Royal Commission into Family Violence

WITNESS STATEMENT OF PROFESSOR JAYASHRI KULKARNI

I, Jayashri Kulkarni, Professor of Psychiatry, of 607 Commercial Road, Melbourne 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 a Consultant Psychiatrist and Professor of Psychiatry, employed by the Alfred Hospital and Monash University.

3. In 2009, I established the Monash Alfred Psychiatry Research Centre Women's Mental Health Clinic. It is a women's only outpatient clinic within Alfred Psychiatry. We have developed a world-first treatment approach for women with schizophrenia, bipolar disorder and depression using hormones and we have established a national register to improve the management of pregnant women needing treatment with antipsychotic medications.

4. I take referrals from general practitioners and other specialists but unfortunately we have a seven month wait list due to demand.

Background and qualifications

5. I graduated from Monash University Medical School in 1981 and I became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1989.

6. I obtained a Masters in Psychological Medicine in 1989 and I was awarded a PhD from Monash University in 1997.

7. I have worked in the area of women's mental health as my specialty in psychiatry. It was the subject of my PhD thesis, which is titled "Women and Psychosis", and it has been the focus of much of the research I have undertaken since the commencement of my career.

Mental health impacts of family violence on women

8. In my day-to-day work at the clinic, I see a great number of women who have experienced family violence either very recently or in their distant past. I am seeing them to treat their mental ill-health as a result of their experiences of family violence.

9. More recently, I have been receiving an increase in referrals of adolescent girls between the ages of 10 and 16. I am not a child psychiatrist but the Alfred Hospital does have a child psychiatry unit, based in Moorabbin. I am finding that girls are now coming for early help with family violence related issues, particularly sexual violence or aberration in terms of crossing what are considered normal boundaries of behaviour. That is another trend that I have observed over the course of the last six-months.

10. Women's mental health, in general, has not been a priority but it is coming into focus now that there is increasing awareness about family violence. That said, it is important to not just look at violence as distinct from mental health because the consequences are clearly linked.

Common condition in women who have experienced family violence

11. The most common condition that I am managing in particular for women, is a condition that we are calling Complex Trauma Disorder. It is difficult to diagnose and define but in the official classification, it is known as Borderline Personality Disorder. In my view, this term is not helpful for either the patient or the practitioner and for the purposes of this statement I will refer to it as the 'Condition'.

12. Essentially what we see in this Condition is that there is a trauma or violence against the woman (and often we see this with family violence), over an extended period of time when the girl is growing up, particularly in the childhood years and early puberty years. This could involve the woman growing up in a household where she was subjected to violence either of a sexual or a physical nature, or emotional deprivation or other emotional abuse.

Key symptoms of the Condition

13. A woman, or young girl, having had such experiences can develop a series of responses, including but not limited to:

    (a) lifelong anxiety, even when removed from the violent situation;

    (b) difficulties with new learning;

    (c) difficulties with memory;

(d) difficulties with emotional regulation;

(e) flash backs of the violent event(s);

(f) difficulties forming intimate relationships that are healthy; and

(g) severe problems with self-esteem.

14. These are examples of the emotional symptoms but self-harm is another major indicator that a woman is suffering from the Condition. There are also a range of physical symptoms that result from the connections between the emotional and biological responses in the brain.

15. What happens with stress in early childhood is that it raises the body and brain cortisol levels. That then has a flow on effect into the other hormone systems. This is why we are finding that obesity is increased in this traumatised group, beyond what you would see in the normal population, which of course has all the other health consequences such as diabetes, heart disease etc. that relate to being overweight.

16. Infertility is another common condition because cortisol levels effect the reproductive hormones. Hirsutism is also common (being an abnormal growth of hair on a woman's face and body) as is polycystic ovarian syndrome, which involves unusually high level of testosterone and creates complex emotional dysfunction.

17. The elevated cortisol levels also affect the learning circuits in the brain, which is why a young girl suffering from this Condition might have difficulty concentrating at school and consequently does not go on to obtain a higher education resulting in her falling into a lower income and socio economic bracket later in life.

18. In short, the psychology, biology and environment are connected and this all needs to be taken into account in terms of treatment (which I expand on later in this statement).

Women experience symptoms at various stages in their life

19. In addition to the increase in very young women seeking help early, the bulk of my patients would either be:

(a) in their mid-twenties to early thirties; or

(b) in their mid-forties to early fifties.

