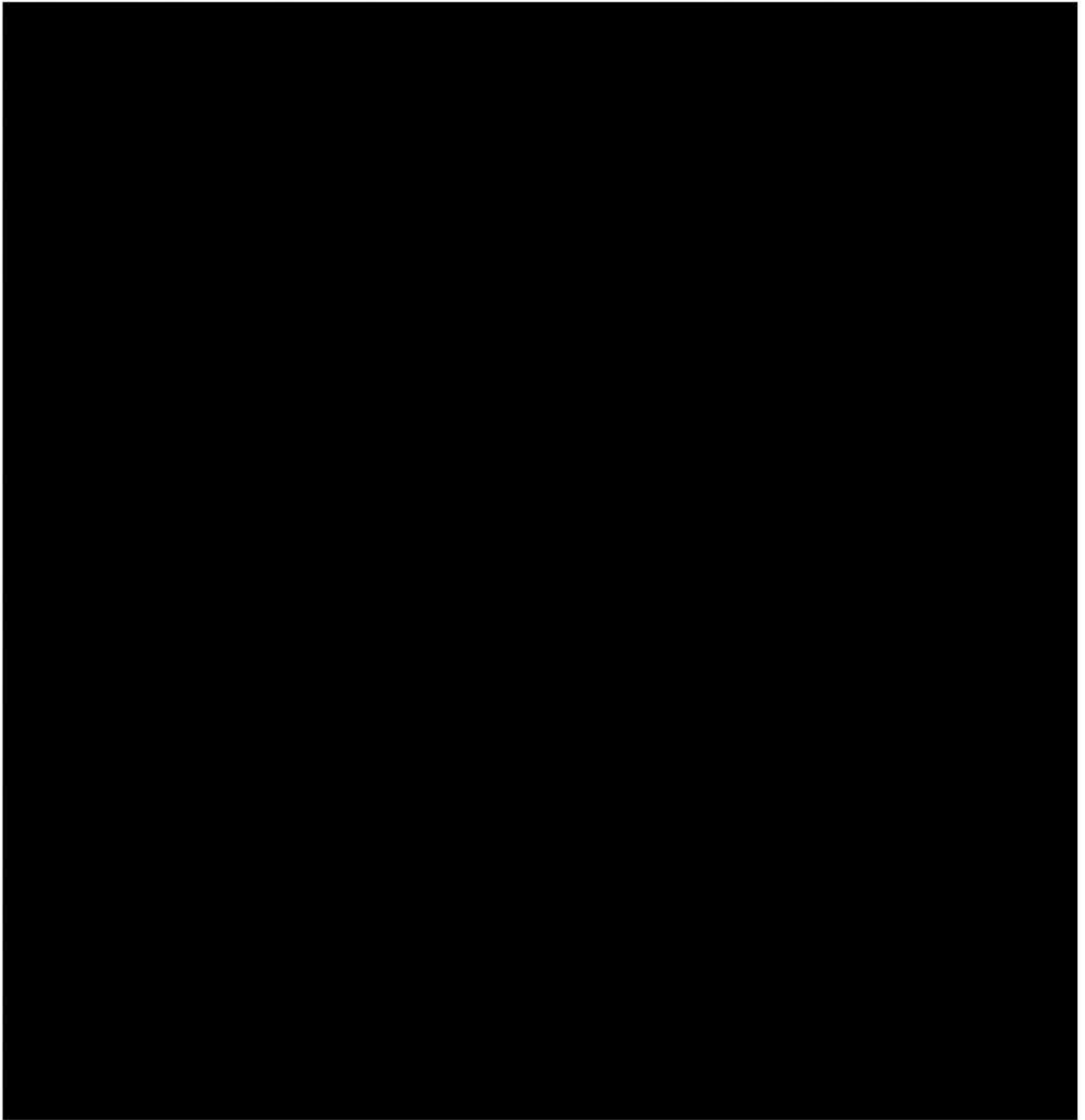
I get the usual buttock gesture, run at me, calling others to play victims during this obstruction.

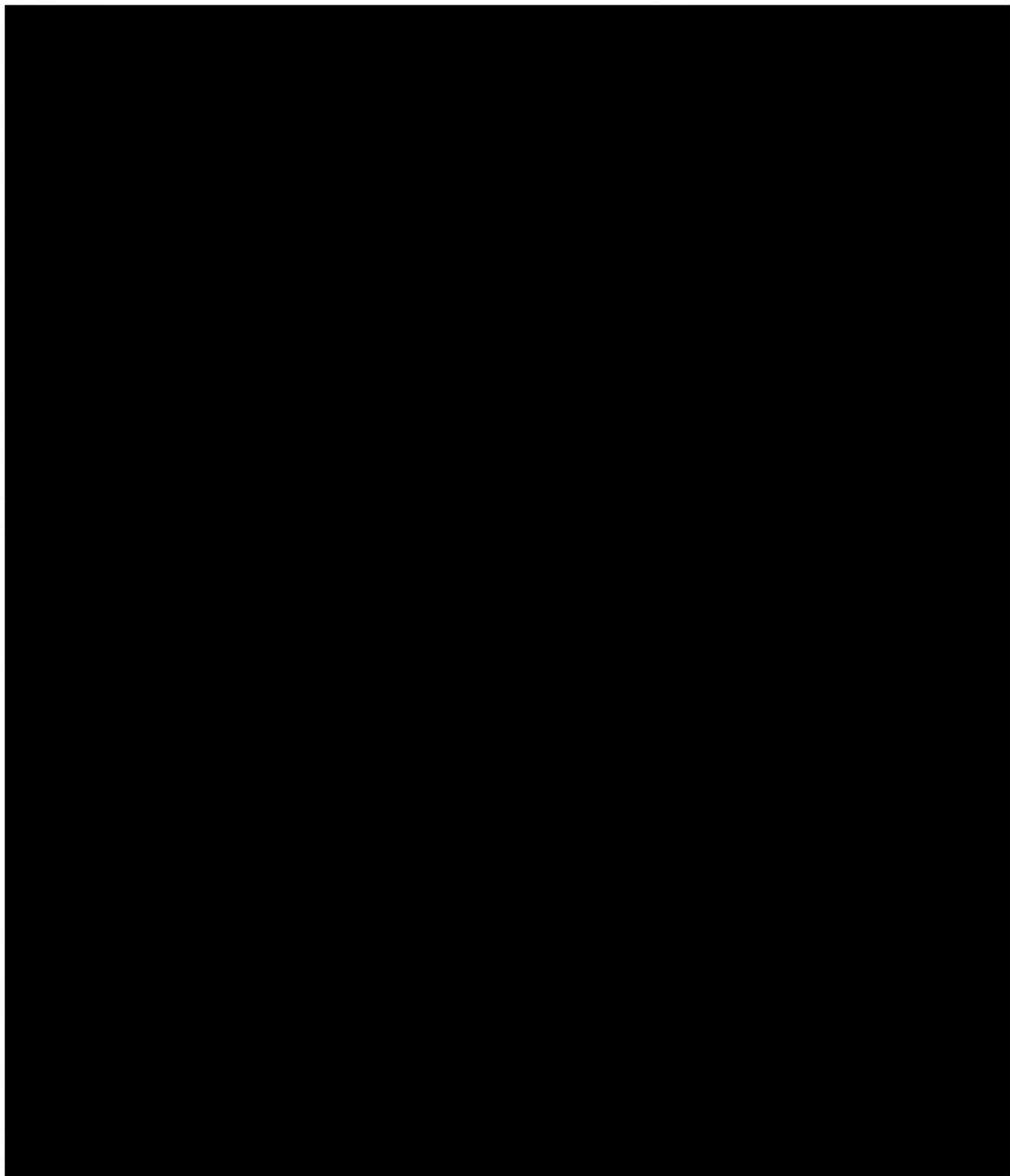


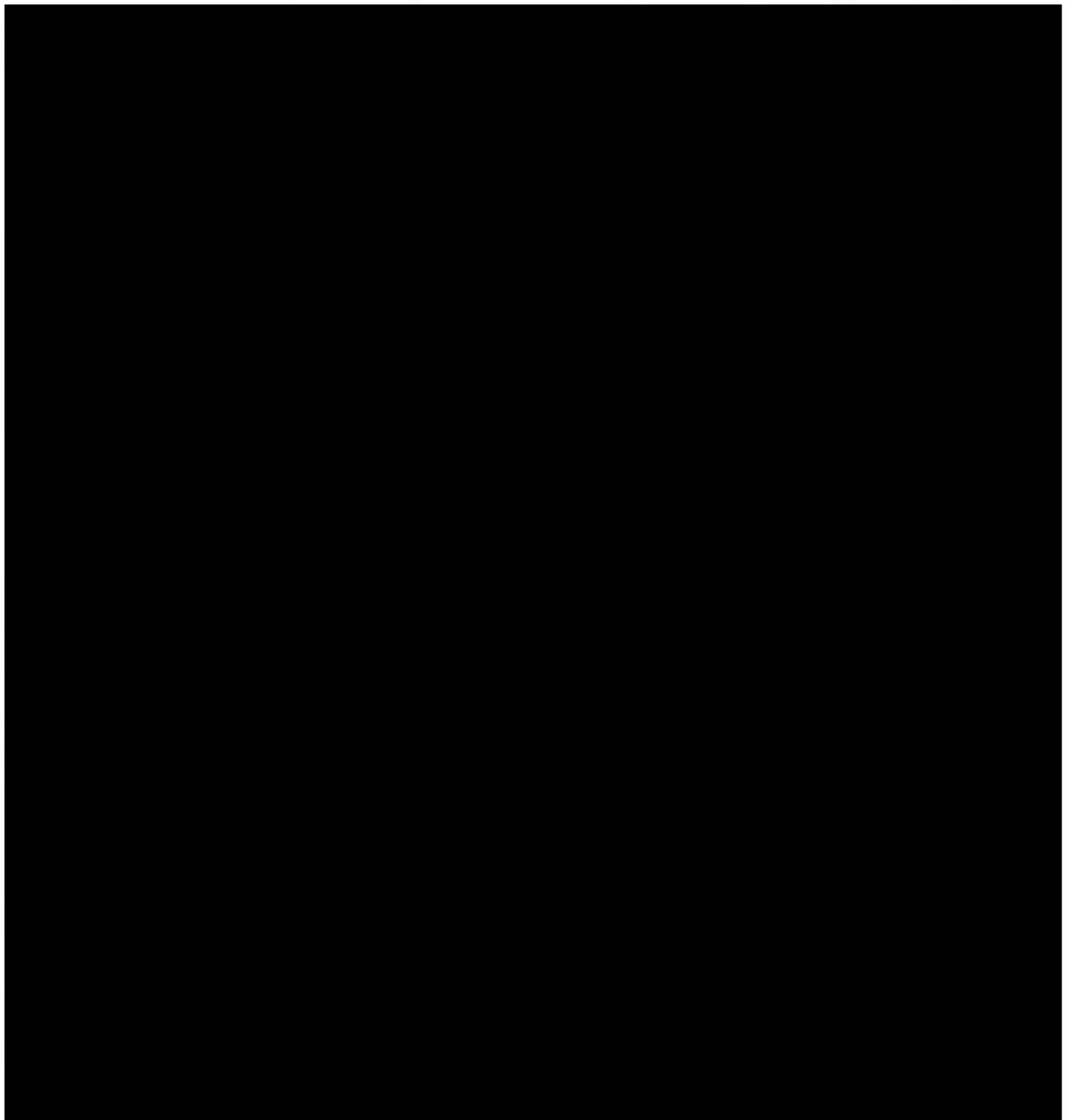






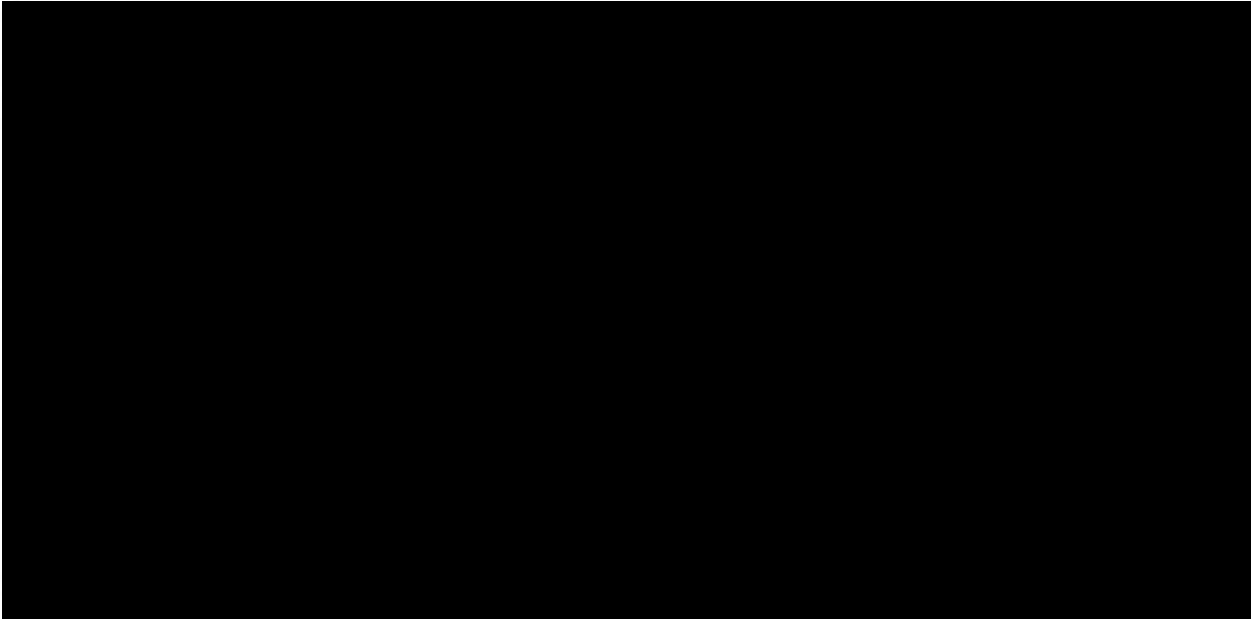
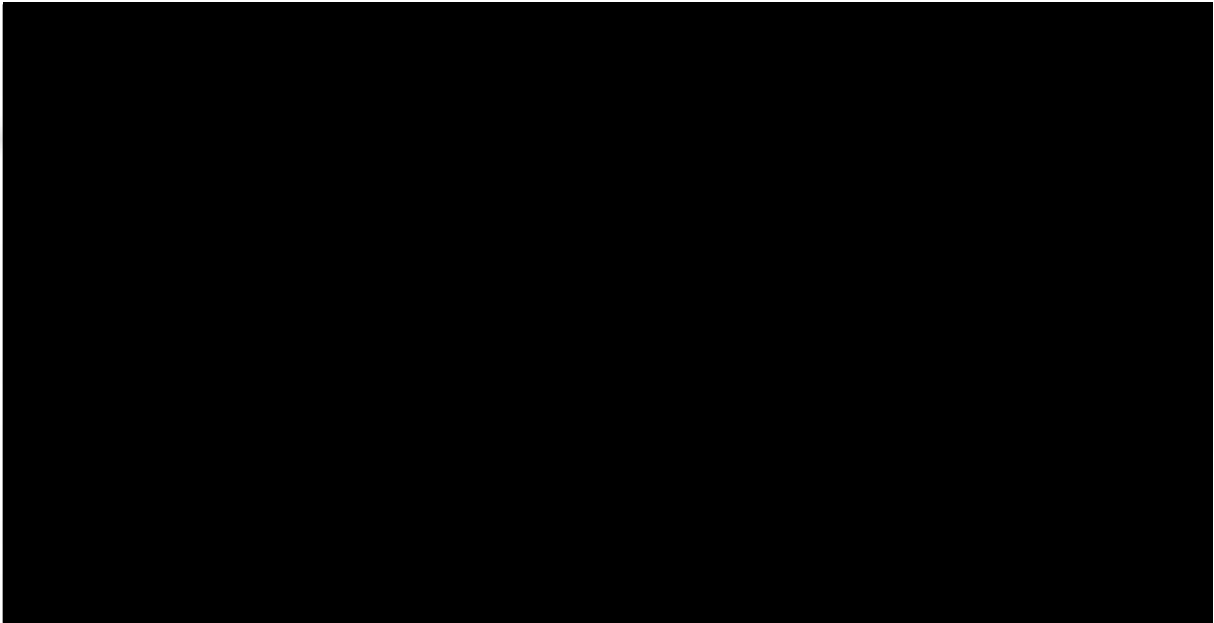


