Royal Commission
into Family Violence

WITNESS STATEMENT OF PROFESSOR LOUISE KATHRYN NEWMAN AM

I, Louise Kathryn Newman, Psychiatrist of 20 Flemington Road, Parkville, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

2. I am the Director of the Centre for Women's Mental Health at the Royal Women's Hospital and Professor of Psychiatry at the University of Melbourne.

3. My speciality is infant psychiatry and I have clinical expertise in developmental mental health, parental mental disorder, infant trauma and clinical infant-parent interventions for mothers with significant trauma.

Background and qualifications

4. I commenced as Director of the Centre for Women's Mental Health in November 2014. The Centre provides clinical and therapeutic services for patients at The Royal Women's who have a maternity, cancer or gynaecology problem as well as a mental health problem. In my role as Director, I am involved in clinical practice as well as leading the Centre's program of research, education and training.

5. I also teach undergraduate and postgraduate psychology and psychiatry courses at the University of Melbourne. I lecture to medical students and trainees in psychiatry and clinical psychology on child development, child maltreatment, trauma and neglect and its developmental impact and treatment. I also teach courses in infant mental health and mental health of asylum seekers and refugees. I have an Adjunct Chair of Psychiatry at Monash University and teach in psychology and psychiatry and supervise research students.

6. Since qualifying as a Psychiatrist and Child Psychiatrist in 1994 I have held academic and research roles and was Director of the NSW Institute of Psychiatry

until 2006. I was appointed as Chair of Perinatal and Infant Psychiatry at Newcastle University in 2006 and Chair of Developmental Psychiatry at Monash University in 2009. In that role I was Director of the Centre for Developmental Psychiatry and Psychology and clinical director of perinatal and infant mental health for Monash Health.

7. My current research focuses on the evaluation of infant-parent interventions in high-risk populations, the concept of parental reflective functioning in mothers with borderline personality disorder and the neurobiology of parenting disturbance.

8. I have published on topics such as improving antenatal risk assessment in women exposed to high risks, identification of risk in early childhood and immigration detention and mental health care. Attached to this statement and marked "**LN1**" is a copy of my curriculum vitae. Attached to this statement and marked "**LN2**" is a copy of my publication record.

9. From 2009 – 2010, I was President of the Royal Australian and New Zealand College of Psychiatrists. In 2011, I was appointed a Member of the Order of Australia for "service to medicine in the fields of perinatal, child and adolescent mental health, to education, and as an advocate for refugees and asylum seekers."

10. I hold a Bachelor of Arts (Honours in Psychology) from the University of Sydney, a Bachelor of Medicine and Bachelor of Surgery from the University of Sydney and a Doctor of Philosophy from the University of Sydney. My doctoral thesis investigated trauma in infancy.

Impact of family violence on children

11. There is now an established body of evidence showing that in terms of overall psychological and emotional development of children, there are significant impacts of being in an environment characterized by violence and conflict. These impacts are both immediate and longer term.

12. Even before a child is born, they can be impacted by family violence whilst in utero. Women experiencing family violence whilst pregnant are incredibly vulnerable. They may be subject to sustained physical assaults which can lead to foetal loss. They may also be subject to psychological abuse by their partner who feels jealous that the woman's attention will soon be directed towards the baby and not him.

13. Women experiencing family violence during pregnancy will be highly stressed. They will have high levels of stress hormones – adrenalin and cortisol – which travel across the placenta and impact on the foetus' brain development. The foetus, as well as the mother, is in a state of stress.

14. Babies born in these circumstances are vulnerable at birth because of the stress they have been exposed to in utero. Studies have shown that these babies are more likely to be small, have a smaller head circumference and fail to grow. Babies who have been exposed to stress in utero also have an increased rate of premature delivery which means they are vulnerable neurologically in terms of brain development and may have other physical difficulties such as lung problems. High levels of maternal stress are also associated with parenting difficulties and post natal problems such as depression.

