[redacted]
(m)
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Sun 12 Apr 15

Attention: Royal Commission into Family Violence

To Whom It May Concern,

First of all, I am grateful for the opportunity to, like many others I am sure, make a submission to this important public inquiry.

The following constitutes my submission to the Royal Commission into Family Violence.

In my submission, I will address these two terms of reference:

> ***1c. Support for victims of family violence and measures to address the impact on victims, particularly women and children***
>
> ***6. The needs and experiences of people affected by family violence with particular regard to children, seniors, Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, gay, lesbian, bisexual, transgender and intersex communities, regional and rural communities and people with a disability and complex needs***

I request that my identity and the identities of other individuals mentioned in my submission remain anonymous, since my submission contains sensitive, personal health information about me and similarly sensitive information about others.

Introduction

1. I am a qualified social worker, with significant experience in providing therapeutic services to adult men who, as children, were traumatised by domestic and family violence (DFV) to which they were subjected.

2. I presently work as the [redacted], rolling out the new, state wide [redacted] program. [redacted] provides enhanced identification of, and care coordination and referral options for the victims of DFV and their children.

3. In this submission, I wish to focus on my own personal experience as someone who was subject to unrelenting DFV for the first [redacted] years of my life, and the consequent legacy of complex trauma that resulted from those decades of violence.

Background

4. I was never supposed to be born. I was conceived in [redacted], during my father's [redacted] week leave from [redacted], where he had been certified for several months

due to his mental ill health and more particularly, his unmanageable problems with violence against my mother, siblings, neighbours, shopkeepers, etc.

5. In the [redacted]s, there was no such diagnosis as posttraumatic stress disorder (PTSD). The Repatriation Department (later, the Department of Veterans' Affairs [DVA]) diagnosed and treated my father as suffering with paranoid schizophrenia, even though by their own admission he never displayed any of the textbook symptoms of that mental illness.

6. My father's treatment consisted solely of ad hoc, sporadic periods of hospitalisation, coupled with massive doses of anti-psychotics, the later which aggravated rather than subdued his unmanageable problems with violence. He remained a cruel, sadistic man until his death from [redacted] cancer in [redacted].

7. My mother organised a termination with a doctor in [redacted]. Hospital and other records obtained by me through Freedom of Information (FoI) requests show her repeatedly begging social workers, nurses, etc. in the months after my conception that she would rather kill herself than bring another child into the world.

8. Home was racked with constant violence, [redacted] of my [redacted] siblings were wards of the state of Victoria, repeatedly placed by my father into orphanages as acts of hate against my mother, [redacted] of my siblings had attempted suicide ([redacted]), and my mother herself was certified at [redacted] (psychiatric hospital) on several occasions for severe, reactive depression and suicide attempts.

9. For reasons that are unclear from the papers, Victorian government health and welfare workers blocked my mother's planned abortion. The most plausible explanation is that they were unsure that my father's consent to that procedure would not hold, as he was reported prone to change his mind.

10. While my mother's planned abortion pre-dated the Menhennitt Ruling in ***R v Davidson 1969 (Vic)*** by some [redacted] years, comments made by the Victorian Law Reform Commission characterise the legal status of abortion around the time I was conceived:

    'Given the general acceptance of the Macnaghten ruling in ***Bourne****, medical schools were teaching that an abortion performed in a hospital setting with the agreement of two medical practitioners was lawful. Despite the secrecy surrounding abortion, it played a necessary role in medical practice in 1950's Australia'*

11. My mother was distraught that she had to bring this pregnancy to term. My father 'medicated' her with his own potent anti-psychotics to try and keep her quiet. My mother and my siblings blamed me for contributing to my mother's suffering.

12. On the day that I was born, [redacted], my father had my siblings removed by Victoria police and placed into institutional care. He later conveyed the unsettling news to my mother while she was in [redacted] Hospital, [redacted] recovering from the birth of a child she so desperately did not want to have.

13. Fully cognisant of the inevitable harm to me and, therefore, a flagrant breach of child protection legislation at that time, Victorian government health and welfare workers nonetheless allowed my mother to take me home, into the aforementioned, toxic environment. They then left me for dead.