20. For the first group, the predominant symptoms are those that I have listed at paragraphs 13 and 14 above. This is the case even if the trauma was experienced 15 years earlier and what we are calling the Condition continues to be a problem for these women during their adult life.

21. In relation to patients in their mid-forties to early fifties, what we are seeing is a relapse of symptoms during menopause and we are presently undertaking research in this area. By way of example, a woman who experienced family violence as a child and received help at an early stage, managed to find stability, having children of her own and going on to pursue a career and healthy intimate partner relationships. Then, the biological and social changes that happen around menopause lead to that woman having a setback and we think that this is related to the declining levels of oestrogen, which is a brain protective agent. This results in the woman being thrown back into a re-experience of the earlier traumas and this can happen even without any new traumas occurring.

22. Women who do not receive early intervention, often sadly end up going from one violent situation to another and the re-experiencing of trauma continues throughout their entire life.

Self-harm is a significant issue

23. The biggest issue we see in the adult sector is deliberate self-harm. It is common for women to present in the emergency department because they have lacerated their wrists, or burnt themselves, or engaged in very risky sexual behaviour or having taken excessive amounts of illicit drugs and these are perceived by people working in the emergency department as "acting out" behaviours. The problem is that the behaviour is seen but not the two-thirds of the "iceberg", which is underneath the surface, that being what has caused it to occur.

24. Unfortunately, a woman in this situation is not always seen as a deserving patient because "she has done it to herself". In addition, she is not always forthcoming with the story of her trauma experience and as a result the behaviour is not linked with the fact that the person is in real trouble because, for example, she is living in a very difficult and violent family situation.

25. This is a particularly common scenario for young women who (often repeatedly) present to our hospitals for treatment and are seen as being a 'nuisance', without the trauma being identified or dealt with.

Relationship difficulties

26. Another issue for women who did not receive early intervention (either professional or by some other family member or mentor) is that the relationships they form later in life are often very poor. The fundamental issue in this regard is that they learn from an early age, not to trust others. Along with the experience of violence is a fear of abandonment, which means that even if a relationship is violent, the woman will not want to leave or upset the balance in any way, because there is this major fear that she will be left to fend for herself and she feels as if she cannot.

27. It is factors like this, which result in young girls and girls in their adolescence putting up with violence and the double insult is that when they *do* tell someone, usually their mother, there is a disbelief.

28. Many of my patients say that a lie is easier than the truth and so they carry the secret with them and they often feel that they are bad or dirty and they feel that they deserve to be punished. This leads to incredible distrust in other people and includes the help-givers that they distrust as well. Women whose trust has been broken in this way often do not have the capacity to bond with health professionals as they do not believe that they will help or will continue to be around. The same applies in relation to police and other authority figures.

29. If violence has occurred in childhood and the perpetrator is an authority figure, in the woman's head, all authority figures are tarred with the same brush. That is the way that person perceives adults and when she herself is an adult, relationships are always seen in that light. She will often pick an abuser as her intimate partner because she has an incredibly low self-esteem.

Diagnosis is not well understood

30. We estimate that 28 percent of the female population have some version of the Condition and we are presently trying to develop an understanding of the antecedent types of trauma and corresponding problems experienced by women. For example, I have noted that women who have experienced prolonged sexual abuse from a male parental figure before puberty, tend to have the worst form of the Condition, while women who have experienced emotional deprivation - which is still a trauma - have some but not all of the Condition's symptoms. I am collecting research data to support this observation

31. The connection between past trauma and psychological symptoms described is very poorly understood, particularly by health professionals. There is a stigma attached to the Condition, in that a person who presents having slashed their own wrists or overdosed on prescription medication is not regarded as someone who has a legitimate medical problem that requires help.

32. The other issue with this Condition is that it has a number of mimickers. For example, poor emotional regulation is a part of the condition, which means that a person can have depression on one day and the polar opposite of depression on other days. This, combined with the woman's reticence to talk about the past, or her fear in not being believed, means it can be extremely difficult for health professionals to correctly diagnose the Condition. Many medications are used for the various symptoms but not for the Condition itself.

33. We have seen an increase in this Condition and whilst it is not clear whether there has been an increase in the incidents of family violence or simply increased reporting of family violence (perhaps due to heightened public awareness), it does not matter. What matters is that there are far too many women with this Condition, who are experiencing poor quality of life.