15. The first three to four years of life is when the brain is growing at its most rapid rate across the life span. It is a critical time for child development. The brain grows rapidly during this period as a result of stimulation and input with the development of connections between neurones and growth of neural pathways. These pathways are crucial for ongoing healthy brain development. Attached to this statement and marked "**LN3**" is a CT scan which shows the impact of neglect on brain development, and two diagrams which illustrate the growth of synapses from birth until 14 years, and the growth in the brain by age.

16. We now know that these early years are opportunities to enhance child development. It is essential to identify infants with risk factors impacting growth and development including those with sensory problems, neurological conditions and those experiencing trauma and neglect. Early intervention is focussed on improving the opportunities for brain development, learning and emotional development. Involving parents and carers in providing emotionally attuned care and secure attachment is central. Providing children in the 0-4 period with quality child care and learning opportunities is the foundation of healthy social and emotional development.

17. We also know that the environment to which infants and young children are exposed can, if it is a positive one, enhance a child's health and development. Conversely, a negative environment and exposure to violence can have serious detrimental consequences for children's development affecting physical and mental

health, intellect and educational outcomes. Strong and secure attachment to a parent, carer or other person significantly improves child outcomes.

18. We know from infant research that young children are very aware of and influenced by what goes on around them. We now have a better understanding of the impact of exposure to violence and conflict on child development. We know that even very young children are responding to and attempting to process conflict and situations that might feel threatening to them.

19. Children affected by family violence often witness physical attacks and threats to the person who is their primary carer or attachment figure, their mother. The attachment figure is the person who in the psychological world of the child is their caring relationship. A child will have a primary attachment figure and can have other attachment figures. The attachment figure is the person they go to for feelings of security when they are stressed and afraid. The attachment figure is essential for the child's developing sense of self and understanding of how relationships work. Young children are absolutely dependent on the attachment figure for their physical and psychological survival.

20. The most damaging type of situation for a young child exposed to family violence is where the child believes that their primary carer will be unavailable to them and will die. This belief is as damaging to the child as the belief that the child itself will die. This reflects the dependency of the child on his or her primary carer and attachment figure. The situation is slightly different for older children who, due to their different level of cognitive awareness, may realize they could survive the death of their primary carer. However, it is still an incredibly damaging experience for older children.

21. Children affected by family violence are very much exposed to feelings of fear and stress which can have biological effects on child brain development. In the immediate sense, children can have a stress response where they have high levels of the stress hormones cortisol and adrenalin. This can have a negative impact on brain development and the development of the child's nervous system. The brain can be sensitized to ongoing trauma. The child may always be on the lookout for danger and may be over aroused and primed to defend. In terms of the child's brain, the stress response sensitizes the brain and makes it less efficient in dealing with stress. It means that the child can be in a state of ongoing stress which has a negative effect on ongoing brain development and physical health. There is

evidence that children who are exposed to trauma very early on have higher rates of various health problems such as high blood pressure and type 2 diabetes as adults. This is a result of the impact of stress related hormones such as cortisol on other hormonal systems. The impacts of early trauma on both physical and psychological health are well documented.

22. We do not know if the neurological changes in a child's first 3-4 years of life can be reversed. However, we do know that it is very important to intervene early for children who have experienced stress and trauma. It is important to help them deal with stress and regulate their stress responses. We also know that some children who have been exposed to severe early stress will still show the biological changes 10-15 years down the track, even in safe environments.

23. All situations where a child experiences unresolvable fear and trauma are associated with negative developmental impacts. A child may be extremely traumatised by witnessing conflict and violence between carers or parents and may also be stressed by experiencing direct psychological and emotional abuse. For the young child the threats to safety and care are very significant as the child is dependent on the carers for survival. Witnessing relationship disturbances raises significant anxiety in children and this will impact their developing understanding of relationships and attachment. There is no clear level of "safe" exposure to family violence and all types of family violence should be seen as having a potential for negative impact on child development and well-being. The available research evidence has focussed on the most severe forms of trauma exposure to allow better understanding of the relationship between trauma and mental health problems and the impact on neurodevelopment. It is important that research also looks at the impact on children to explore the variety of forms of family violence and the impact on attachment and interpersonal functioning.

