

Early Trauma and Subsequent Antisocial Behavior in Adults

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This study describes the prevalence of childhood trauma and maltreatment antecedents among 111 criminal offenders referred for forensic and mental health counseling. Sixty-nine percent reported such antecedents. Seventy percent had Axis 1 mental health disorders including anxiety, depression, posttraumatic stress disorder, and substance-related disorders. Many were comorbid. The implications of developmental psychopathology arising from childhood trauma and maltreatment for counselors who treat forensic clients are addressed.

KEY WORDS: childhood maltreatment, antisocial behaviors, criminal offenders.

Understanding factors and events that contribute to the development of antisocial behavior and substance misuse among forensic clients referred for counseling is important. The courts' dockets are filled with repeat offenders for whom punishment has not prevented recidivism. A key to treating antisocial behavior and substance misuse may lie with an interpretation of the forensic client as having underlying developmental psychopathology requiring treatment rather than punishment.

This study will describe the prevalence of trauma antecedents among offenders and attempt to show that childhood trauma may be related to their subsequent adult antisocial behavior. These antecedents may serve as a

better starting point for psychological treatment of criminal offenders who do not meet the criteria for antisocial personality disorder but end up in the legal system facing charges for various offenses (e.g., substance abuse, driving while under the influence, domestic violence, drug possession, battery upon another, conduct problems) that take up much of the judicial system's resources and time. Subsequent corrective treatment interventions focusing on the underlying developmental psychopathology, rather than the symptomatic behavior, may reduce the overburdened court system as well as help those who should be treated for their pathology.

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Antecedents to Antisocial Behavior and Substance Misuse: A Review of the Literature

Myriad factors and events have been linked to developmental psychopathology and its antisocial consequences or sequelae. These include

abuse and neglect, exposure to interpersonal/interparental violence, intergenerational substance abuse, maladaptive attachments in early life, maltreatment such as abandonment, and neurodevelopment. Sources with both theoretical and empirical referents for these factors are reviewed below.

Abuse and Neglect

Horwitz, Widom, McLaughlin, and White (2001) found that, after gathering 20 years of documented child abuse and neglect records of court cases, adults who report experiences of abuse and neglect as children report considerably higher rates of virtually every type of psychopathology including depression, anxiety, drug and alcohol disorders, personality disorders, and generalized distress. Both men and women who were victimized as children report more stressful life events over their lifetimes suggesting that early child abuse and neglect is part of a broader constellation of life stressors.

Childhood physical abuse in the general population is approximately 15%, with childhood sexual abuse estimated at 20%–30% for females and 10%–15% for males (Adams, 2002). These rates are somewhat higher among psychiatric outpatients and psychiatric emergency room patients and are even higher among forensic populations. Adams (2002) discovered that many forensic clients have histories of multiple abuse and therefore suffer from complex posttraumatic stress disorder (PTSD), anxiety disorders, and dissociative disorders, which are often misdiagnosed as malingering, overlooked, or neglected by forensic mental health professionals largely unfamiliar with child abuse and trauma issues. Many of the “thinking errors” and “core beliefs” cited in manuals for criminal thinking groups are directly traceable to childhood abuse experiences (Adams, 2002).

A less adverse manifestation of childhood maltreatment concerns social functioning. Findings indicate that the intimate relationships of adults maltreated as children differ in stability and quality from those of other adults (Morton and Browne, 1998). Both male and female adults who had been abused and/or neglected in childhood reported significantly higher rates of relationship disruption (walking out and divorce) than adults without abuse histories (Sheridan, 1995). Abused and/or neglected women were also less likely than controls to perceive their current romantic partners as supportive, caring, and open to communication and were less likely than other women to be sexually faithful to their partners and spouses.

Parental risk of using severely punitive discipline is increased by exposure to abusing parents as a child. Knutson (1995) found that of referred children who had one parent reporting an abusive childhood, 32% have been abused. A small number of children who reported a childhood history characterized by physical abuse had two parents; of those children, 50% had been physically abused (Knutson, 1995). In a recent study comparing the relationships of indicators of childhood abuse and neglect to changes in the symptoms of mental disorders over the period from early adolescence to adulthood, youths with an official record of victimization of child physical abuse showed elevated levels of disorders and symptom rates for almost every Axis I and Axis II disorder (Cohen, Brown, and Smailes, 2001). The children who had been victims of neglect by official records had elevations in anxiety, depression, Cluster A personality disorders, and in disruptive and depressive symptoms (Cohen, Brown, and Smailes, 2001). Physical abuse added significantly to other risk factors in accounting for lifetime diagnoses of major depression, dysthymia, conduct disorder, and drug use.