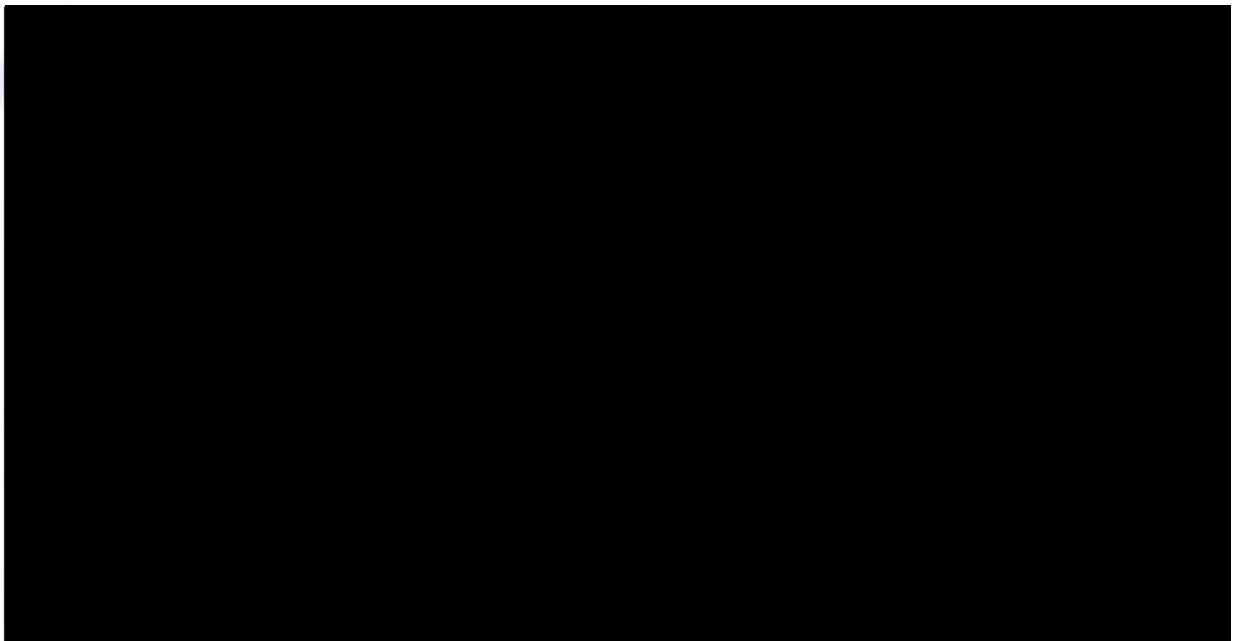
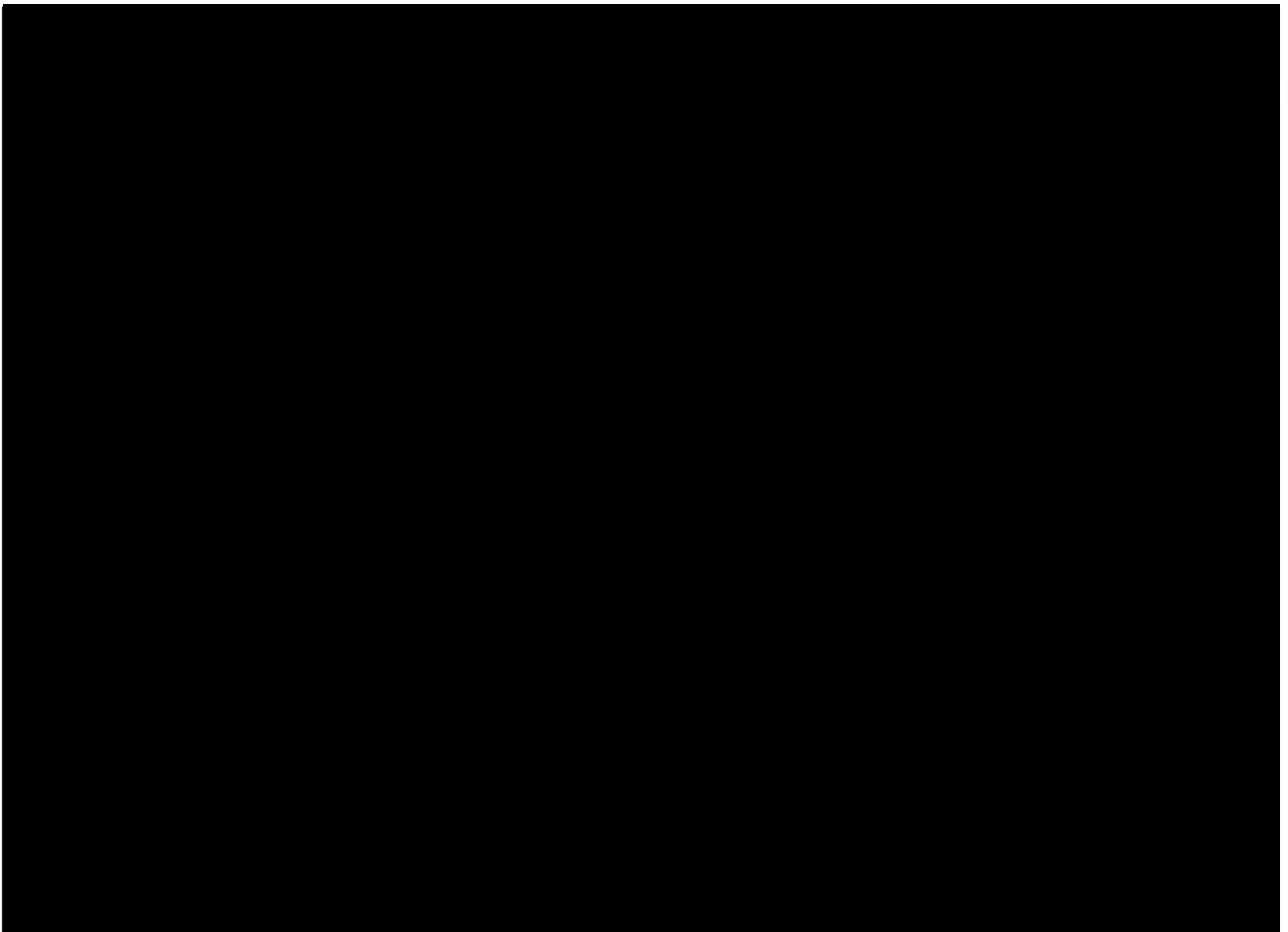


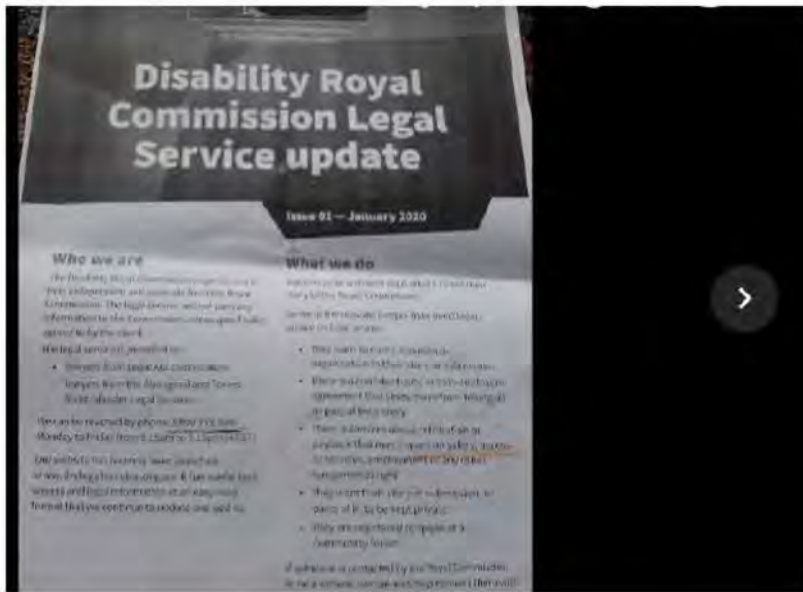
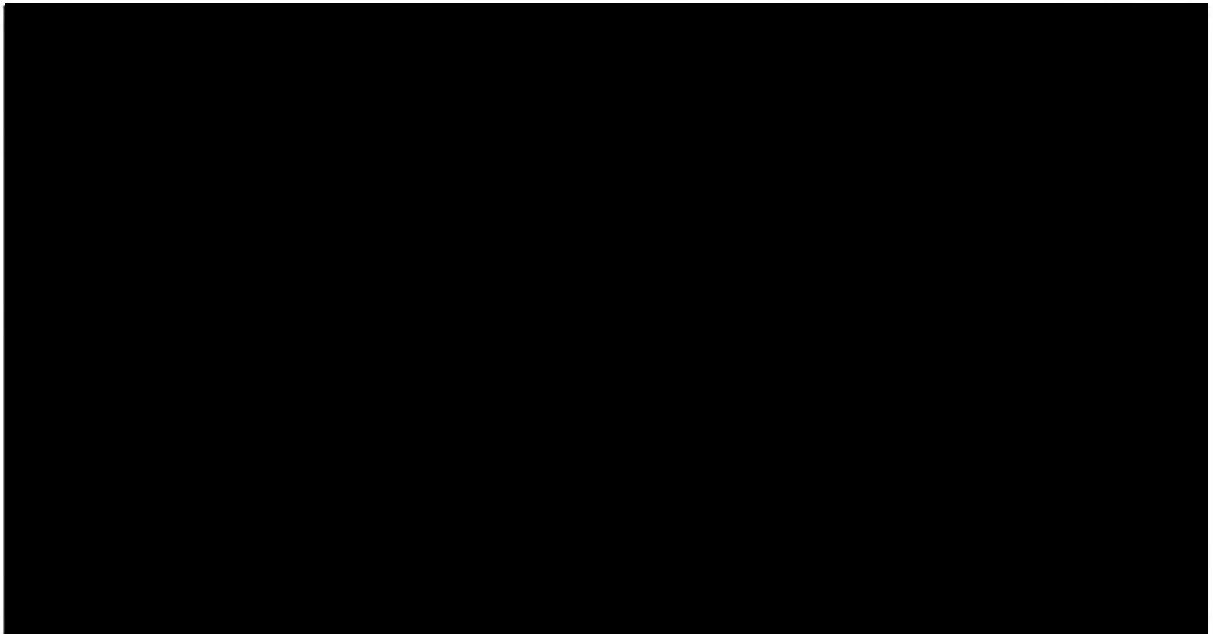