14. The ***Children's Welfare Act 1958 (Vic)*** was unequivocal, for example, at s.16(f) (h) (j) that I would be considered a child or young person in need of care and protection.

15. Rejected by my mother, spurned by my siblings, witness to and subject of my father's unbridled, explosive rage and other bizarre behaviours, I spent my entire life up to the cusp of my ███ birthday, living with the total absence of safety and the total presence of fear.

16. Trauma specialists like Courtois, Cloitre and Van Der Kolk have demonstrated through their extensive research, the long-term impacts of exposing children to sustained threats from which those children cannot escape. I spent my every waking moment from birth to ██, always anticipating and often trapped with, terrifying acts of violence.

17. Please refer to Appendix A: ***Complex Trauma***

18. In ████, and with the permission of Victorian government health and welfare workers, my father relocated our family to New South Wales (NSW). Along the way, he again placed my siblings into institutional care. That included placing my brother ██████████, who had been until leaving Victoria a ward of that state, into an orphanage run by the ██████ ████.

19. ████, █████ years old at the time and suffering with █████, was dragged out of bed in the middle of night by the ████████ whenever he wet the bed. They would forcibly hold him screaming under an ice cold shower. The next day they would force ████ to 'confess his sins' in front of all the other children.

20. ████ remained a deeply traumatised child, adolescent and young adult. He had an explosive temper and could be violent. He also became an alcoholic.

21. In ████, in a fit of rage, ████ deliberately ████████████████████. He lost his ████ in that failed suicide attempt.

22. After █████ years of intolerable pain, due primarily to the fact that his ████ never healed and his underlying mental health problems, ████ committed suicide in ████. He was ██.

23. For the ████████ years up to ████'s death, I could hear him every night through our bedroom wall, groaning in excruciating pain because of his unhealed ████.

24. In the same year that ████ died, my mother was diagnosed with ██████████ dementia. My surviving siblings attributed this diagnosis to all the stress that I had caused her, later referring to same at my mother's funeral in ████.

25. Since my father's aggressive outbursts at home often ended with several police officers fighting to restrain him before dragging him off to hospital, I suffered the stigmatised responses that typically come from being the son of a 'schizo.'

26. While a student at School, on the western outskirts of , NSW, I was monstered for years by the Deputy Principal, would routinely 'shame' me in front of my peers by forcing me to engage in classroom discussions about my father's aggressive outbursts and other bizarre behaviours.

27. was insistent that I too would head down the same tragic path as my father had and in that regard, I was doomed by my genetic inheritance. By , 's obsession had become so maniacal that he directed my peers not to sit near me in class, or communicate with me.

28. Later in , I had mobs of 30 peers or more, waiting behind bushes to 'ambush' me on the way home from school, phoning me at home to threaten me with death and altogether, to make my already hellish life, even more despairing.

29. High school was no less torturous. I attended the now infamous College in . With the arrival in of the later, convicted serial paedophile priest, , I was prey to his 'textbook' grooming. He visited my parents' home for dinner, introduced me to alcohol, took me on trips to , and fawned all over me. And yet, when he tried to step up his grooming behaviours, I rejected his advances. For that rejection, and in front of my peers, he grabbed me by the throat, verbally abused me, shook me violently and threw me into a chair.

30. If I had thought that was that then I was sorely wrong, since as other victims of have subsequently noted, he got off on causing pain to students. Struggling as I was with my own emerging homosexuality, *'outed'* me in front of my peers, distinguishing me as a delicate fag and as his 'special' student in what was an extraordinarily conflicted, homophobic milieu. His purposeful, malevolent actions were akin to tying a piece of meat to a child's leg and then thrusting that child into a lions' den.

31. 's strategy 'worked'. My peers bashed me, spat on me, beat me with rattans, and called me every homophobic slur you could name. The latter mostly related to me being derided as 's '*bitch*'.

32. For the first time in my life, and as trauma sufferers often do, I '*withdrew*,' and instead of going to school, I spent my time walking around the , which abutted my home in . Home was unsafe, school was unsafe and only when alone, walking amongst the trees, could I feel any semblance of peace.

