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Assessing Complex Trauma In Adults Adjudicated for Sex Offenses

Lucinda A. Lee Rasmussen, Ph.D., LCSW and Jay Adams, Ph.D.

Adults who are adjudicated for sex offenses (AASOs) are a heterogenous group of individuals. The majority have experienced some form of childhood maltreatment (i.e., physical abuse, sexual abuse, child neglect, exposure to domestic violence). Hanson (1997) found that 75% of 409 adult sex offenders in treatment reported being sexually, physically and/or emotionally abused.

Sexually abusive individuals who have experienced abuse trauma likely come from chaotic families with multiple risk factors (e.g., substance abuse, exposure to domestic violence, parental mental illness, family members with criminal history). As with other populations of abuse survivors, AASOs who have experienced abuse trauma differ as to its extent and severity. A certain number (exact percentage unknown) have experienced severe and chronic trauma (i.e., multiple incidents of abuse over an extended period), also referred in the literature as adverse childhood experiences (ACEs). The impact of ACEs is cumulative, as evidenced by Felitti et al.'s (1998) seminal research on a large representative sample of adults who had received a standardized medical evaluation at an HMO. Subjects ($N = 9{,}508$) completed a survey questionnaire covering seven categories related to childhood experiences of abuse (i.e., physical abuse, sexual abuse, psychological abuse) and household dysfunction (i.e., exposure to substance abuse, mental illness, violent treatment of mother or stepmother, criminal behavior in the household). The study showed that the more ACEs that subjects reported, the greater the number of health risks for the leading causes of death in adults (i.e., heart disease, cancer, stroke, chronic bronchitis or emphysema, diabetes).

Individuals who have experienced multiple ACEs may present a configuration of long-term post-traumatic cognitive, emotional, and behavioral symptoms identified by trauma theorist Judith Herman (1997) as "complex Post-traumatic Stress Disorder (PTSD)." Renowned trauma expert Bessel van der Kolk and his colleagues developed a diagnostic schema to assess complex PTSD, that is, Disorders of Extreme Stress Not Otherwise Specified (DESNOS - Disorders of Extreme Stress Not Otherwise Specified [DESNOS]). DESNOS was designed to "more precisely identify etiological issues and target early, effective interventions" (Luxenberg, Spinazzola, & van der Kolk, 2001, p. 373). According to the National Center for PTSD (n.d.), DESNOS:

> was not added as a separate diagnosis to DSM-IV because results from the DSM-IV Field Trials indicated that 92% of individuals with complex PTSD/DESNOS also met diagnostic criteria for PTSD (3). Although its inclusion was reconsidered for DSM-5, complex PTSD was again excluded because there was too little

> empirical evidence supporting Herman's original proposal that this was a separate diagnosis.

Nevertheless, DESNOS provides a useful way of categorizing trauma symptoms. It encompasses disturbances in six areas of functioning, each including a constellation of symptoms seen in individuals who have experienced complex trauma. Accurate assessments of the trauma history of AASOs and effective treatment of its impact are contingent on obtaining as much information as possible about their history of ACEs. This includes identifying salient risk factors in their family history, family dynamics, and stressors in the family's environmental context. Additional data are obtained over time as there is more opportunity to observe the client. Luxenberg et al.'s six symptom clusters may have possible utility when evaluators assess AASOs that have histories of severe trauma. Though not diagnostic, the clusters are descriptive, identifying behaviors that may be important to consider in assessment and when planning treatment. Each set of symptoms is described below, followed by the possible application to AASOs with severe trauma.

Affect Dysregulation (Poor Impulse Control)

Childhood trauma occurs at a time when the human brain is not fully developed and is much more likely to be affected by adverse circumstances (Badenoch, 2008). Infants are born with the capacity to experience certain emotions that have a survival value. The innate startle response is frequently triggered by environmental events (e.g., parental yelling or fighting, breaking dishes or furniture, or other loud noises). Each time the startle response is triggered, the connections in the brain that cause it are strengthened, and these in turn make it more likely to be triggered in the future. As the connecting fibers become more numerous, it takes less and less to trigger the response, making it more likely that it will recur. What results is a child who is hyper-aroused and may respond with fear to stimuli that other children would perceive as neutral.