Add a description

DETAILS

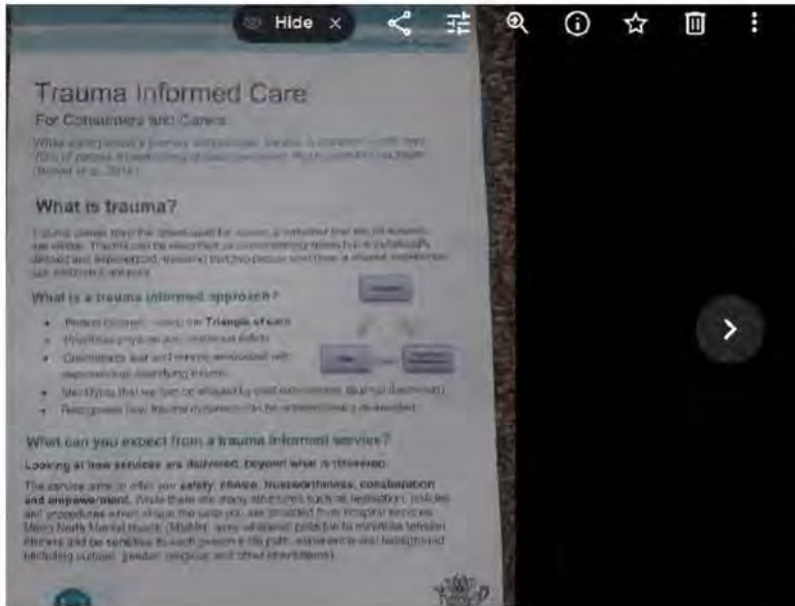
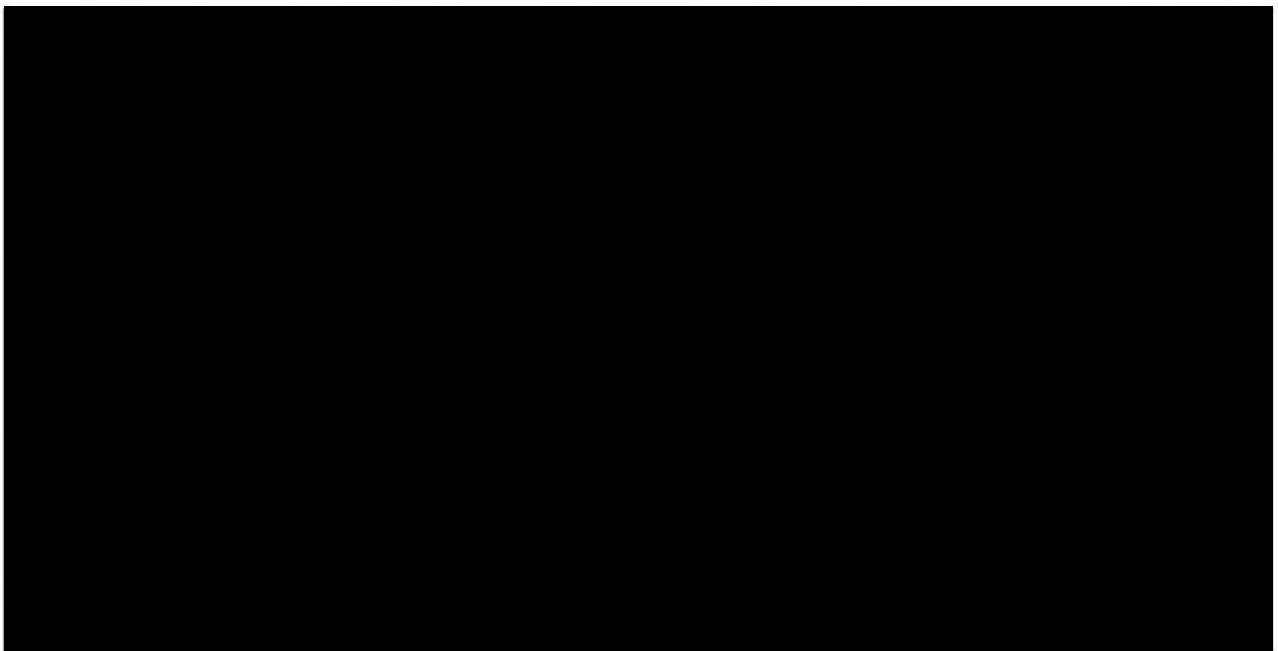
4 Apr 2021
Sun, 11:27 GMT+10:00

samsung SM-A505YN
f/1.7 1/50 3.93 mm ISO100

20210404_112700.jpg
12.2 MP 3024 x 4032

Uploaded from an Android device

Backed up (3.4 MB)



Info

Add a description

DETAILS

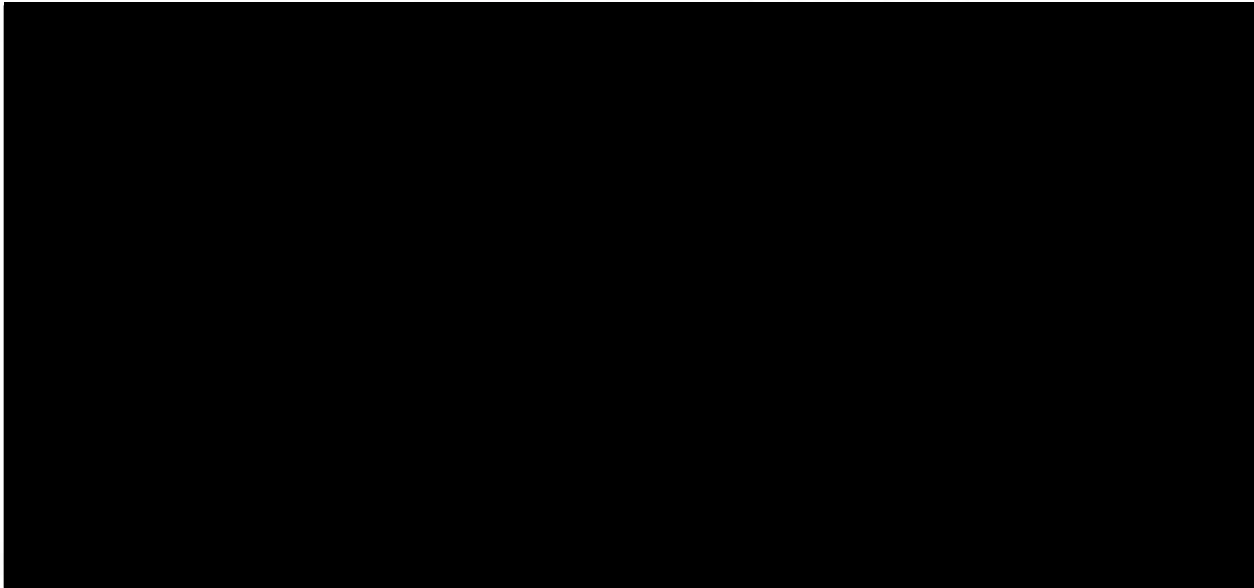
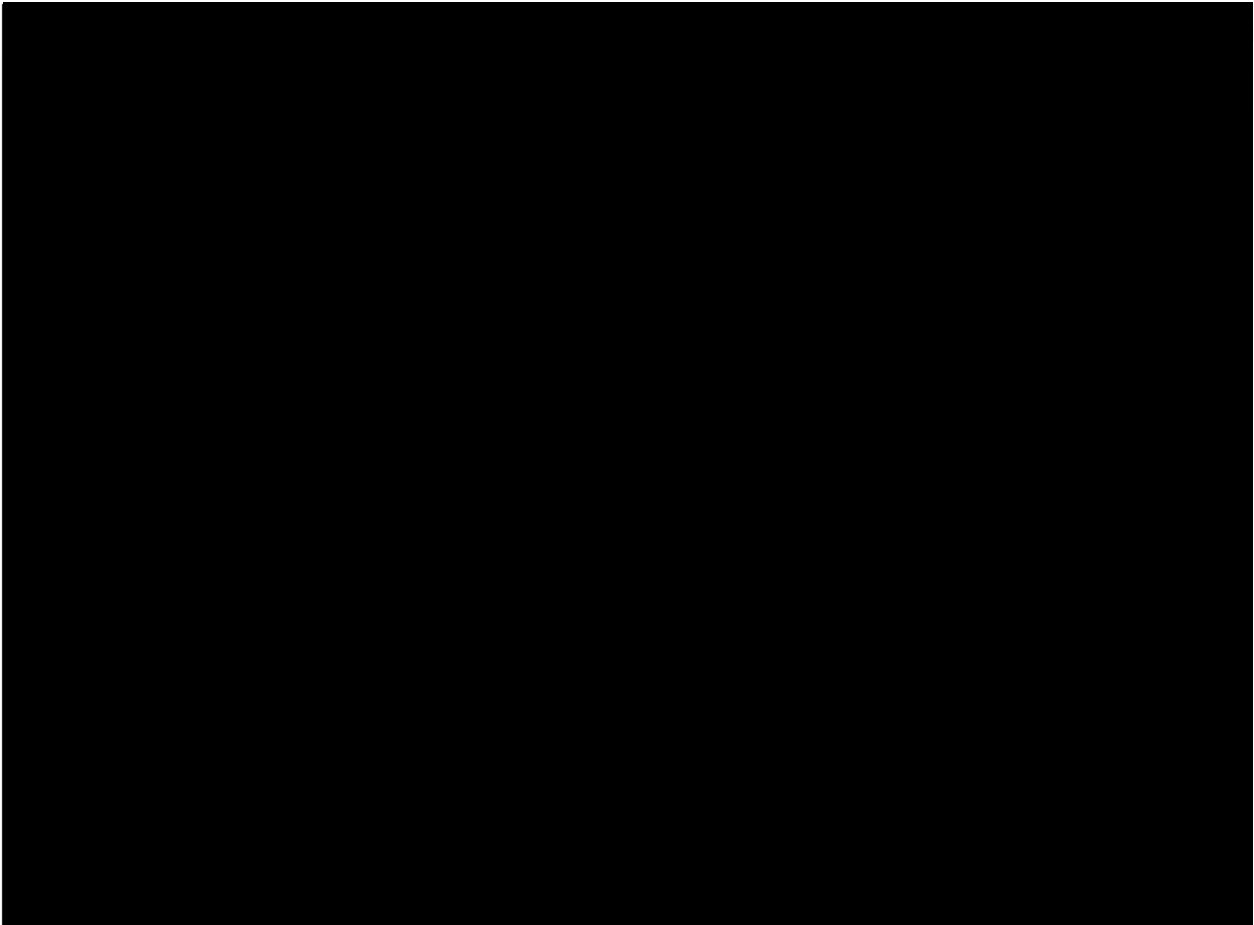
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Tue, 13:02 GMT+10:00

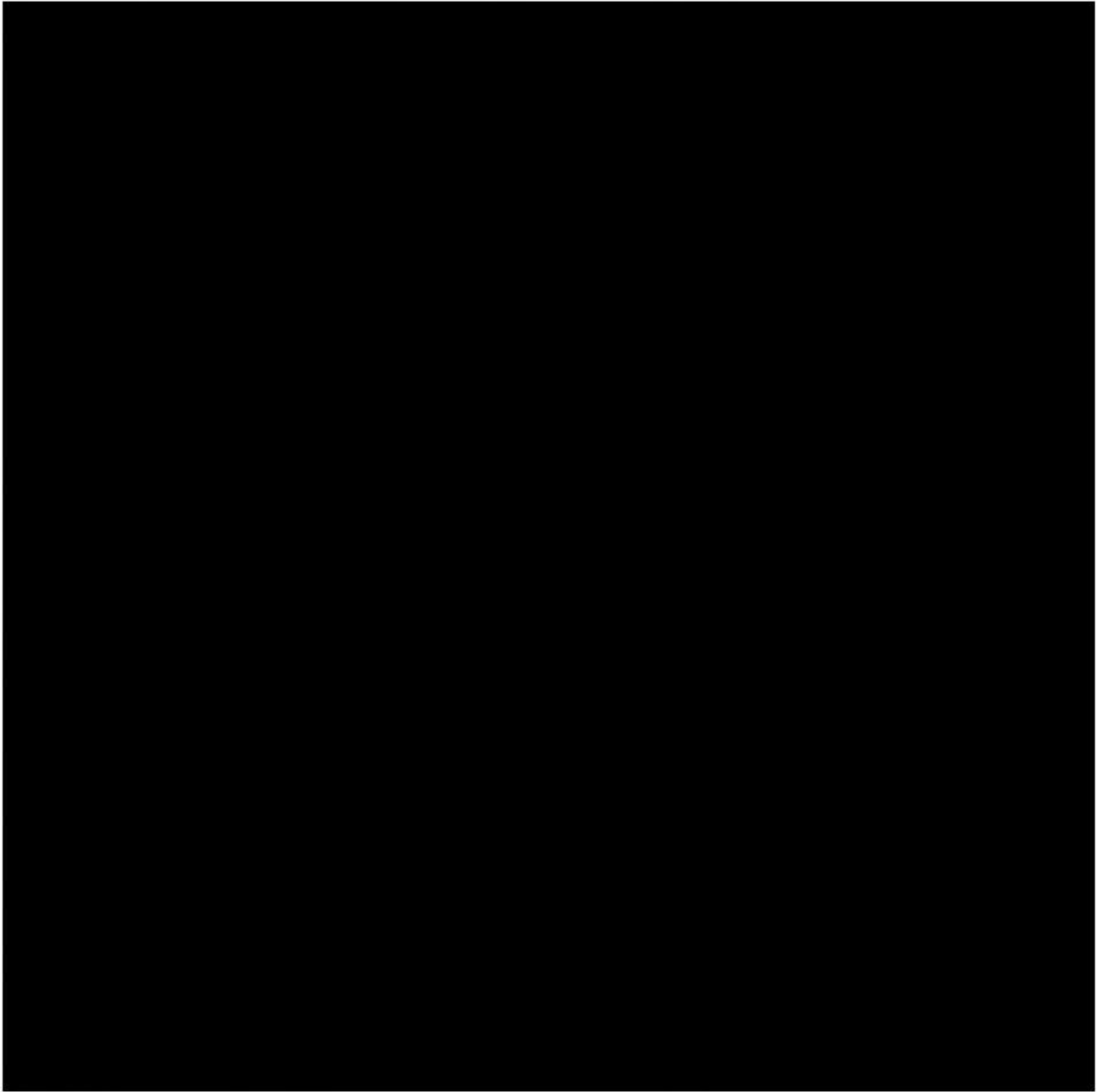
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f/1.7 1/60 3.93 mm ISO100