33. The response of the Youth and Community Services (now Family and Community Services [FACS]) caseworker, , to my abuse, was to issue me with a horrific ultimatum: either I returned to College to face further abuse or he would have me incarcerated in School (a juvenile justice facility) as a 'truant'.

34. On , had visited the Principal of College, . openly advocated for my peers to beat the fag out of me, as he believed that only by my standing up to such violence could I shake off my homosexuality.

35. In response to 's ultimatum, I made several suicide attempts.

36. My father wrote to on , stating: 'Sir, apart from refusing to go to school, abuses me and causes a lot of trouble in the home. He is out of control and I want him removed from my home. He took an o/dose of my pills last night.'

37. When I was, eventually, bound to return to College, the inevitable was only a matter of time and by early , I was so broken by all the abuse that was being dumped on me that I suffered what would, in common parlance then be called, a 'nervous breakdown'.

38. We would now call this a predictable consequence of years of cumulative harm, leaving me with complex trauma that has afflicted me to the present.

39. From early to , I remained because of my complex trauma and my parents' demands, completely cut off from the outside world. I did not study and I did not work. I had no friends or any other social connections. I had no wage or benefit. My parents were insistent that I cared for them and I was helpless to challenge their authority.

40. In , I was somehow able to muster enough courage to commence my academic studies, by enrolling in a course at the University of . I can still recall the utter terror I felt as I sat in that lecture theatre for the first time. After more than a decade cut off from the world I was having, albeit tenuous, social contact with other people.

41. While studying full-time at the University of , I was pressured by my parents to maintain the high level of full time care for them. My father would not allow any external services to provide respite or other care for my dementing mother.

42. My father was diagnosed with cancer in early and died from that disease in .

43. For the first time in my life, I was no longer slave to my father's excessively unreasonable demands or fearful of his unpredictable violence. However, all at once and without any support I had to find somewhere to live, and to live with other people, and to try to do all those 'normal' things that I should have been able to experience more than a decade earlier.

44. I also crawled through hell trying to come to terms with my much repressed homosexuality. Like , my father had been demonstrably homophobic and would oft criticise me for being effeminate, 'too much like a woman.' I was so ashamed of being gay.

45. My mother, who had been in robust physical health was in , placed in , the psycho-geriatric holding facility attached to Hospital, in . Due to her vigour and her 'active wanderer' status, finding her a suitable nursing home placement was difficult.

46. Despite her prior stated objections, the staff at [redacted] decided that they would move my mother to [redacted] Hospital. As retaliation to my blocking that move, the staff at [redacted] withdrew all nursing care to my mother. A woman who had been in peak physical health was, within the space of a few weeks, reduced to being a heaving wreck. She sustained what dermatologists called, and what would have been, had nursing care been made available, a wholly avoidable [redacted].

47. I can never sufficiently account for the needless and utterly devastating pain my mother endured in [redacted]. The question that lingers for me is how anyone, let alone a team of helping professionals, could knowingly torture a sick and defenceless woman?

48. That night, [redacted], when my mother, at the point of death, was transferred to a suitable nursing home, [redacted], will remain etched into my soul, forever. Every moment, every sensation of that night and the day thereafter remains as real to me today as if I was still actually *back there*.

49. My mother died, peacefully, in [redacted].

50. On the evening of [redacted], I was assaulted by my then colleague, [redacted], at the opening of the [redacted] in [redacted], after I intervened to stop him having sex with a cognitively impaired student from the [redacted] College where we both worked as teachers.

51. I was, at the time, living in a flat above the centre. When [redacted] returned in the early hours of the morning, I was still so immensely traumatised that I repeatedly begged him to kill me. I was sitting at the foot of the stairs with a rope tied tightly around my neck, sobbing uncontrollably.

52. Within months, I had dropped out of my law studies at [redacted] University, left my job at the [redacted] College, gained and then abandoned my job as an [redacted], [redacted] with the [redacted]. I became destitute, homeless and acutely suicidal.

53. I moved to Sydney in late [redacted]. I started work again as an [redacted], [redacted] with the [redacted].

54. In part because they were abusive workplaces and in part due to how I react to violence because of my complex trauma, including my vulnerability to re-traumatisation, I have been seriously harmed by bullying to which I was subjected at the [redacted] and at the University [redacted].