Impact of psychological violence on children

24. The impact of psychological violence on children is less understood. In these cases, children usually witness situations where their mother, the primary carer, is devalued and criticized. The perpetrator (usually the child's father or step-father) asserts his power by belittling and denigrating his partner. The perpetrator aims to undermine his partner's sense of self-esteem and capacity for autonomy, to disempower her. In other situations a child is exposed to relationships where both partners engage in denigrating behaviours, anger and hostility towards each other

and fail to consider the impact of this on the child. Children in this situation are often treated in this way themselves and are learning that relationships operate around a dynamic of unresolvable conflict and psychological abuse of others. This is likely to have long term impacts on the child's developing understanding of attachment relationships and interpersonal relationships. Children are at risk of replicating these dynamics in their own later relationships.

25. Children witnessing these sorts of events are learning about how relationships work through that exposure. From an attachment theory point of view, we see children adopting and being influenced by what they see modelled by their parents. For example, a boy may think it is acceptable to speak to women in an abusive way because that is how his father speaks to his mother.

26. A child in this situation has a terrible dilemma. They want to be loved, accepted and in the company of their parents or carers. They are trying to have their own emotional needs met. In these distorted relationships, the only way they can get that closeness is often to join with the abusive, aggressive parent. If the child's mother is denigrated by her partner, the partner might reward a child who joins in that sort of behaviour. The long term risk is that the child's emerging ideas of how relationships work is very distorted.

27. There are similar issues for children who have witnessed sexual assault. I have worked with several children who have witnessed the sexual assault of their mother as well as emotional and physical abuse. These children are often very confused and traumatized by what they have witnessed. Some of these children might re-enact violence and pseudo sexual behaviour in their own peer relationships. For the child, the dilemma is that being close to others is confused with violence and abuse. Children are too young to understand that what they have witnessed is wrong and harmful. Sometimes abusive behaviour is the only way they have experienced attention or closeness.

Longer term psychological impacts of family violence on children

28. Although there are individual differences and differences between girls and boys, a child who is exposed to high levels of family violence will typically present clinically in one of two ways. The child may present as silent, sad, emotionally constricted and unable to engage in normal peer interactions. They tend to be withdrawn because being close to people is frightening. Some of these children are wary of

being close to others, even at a young age. They may be seemingly well behaved children who go undetected at pre-school or school, but they are incredibly frightened and traumatized. Children may be reluctant to discuss their concerns and not show obvious signs of distress or trauma. However, assumptions should not be made that they are not impacted by trauma or at risk of harm secondary to this.

29. On the other hand, a child may present as angry and be inclined to act out and behave "badly". Generally, boys are more likely to present in this way. These children may re-enact violent situations in play, both by themselves and with other small children, and are more likely to hit out and be impulsive. This is quite common in children who have witnessed or experienced abuse. The child may be disruptive at school and could be diagnosed with Attention Deficient Hyperactivity Disorder (**ADHD**). The problem with these kinds of diagnoses is that it only deals superficially with the presenting behaviour and does not address the underlying trauma.

30. For both of these clinical presentations, children might find it difficult to concentrate at school. They might be so preoccupied with things going on at home and so traumatized that they can't speak to anyone about what they have experienced. The difficulty detecting the trauma is that the violence and abuse which the child has been exposed to is often hidden. In these cases we very quickly see secondary accumulation of other problems, such as ongoing anxiety, fear, confusion and depression. Children exposed to trauma and family violence can present with a variety of difficulties including behavioural and emotional problems. The longer term impacts of trauma relate to the impact on the child's sense of self and self-esteem and difficulty in developing trusting relationships.