At least one effective treatment strategy

34. Marsha Linehan from Washington, is the originator of Dialectical Behaviour Therapy, for this prevalent Condition. The difficulty is that it requires specialist training. In Victoria, I would estimate that approximately:

(a) one quarter of the psychologists that are certified by Australian Psychological Society;

(b) one tenth of psychiatrists; and

(c) very few general practitioners,

would be trained in Dialectical Behaviour Therapy.

35. The other layer of complexity is that whilst Dialectical Behaviour Therapy is seen as the specific therapy for this Condition, there are others that might be useful for patients as well. That said, a good starting point would certainly be to resource some of the training to make Dialectical Behaviour Therapy more available to people.

Issue with the term Borderline Personality Disorder

36. I consider the current official term for the Condition to be entirely inadequate and my reasons are twofold:

(a) firstly, the word 'borderline' invalidates the Condition and gives rise to a question about whether or not it even exists; and

(b) the subsequent words 'personality disorder' are integral to who the patient is and imply that we as clinicians cannot treat the patient because it is not actually an illness, rather just someone of poor or unstable character. condition. This adds to the stigma of the diagnosis and the helplessness for the patient plus clinician.

37. I am very keen to challenge this Condition's current name because as I have already foreshadowed, the term makes a difference for both patients and clinicians. The term Complex Trauma Disorder names the origin rather than describing one's personality as being the origin. It puts the focus back on what has happened in someone's past, rather than on the person's own sense of self. In my view, even if the term is not formally changed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, we should at least adopt a different term informally within the health profession and general community.

38. It is a big condition, with no objective measure to make the diagnosis, there is no definitive treatment per se and there should be more resources focussed on understanding it better and generating public awareness.

A need for change in health systems

39. I have recently completed a 100 case audit study of women who were admitted to a general psychiatric in-patient unit in a major teaching public hospital. To my dismay, in 51 percent of cases there was no question asked of those women about any trauma (either in relation to a history of trauma or current trauma). Of the remaining 49 percent, there was a small percentage which had detailed history and others that were very sketchy.

40. We expected that the psychiatry profession would have the best understanding of trauma and the best competence in relation to history taking and formulating a plan, including management of trauma.

41. Despite these findings, I recognise that we have made progress in the past 25 years. When I commenced my career, I heard dreadful things said of women who

displayed some of the symptoms I have described above. For example, comments like "*…this is about attention seeking*" and "*…she has a masochistic personality*" were commonplace.

42. I believe we still have a long way to go as a profession.

43. This issue of not asking about trauma is even more problematic in primary practice or general practice and other health settings. I think this is largely as a result of practitioners not being taught how to ask about a patient's history with trauma at medical student level.

44. We are currently conducting another study about general practitioners' capacity and regular practice of taking trauma history. Informal comments from GP participants are that they do not have enough time to take a trauma history in a busy General Practice and that if trauma is found then they do not have the resources or training to provide adequate help for their patient

45. We have also developed toolkits to help general practitioners to take a trauma history and a resource kit on what to do if they find it. However, we have a lot of work to do in the health professional sector to better equip health professionals to identify and treat this Condition.

Measures to decrease violence against women in public institutions

46. Women admitted to psychiatry wards experience high levels of violence and sexual assaults.

47. In 2010, I obtained funding from the Victorian State government to renovate one of the Alfred psychiatric units to separate male and female patients. Since this renovation, the number of incidents of aggression and assault against women inpatients has decreased. Attached to this statement and marked '**JK 1**' is a copy of the paper that I co-authored entitled *Establishing female-only areas in psychiatry wards to improve safety and quality of care for women.* It concludes that establishing female-only areas in psychiatry wards is an effective way to improve the safety and experience of care for female patients.

48. It is still standard practice to manage male and female patients together in Acute Psychiatric units and there have been reported rapes and reported assaults on women across Victoria and this is in a population of women who we know has a high rate of trauma in their background.

49. In response to escalating assaults in in-patient units, the United Kingdom government adopted a strict policy of gender segregation on psychiatric wards in 2006. In my view, the same should occur in Australia. Inpatient psychiatry units should be safe havens for managing women with psychiatric conditions that often have an aetiology of family violence. Further traumatising women in the very place where treatment is to be provided is detrimental to her mental health.