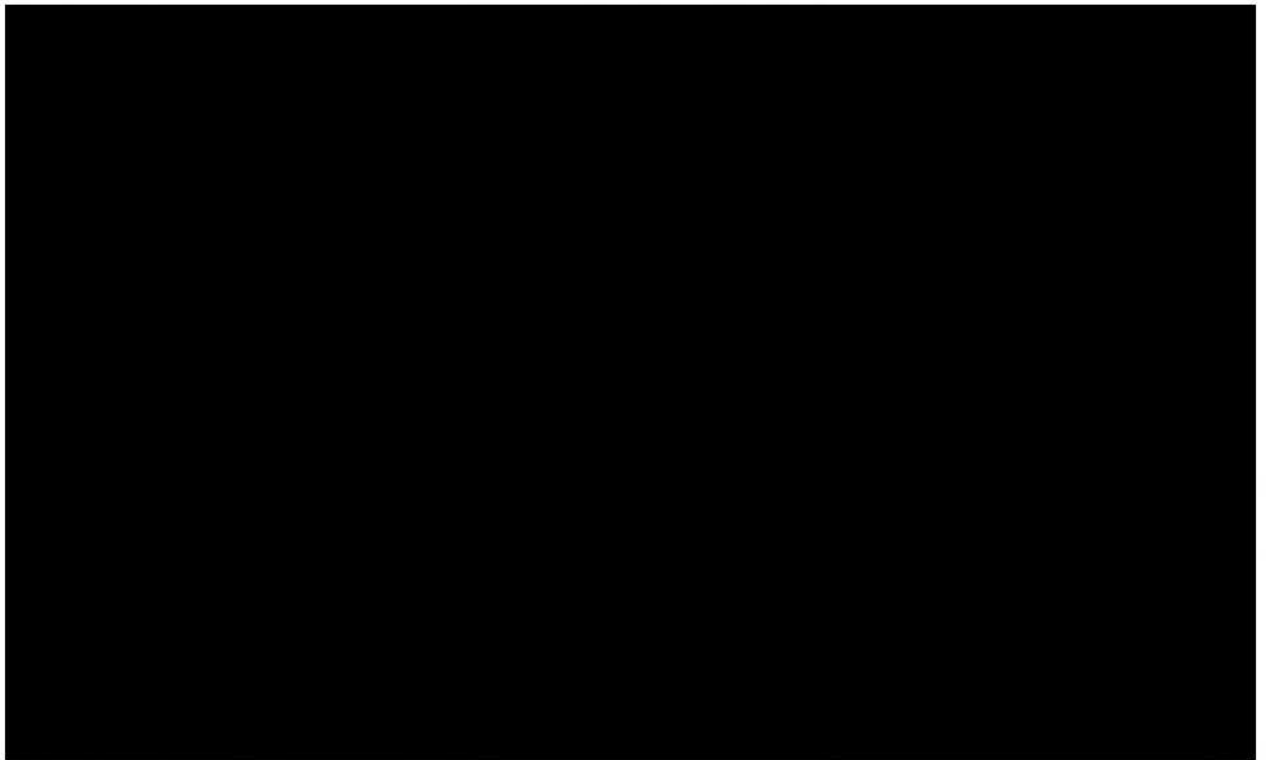
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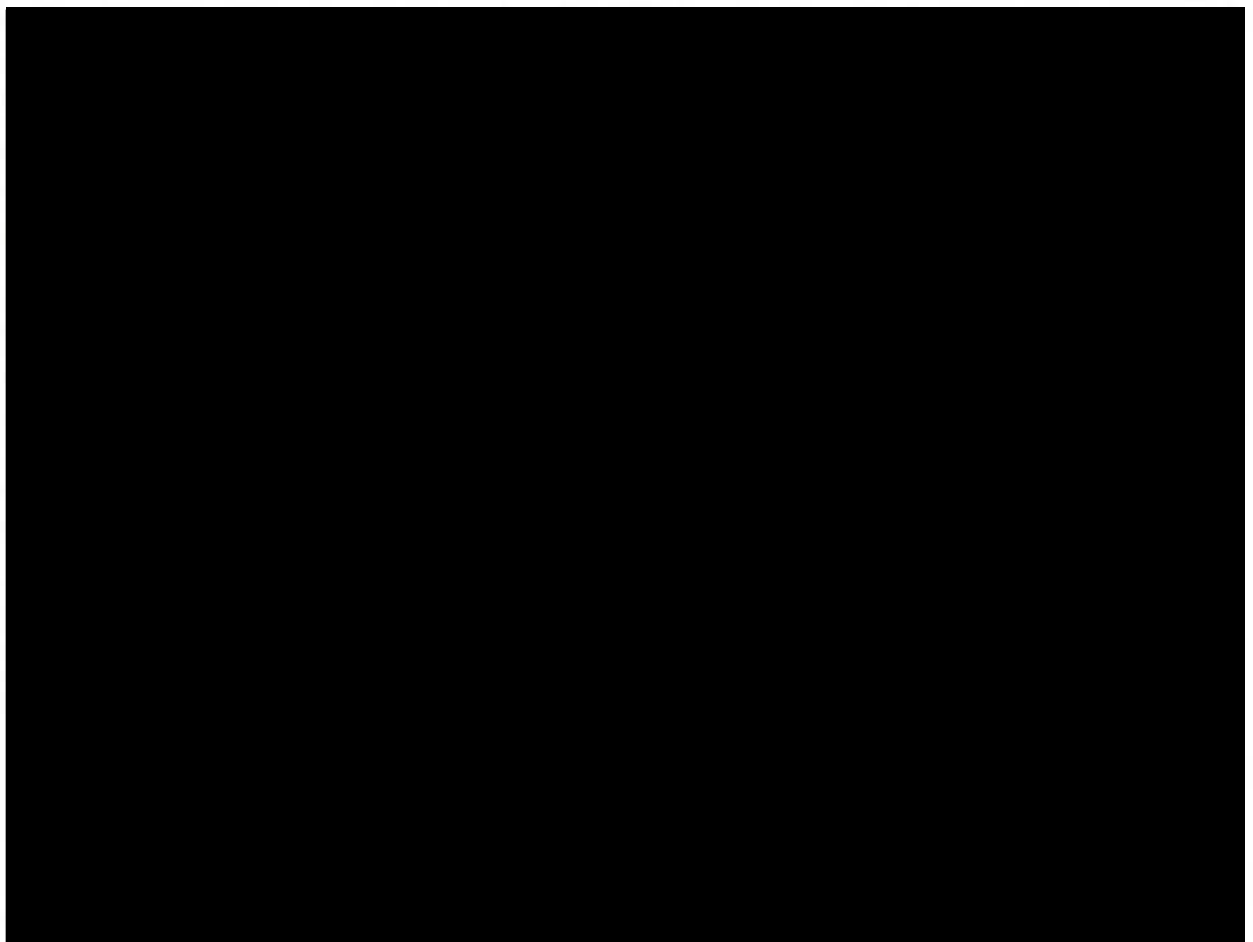
Uploaded from an Android device

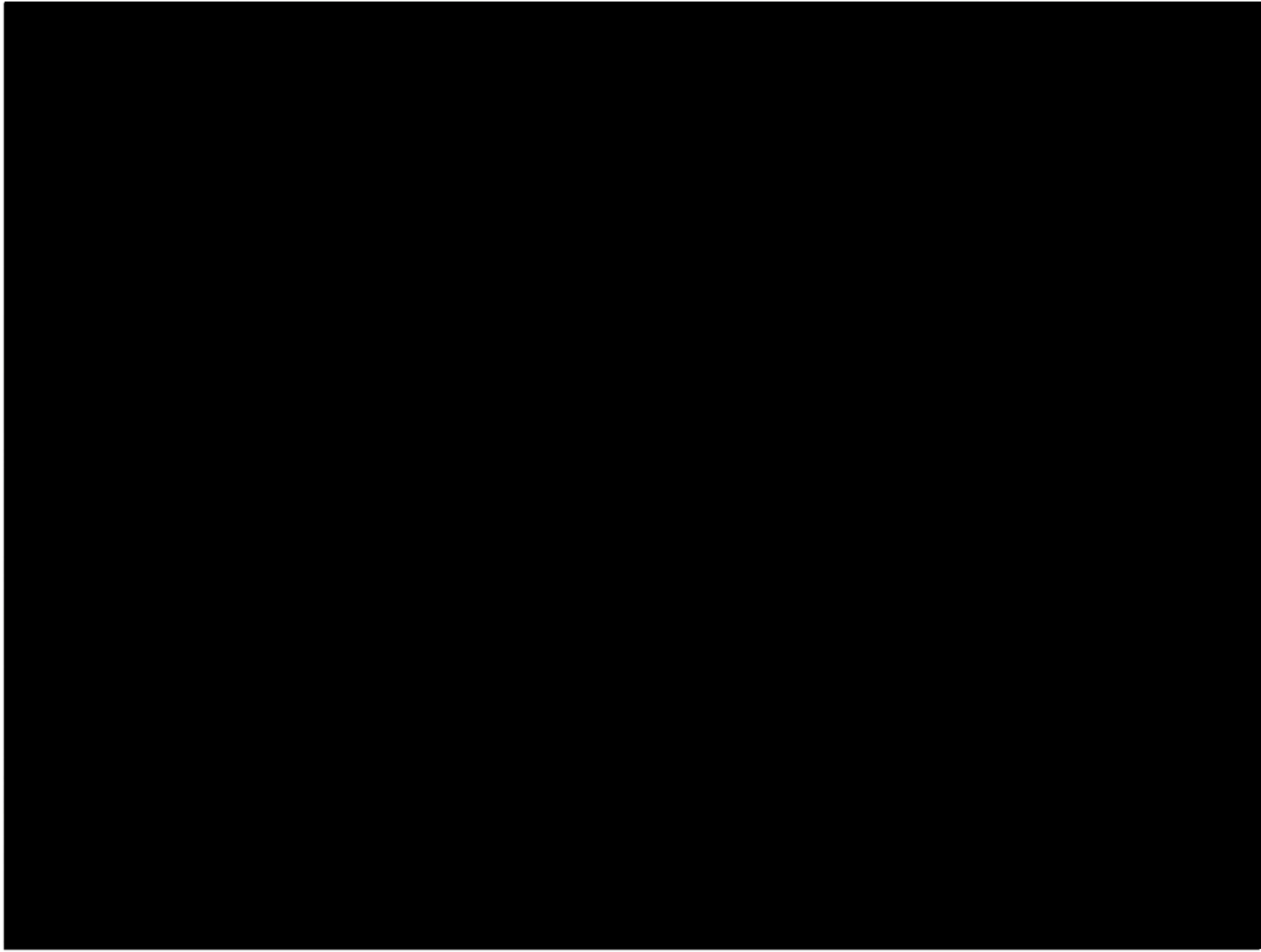
Ranked in (3.1 MR)











My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights**.

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

I have a right to:

Access

- Healthcare services and treatment that meets my needs

Safety

- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

Respect

- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

Partnership

- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

Information

- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

Privacy

- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

Give feedback

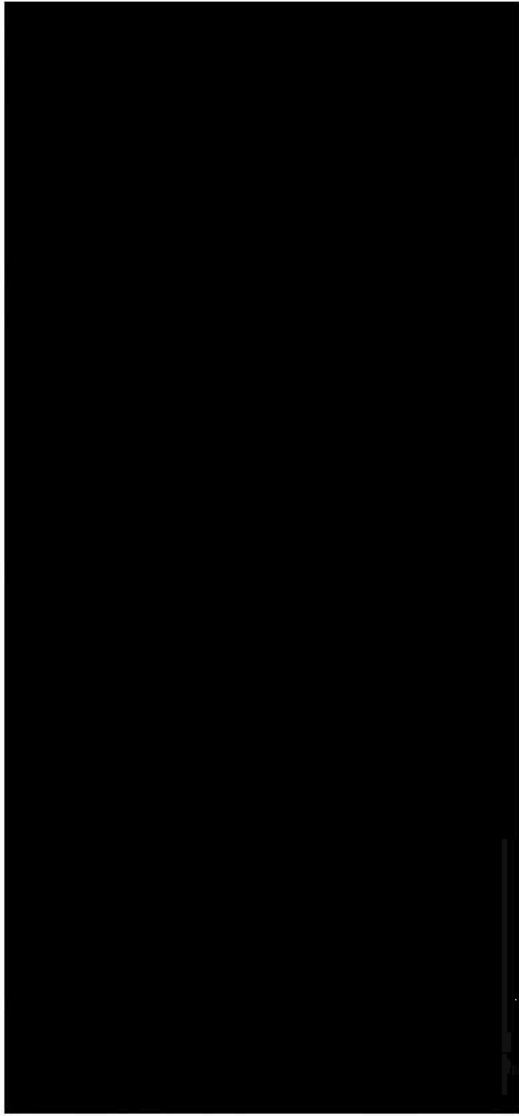
- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services

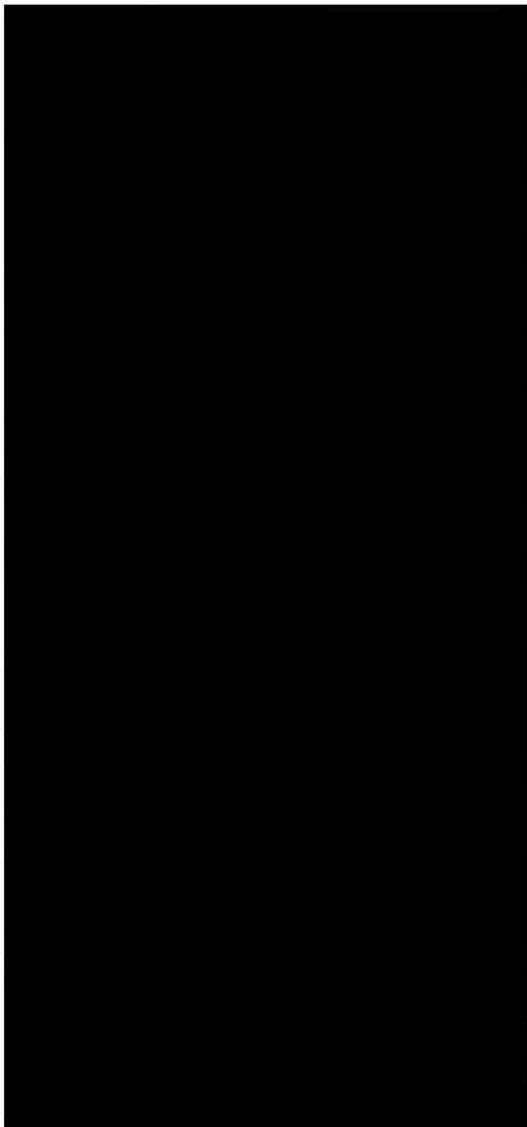
PUBLISHED JULY 2015

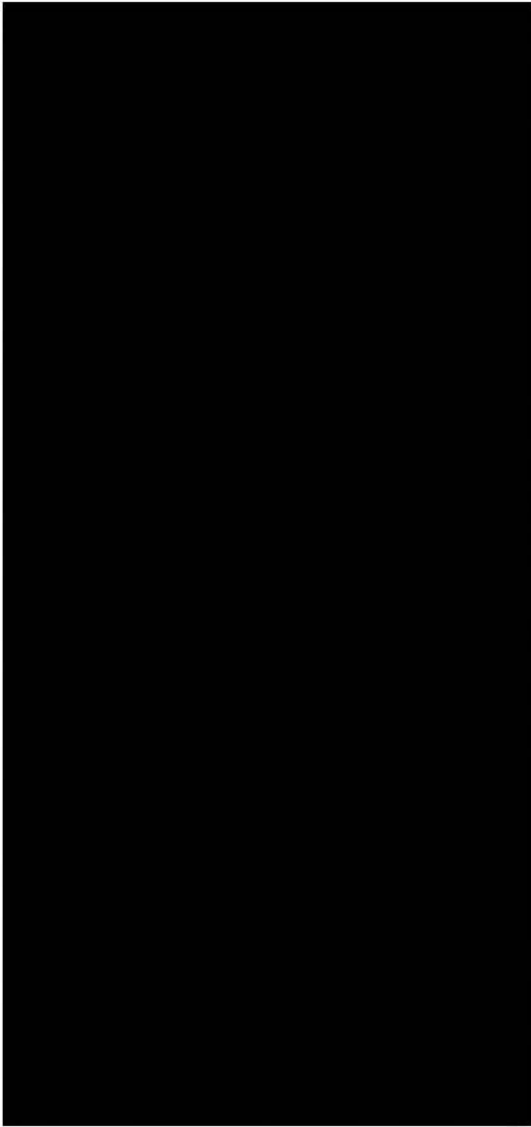


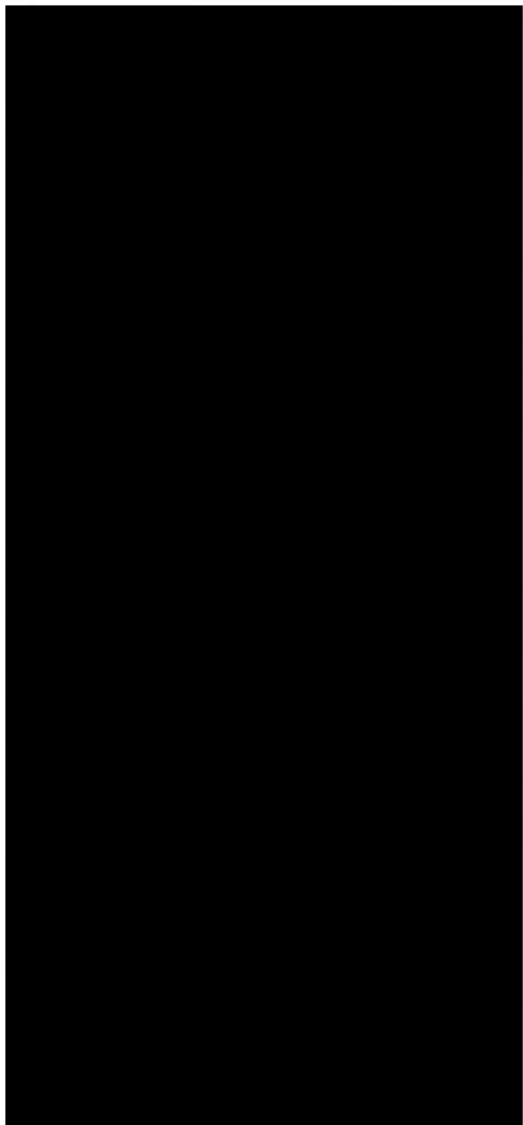
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