31. Those children who are violent and aggressive are more likely to develop anti-social behaviour. There is a clear link between very early antisocial and aggressive behaviour in young children and anti-social personality disorder as an adult. These adults are likely to be unempathetic and to engage in harmful and sadistic behaviour either towards humans or animals, or both. This is a clear pathway which we have known about for some time. It can be too late to change a lot of this behaviour in adolescence and adulthood, which is why interventions for children are so important. We need to teach children very early on that there are ways of dealing with conflict which are different to violence.

Why don't women just leave?

32. Many people in the community ask why women in abusive relationships don't "just leave". Women in these relationships often don't "just leave" because they can't. They are often emotionally dependent on the perpetrator and feel very confused about their situation. In my experience, many women hope that things will improve. They don't like their situation, but they have a belief that somehow it is their responsibility and they have to work at improving their relationship. They might be angry at the perpetrator, but they are also dependent on them. The woman might make attempts to separate or her partner might leave her for a period of time, and then the woman goes through a period of wanting him back, even though it was bad when they were together.

33. These situations involve complex psychological dynamics. Women victims I see were usually abused as a child and sadly some abuse their own children. They repeat what happened to them. They are victimized by their partner and they victimize their own children. Their model of understanding relationships is that intimacy works on power and domination and violence is normative.

34. Women sometimes make choices to give up their baby in order to stay with the perpetrator of the violence. In my clinical practice, I have seen 15 and 16 year old girls in fearfully brutal relationships where they don't see that there is an alternative.

35. What this means in practice is that there is a longer term issue of helping women in abusive relationships make healthier decisions for themselves. We can be quite punitive in our responses to women in abusive relationships. We need to have a

radical rethink of what support means for women and children in these situations. We need to be responsive to women's psychological needs. Telling people what to do is not effective.

Why don't men just stop using violence?

36. The flipside of "why don't women just leave", but a question that is less commonly asked, is why men don't simply stop using violence. Attachment theory can help us understand the complexities of this issue. Usually there are factors in the perpetrator's own childhood which have influenced his use of violence and the violence is often transgenerational. Men who are perpetrators have usually grown up with distorted relationship dynamics and they may have been child victims themselves. They identify with the aggressor figure. They have a similar model for rationalizing their relationships. They don't have any other way of relating. Some may think: "I survived it, I'm going to raise my kids to be survivors." They deny the severity of their own behaviour.

37. In some cases, the perpetrator may be unhappy about the way he is behaving in the relationship, but he is also dependent on having an abusive dynamic and asserting his power.

Response of mental health services

38. The mental health system will often see children who are traumatized as a result of experiencing or witnessing violence or abuse. Mental health services find it very difficult to respond as it has traditionally been seen as a child protection issue and not a mental health issue. Child abuse and trauma is not necessarily dealt with in mental health. There is a siloed approach to services for these children.

39. We now know that child abuse, trauma and neglect are the major risk factors for all mental illness and disorder, including the broad range from schizophrenia and bipolar disorder to depression and anxiety. It is a major risk factor for a whole range of other problems such as personality and relationship difficulties. Given that this association is now clear, we need to be doing more to intervene early and treat the underlying causes of trauma and to provide effective early intervention services for children who have experienced trauma.

40. The focus of child protection is identifying children at risk and children who are traumatized. However, they have limited options in terms of referring children for

treatment. In the event that a child is seen by a mental health practitioner, they may be diagnosed with a variety of different conditions which do not tell the whole story. Child abuse, trauma and neglect are the major factors contributing to a whole range of presentations.

41. For example, in my experience the vast majority of children diagnosed with ADHD are children who have experienced trauma. A child diagnosed with ADHD may be offered counselling or support which only superficially addresses their disruptive behaviour and fails to engage with the underlying attachment issues and anxiety experienced by the child. This means that as the child grows into adolescence and adulthood, he or she will continue to carry the legacy of their trauma and their confusion about themselves and their relationships.

42. Giving children diagnostic "labels" is not necessarily helpful. It stops practitioners thinking about the underlying trauma and associated developmental implications. Children who have been exposed to violence and abuse can end up in the mental health system where their trauma is not properly understood and treated, or the child protection system which has limited services on the ground which are trauma informed.