Physically abused adolescents were seven times as likely to develop a major depressive disorder and/or dysthymia, approximately nine times as likely to develop conduct disorder, and nineteen times as likely to abuse drugs (Kaplan et al., 1998).

Intergenerational Substance Abuse

Although parental substance abuse is found to be directly related to child maltreatment, it is suggested that it may also be indirectly associated through its relationship with family-of-origin competence. The negative impact of parental substance abuse may be best understood as having adverse consequences on family dynamics that, in turn, increases the likelihood of exposure to child abuse and neglect. When a parent or both parents are substance misusers, the child's needs and well-being become secondary to the parents' needs. Offspring of substance abusing parents are shown to have lower self-esteem and a lower sense of self, creating higher needs for affirmation and nurturance and increasing vulnerability to victimization by others external to the family (Sheridan, 1995).

Miller, Smyth, and Mudar (1999) reported that studies of substance abusing parents have largely been focused on the male parent; but mothers provide the predominant child care and their alcohol or other drug (AOD) problems may have a more direct adverse effect on the child. Substance abuse may affect the quality of parenting and increase the risk of neglect or abuse. These authors suggest that there is a connection between a woman's history of physical abuse and childhood sexual abuse and her development of AOD problems. In a study of 170 mothers previously identified with AOD, using five measures to identify mother punitiveness (mother's AOD problem, mother's history of childhood sexual abuse, mother's his-

tory of parental severe violence, mother's history of partner violence, and mother's hostility), Miller, Smyth, and Mudar (1999) found that women with AOD problems were significantly more likely to report victimization histories and were more likely to be punitive toward their children compared to women without AOD problems. This punitiveness did not necessarily disappear when AOD problems were in remission. These authors concluded that a woman's experiences of violence influence her parenting strategies around discipline. In particular, her experiences with partner violence appear to increase the stresses that produce harsh diplomacy tactics. The association between childhood sexual abuse and subsequent poor parenting could be a result of an internalized model of poor parenting, resulting from intergenerational transmission (common to victims of childhood sexual abuse) being enacted in adult years. More problems of hyperactivity, misconduct, and peer and emotional problems were noted in the children of mothers reporting childhood sexual abuse compared to the children of other mothers (Roberts, O'Connor, Dunn, and Golding, 2004).

Maltreatment and Exposure to Family Violence

Characteristics of the family during child development may be one of the most important influences on the adjustment patterns of a person's journey to adulthood. Higgins and McCabe (2000a) evaluated the interrelationships between five different types of child maltreatment (sexual abuse, physical abuse, psychological maltreatment, neglect, and witnessing family violence), focusing on the role of both family factors and all forms of child maltreatment and linking those to the adjustment problems of adults. These authors found that family violence during childhood was more likely to

have negative consequences for psychological adjustment in early adulthood than an experience of childhood sexual abuse. Growing up in a noncohesive (or detached) family was also a risk factor for experiencing higher levels of physical abuse and psychological maltreatment. The results suggest that, in general, childhood maltreatment is associated with interparental conflict, lack of affection, rigid or distant familial relationships, and lack of flexibility and connection with family members. Experiences of maltreating behaviors, particularly sexual and psychological abuse in childhood, were associated with both trauma symptomatology and self-deprecation in adulthood.

Higgins and McCabe (2000b) state that maltreatment types are strongly interrelated. If an adult experienced one type of maltreatment during childhood, it is likely that he or she experienced other types as well. These authors suggested that "pure" forms of maltreatment are atypical. They commented that children who experience dysfunctional family dynamics, such as parental conflict, lack of closeness and affection, inflexibility, rigidity, or other nonsupportive features, may be at greater risk for multitype maltreatment such as repeat victimization (different maltreatment types on more than one occasion by the same perpetrator) or revictimization (different maltreatment types on more than one occasion by different perpetrators).