55. I sought assistance from the Fair Work Ombudsman (FWO) and WorkCover NSW to help me deal with the bullying, discrimination and harassment that was being perpetrated against me at the University [redacted]. However, neither agency could assist as they, like many other government agencies, do not recognise the existence of complex trauma or the specific issues raised for its sufferers when subject to workplace violence.

56. I have since my brother [redacted] suicided in [redacted], proactively sought to gain therapeutic support to help me with my complex trauma. That has included lodging a complaint with the Australian

Human Rights Commission (AHRC), whose response was that I am not entitled to the sort of long-term therapy I require to facilitate my recovery, either through Medicare or the [redacted] Veterans' Counselling Service.

57. There is no alternative counselling support offered by the NSW State Government, particularly since complex trauma is a neuropsychological disorder not recognised as a mental illness, when having a recognised mental illness is a precondition for access to treatment.

58. At my own choosing, I was comprehensively assessed by a psychiatrist, Dr [redacted] on [redacted], who confirmed that I am not mentally ill.

59. For further information relevant to my submission, please refer to Appendix B: ***Additional Notes***

Subjective impacts

I have identified the following features of my complex trauma:

1. Dissociating without volition from social interactions, even when no perceived or actual threat is present.

2. Constantly fearing harm from threats that may or may not be real. That includes catastrophising those threats to imbue them with a grossly inflated sense of danger.

3. Struggling everyday with the core message imparted by my mother and siblings that not only should I never have been born but that my birth contributed to my mother's suffering.

4. Racked with feelings of abandonment whenever treated or believing that I have been treated less favourably than others.

5. Perceiving my death at the hand of others as inevitable and, perversely, relieved because that outcome will end my inexorable suffering.

6. Failing to attend to my own health, wellbeing and safety, including refusing to seek medical assistance when sick.

7. Unable to trust others, including an incapacity to distinguish the motivation of others. That is, to discern if they mean me well or harm.

8. Persistent suicidal ideation, where not one day passes without me either wishing I was dead or thinking through the steps by which I could successfully complete suicide.

9. Extreme vulnerability to re-traumatisation, where in the flight-fight-freeze-submit spectrum, I invariably, habitually, submit to those who would cause me harm.

10. Fleeing or avoiding the ordinary problems of life, problems that trigger intense emotional reactivity, leading to my rapid decompensation.

11. Resorting to alcohol misuse every weekend, which I always spend alone, as a way to numb the overwhelming emotional torpor that I would otherwise experience.

Conclusion/recommendations

My prognosis is bleak. Even if at this late stage of my life I was afforded a long-term therapeutic intervention proven effective in ameliorating the harsh symptoms of complex trauma, for example, schema therapy, the chronic DFV to which I was subjected across the first ██ years of my life, the devastating consequences of many re-traumatising incidents and the abject refusal of the State to either recognise my disability or provide appropriate therapeutic support for it, reduces my opportunity for recovery to zero.

Complex trauma is not merely behavioural manifestations but a neurological disorder that causes permanent brain damage.

When I ask myself the question, what would have made a positive difference when I was growing up as a baby in Victoria and later, a child and adolescent in NSW, in a home that health and welfare professionals across both states agreed was starkly violent, I would respond in the following terms. Those terms are my recommendations for how children subject to DFV can be better assisted and how the adult survivors of DFV who, like me, live with the legacy of complex trauma, can not only receive treatment but treatment that works:

1. Establish a 'National Centre of Excellence' for complex trauma, which would include opportunities for research on the impact of DFV on children and adolescents. Bessel Van Der Kolk's Trauma Center stands as an excellent example of what can be done (www.traumacenter.org)

2. Provide training for frontline DFV workers, including those working in child protection, to not only be nominally 'trauma informed' but fully competent in understanding and responding to child and adolescent victims of DFV.

3. Develop an Adverse Childhood Experiences (ACE) approach to child protection, since a child's ACE score readily identifies her or his exposure to violence, including DFV (www.cdc.gov/violenceprevention/acestudy).

4. In addition to the above, I plead for governments state and federal to fund professional counselling services for the adult survivors of DFV who suffer with complex trauma. The resistance by the State to fund such services makes no sense in economic or social terms, as left without the opportunity to recover, these damaged individuals rarely come close to realising their full potential.