43. There are also limited mental health services for longer term victims who have complex needs based on their own childhood abuse and re-victimization as adults. There are few mental health services which will see these women and many end up with lots of diagnoses, such as borderline personality disorder, which again fail to address the underlying trauma.

44. We have never really tackled the issue of helping mental health services become more trauma informed. Throughout my career, I've attended several meetings about this issue and have engaged with survivor groups but it is hard to achieve this sort of change at a systemic level. We need to improve linkages between child protection and mental health so early intervention can be offered as a routine response. Removing children from their family is not solving the problem. In fact, the threat of child removal for victimized women is one of the most damaging things that can happen in terms of the woman's mental health.

45. Unless we develop more trauma informed services for children which do both preventative and early intervention work, we will keep seeing an endless transgenerational repetition of violence and abuse.

Opportunities for improvement

46. Our current ante-natal systems are not good at identifying family violence. Given we now know a great deal about the significant impacts of stress on foetal development and the potential risk and vulnerability for babies born in these circumstances, we should have more systematic ways of identifying family violence experienced by pregnant women.

47. Currently, there may be some general questions asked of pregnant women in the ante-natal clinic such as "how are things going?", but we don't specifically ask "do you feel safe?" Clinicians can detect stress and anxiety, but we don't necessarily ask whether that is related to the woman's relationships and whether she feels safe at home.

48. I have recently reviewed a screening instrument used in New South Wales which asks "do you feel safe in your relationship?" I'm not aware of the status of this screening instrument and how widely it has been rolled out.

49. As well as having a screening tool, what we would like to be able to offer women at The Royal Women's is a program which does not tell them what to do, but which aims to help women think more about the impact of stress on their baby. Engaging women by talking about the impacts of family violence on their baby is powerful. In my clinical practice, I talk to women about the impact the stress they are experiencing is having on their unborn child. I find this is a way of helping women feel more empowered about their situation and helping them think about the challenges of being a parent in a highly stressful environment.

50. We also need to ensure that our response to diverse cultural groups is not alienating or judgemental or Western centric.

51. The Royal Women's hospital is currently working on a program with Aboriginal midwives and early childhood nurses to raise awareness of the impact of violence and substance abuse on child development in the Aboriginal community. These issues are intrinsically linked. This program is funded by the Victorian Department of Health and Human Services.

52. There are also some examples of trauma informed programs which work well. I have done some consulting for a community organisation called Marymead in Canberra which runs a Centre for Early Life Matters. The Centre provides

counselling services for families who have babies and young children and are worried about how they are behaving or feeling. The Centre also works with parents to prepare them for the arrival of a new baby. The strength of the Centre is that it takes a child centred, family focused, strengths based approach which identifies and builds on the capacities of the children, parents, families and their supporters to improve the situation. The Centre delivers its services in a range of different ways including child and family counselling, home visiting services, individual and group therapy (including with families) and parent-baby and parent-child therapy.

Training of mental health professionals in relation to family violence

53. The training of mental health professionals about family violence varies greatly according to different professional groups. There is little content dedicated to family violence in undergraduate training for psychologists and psychiatrists. In clinical psychology and specialist psychiatry courses, there is more content relevant to family violence however there is not necessarily an opportunity for hands on experience. In general, education about family violence for mental health professionals is patchy.

54. Currently, the level of support and training provided varies depending on workplaces. For example, training is available for all staff members at The Royal Women's hospital about family violence, regardless of their position. The hospital has identified family violence as a significant issue not just for patients, but for staff.

55. In my view, before we implement mandatory training for health professionals on family violence and introduce better screening tools, we need to have clearer systems of response. The system currently is very fragmented. If we did have proper identification and safe disclosure of violence by women to health professionals, there would be increased demand which we would struggle to meet in the current service environment.

Professor Louise Kathryn Newman AM

Dated: 14 July 2015