The Mental Health Status of People who have been in Institutions and Abused during Childhood years.

"*…all these grotesque and yet tragic incongruities* ***[child molestation/ child abuse]*** *reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects……..*

Sigmund Freud – 1875 +/-

" *Because childhood abuse occurs during the critical and formative time when the brain is being physically sculptured by experience, the impact of severe stress can leave an indelible imprint on its structure and function. Such abuse, it seems, induces a cascade of molecular and neuro-biological effects that irreversibly alter neural development."*

Martin Teischer – 2002

Dear Senator Moore,

I understand that you are to meet again with Janne McMahon (Private Mental Health Consumer Carer Network - Australia) for further suggestions about the proposal that there be a Taskforce set up to look at the issue of Borderline Personality Disorder. If this were to happen, I understand that it might come about as a consequence of the current Inquiry. At the moment I am in Prague and I hope you will excuse that fact that I am only able to send you this submission as an e-mail. It is a little difficult working from an internet cafe and sitting in front of a screen upon which all of the icons and the language is Czech. Anyway here goes.

You will recall that we have met on a number of occassions and that I appeared before predecessors of this Sentate Committee in its condict of inquiries into the Child Migrant Schemes and the Children in Institutions. I was present in the Senate Chamber on the day that "Forgotten Australians" was tabled. It is a day and an event that I will never forget. For me it was a day of both sadness and pride as I had done a lot of work with Senator Andrew Murray in order to get that inquiry started. Soon after the report "Forgotten Australians" was tabled, the organisation CLAN held a forum in the National Parliament. I was asked to make a presentation which I did, and in which I attempted to summarise the mental health status of persons who have experienced various forms of trauma and abuse during childhood years that had been spent in total or in part in institutions.

Some of the focus of my paper was on the undiagnosed level of Borderline Personality Disorder in these people. A couple of weeks ago I emailed a copy of my presentation to Janne McMahon. After reading it, she has suggested that I submit a form of the paper to you. Since making that presentation, I have come to the view that there is also a very high level of Post Traumatic Stress Disorder in people who have

these childhood experiences. At the present time, I am sure that many people in each category are not being diagnosed and they are not receiving any treatment.

My own observations from working with so many survivors of abuse leads me to conclude that every one of these persons has been affected by their childhood experience(s). A high proportion have psychiatric illness and a significant munber of the persons with psychiatric illness have co-morbid conditions ie. more thatn one form of illness at the same time. Sadly for most and tragically for too many, their illnesses have remained untreated for decades.

Many people who have spent childhood years in one or more institutions have also experienced various forms of abuse. These two experiences during childhood means that the person will have experienced one and often two phases of "critical assault".

THE FIRST CRITICAL ASSAULT.

The initial assault came in the form of a disturbance and/or severance of the attachment relationship between the child and principal caregivers. There is a good understanding now that a disturbance and/or severance of the attachment relationship can have its own, long-term effect upon the child. In most infants around the age of one year, even short periods of separation from a dedicated caregiver create a situation of high stress. With re-appearance of the caregiver, the child displays sequences of contradictory behaviour. Arms will be out-stretched; the child may run to the person then avoid the person. There can stilling; the child will stay rigid, facial expression will remain fixed. Behaviour has become disorganised and disorientated.

For the child, so often there was insufficient presence of a caregiver and in responding to the infant with insecure/ambivalent attachment. The caregiver had been inconsistent and unreliable in responding to the infant's stress. In adults who present with Borderline Personality Disorder (BPD), because this attachment relationship was never allowed to mature, the insecure/ambivalent feature carries over. Four of the nine diagnostic criteria relate to this:

- Past, frantic efforts to avoid real or imagined abandonment.

- A pattern of unstable and intense personal relationships characterised by extremes of idealism and devaluation.

- Identity disturbance: marked and persistently unstable self-image and/of sense of self.

- Chronic or frequent periods where there are feelings of emptiness.

THE SECOND CRITICAL ASSAULT.

This is the child's experience of one or more types of trauma including emotional, psychological, physical and sexual abuse. Often these traumas have been experienced time and time again with the child moving into a prolonged state of fear.

I consider that when the child or young teenager experiences extreme abuse, the equivalent of an "emotional landmine" is set deep in the victim's psyche. It just sits there and at a young age the victim is usually unaware of this. Memory of the trauma may or may not be repressed and where repression is achieved, this can last for decades. Often emotional and behavioural problems will be encountered during early years and these can include sadness, low self-esteem, anxiety and depression, poor school performance, early interest in drug and alcohol experimentation as well as eating disorders. These are not reported because of the person's shame and fear about the abuse event(s) and his/her increasing awareness about the level of stigma in the community towards mental illness.