Children who have been traumatized by family violence exhibit a low tolerance for stress and tend to react with either aggression or withdrawal (Levendosky and Grahman-Bermann, 2000). They may develop maladaptive internal working models of relationships when caregivers are inconsistent, producing anger, anxiety, fear, and mistrust toward the parental figures; this, in turn, results in insecure attachments and maladaptive development of regulator affect. Van der Kolk (1987) suggests that prolonged separation and inse-

ecure attachment in childhood produce permanent changes in neurochemistry, creating a neurological sensitivity to loss based on early trauma experiences. Witnessing one parent's abuse by the other may affect the child's belief that he or she is less protected and safe, thus opening holes in the attachment safety net, exposing the opportunity for the child to experience trauma. Domestic violence and child abuse are known to be highly correlated. A clinical concern for mothers and children of domestic violence is the potential for the development of PTSD. In a study of 50 mothers and children referred by service agencies for psychological assessment, Chemtob and Carlson (2004) show very high rates of PTSD among children (40%) and their mothers (50%).

Childhood trauma may form a primary core of the abusive personality. Those with an abusive personality struggle modulate their aggression and, as adults, often abuse their partners (Lawson, 2001). Many men who are abusers have psychological profiles similar to trauma victims and fit the diagnostic criteria for PTSD (Dutton, 2000). When violence is directed at the mother, for example, a constant state of fear results, affecting her parenting style and consequently threatening a secure relationship with her child. New data reveal strong relationships between frequency of witnessing intimate partner violence as a child and substance use and depressed affect later in adulthood (Dube, Anda, Felitti, Edwards, and Williamson, 2002; Hamilton and Browne, 1998).

Attachment in Early Life and Developmental Personality Style

Children face a range of age and stage relevant developmental tasks; failure to achieve competent adaptation at one developmental period makes adaptation to the next more difficult (Maughan and McCarthy, 1997). Attachment

is one of those early tasks and lays a foundation for the basic sense of self. Failure to form secure attachment relationships in early childhood may compromise the foundation of loyal friendships and effective peer relationships later in childhood and, in turn, be associated with relationship difficulty in adult life (Maughan and McCarthy, 1997). Factors such as family history of psychopathology, trauma, and unfavorable social or economic conditions, coupled with insecurity in attachment relations, contribute toward the ultimate emergence of insensitivity, emotional unresponsiveness, and even psychopathy. A study by Brody and Rosenfeld (2002) illustrates this point. They studied 74 males sentenced to probation and found that developmental experiences with caregivers revealed a history of parental discord in 25 cases (33.8%), parental drug abuse in 18 cases (24.3%), and physical abuse in 19 cases (25.8%). Their data offer some support that attachment deficits comprise a core component of psychopathy; but whether these deficits are the consequence or cause of deficient attachment is unknown.

Neurodevelopment

Antisocial behaviors have long been linked to brain pathology. Hare (1993) described several studies in which frontal lobe dysfunction, as evidenced by electroencephalogram abnormalities and positron emission tomography/single photon emission computer tomography scans, is speculated to play a crucial role in dysfunctional regulation of behaviors typically associated with antisocial traits, for example, aggressiveness, irritability, impulsivity, egocentricity, callousness, substance misuse, manipulativeness, lack of remorse, and grandiosity. Martens (2000) reviewed research on the causes and course of antisocial behavior and reported links between brain neurotransmitter dysfunction (i.e., low serotonin, elevated triiodothyro-

nine, low monoamine oxidase, and low cortisol) and antisocial behavior in males. Siegel (1999) cogently delineates how early experiences, especially repeated ones, whether trauma or relationship attachment issues or expression of genes, shape the structure of neuronal circuits in the brain. He suggests that neural instability then becomes an enduring feature of an individual's mind or states of mind and mental models or world view. These, in turn, influence ongoing perceptions and interpersonal experiences. Weber and Reynolds (2004) demonstrate how stress, maltreatment, and psychological trauma result in permanent structural changes, and subsequent functional deficits, in the amygdala, hippocampus, and temporal lobe. Their findings are echoes of those of Hull (2002) and Cozolino (2002) to neural integration and PTSD.

Methods

Participants

The study population included 111 criminal offenders referred by defense attorneys for mandatory pretrial evaluation and community-based counseling: 84 (76%) were males and 27 (24%) females. These individuals ranged in age from 18 to 66. Their educational backgrounds ranged from high school dropouts to degrees of higher education; most were high school graduates. Their offenses were divided into four categories: (a) first time Driving Under the Influence (DUI), (b) two or more instances of DUI, (c) domestic violence, and (d) miscellaneous (e.g., possession of illegal substance, battery, assault, forgery, shoplifting, resisting arrest, violation of probation, or probation referral).

