

APPENDIX 2.

The Mental Health Status of Adults who have been in Institutions and abused during their Childhood Years.

Recent advances in and access to the use of Positron Emission Tomography has provided opportunity for Psychiatrists, Neurobiologists and Neuro-psychologists to apply this technology (PET Scanning) to selected groups of adult patients. These adults have presented with chronic and complex psychiatric illness that has been very difficult to treat in a satisfactory manner. In addition, it has been possible to establish that all individuals in particular groups have reported particular, prolonged, negative childhood experiences.

Although the subject numbers are small, the separate studies of Mary Zanarini and Rachel Yehuda in the USA focused upon people who, during their childhood, experienced either institutionalization or abuse and neglect, or both. These very impressive studies have begun to reset thinking about the links between these undesired childhood experiences and subsequent serious mental illnesses in the adult person. Whilst PET scanning has been used in Australia, as an investigative tool in patients with psychotic illness, I can find no evidence of studies carried out in adult patients with these particular risks from their childhood (i.e. institutional upbringing and/ or abuse). More recently it has been acknowledged that childrens' witnessing of and endurance of domestic violence can be another very significant risk factor.

My own observations from working with so many people who were raised in institutions during the last century and who are also survivors of extreme neglect and all forms of cruelty and 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 number of the persons with psychiatric illness have co-morbid conditions i.e. more than one form of illness at the same time. In addition, many have had quite pronounced learning difficulties and this too has had consequences because it had determined their standard of living. Sadly for most, their illnesses have remained untreated for decades and there is no sign that they will ever get appropriate and proper treatment.

There is a very high incidence of Post Traumatic Stress Disorder (PTSD) in these people often associated with either episodic and severe depression or a chronic state of lower grade depression. Some of the focus of my paper looks also at the undiagnosed level of Borderline Personality Disorders (BPD) in these people. At the present time, I am sure that many people with these conditions are either not being diagnosed or diagnosed incorrectly and they are not receiving any treatment.

These two experiences (institutional upbringing and abuse) during childhood years means that the person will have encountered both types of "critical assault". These "critical assaults" have taken place during years

when the brain is passing through a particular developmental stages and the investigations by Zanarini and Yehuda demonstrate that brain development can be compromised as a consequence of the experiences. It is compromised because the abuse has occurred during the same timeframe (childhood and early teenage years) when particular centres (the limbic system – amygdale and hippocampus) are becoming fully functional. This is further explained in the paper.

THE FIRST CRITICAL ASSAULT.

The initial assault comes 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 behavior. 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. Behavior has become disorganised and disorientated. For the child in the institutional setting, 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 BPD, because this attachment relationship was never allowed to mature, the insecure/ambivalent feature carries over.

Four of the nine diagnostic criteria for BPD relate to this:

1. Past, frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense personal relationships characterised by
3. extremes of idealism and devaluation. Identity disturbance: marked and persistently unstable self-image and/of senseof self.
4. 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, neglect in terms of starvation, poor hygiene, insecure placement etc, and cruelty. Often these traumas have been experienced time and time again and the child has experienced several prolonged states of fear. I believe that the child who has been raised in a "family" situation and has witnessed and endured frequent episodes of conflict and domestic violence between adults in the same household, has also experienced episodes of prolonged 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 behavioral 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 counseling programs, there are long-term consequences with the victims, as adults, having low self-esteem, anxiety and depression, as well as often dangerous and impulsive behavior. They can also resort to drug and alcohol use, high levels of risk-taking and sometimes, criminal behavior. 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 their life 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 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 kilograms and different groups of nerve fibres (neurones) grow and become interconnected. The nerve fibres grow in length and they can also grow branches as a response to diverse, sensory experiences. The number of connections (synapses) formed can reach 100 trillion and a number of different chemical neurotransmitters are being used in different parts

of the brain, allowing the connections to work. These neurons and synapses eventually constitute a conductivity network so that the brain (and the mind) operate through the local generation of tiny amounts of current that is then transmitted around the network so that it eventually reaches specific processing centers. Thus, specific behaviors, activities and emotional responses are being expressed, modulated and controlled by neuronal activity in specific brain structures and centers.

An understanding of this pattern of brain development has led to the current acceptance and agreement about two general phenomena. One phenomenon is that during normal growth and development from the baby to the adult, a process of brain "wiring" and sometimes "re-wiring" takes place and this must take place in a chronological order.