In the absence of early intervention, treatment and counselling programs, there are long-term consequences with victims, as adults, having low self-esteem, anxiety and depression, as well as often dangerous and impulsive behaviour. They can also resort to drug and alcohol use, high levels of risk-taking and sometimes, criminal behaviour. In the course of a life journey other normal, day-to-day stresses take their toll and the "emotional land mine" can be set off anytime. People present with high levels of social dysfunction, major psychiatric illness and too many choose to take their own life. The main psychiatric illnesses that they are experiencing are:

- Anxiety and depression
- Phobias
- Post Traumatic Stress Disorder (PTSD)
- Borderline Personality Disorder (BPD)
- Dissociative Identity Disorder (DID)
- Co-morbid Depression with drug or alcohol dependency
- Co-morbid cannabis- induced psychosis
- Co-morbid PTSD with BPD

I consider that these categories of illness are directly attributable to the childhood experiences and as a consequence, adult lives have often been blighted all the way through life's journey.

At the present time, advances in Neuro-biology and Psychiatry are being made at a rapid and exponential rate. It is worth recognising some of the facts (post-Freud) that have been established, since a general appreciation of these may allow us now to gain

some insight into what might be happening in the person who experiences abuse (sexual abuse, physical assault and abuse and neglect) as a child or young teenager.

When the baby is born, the brain weighs a few hundred grams and it has a compliment of about 100 billion nerve cells. During the first 25 or so years of a normal life, the human brain (and mind) is able to develop. This brain grows to a final adult weight of about 3.5 kilograms and different groups of nerve fibres (neurones) become interconnected. The number of connections (synapses) formed can reach 100 trillion and about 100 different neurotransmitters are being used in different parts of the brain. Specific behaviours, activities and emotional responses are being expressed, modulated and controlled by neuronal activity in specific brain structures and centres.

An understanding of this pattern of brain development has led to the current expression of two general concepts. The first concept is that during normal growth and development from the baby to the adult, brain "wiring" and "re-wiring" takes place. The second concept is that of "brain plasticity" or "brain elasticity". This relates to the fact that neuronal activity in a particular brain centre(s) can be increased through the development of more connections between the neurones in that brain centre and/or more connections with neurones in other centres. There are strong indications emerging from current research which suggest that in people who live through prolonged states of fear, these neuro-biological mechanisms can be compromised to the detriment of the person.

I want to spend the remaining time looking at the link between childhood abuse and the significant amount of the psychiatric illness which is seen amongst victims.

Major advances in the understanding and capacity to treat mental illness have gone hand in hand with the advances in neurobiology. Modern drugs and advanced neuro-imaging technologies are now available and as well, the Diagnostic and Statistical Manual (DSM–IV) provides a modern classification for psychiatric illnesses and a key aid to accurate diagnosis and assessment.

The DSM-IV divides mental illnesses into two broad categories; the Axis-1 and Axis-2 disorders. Axis-1 disorders are the clinical disorders of which there are sixteen described groupings (eating disorders eg. bulimia, psychotic disorders eg. Schizophrenia, affective disorders eg. Major depression etc). Generally some form of medication will be part of the treatment regime for an Axis-1 disorder. For many of these disorders the treatment should also include access to behaviour therapy, psychotherapy counselling etc. this dual approach to treatment is not always offered particularly for people who happen to be public patients. The Axis-2 disorders have been labelled as the personality disorders. The most popularly known of these is probably narcissistic personality disorder. The traditional approach to the treatment of these disorders is psychotherapy with access to counselling and behaviour therapies.

BPD is considered at the present time to be an Axis-2. As the descriptor implies the symptoms don't fit for a comfortable diagnosis. Indeed in the early 90's some authorities in the field were suggesting that it was really a complex form of Post Traumatic Stress Disorder (PTSD).

During the past 10 or so years two very important themes have begun to emerge in the literature.

- The first is that the childhood experience of extreme forms of abuse is a major risk factor in BPD.

- The second is the emerging evidence that childhood experiences of this kind appear to be compromising normal development in some key centres of the brain.

These new observations really underlie that difference in the summary statements of Sigmund Freud and Martin Teicher. Freud considered that these childhood experiences could translate to some expression of a disturbance of the mind whereas Teicher has gone beyond this, recognising that in the abused child, brain development and brain function are actually being compromised.

There is another dimension to this that relates to this question of criminal behaviour in some adults. We have very patchy data suggesting that care leavers represent a significant group amongst the populations within our prisons. The data is patchy because we don't have any systems in place that would give care leavers an opportunity to identify their situation when they might become a recipient of any government service. In addition to this deficiency it is unlikely that we have very reliable data about the diagnostic profile of prisoners who have a psychiatric illness.

We need to revisit this issue now and look for the links between a childhood history of abuse, serious criminal offence and the proper psychiatric assessment. My thesis here is that childhood abuse resulting in compromise of the deep brain centres that are involved in the regulation of anger, negative emotions and impulsive behaviour may result in an adult who, when faced with real hunger, a perceived real threat etc. is most likely to respond with violent behaviour.

I believe that BPD will come to be seen as a common disorder (? as common as bipolar disorder). Hopefully there will be a recognition and re-description of a group of disorders that are attributable to adverse childhood experience. These will come to be seen as Axis-1 disorders with the understanding that there is a biological basis to the person's emotional states and behaviours. To be able to gain a better quality of life, these people will require access to specialised, longer-term treatment programs.

Dr Wayne Chamley