Prolonged hyperarousal while the brain is developing, without repair through maternal attunement and soothing, causes difficulties in affect regulation. This may lead to the child having an insecure attachment with the primary caregiver. Repeated experiences in which infants have been emotionally stimulated and upset, without consequent soothing by the attachment figure, impair their ability to learn to modulate arousal. Attachment problems have long-term effects. According to Davies and Troy (2020), "children who have not been helped to regulate arousal within the attachment relationship tend, as they get older, to feel at the mercy of strong emotions and impulses" (p. 11). Consequently, they have more behavior problems as children and youth, and may be highly reactive to emotional and sexual stimuli as adults.

The first symptom cluster of Luxenberg et al.'s (2001) DESNOS diagnostic schema pertains to difficulty modulating and tolerating strong emotion. Symptoms include high reactivity to

emotional and sexual stimulation, difficulty modulating anger, and an inability to self-soothe. Individuals with affective dysregulation tend to overreact to minor stress, becoming easily overwhelmed because they experience their emotions more intensely than other people. They have trouble calming themselves once emotionally aroused and may engage in extreme and/or self-destructive behaviors to distract from emotional pain. Maladaptive attempts to regulate affect can include eating disorders, substance abuse, compulsive sexual activity, self-injury, excessive risk taking, and suicidal preoccupation (Luxenberg et al.). For AASOs who have a history of severe trauma, the combination of affect dysregulation and poor impulse control may play a significant precipitating role in their sexually abusive behavior.

Disturbances in Attention and Consciousness

Luxenberg et al.'s (2001) second cluster of symptoms consists of amnesia and dissociation. Research on the impact of trauma on the brain has demonstrated that chronic trauma can result in a high concentration of stress hormones (e.g., cortisol). An overload of stress hormones can have a deleterious effect on the hippocampus, the part of the brain that is the repository of autobiographical memory (Nelson & Carver, 1998). According to Terr's (1991) classic model of Type I/Type II trauma, children who have experienced chronic trauma (Type II) cope by means of denial and psychic numbing. Memories of the abuse "appear to be retained in spots, rather than as clear complete wholes" (p. 14). Individuals who were severely abused at an early age, and/or experience multiple incidents over an extended period often have extensive memory gaps that may in some cases include forgetting "whole segments of childhood" (p. 16).

Dissociation in survivors of complex trauma is described by Luxenberg et al. (2001) as "relegating such [traumatic] experiences to separate aspects of consciousness that do not impinge on the individual's day-to-day level of consciousness" (p. 377). They assert that dissociation may be seen in such behaviors as "spacing out", retreating within themselves "when confronted with painful emotions or reminders of their traumatic experiences" (p. 377), and amnesia for large segments of their lives.

Therapists who work with AASOs who have experienced severe trauma will no doubt see some clients who exhibit signs of dissociation. AASOs self-reported a variety of dissociative symptoms in Becker-Blease and Freyd's (2007) non-representative, very small study of 17 adult male sex offenders ages 26 to 61 years. Over half (53%) reported memory impairment for some of their sex offenses Dissociation was highly variable among the sample suggesting that "both a predisposition to dissociation, as well as traumatizing event(s) are necessary to produce pathological dissociation" (p. 77). Findings showed a strong relationship between dissociation during victimization and dissociation during perpetration. However, the small size of the sample and wide age range preclude generalizing the findings. Cognitive developmental variables differ

according to age. For example, cognitive changes associated with aging may account for some AASOs' memory gaps and/or capacities, not dissociation.

Briere (2011) noted that avoidance strategies are used by survivors of abuse to: (a) reduce awareness of potential environmental triggers; (b) lessen awareness of memories once they are triggered; and (c) reduce cognitive and emotional activation once conditioned emotional responses to these memories are evoked. Likewise, AASOs who have experienced abuse trauma may use avoidance strategies to lessen awareness of the sex offenses they perpetrated and/or their own victimization. Therapists may see this avoidance in the way AASOs who have been severely abused take part in a treatment program. Reluctance to participate in groups and failure to complete assignments may not necessarily be oppositional behavior. Rather, the AASO's failure to fully engage in treatment may reflect the avoidance strategies delineated by Briere. Also, professionals must remember that many AASOs have learning disorders and/or were in special education, thus are simply unable to complete assignments that involve reading and writing.