The second concept recognizes the phenomenon of "brain plasticity" or "brain elasticity". This recognises the fact that neuronal activity in particular brain centre(s) can be increased through the growth of more branches and the development of more connections in that brain centre and/or more connections with neurones in other centers.

After birth, particular parts of the brain develop during particular intervals in chronological age. Thus deeper brain centers (the Limbic System) "wire up", develop and network across the ages 2 months to 12/14 years. Components of the Limbic System regulate the expression and control of emotions and a range of pleasure states. These are the pleasure states arising from childhood love, security, safety, positive achievement and recognition as well as the being "able to please others". Other components are involved in memory formation.

In the large outer brain (the cortex), developmental processes can continue throughout the first 25 years. Furthermore, the extent to which particular centers do develop, can be determined to a significant degree by the person's range of positive experience and the re-enforcement of particular experiences.

Comparative PET Scans would show that the brain of Richard Tognetti is vastly different to that of the young child who was taught the play the violin for say four years.

There are strong indications emerging from current research which suggests that in people who have lived through prolonged states of fear, these neuro-biological mechanisms can be compromised to the detriment of the person's mental and emotional resilience, emotional expression and control, ability to interact with others and even their perceptions of themselves and the social environment around them. Into the future, I believe that this sort of compromisation will also be linked to these children often having major learning difficulties

In the rest of the paper, I want to explore the link between childhood abuse (in all of its forms) and the significant amount of the psychiatric illness which is seen amongst adults who have experienced it.

Major advances in the understanding and capacity to treat mental illness have gone hand in hand with advances in neurobiology/ neuro-psychology. Modern drugs and advanced neuro-imaging technologies are now available and as well, the Diagnostic and Statistical Manual (DSM.IV) provides a contemporary classification for psychiatric illnesses and a key aid to accurate diagnosis and assessment. The DSM-IV (sometimes described as the Psychiatrists' Bible), 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. Forms of Depression etc). Generally some type of medication will be part of the treatment regime for an Axis-1 disorder. For many of these disorders treatment should also include access to behavior therapy, psychotherapy, counseling etc. This dual approach to treatment is not always offered particularly for people who happen to be patients in a public mental health system. Included in the Axis-2 disorders are conditions that have been labeled as the personality disorders (so called). The most popularly known of these is probably Narcissistic Personality Disorder. The traditional approach to the treatment of these conditions is to emphasise use of the talking therapies.

At the present time BPD is considered to be an Axis-2 disorder. 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 revision of the DSM IV, and this will come out next year as the DSM V, some of the experts argued that this group of complex disorders that are seen in victims of abuse, should in fact be given a specific diagnostic category. Whilst there will be no such change will be made in the DSM V, I feel sure that this change in thinking will eventually gain broad acceptance.

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. Furthermore, childrens' frequent witnessing of violence done to others (physical assault of other children, domestic violence in the family unit etc) is now to be recognized as another major risk factor.
- 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 and in particular, the centres that regulate emotional expression, attachment, pleasure responses (and possibly memory formation).

There is an important dimension to this that relates to this question of some types of criminal behavior, in males in particular. We have very patchy data suggesting that adults who as children were raised in institutions (and no doubt experienced all forms of abuse) 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 these adults an opportunity to voluntarily 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 and chronic mental illness in the adult, serious criminal offence and the lack of proper psychiatric assessment of these Australians. 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 behavior may result in an adult who, when faced with a confronting situation, insult, assault, real hunger, a perceived real threat etc. is most likely to respond with violent behavior towards others (violence, homicide) or to the self (self-harm, suicide etc). Hopefully there will be a recognition and a re-description of a group of disorders that are attributable to adverse childhood experience. These should come to be seen as Axis-1 disorders with the understanding that there is a profound biological basis to the person's emotional states and expression (or lack of) as well as particular responses and behaviors. To be able to gain a better quality of life, these people will require access to specialised, long-term treatment programs which are not in place at the present time.

Dr Wayne Chamley

SENATE INQUIRY INTO CHILDREN IN INSTITUTIONS.

SUBMISSION No. 329

“Both Ben and James told me that between them they could recall the names of about thirty boys who had been in institutions with them. They knew of twenty of them who had been incarcerated for murder. Both James and Ben have been sentenced for murder. One of the more notorious figures who had spent time as a boy at Tamworth Boys Home with Ben was James Finch (the Whisky Au GoGo Bomber). Ben said that he was a “poor sod” who never had a chance as he had ended up in Tamworth Boys Home some time after coming to Australia as a “Leaving Liverpool” boy.”