Mental health related to family violence in pregnancy and opportunities for early intervention

50. One period in which trauma against women tends to increase is during pregnancy, which has many ramifications. There are some studies now looking at the impact of the stress levels in the mother on the developing foetal brain. The maternal cortisol level has a big influence on the developing foetal brain. We are very concerned that what we are seeing is a baby that is born predisposed to the Condition because of what happens in utero.

51. Women's stress during pregnancy can increase considerably as a result of the behaviour of their partner, who feels displaced because of his own early life deprivation. In a relationship with his partner, he was the recipient of attention and when the woman becomes pregnant, her attention changes and he may perceive it as displacement and begin to think he is being rejected.

52. The resulting problem is that the parents are predisposing an unborn infant to a brain architecture that lends itself to developing various mental health conditions and if the baby is born into an environment where there is violence it is then ongoing and turns into another generation of problems.

53. For these reasons, we are also undertaking work in antenatal clinics, which are prime settings for intervention. We provide educational material, work through complex social situations and try to achieve a better mental state for the mother-to-be, in the Clinic . The goal of this work is to improve the brain development of the foetus in utero and subsequently the young infant.

54. We are also seeing more isolated women and single mothers, significantly struggling to raise a child by themselves against many economic odds and social factors. They do not have social networks to draw upon and have a desperate need for relationships. This means those women are partnering and re-partnering. This is a very isolating and difficult existence and promoting inherent dangers for children being exposed to risks that may not exist if there was more

connectedness in the woman's network. Extended family support and a connected community are often missing, hence leading to greater isolation.

Mental health services dealings with family members

55. There is scope for improving the way in which mental health professionals deal with family members when their patient has perpetrated violence. The acute admission of a patient can be involuntary, if they pose a 'danger to others'. The difficulty is that more often than not, they will be discharged approximately 14 days later.

56. The acute psychiatric units are working under immense pressure with strict guidelines to get people out of hospital as quickly as possible. Patients may subsequently be referred to a community treatment team and there may be a Community Treatment Order (CTO) in place. This CTO only requires a patient to comply with treatment (e.g. to attend a Clinic appointment or receive medication) and does not deal with behaviour.

57. The reality is that there is not capacity to manage patients for a longer period, even if they may pose a risk because of the lack of longer stay units and community teams to deliver the required monitoring, family reviews and patient treatments. What would be helpful in this regard, are more step down units where patients can reside after being in an acute ward and be monitored over a longer period of time. This would enable the mental health professionals to get a better view of how patients are interacting with their family, before being discharged. There are a few of these programs operating in Victoria that I am aware of but nowhere near enough.

Patient confidentiality in family violence situations

58. In terms of the provision of information to family members of a patient who is in a mental health institution, the applicable legislation allows the treating practitioner to share information with family members who are part of the 'treating team'. I am firmly of the view that the family is there to look after the patient and I will not be bound by a patient saying I cannot tell their family. This needs to be managed transparently. I would not speak to family members without the patient's knowledge but usually if you make it clear that the patient, family and mental health practitioners are all in it together, it is rare for a person to say no.

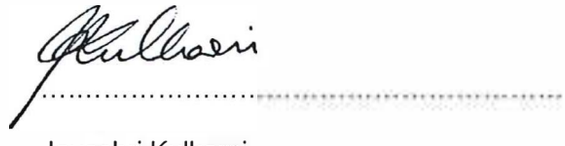
59. I consider that patient confidentiality is misused in a number of ways, usually by young practitioners who hold concerns about being sued by their patients for

speaking with families. For example, a patient managed on the inpatient unit may state that he/she does not want their family to know of the details of their illness. If the patient is going to return to their family, then it is important that the family know about medications, what to expect and so on. In this instance, experienced clinicians are able to convince the patient and family to work together. A less experienced clinician may just leave the situation with the initial refusal of the patient to involve family.

A need for further research and education

60. I think we need more research to bring the conditions that are related to trauma into clearer focus, with a view to making the conditions diagnosable and therefore treatable. This is an area which is presently too vague and we need to prioritise it so that the needs of those affected women are being met. By adopting a special focus on Women's Mental Health, we can provide a better approach for specific issues such as violence against women. A gender-based focus also assists men with their special mental health issues too.

61. Further, there is an obvious need for general practitioners and other health professionals to be trained in identifying cases of family violence, taking trauma history and knowing how to respond appropriately when a patient does disclose.



Jayashri Kulkarni
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