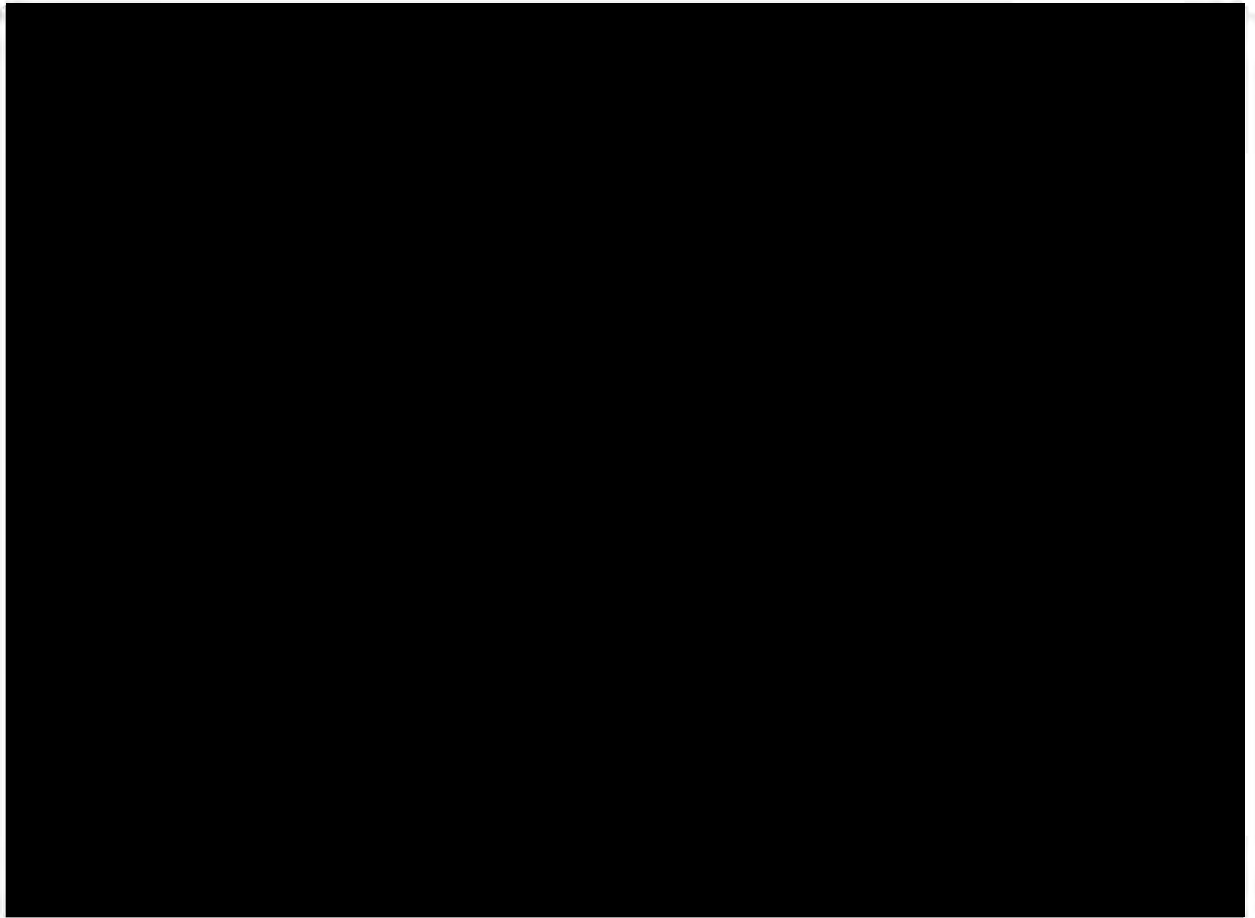
For more information
ask a member of staff or visit
safetyandquality.gov.au/your-rights