Sincerely,

Appendix A: Complex trauma

Hibbard, et al. 2012, pp.373-374

'…some parental mental health problems are associated with unpredictable and frightening behaviors, and others (particularly depression) are linked with parental withdrawal and neglect. Similarly, in terms of family conflict, attacks on a parent almost always frighten a child, even if the child is not the direct target. Threats or actual violence as part of a pattern of aggression against one parent will sometimes exploit the other parent's or child's fears'

'The effects of psychological maltreatment during the first 3 years of life can be particularly profound, because rapid and extensive growth of the brain and biological systems takes place during this period, and this growth is significantly influenced by the young child's environment and, in the particular, the early parenting that he or she receives. Psychological maltreatment also negatively affects the organization of the child's attachment to important adults in his or her life'

'Longitudinal studies have shown that impairment in security of attachment is associated with a range of later problems, because early parenting plays a significant role in influencing children's beliefs about themselves (ie., in terms of the extent to which they are lovable) and about themselves in relation to other people (ie., when they have needs, people will respond appropriately to them). The research suggests that these internalized beliefs can affect children's later cognitive schemas and, thereby, their psychological adjustment'

'Psychological maltreatment in early childhood is also associated with insecure attachment in adulthood. A recent overview of the evidence found that as the child grows older, such attachment problems interfere with a number of aspects of later functioning, including peer relations, intimacy, caregiving and caretaking, sexual functioning, conflict resolution, and relational aggression. The findings from longitudinal and retrospective studies also suggest a strong association with psychiatric morbidity'

Brosbe et al. 2013, pp.98-99

'Complex traumatic stress arises in response to prolonged or repeated interpersonal trauma (eg. child maltreatment) or growing up in highly conflictual and uncohesive family environments. These traumatic stress reactions often affect multiple aspects of a child's functioning, including psychological and behavioral health, as well as attachment and interpersonal functioning'

'One model views complex traumatic stress from the perspective of developmental neurobiology. This model posits that growing up in a developmentally adverse environment in the context of complex trauma, high levels of family conflict, and low levels of family cohesion influences the development of brain structures associated with emotion regulation (eg. hypothalamus-pituitary-adrenal axis, limbic system) and information-processing (eg. prefrontal cortex) abilities. Essentially, complex trauma influences the development of these neural networks such that it impairs the child's ability to appropriately experience, regulate, and express emotions and causes him or her to selectively attend to potentially threatening stimuli in the environment. This, in turn, is thought to account for the broad symptom presentations in individuals with complex traumatic stress'

Spermon et al, 2012, n.pag.

'When prolonged interpersonal trauma occurs during childhood development, dissociative responses can fundamentally reshape the personality. The result is a 'profound distortion of a core self-process [with a] fragmentation of the self' (Ogawa, Sroufe, Weinfeld, Carlson, & Egleland, 1997, p.856)'

'A common description of survival techniques used in response to early abuse was to become exquisitely attuned to the perpetrator's expectations, and mold the self almost exclusively to meet them. One result of this narrowing of self-definition in adulthood was the sense of being an 'imposter', 'a shell,' 'a façade,' and a 'pretence,' with little sense of a genuine identity'

'Abuse corrupted acts of choice and enforced the will of another onto the victim, and then invalidated any chance to redress it. There was no choice but to comply with the demands of the perpetrator - any alternative became a threat to survival. Without the ability to choose, reacting to circumstances moment to moment became habitual, with addictive behaviors at times a support for and a consequence of high levels of reactivity'

Lanius et al. 2011, n.pag.