Dissociation is a self-protective reaction. Clinicians need to be familiar with the signs of dissociation described above by Luxenberg et al., (2001) (e.g., "spacing out", memory gaps). When a client is observed staring off into space with a vacant gaze, it may indicate dissociation. However, it is important to differentiate dissociation from other altered states of consciousness (e.g., zoning, sleepwalking, sleeptalking). Momentary lapses of consciousness (i.e., zoning) likely relate more to the ability to sustain attention than a dissociative response.

Assessing for dissociation should be ongoing throughout treatment for AASOs who have experienced multiple and chronic traumas. Memory gaps may be addressed in therapy sessions by encouraging clients to talk to non-abusive relatives, look at childhood photos, or draw the floor plan of where they lived during the time when they believe their abuse occurred. However, it is important to remember that AASOs who have experienced severe abuse often come from chaotic circumstances (e.g., domestic violence in the home, multiple moves, separations, divorces). They may not have photos to document much of the childhood, or have clear memories of the multiple places where they lived. The therapist might encourage these individuals to have historical conversations with those family members or friends with whom they have a long-term connection. Such conversations might include recalling family celebrations (e.g., birthdays, holidays) or other events (e.g., times of sadness, deaths, funerals). Therapists need to caution these clients that some of these recollections may evoke intense memories or reactions.

A trauma-informed model, *Trauma Outcome Process Assessment (TOPA* – Rasmussen, Burton, & Christopherson, 1992; Rasmussen, 1999, 2001, 2012) provides concepts and intervention strategies that may be helpful in this regard. In the *TOPA* model, outcomes of abuse trauma (and

triggers that bring back memories and feelings of past trauma) are conceptualized as emotional (e.g., affect dysregulation), cognitive (e.g., cognitive distortions), and behavioral. The behavioral outcomes are viewed as three separate possible responses. Two are maladaptive: Self-victimization (more associated with victims), and Abuse (associated with offenders). The third, Recovery and Integration, is an adaptive response facilitated by self-awareness and a safe environment for healing (Rasmussen, 1999, 2012). The *TOPA* model offers intervention strategies to increase self-awareness. These include expressive interventions that may be verbal (e.g., talking about feelings, relating one's "story", journaling); or experiential (e.g., expressing self through art, poetry, music, dance, etc.) (Rasmussen, 2001, 2012).

Disturbances in Self-perception

Dissociation and the necessary adaptation of scanning the external environment for signs of danger occur at the expense of the trauma survivor's awareness of internal cues. Severe child maltreatment interferes with the child's access to a sense of self and may result in a cluster of symptoms Luxenberg et al. (2001) identify as disturbances in self-perception. A related concept described by Briere and Runtz (1993) is "impaired self-reference"; that is, a disturbance in the individual's "internal awareness of personal existence that is relatively stable across contexts, experiences, and affects" (p. 323). Without such an internal base, the survivor of complex trauma "is prone to identity confusion, boundary issues and feelings of personal emptiness" (p. 323).

Survivors of childhood abuse are vulnerable to a host of painful emotions and cognitive distortions. Some of these long-term effects are the result of direct messages from perpetrators, who often blame the victim and/or invalidate the victim's feelings (e.g., "Shut up or I'll really give you something to cry about"; "I know you want it"; "Don't tell anyone or we will both be in a lot of trouble"). The immature, egocentric nature of a young child's thinking likely results in children blaming themselves for the abuse. Physical and sexual abuse are also emotional abuse because they represent an attack on the self. The assault is not only upon the physical body, but upon the individual's perception of the self as competent, and perception that the world is beneficent or neutral, rather than innately hostile.

In AASOs who have experienced severe trauma, disturbances in self-perception and impaired self-reference may be seen in them being out of touch with their feelings and bodily cues, and having distorted cognitions related to their view of themselves and others. Not dealing with feelings paradoxically likely makes them prone to problems in regulating their emotions and managing their impulses. Subsequent behaviors can be either self-destructive (Self-victimization response in the *TOPA* model), or hurtful to others (Abuse response in the *TOPA* model). As previously stated, problems in affect regulation and low impulse control may put these AASOs at high risk to engage in sexually abusive behavior. Lack of self-awareness of feelings also fuels cognitive distortions externalized against others (i.e., denying responsibility for sexually abusive

behavior, minimizing its consequences to the victim and others, blaming others [including the victim]).