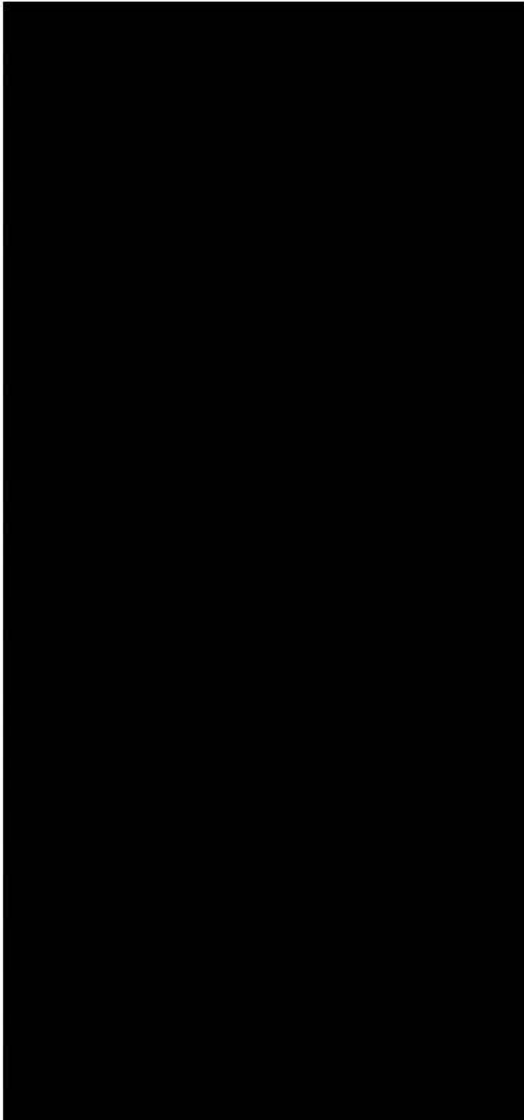


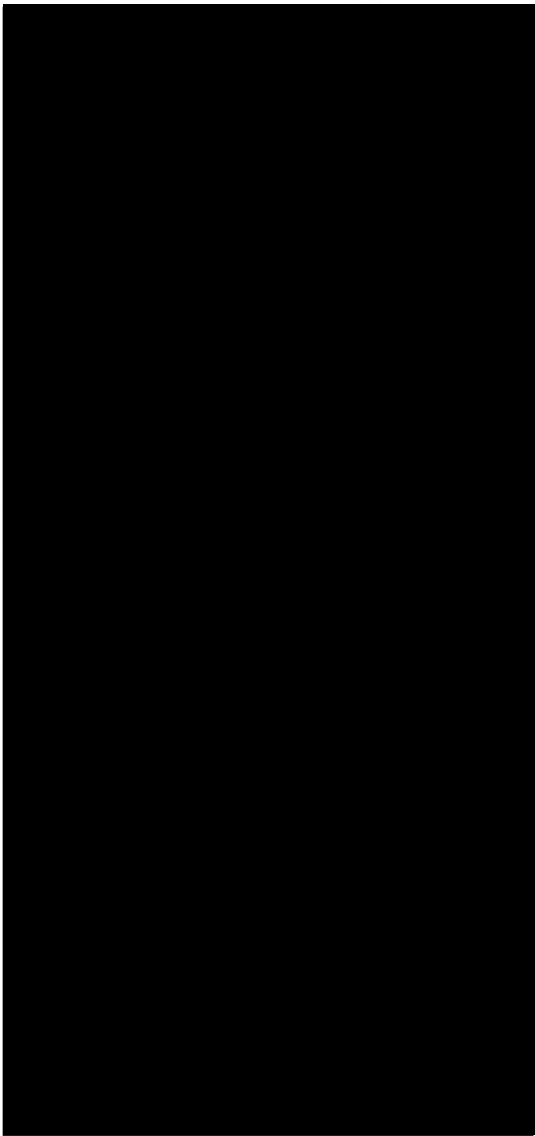


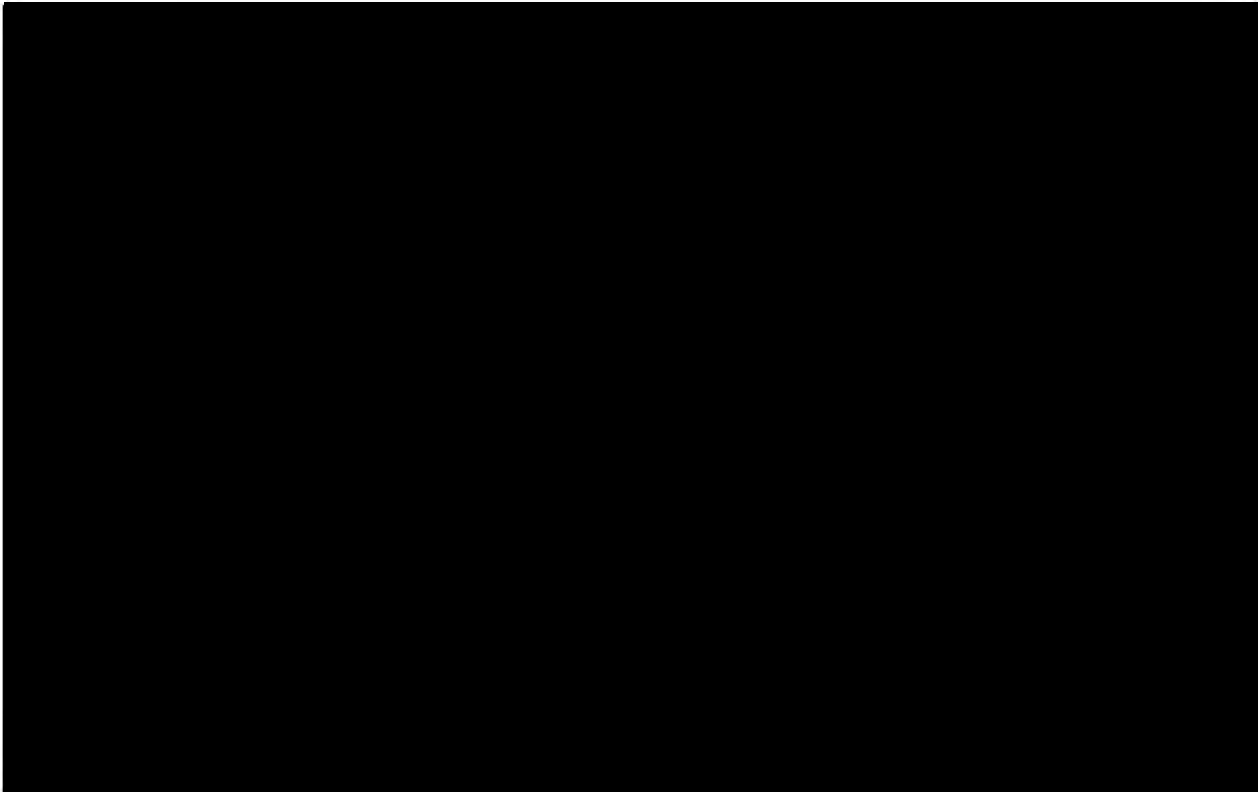








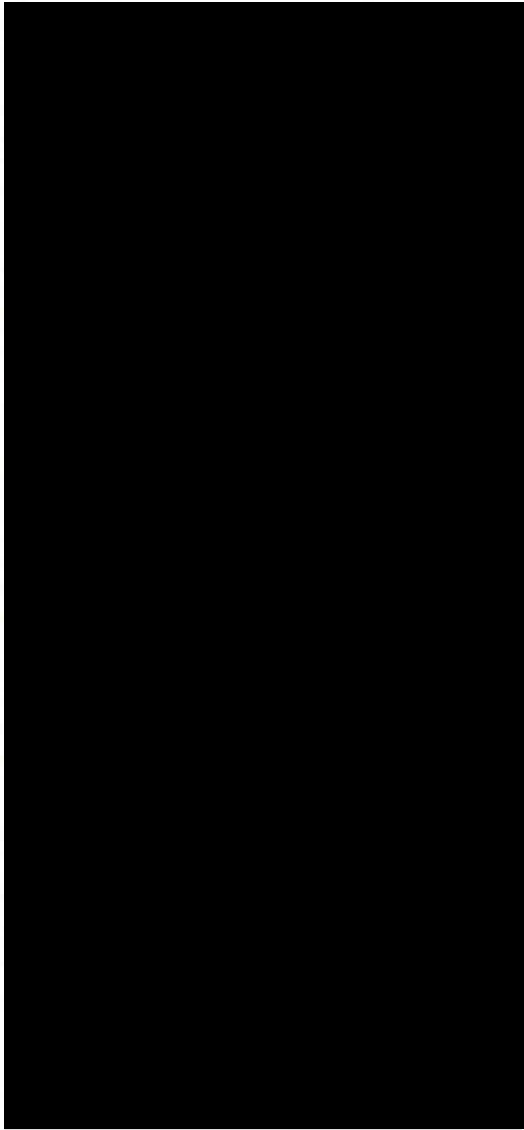


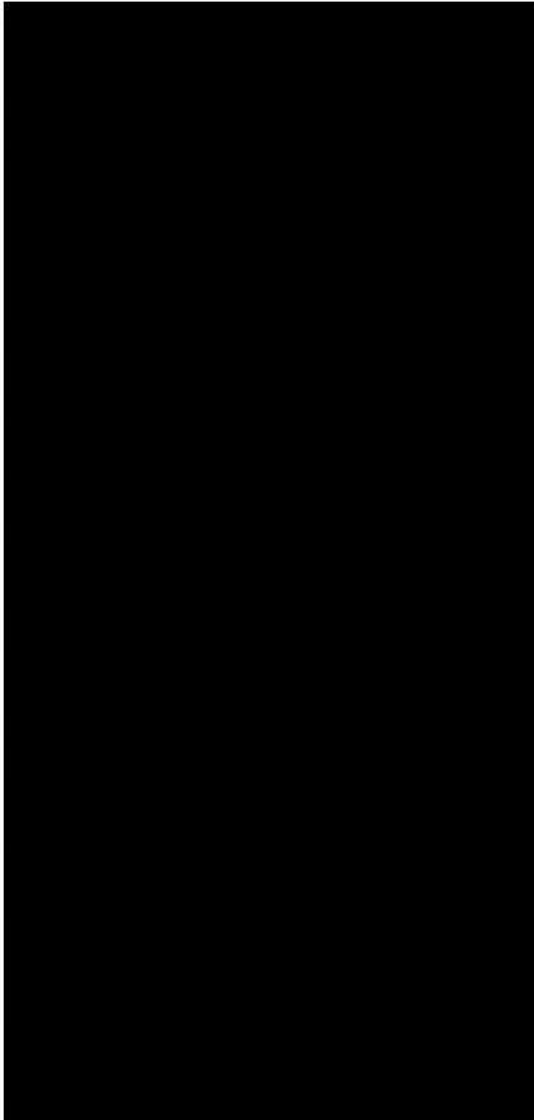


I feel trapped .. and triggered..

19 October 2021 9.06 am.

I return from quick grocery shop to see Defendant waiting out in a concealed position, such that I don't realise she's there until I'm within reach.







Live Committee Broadcast



Mental Health Select Committee - Public Hearing
Inquiry into the opportunities to improve mental health...
9:00 am to 9:30 pm

If you experience difficulties accessing the broadcast, please refer to the 'Help' page. We would be happy to receive your feedback of the site through the [Parliament's contact us page](#).

Recent Committee Archives

No recent committee archives available.
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From



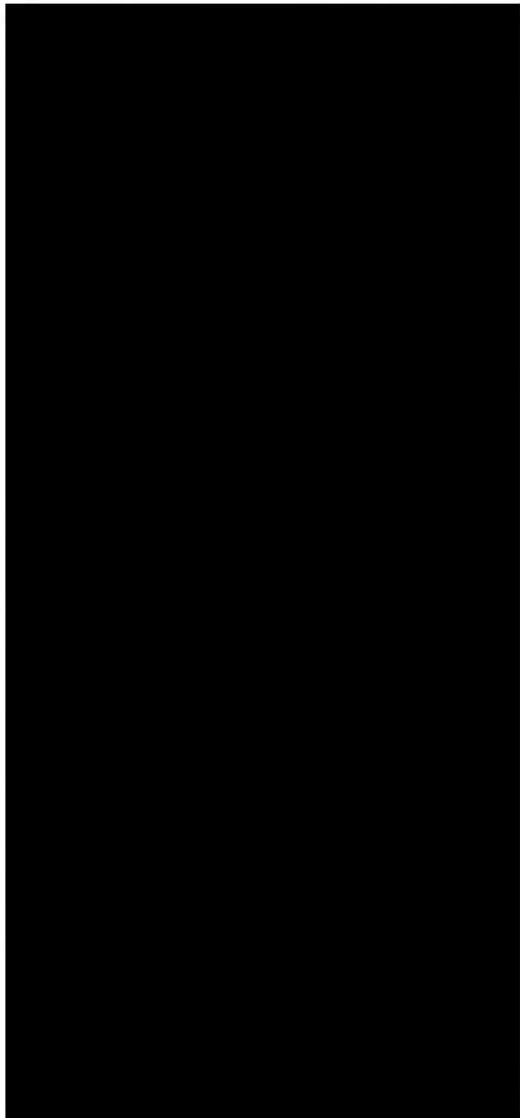
To

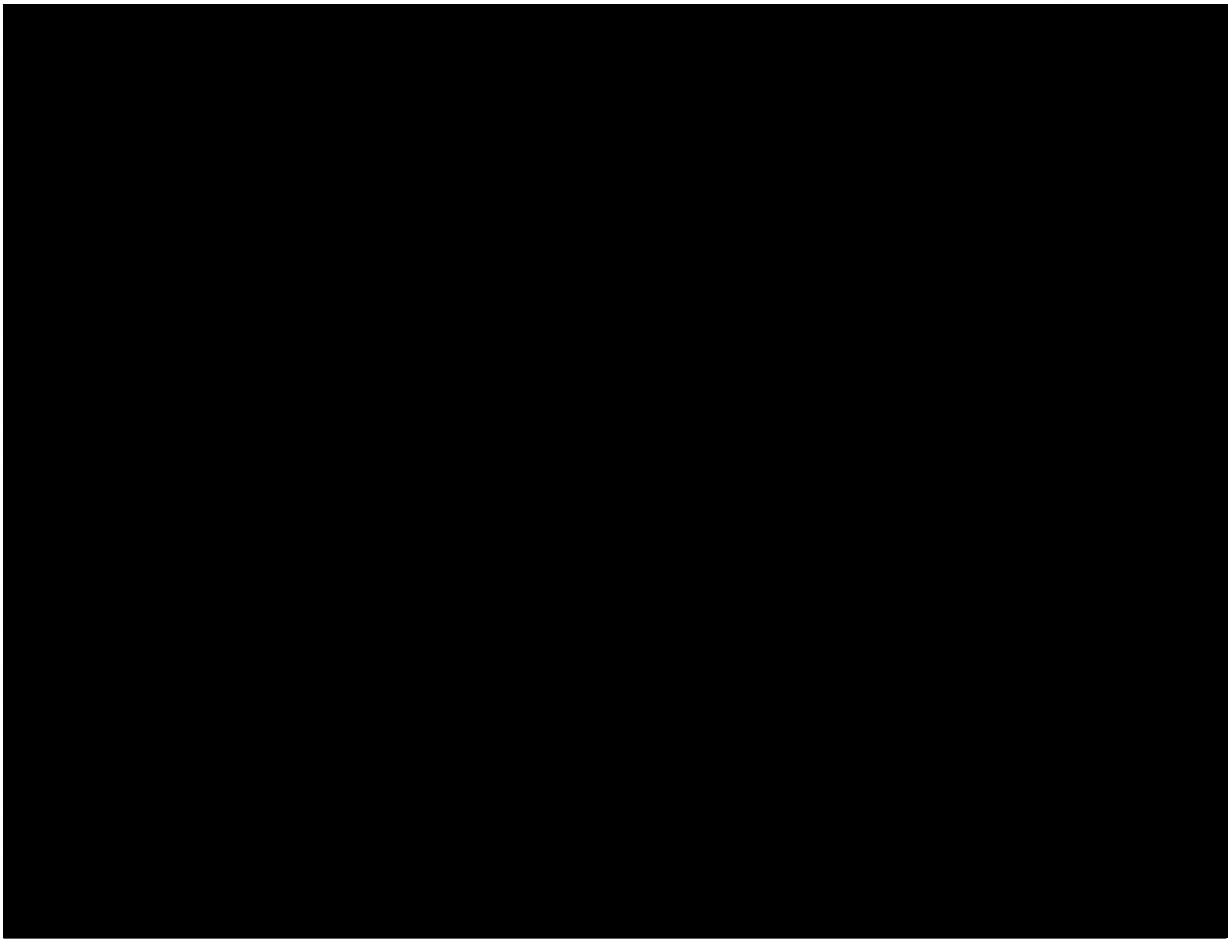


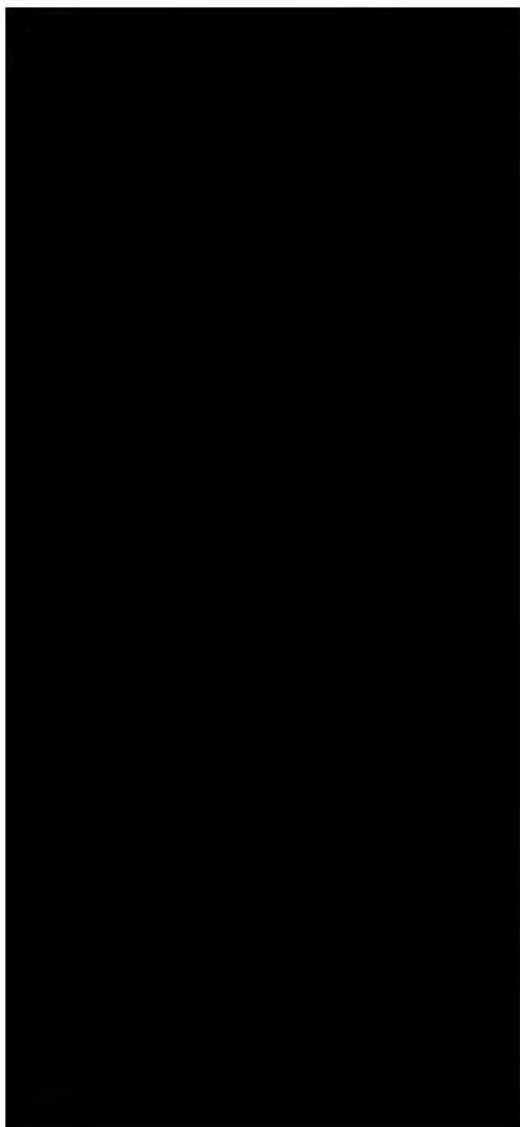
- Current Committee -

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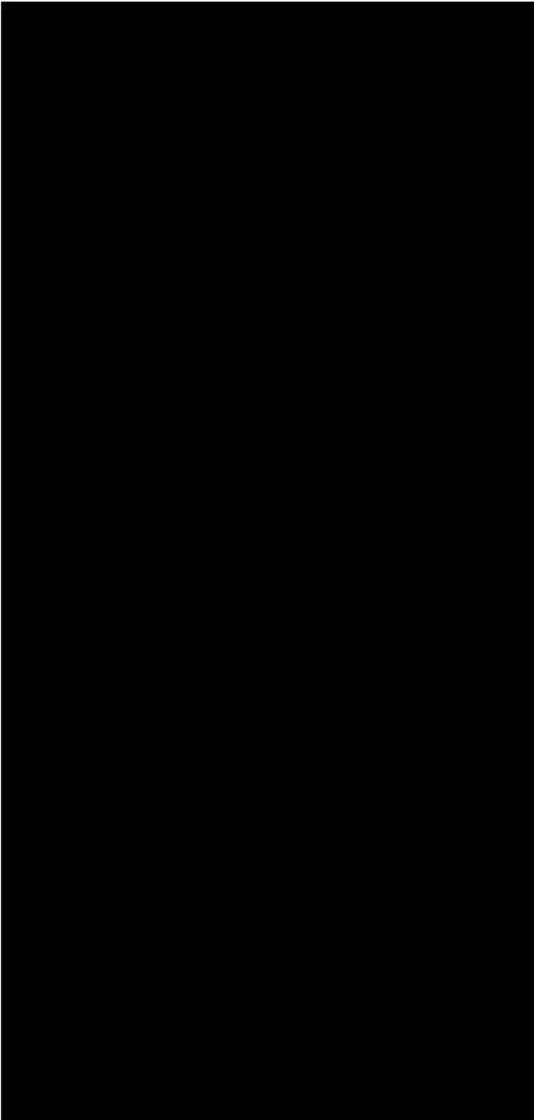






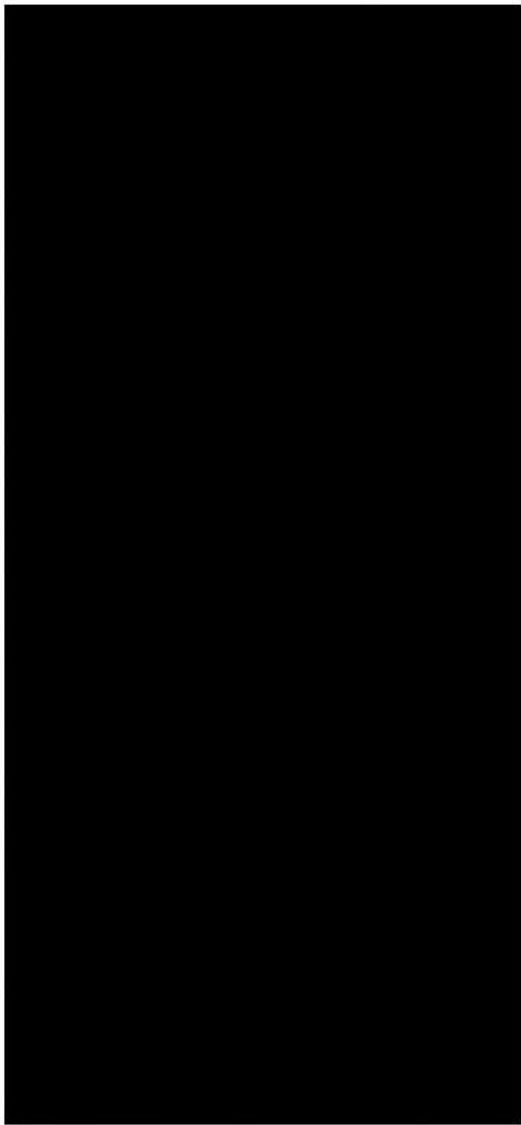
The defendant also parks her vehicle ahead of where I usually cross the street returning from grocery shopping, despite such being a no standing zone.