'Early adverse experience can significantly interfere with the development of emotional awareness. Being trapped in a dangerous environment, such as being with a chronically physically or sexually abusive caregiver, prevents individuals from using their emotional responses to guide effective actions and behaviours. For example, if a child is in an abusive relationship with a caregiver and has the impulse to escape, he⁄she may quickly learn that escape is not possible. A sense of learned helplessness may ensue. Individuals with such experiences therefore learn that emotional responses to traumatic events are futile because there is no escape from the situation and hence become increasingly disconnected from their inner emotional life in an attempt to disconnect themselves from extreme emotions that are out of their control'
Cantor & Price, 2007, p.378

'Compared with ordinary PTSD, complex PTSD involves more complex, diffuse and tenacious symptoms, characteristic personality changes, and vulnerability to repeated harm, both self-inflicted and by the hands of others'

Price-Robertson, et al., 2013, pp.5-6

'Research findings indicate that trauma occurring early in life, that is prolonged, and which has an interpersonal element (eg. sexual abuse), can impact on psychological health beyond the traditionally diagnosed PSTD symptomatology. A characteristic of complex trauma is dysfunction in the individual's ability to relate to others, often affecting their capacity to form healthy relationships. Other features include inability to regulate emotions, changes to the sense of self, changes in sense of wellbeing, potentially leading to despair and hopelessness as well as elevated risks to personal safety and somatic symptoms (ie. physical symptoms for which there is no medical explanation)'

'The phenomenon of re-victimisation is frequently faced by sufferers of complex trauma, as previous victimisation is known to be a strong predictor of further episodes of victimisation'

'Currently, 'complex trauma' or 'complex PTSD' is not recognised by the international classification manual known as the Diagnostic and Statistical Manual of Mental Disorders or DSM. This is despite extensive consideration by the mental health, traumatology and psychiatric sectors. Instead, reactions and behaviours such as dissociation, impulsivity, and substance dependency are described as, or within, separate and distinct diagnostic categories. There is concern that without the diagnosis of

complex trauma as an umbrella term for the set of behaviours and features common to some abuse victims, there is potential for a negative impact on treatment interventions'.

Leeb et al., 2011, pp.459-460

'There is evidence for neurobiological changes resulting from childhood abuse and neglect that appear to have an impact on development, health, and behaviour. Both animal and human models indicate that there may be lasting changes to specific anatomical features of the brain, for example, reduction in overall brain volume, and changes to specific physical structures (eg. corpus collosum, hippocampus, amygdale) and the stress-response system (hypothalamic – pituitary – adrenal axis). Nonprimate animal research on early stress has shown evidence for atypical stress responses in rats and pups after repeated separation from their mothers during the neonatal period. In nonhuman primate studies, researchers have found anatomical brain changes (decreased corpus collosum volume) and increased stress response in rhesus monkeys reared in atypical social environments'

'In adults, stress resulting from childhood victimization may be responsible for chronic activation of the stress response system, which may result in hypersensitivity or vulnerability to pain…'

'…adults who have experienced childhood abuse or neglect manifest a vast array of poor mental health outcomes…'

'There is evidence that factors such as the timing, severity, and type(s) of maltreatment experienced; other co-occuring adverse childhood experiences; and family background characteristics may exacerbate or attenuate the effects of childhood maltreatment on adult mental health outcomes. Poorer outcomes have been found for those who experience early onset, chronic, severe, or multiple types of maltreatment…It has been suggested that there is a direct relationship between the number of different types of negative experiences in childhood and the degree to which the individual's health is impaired in adulthood. Individuals with a history of a greater number of victimizations also have increased odds of reporting multiple health problems, pain, poor self-rated health, disability, and utilization of health services in adulthood'

Cloitre et al., 2011, p.616

'In addition to being prolonged and repeated, complex trauma is typically of an interpersonal nature and occurs under circumstances where escape is not possible due to physical, psychological, maturational, environmental, or social constraints'

Shonkoff & Garner, 2012, pp.e235-e248

'…significant stress in the lives of young children is viewed as a risk factor for the genesis of health-threatening behaviors as well as a catalyst for physiologic responses that can lay the groundwork for chronic, stress-related diseases later in life'

'Beginning as early as the prenatal period, both animal and human studies suggest that fetal exposure to maternal stress can influence later stress responsiveness'

'Early postnatal experiences with adversity are also thought to affect future reactivity to stress, perhaps by altering the developing neural circuits controlling these neuroendocrine responses'

'Physiologic responses to stress are well defined. The most extensively studied involve activation of the hypothalamic-pituitary-adrenocortical axis and the sympathetic-adrenomedullary system, which results in increased levels of stress hormones…'