Design and Instrumentation

This study employed a descriptive research design. Instruments included the following: (a) a self-report of trauma or maltreatment

during childhood was developed especially for use in this study. Both open- and close-ended items were created and incorporated into this instrument; (b) a biopsychosocial assessment form was also developed and included in the packet of materials completed by participants; (c) therapist intake reports and arrest history information provided by the courts were included; and (d) the Millon Clinical Multiaxial Inventory III (MCMI-III) for Clinical Diagnosis was utilized to validate clinical diagnoses. The MCMI-III is a frequently used instrument in forensic evaluation; its reliability and validity are well established (Retzlaff, Stoner, and Kleinsasser, 2002). The informed consent form was read and discussed with participants prior to their completion of the study instruments.

Data Collection and Analysis

Descriptive statistics were computed for quantitative items. Content analyses of responses to open-ended items were conducted using NUD-IST software. These yielded 10 themes or categories of childhood trauma or maltreatment reported by participants as follows.

Abandonment (Including Divorce or Separation of the Primary Caregivers).

The departure, including death, of one or both of the primary caregivers from the family dynamic or home led to added stress and anxiety, possibly resulting in less effective caregiving by the remaining caretaker (Brody and Rosenfeld, 2002). In addition, the loss of a primary role model affected the child's long-term internalized sense of self.

Substance Misuse. One or more substance misusers were identified either within the family of origin or outside, such as aunts, uncles, or grandparents, who may have had ongoing direct contact with the participant.

Physical Abuse. The abuse was part of ongoing behavior by a family member or someone with authority over the participant. Included were reported physical consequences for actions or behaviors of the offenders.

Sexual Abuse. Sexual abuse was identified by the participants as whether an adult, family member, friend, relative, or a stranger had touched or fondled them in a sexual manner, or had them touch the abuser in a sexual manner, and attempted or forced the participant to have intercourse with them.

Neglect. Neglect was defined as any behavior by a caregiver that had a negative effect on caregiving (e.g., did he/she have enough to eat, did they feel safe and protected, were the parents neglecting care due to substance misuse, was the environment clean and healthy, did the child have clean clothes and appropriate hygiene, did the child get appropriate medical care when needed, were the child's physical needs met by the primary caregivers). If the participants did not feel loved, were not looked after, did not feel close to the other members of the family, or did not find the family as a source of support, neglect was suspected.

Emotional or Verbal Abuse. Emotional or verbal abuse occurred when a child was insulted, debased, threatened with physical abuse or some other consequence, sworn at, compared to another in a negative and degrading manner, or any other behavior by another that may have effected the child's positive self-view.

Witnessing Violence in the Family. Participants witnessed physical blows by one or both of the primary caregivers with slapping, pushing, grabbing, or throwing items within the family dynamic; knives or guns were used as a form of intimidation or force by a caregiver.

TABLE 1. Incidence of Self-Reported Trauma or Maltreatment by Types of Offense

Type of maltreatment or trauma in childhood	One DUI (<i>n</i> = 17)	Two or more DUIs (<i>n</i> = 27)	Domestic violence (<i>n</i> = 21)	Other (<i>n</i> = 46)	Total (<i>N</i> = 111)
Abandonment or neglect	8	9	8	27	52
Substance abuse	0	13	5	14	32
Exposure to or witnessing violence	0	11	4	3	18
Psychological abuse	0	4	0	3	7
Geographic instability	0	2	0	0	2
Sexual abuse	0	3	0	1	3
Other	3	0	0	1	4
Number reporting early trauma or maltreatment	11 (65%)	20 (74%)	12 (57%)	34 (74%)	77 (70%)

Note. Percentages are rounded.

Mental Illness Existing in a Family Member.

The participants were exposed to a severe and persistent mental illness, such as depression, schizophrenia, or bipolar disorder.

Geographic Instability. Participants reported excessive moving of the family from one geographic location to another throughout the child's life.

Removal from the Home by a State Agency. Participants were removed from the home by a state agency for the protection as deemed by the rules and regulations of a governing child protective agency or by state statutes protecting the child.

Results

Most participants (70%) reported a history of multiple types of childhood trauma or maltreatment. Abandonment was identified most frequently (48 participants) followed by substance abuse (33), physical abuse (17), witnessing violence (12), and psychological abuse (8). Other types of maltreatment included geographic instability, neglect, removal from the

home by a state agency, and major mental illness impacting a family member.