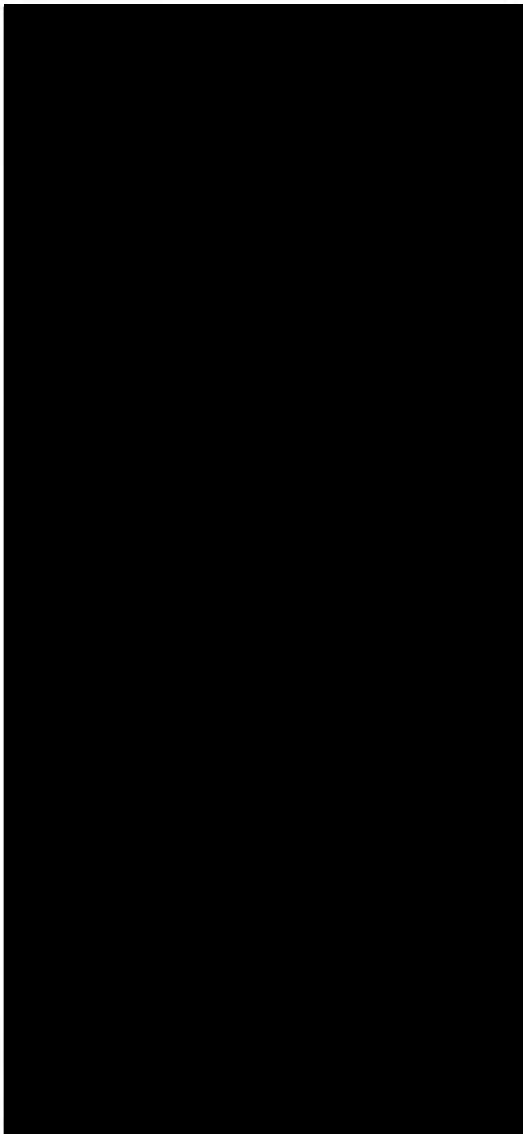
Seeing me I get the non verbal ridicule with buttock presentation, then middle finger etc as defendant blocks my path.





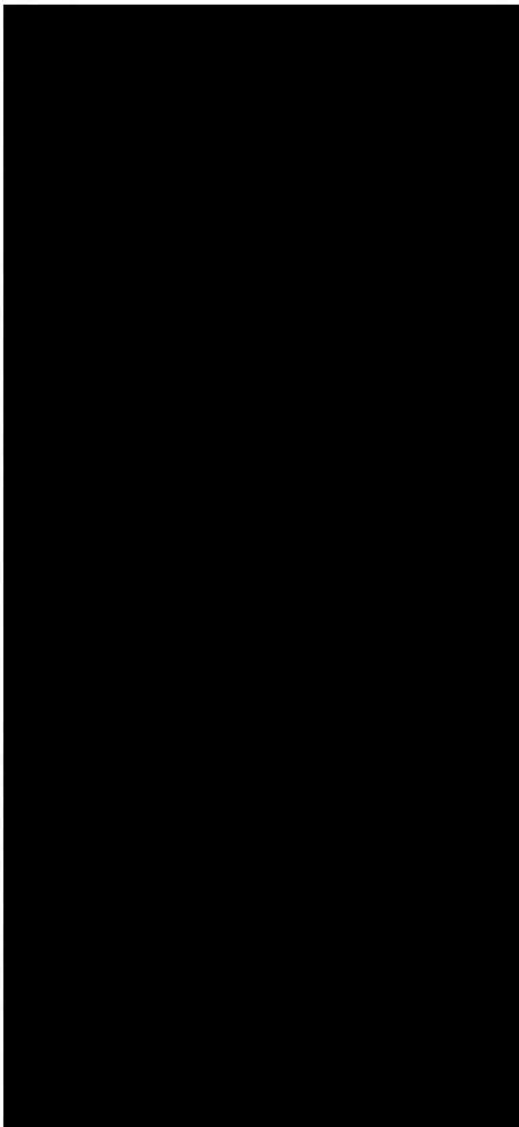
No despite as usual having a maniacal smile as she stresses me, the same claims to be the victims of harrassment and as usual threatens to immediately go to QPS and Housing to report me for harrassment with intention of getting me evicted or locked up in psychiatric ward again.

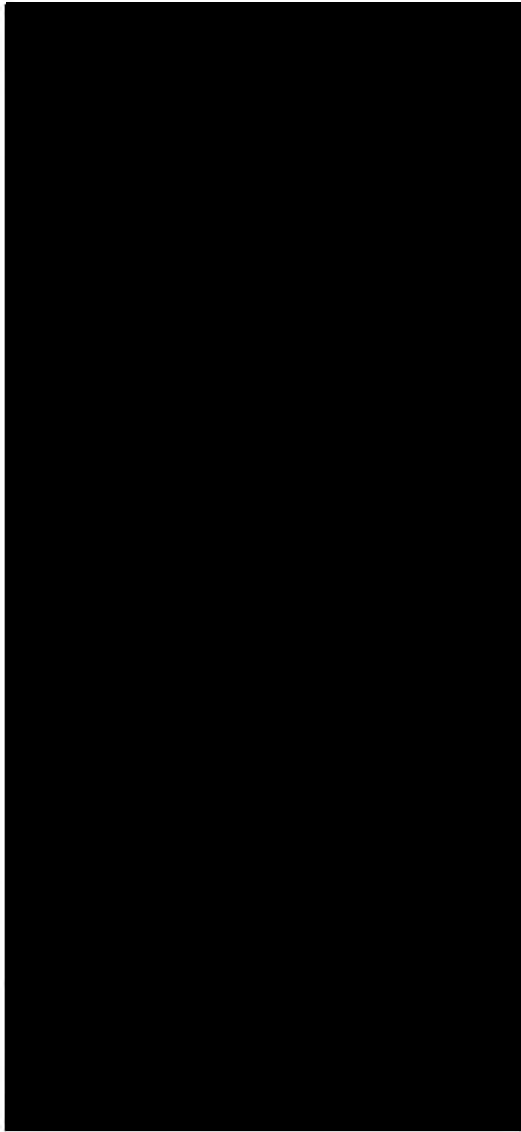




Even going out of my way to avoid confrontation I face accusations of being the aggressor which tend to be believed over me.

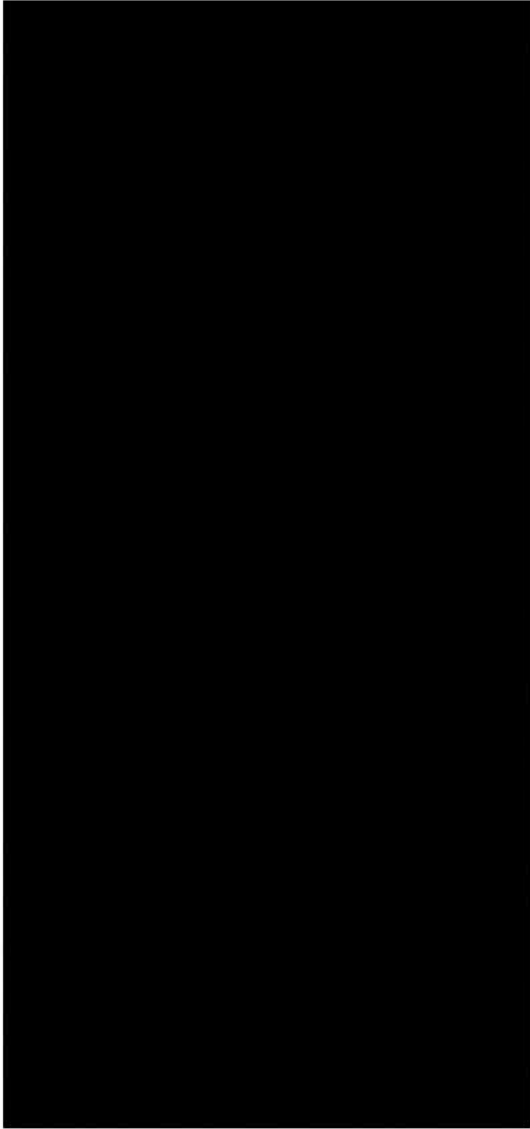
I have to calm down while showing QPS and Housing footage to prevent action being taken against me based on false allegations of me being "crazy" and other slurs on my mental well-being while provoking damage to same via fear/ stress/ triggering memories of her almost killing me and standing over me to tell me the head injury was a "warning". Not an accident as QPS have allowed her to pretend.





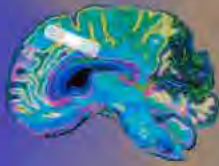
Back waiting for me to collect a package from postman.

Stood watching me though would claim otherwise.



EXPERIENCES THAT CAN LEAVE A MENTAL SCAR

- Chronic pain
- Neglect
- Bullying
- Witnessing violence
- Undiagnosed learning disabilities
- Abuse
- Experiencing oppression
- Non-consensual encounters
- Undiagnosed health challenges
- Divorce
- Supporting someone with a severe mental illness
- Emotional abuse
- Infertility

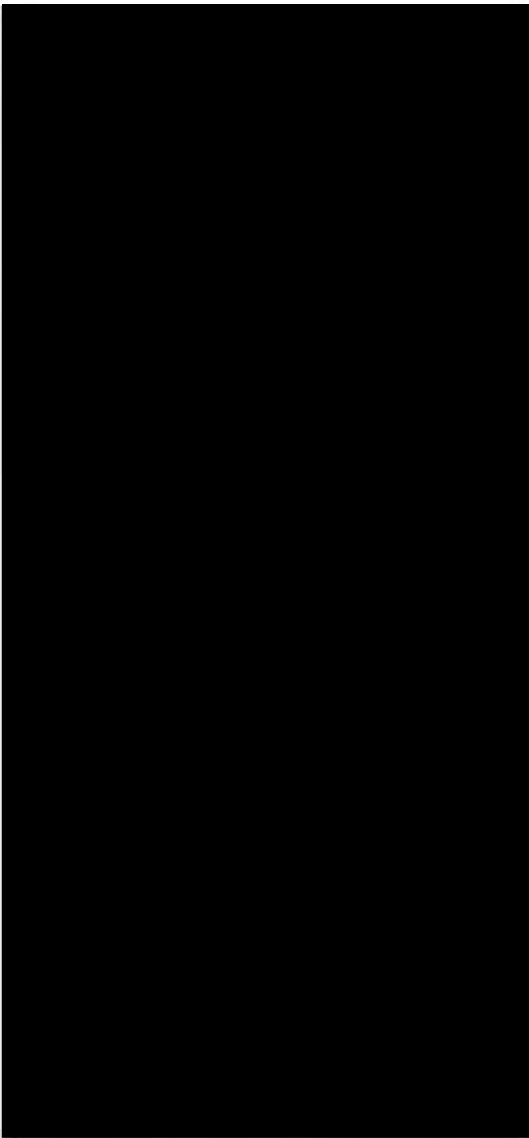


Queensland Health

Emotional injury can be hard to overcome. In some instances, it can leave a mental scar. 🙄

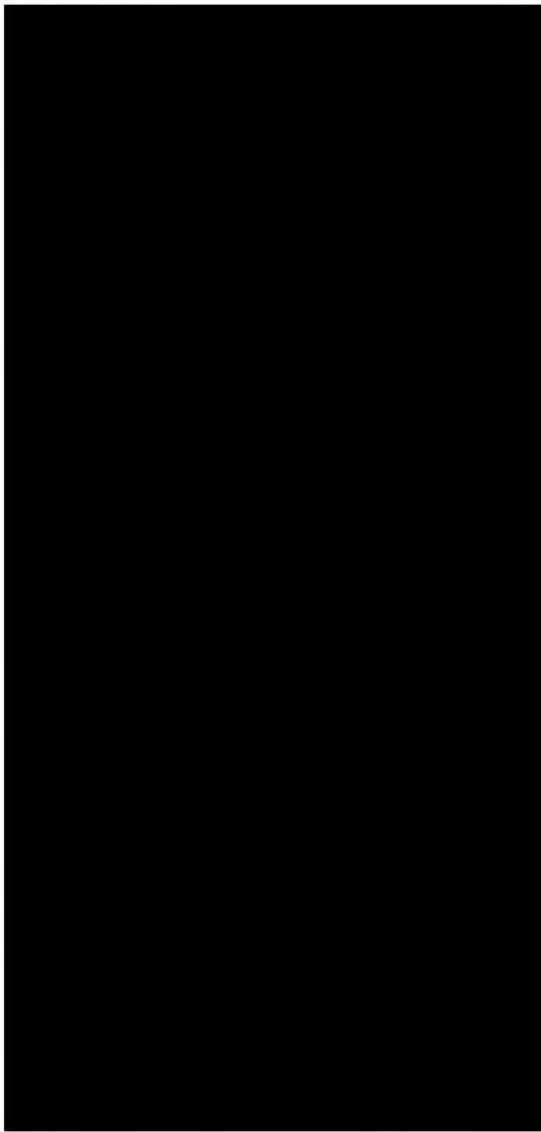
After a traumatic event, it's normal to e... See more

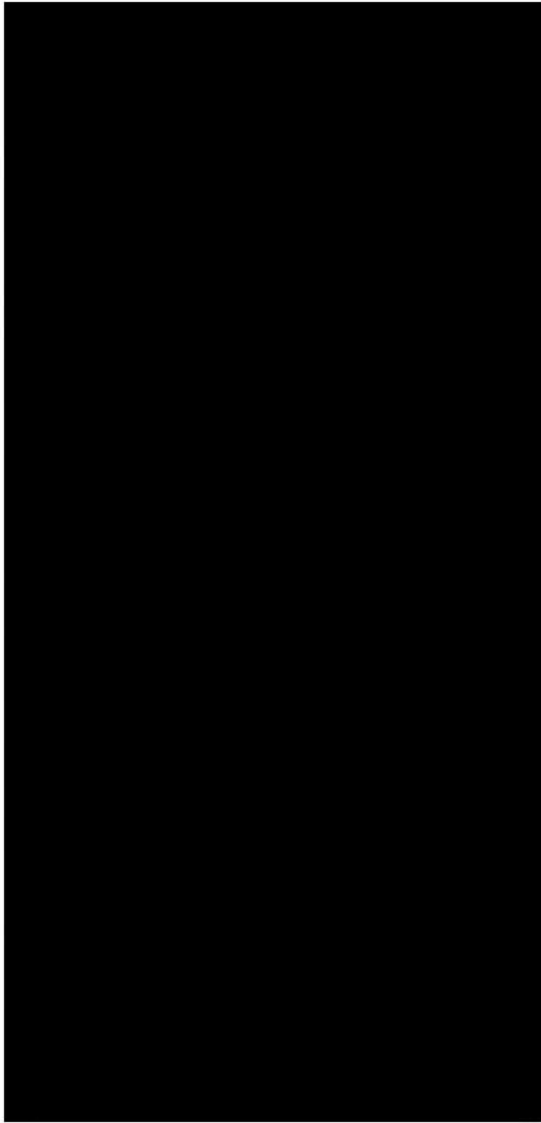
THU AT 6:00 PM



Parked at entrance, closer to unit, harder to get past, wih door open ready to drive at me.