‘Whereas transient increases in [these] stress hormones are protective and even essential for survival, excessively high levels or prolonged exposures can be quite harmful or frankly toxic, and the dysregulation of this network of physiologic mediators (eg, too much or too little cortisol; too much or too little inflammatory response) can lead to a chronic ‘wear and tear’ effect on multiple organ systems, including the brain’

‘…stress-induced changes in the architecture of different regions of the developing brain (eg, amygdale, hippocampus, and PFC) can have potentially permanent effects on a range of important functions, such as regulating stress physiology, learning new skills, and developing the capacity to make healthy adaptations to future adversity’

‘…it is critically important to underscore the extent to which toxic stress in early childhood has also been shown to cause physiologic disruptions that persist into adulthood and lead to frank disease, even in the absence of later health threatening behaviors. For example, the biological manifestations of toxic stress can include alterations in immune function and measurable increases in inflammatory markers, which are known to be associated with poor health outcomes as diverse as cardiovascular disease, viral hepatitis, liver cancer, asthma, chronic obstructive pulmonary disease, autoimmune diseases, poor dental health, and depression’

‘Thus, toxic stress in early childhood not only is a risk factor for later risky behaviour but also can be a direct source of biological injury or disruption that may have lifelong consequences independent of whatever circumstances might follow later in life. In such cases, toxic stress can be viewed as the precipitant of a physiologic memory or biological signature that confers lifelong risk well beyond its time of origin’

‘Advances in neuroscience, molecular biology, and genomics have converged on 3 compelling conclusions: (1) early experiences are built into our bodies; (2) significant adversity can produce physiologic disruptions or biological memories that undermine the development of the body’s stress response systems and affect the developing brain, cardiovascular system, immune system, and metabolic regulatory controls; and (3) these physiologic disruptions can persist far into adulthood and lead to lifelong impairments in both physical and mental health’

Hagenaars, et al, 2012, p.99

‘There are some indications that early aversive events affect automatic stress responses in humans as well, such as blunted cortisol responses to a psychosocial stress task. Furthermore, the consequences of experiencing single or multiple traumas have been found to be different. For example, persons with multiple traumas showed more interpersonal dependency and higher levels of dissociation and shame than those who experienced a single trauma. Increased frequency of aversive life events also seems to be associated with decreased coping abilities in response to current threat…Repeated or sustained life stress is suggested to lead to increased sensitization of the neuroendocrine stress response’

Ford, et al., 2012, pp.695-696

‘Complex trauma has been defined as exposure to traumatic stressors at an age (e.g. early childhood) or in a context (e.g. prolonged torture or captivity) that compromises secure attachment with primary caregivers and the associated ability to self-regulate emotions. Complex trauma includes physical or sexual abuse or neglect, and chronic childhood victimisation such as family and community violence, physical and sexual assault, and bullying…. Complex trauma tends to be multifaceted (i.e. several forms of traumatic stressors) and cumulative (i.e. involving repeated re-victimisation). Revictimisation

occurring repeatedly in several different forms ("polyvictimization") is associated with especially severe emotional and behavioural impairment’

One way to understand wide range of adverse sequelae of complex trauma is to distinguish between the exploration and learning that is a hallmark of healthy biopsychosocial development in childhood this is a survival-oriented preoccupation with detecting and surviving threats. In the brain operates in survival mode, chronic changes occur not in only psychological and behavioural functioning (e.g. hypervigilance, dysphoria, reduced tolerance for frustration and delayed gratification, impulsivity) but also in the body's central and autonomic nervous systems. Such biological changes can severely compromise physical health, as well is override and reduce the functionality of key learning networks in the brain: reward and motivation systems (involving neurotransmitter dopamine), distress tolerance systems (involving neurotransmitter serotonin) and "executive" systems (involving emotion and information processing in limbic and prefrontal cortex areas)’

La Noue, et al., 2012, pp.187

‘… Evidence suggests that individuals who experienced childhood adversity have an increased incidence of adult adversity. A significant detrimental long-term consequence of child maltreatment is subsequent victimisation in adulthood, with abused and neglected children reporting higher overall rates of adult revictimisation and adversity. The literature thus suggests an interaction between adverse childhood events and adverse adult events (AAE)…’