Table 1 shows the incidence of self-reported trauma or maltreatment by types of offense, that is, either single or multiple DUI arrests, domestic violence, and other. Of 17 first time offenders, 65% reported abandonment and parental rejection. For 27 participants with multiple DUIs, 74% reported substance abuse in their families, abandonment, physical abuse, and witnessing violence in the family. A small number (*n* = 7) identified sexual or psychological abuse and geographical instability as maltreatment issues in their developmental years.

Of 21 individuals arrested for domestic violence, 12 reported multiple incidents of abandonment, substance abuse within the family, and witnessing violence in the family. Forty-six participants were charged with offenses such as violation of probation, battery, forgery, assault, shoplifting, resisting arrest, and probation referral. Of this number, 74% reported incidents of abandonment, substance, physical, and psychological abuse; witnessing violence in the family; and major mental illness within the family.

Table 2 displays the incidence of MCMI clinical disorders by types of offense. Of all

TABLE 2. Incidence of MCMI Clinical Disorders by Types of Offense

Clinical disorders validated by MCMI	One DUI (<i>n</i> = 17)	Two or more DUIs (<i>n</i> = 27)	Domestic violence (<i>n</i> = 21)	Other (<i>n</i> = 46)	Total (<i>N</i> = 111)
Anxiety	1	11	4	14	30
Depression	1	6	2	19	28
Substance related	0	10	3	13	26
PTSD	0	2	0	3	5
Other Axis I disorders	1	6	3	21	31
Cluster B personality disorders (antisocial, narcissistic, histrionic)	0	2	0	4	6
Cluster C personality disorders (dependent)	0	2	0	3	5
Participants with disorders ^a	10 (59%) ^b	22 (82%)	16 (76%)	30 (65%)	78 (70%)

^aDisorders are multiple and cooccurring.

^bPercentages are rounded.

participants ($N = 111$), 70% met criteria for dual Axis I and Axis II diagnoses. The most prominent were anxiety disorders, depression or dysthymia, substance abuse, PTSD, and Cluster B personality disorders (antisocial, histrionic, and narcissistic). Especially noteworthy is the preponderance of Axis I psychopathology in participants with multiple offenses including domestic violence. These same individuals also experienced the greatest incidence of abandonment or neglect and/or substance misuse in their families. Less than one-third of all offenders (a) reported no trauma or maltreatment and (b) had no psychopathology as identified by the MCMI.

Discussion

Generalizability of these results is limited by nonrandomization and a modest, perhaps nonrepresentative, sample. The small number of participants prevented inferential statistical analysis on key variables such as gender. And the retrospective nature of the study may have limited participants' ability to accurately remember and/or report the nature of their early experiences with trauma and mal-

treatment. Nevertheless, these data offer support for the initial hypothesis that antecedents of adult antisocial behavior and adult psychopathology are linked to childhood maltreatment and trauma. These findings are consistent with studies reviewed earlier.

It is important to keep in mind that multiple interacting forces contribute to childhood maltreatment and trauma, leading to the development of psychopathology. How early interpersonal relationships are formed may be a contributory mechanism in coping strategies later in life. These factors in turn may contribute to a lack of basic trust, detachment from relationships, and affective experiences causing maladaptive behaviors later in life.

Developmental experiences with caregivers contribute to the construction of clients' qualitative working models of self and others. Problematic working models and beliefs associated with the different personality styles may be construed as having been adaptive in their original developmental contexts but are no longer viable in their current life and relationships (Lyddon and Sherry, 2001).

Results of this study show that early childhood trauma and maltreatment seem to be

significant precursors to participants' adult antisocial behavior patterns and psychopathology. The experience of rejection or loss of love during developmental years appears to create a root cause for underlying emotional pain and poor individuation that are subsequently played out in abusive behaviors.

For counselors who work with offenders, it is important to understand that childhood trauma and maltreatment may be the root cause of their adult antisocial behaviors. Such trauma and maltreatment are issues that should be addressed in treatment. Integrating trauma-related counseling into more standard forensic approaches may require advanced training for counselors who are unfamiliar with the psychological impact of childhood trauma and maltreatment and its relationship to adult antisocial behaviors. Without such integration, however, it may be difficult to change the behaviors that are problematic for the offender. Working in the "here and now" to identify maladaptive cognitions and strategies while connecting the progression of these dysfunctional patterns to childhood trauma or maltreatment may allow corrective experiences to occur and create new adaptive coping skills for the offender.

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