Have video fro





Post-Traumatic Stress

Move to archive

Uriya, MD

...reactivity, enabling people to integrate painful memories—to look at them and begin to deal with them, instead of suppressing them until a stimulus calls them forth with overwhelming force.

William Woodward, MD, of the American Medical Association, testifying before Congress in 1957 against the Prohibition of cannabis, paraphrased a French author (P. Pascal, 1934) to the effect that "Indian hemp has remarkable properties in revealing the subconscious." A Congressman asked, "Are there any substitutes for this latter psychological use?" Woodward replied, "I know of none. That use, by the way, was recognized by John Stuart Mill in his work on psychology, when he referred to the ability of Cannabis or Indian hemp to revive old memories—and psychoanalysis depends on reactivation of hidden memories."

For including the reference to MDI (1867) in the list I have been compiling of conditions amenable to treatment by cannabis, I was ridiculed by Drug Czar Remy McCaffrey in 1998. I stand by its inclusion, of course, and in the 33 years since California physicians have been approving cannabis use by patients, I have found myself appreciating and confirming MDI's insight with every report that cannabis has eased symptoms of post-traumatic stress disorder.

PTSD As a Dissociative Disorder

PTSD—a chronic condition involving horrific memories that cannot be erased—is a dissociative identity disorder. The victim's psyche is fragmented in response to contradictory inputs that cannot be resolved.

Dissociative identity disorders are expressed as bizarre or inappropriate behaviors with intense sadness, fear, and anger. Repression is "herpeting" of the experiences may develop as a coping mechanism.

When traumatic or abusive experiences cannot be integrated into normal consciousness—as in the case of the Jekyll-Hyde behavior of abusive parents or caregivers—creation of separate personalities or identities may occur.

For example, the woman who was molested by a family member may have both superficially compliant and repressed-angry identities. The persona that's presented to the world can be swept away when a stimulus calls forth the overwhelming rage.

Such fragmenting of the individual personality causes tremendous stress. The psyche is incomplete because of repression and denial. The person tries to appear normal and logical but in fact is in turmoil, angry and depressed. The inability to deal directly with emotional issues results in ongoing splitting and compartmentalization of the personality—and in extreme cases, multiple personalities, hysterical fugue (a separate state of consciousness that the individual may not recall), blindness, paralysis, and other functional disorders.

In 1994 the term "Multiple Personality Disorder" was replaced with the name widely applicable "Dissociative Identity Disorder." As an article (by Foa et al) and editorial (Spiegel) in the April 2006 American Journal of Psychiatry state, it is only relatively recently that PTSD has been characterized as a dissociative disorder.

Evidence by Cannabis

Approximately eight percent of the >9,000 Californians whose cannabis use I have monitored presented with PTSD (308.8) as a primary diagnosis. Many of them are Vietnam veterans whose chronic depression, insomnia, and accompanying irritability cannot be relieved by conventional psychotherapeutics and is worsened by alcohol. For many of these veterans, chronic pain from old physical injury compounds problems with narcotic dependence and side effects of opioids.

Survivors of childhood abuse and other traumatic experiences form a second group manifesting the same symptoms—loss of control and recurrent episodes of anxiety, depression, panic attacks and mood swings, chronic sleep deficit and nightmares.

The final case reports in the box at the right of this page, unique though the subjects may be, apply two different forms that PTSD takes, both of which are eased by cannabis. The recurrent nightmares from the vet's

traumatic episode took on a life of their own, causing nocturnal terror and dread. The repeated memories of the steadily abused and beaten woman were symptoms of a fragmented, dissociative response to the disaster.

Evidence by cannabis helped both—the vet by taming down his reaction to the nightmares and restoration of his sleep, the woman by modulating her emotional reactivity and permitting her to process and integrate the experience and give up the fragmented, dissociative defense mechanisms, which in due course she no longer needed.

Repression and suppression are defense mechanisms that break down when the victim is fatigued and/or having and subjected to triggering stimuli. With cannabis, vegetative functions necessary for recovery, growth and repair are normalized.

Cannabis relieves pain, enables sleep, normalizes gastrointestinal function and restores peristalsis. Fortified by improved digestion and adequate rest, the patient can resist being overwhelmed by triggering stimuli. There is no other psychotherapeutic drug with these synergistic and complementary effects.

PTSD often involves irritability and inability to concentrate, which is aggravated by sleep deficit. Physical pain, fatigue, and sleep deficit are symptoms that can be ameliorated.

Practical Treatment Goals

In treating PTSD, psychotherapy should focus on improving both the patient deals with retrigger symptoms rather than reactivation of the event. Decreasing vulnerability to symptoms and restoring control to the individual take priority over insight as treatment goals. Revisiting the traumatic events without closure and support is not useful but prolongs and exacerbates pain and fear of loss of control. To repeat cathartic revisiting of the traumatic experience(s) without support and closure is anti-therapeutic and can exacerbate symptoms.

Physical pain, fatigue, and sleep deficit are symptoms that can be ameliorated. Restorative exercise and diet are requisite components of treatment of PTSD and depression. Cannabis does not leave the patient too immobile to exercise, as do some analgesics, sedatives, benzodiazepines, etc. Regular aerobic exercise (where injury does not interfere) relieves tension and restores control through kinesthetic involvement. Exercise also intrudes on the locus of control and diminishes drug-seeking to manage emotional response.

The importance of sound sleep

PTSD often involves irritability and inability to concentrate, which is aggravated by sleep deficit. Cannabis use enhances the quality of sleep through modulation of emotional reactivity. It causes the triggered flashbacks and accompanying emotional reactions, including nightmares.

The importance of restoring circadian rhythm of sleep cannot be overestimated as the management of PTSD. Avoidance of alcohol is important in large part because of the adverse effects on sleep. The short lived relaxation and relief provided by alcohol are replaced by withdrawal symptoms at night, causing anxiety and the worsening of musculoskeletal pain.

Evening oral cannabis may be a useful substitute for alcohol. With proper dosing, the quality and length of sleep can be improved without morning dizziness or hangover. For more patients, use of oral cannabis should be gradually titrated upward in a supportive setting, but is the key to avoiding unwanted mental side effects.

I recommend the protocol J. Russell Reynolds MD, recommended to Queen Victoria. "The dose should be given in minimum quantity, repeated in not less than four to six hours, and gradually increased by one drop every third or fourth day, until either relief



By Bill Morrison

CASE REPORT: A 55-year-old disabled male veteran had been a naval air crewman on patrol during the Vietnam war. A P-51 turbo-prop engine failed to reverse properly on landing. A propeller broke loose, pierced the fuselage, and instantly killed his crew mate who was two feet away. He brought a large binder of documentation of the incident.

His PTSD was expressed primarily through a haunting, recurrent flashback nightmares that replayed the traumatic event. Attention were the feelings of being emotionally overwhelmed. Sleep deficit was a salient aggravating factor for increasing vulnerability. Cannabis restored sleep and controlled nightmares. Depression and irritability had been eased.



By Karen Keaton

CASE REPORT: A 32-year-old retired executive secretary brought her 23-year-old daughter along to her follow-up interview two years after starting cannabis therapy. During her initial visit she had not disclosed fully the causality of her chronic depression with symptoms of PTSD (nightmares, chronic insomnia, dissociative episodes, rage).

She was experiencing loss of emotional control with crisis psychiatric interventions. Hypervigilance characterized her presentation; she described herself as being "all clenched up."

On follow-up she reported being able to recover and process repressed memories of sexual abuse from age 5 to 15 by her father (a professor) and having been beaten by her stepmother. She reported the dissolution and erosion of dissociative reactions to the painful memories. This permitted her to process and resolve—or come to an accord with—these unthinkable memories. Her continuing psychotherapy focused on these issues. She no longer experienced episodes of loss of control. She was able to relax her hypervigilance. Her self-esteem was significantly improved and she seemed happy and optimistic.

Her daughter confirmed that her mother was less irritable and more emotionally available since starting cannabis therapy. Both described improvement in their relationship.

continued on next page

Cannabis Eases Post-Traumatic Stress

By Tod Mikuriya, MD

Cannabis modulates emotional reactivity, enabling people to integrate painful memories—to look at them and begin to deal with them, instead of suppressing them until a stimulus calls them forth with overwhelming force.

William Woodward, MD, of the American Medical Association, testifying before Congress in 1937 against the Prohibition of cannabis, paraphrased a French author (F. Pascal, 1934) to the effect that "Indian hemp has remarkable properties in revealing the subconscious." A Congressman asked, "Are there any substitutes for that latter psychological use?" Woodward replied, "I know of none... That use, by the way, was recognized by John Stuart Mill in his work on psychology, where he referred to the ability of Cannabis or Indian hemp to revive old memories—and psychiatrists depends on reinvigoration of hidden memories."

For including that reference to Mill (1867) in the list I have been compiling of conditions amenable to treatment by cannabis, I was ridiculed by Drug Czar Barry McCaffrey in 1996. I stand by its inclusion, of course, and in the 10 years since California physicians have been approving cannabis use by patients, I have found myself appreciating and confirming Mill's insight with every report that cannabis has eased symptoms of post-traumatic stress disorder.

PTSD As a Dissociative Disorder

PTSD—a chronic condition involving horrific memories that cannot be erased—is a dissociative identity disorder. The victim's psyche is fragmented in response to contradictory inputs that cannot be resolved.

traumatic episode took on a life of their own, causing nocturnal terror and dread. The repressed memories of the sexually abused and beaten woman were symptoms of a fragmented, dissociative response to the disorder.

Easing by cannabis helped both—the vet by toning down his reaction to the nightmares and restoration of his sleep, the woman by modulating her emotional reactivity and permitting her to process and integrate the experience and give up the fragmented, dissociative defense mechanisms, which in due course she no longer needed.

Repression and suppression are defense mechanisms that break down when the victim is fatigued and/or hurting and subjected to triggering stimuli. With cannabis, vegetative functions necessary for recovery, growth and repair are normalized.

Cannabis relieves pain, enables sleep, normalizes gastrointestinal function and restores peristalsis. Fortified by improved digestion and adequate rest, the patient can resist being overwhelmed by triggering stimuli. There is no other psychotherapeutic drug with these synergistic and complementary effects.

PTSD often involves irritability and inability to concentrate, which is aggravated by sleep deficit. Physical pain, fatigue,



By Bob Mankins

Crew Members A 55-year-old disabled male veteran had been a naval air crewman on patrol during the Vietnam war. A P2V turbo-prop engine failed to reverse properly on landing. A propeller broke loose, pierced the fuselage, and instantly killed the crew mate who was two feet away. He brought a large bundle of documentation of the incident.

His PTSD was expressed primarily through a haunting, recurrent flashback nightmare that re-created the traumatic event. Alcohol use over the

Cannabis modulates emotional reactivity, enabling people to integrate painful memories—to look at them and begin to deal with them, instead of suppressing them until a stimulus calls them forth with overwhelming force.

The modulation of emotional response relieves the flooding of negative affect. The skeletal and smooth muscle relaxation increases the release of corticosteroids and escalating "light-or-flight" agitation. The modulation of mood prevents or significantly decreases the symptoms of anxiety attacks, mood swings, and insomnia.

While decreasing the intensity of affectual response, cannabis increases introspection as evidenced by the slowing of the EEG after initial stimulation. Unique anti-depressive effects are experienced immediately with an alteration in cognition. Obsessive and perinatal thinking give way to introspective free associations (given relaxed circumstances). Emotional reactivity is calmed, worries become less pressing.

Used on a sustaining basis, cannabis can hold depressive symptoms at bay. Agitated depression appears to respond to the analytic component of the drug. Social withdrawal and emotional shutting down are reversed.

The short-term memory loss induced by cannabis that may be undesirable in other contexts is therapeutic in controlling obsessive fixation, amplified anxiety and fear of loss of control ignited by the triggering stimuli.

Mainstream medicine treats PTSD symptoms such as hyperalertness, insomnia, and nightmares with an array of SSRI and tricyclic anti-depressants, sedatives, analgesics, muscle relaxants, etc., all of which provide inadequate relief and have side effects that can become problematic.

The Toxic Alternatives

Commonly prescribed medications for PTSD as listed in "Posttraumatic Stress Disorder Among Military Reservists From Afghanistan and Iraq," by Matthew I. Friedman, MD, PhD, in the April 2006 *American Journal of Psychiatry*:

SSRIs

Paroxetine, Sertraline, Fluoxetine, Citalopram, Escitalopram

May produce insomnia, restlessness, nausea, decreased appetite, daytime sedation, nervousness, and anxiety, sexual dysfunction, decreased libido, delayed orgasm or anorgasmia. Clinically significant interactions for people prescribed monoamine oxidase inhibitors (MAOIs). Significant interactions with hepatic enzymes produce other drug interactions. Concern about increased suicide risk in children and adolescents.

Other second-generation antidepressants:

Trazodone may be too sedating, may produce rare priapism. **Venlafaxine** may exacerbate hypertension. **Bupropion** may exacerbate seizure disorder. **Mirtazapine** may cause sedation.

MAOIs

Phenelzine

Risk of hypertensive crisis; patients required to follow a strict dietary regime. Contraindicated in combination with most other antidepressants, CNS stimulants, and decongestants. Contraindicated in patients with alcohol/substance abuse/dependence. May produce insomnia, hypertension, anticholinergic side effects, and liver toxicity.

Tricyclic Antidepressants

Imipramine, Amitriptyline, Desipramine

Anticholinergic side effects (dry mouth, rapid pulse, blurred vision, constipation). May produce ventricular arrhythmias. May produce orthostatic hypotension, sedation, or ataxial.

Antiadrenergic Agents

Prazosin, Propranolol, Clonidine, Guanfacine

May produce hypotension, bradycardia (slow heart rate), depressive symptoms, psychomotor slowing or bradycardia.

Aniconvulsants

Carbamazepine may cause neurological symptoms, ataxia, drowsiness, low sodium level, leukopenia. **Valproate** may cause gastrointestinal problems, sedation, tumor and thrombocytopenia (low platelet).

<http://www.beyondthc.com/wp-content/uploads/2013/04/THMCannabisPTSD.pdf>

Of course vilification for choice of medical treatment when entirely appropriate is also vital to providing relief and preventing Suicide etc with PTSD.

Figure 1

From: Elevated brain cannabinoid CB₁ receptor availability in post-traumatic stress disorder: a positron emission tomography study