AASOs who have experienced severe trauma may experience triggers to their own trauma during victim empathy work. Attempts to increase empathy in AASOs using victims' experiences may be counterproductive for those who have experienced multiple types of abuse. The feelings they experience (e.g., powerlessness, feeling threatened) may provoke attempts to avoid the guilt they may feel for their sexually abusive behavior. Addressing their own victimization in treatment prior to working on victim empathy may allow them to be more forthcoming in recognizing and acknowledging the harm their sexually abusive behavior has caused their victims and others.

Luxenberg et al. (2001) list shame as one of the possible disturbances in self-perception for survivors of complex trauma. When it involves personal regret for one's inappropriate or harmful behaviors, shame can lead to greater accountability and personal growth. However, when survivors internalize shame, it can be a negative spiral of self-denigrating thoughts leading to negative self-perceptions of who they are (e.g., "I'm stupid," I'm an evil person," "I'm defective," "I shouldn't have been born" - Lancer, 2016).

It is important for therapists to be cognizant that AASOs who have experienced trauma are "a different kind of victim" (personal communication, L.C. Miccio-Fonseca, Ph.D., November 28, 2021) than victims of abuse trauma who are not offenders. Indeed, "people who do atrocious stuff have to find a way to live with that part of themselves" (personal communication, L.C. Miccio-Fonseca, Ph.D., November 28, 2021). The Scarlet Letter of being labeled a "sex offender" may have the most salient impact in motivating the offender to try to make sure the societal consequences they received as a result of their crimes do not happen again.

Nevertheless, therapists must be aware of the possibility that their interventions may trigger excessive shame in some AASOs. Many of the practices common in sex offender-specific treatment may inadvertently elicit shame; however, this is often not recognized or dealt with in treatment. Some examples are the preparation of a detailed timeline and autobiography, the detailed processing of crimes through the construction of a Behavior Chain (i.e., "sexual abuse cycle" [Lane & Zamora, 1984]), phallometric assessment, and writing unsent letters to victims. These interventions are often initiated before any effort is made to assist AASOs to disclose and process their childhood abuse history. Individuals who have difficulty with affect regulation are likely to become overwhelmed and to either increase externalizing the blame for their behavior, flee from treatment, and/or act out in other ways. Also, several of the above interventions (e.g., writing an autobiography, constructing a Behavior Chain, writing unsent letters to victims) require skills in reading and writing, thus ignoring the fact that many AASOs have learning disorders that impair their ability to understand and complete the assignments.

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When AASOs experience triggers to their own trauma during victim empathy work, they may respond in the maladaptive behavioral responses in the *TOPA* model. This may include self-destructive behaviors (i.e., Self-victimization response), or behavior that is harmful to others (i.e. Abuse response) (Rasmussen, 1999, 2012). *TOPA* interventions can help AASOs make connections between triggers provoked by stressful events in the present, and the ACEs from the past. Addressing AASOs' own victimization prior to victim empathy work may in the long run make them more receptive to interventions directed to their sexually abusive behavior. They may be less defensive, more able to recognize the harm their sexually abusive behavior has caused their victims and others.

Disturbances in Interpersonal Relationships

Luxenberg et al.'s (2001) fourth cluster of symptoms pertain to the ways survivors of complex trauma interact with others. The most profound and pervasive disturbance in interpersonal relationships, rooted in insecure attachment, is the inability to trust others. Abused individuals experience fear and ambivalence with respect to interpersonal attachment and vulnerability. As closeness increases, they expect re-victimization, become more anxious, and may push others away or engage in behavior that sabotages the relationship. Due to the problems that resulted from their past abuse and the possible use of dissociation to cope with it, they lack a healthy template for interpersonal interactions. Clinicians who have worked with AASOs can attest that they are not likely to read social cues well or make poor judgments about whom to trust. Some abuse survivors alternate between trusting everyone and trusting no one.

AASOs who are survivors of abuse (i.e., whether sexual or physical, or exposure to domestic violence) often have distorted interpersonal scripts and blurred boundaries. They may reenact their interpersonal traumas with the therapist, intimate partners, and other group members. Their childhood abuse and betrayal by adults have fueled the excessive need for control that may contribute to them engaging in behaviors (both sexual and nonsexual) that are hurtful to others.

Somatization

Luxenberg et al.'s (2001) fifth cluster of complex trauma symptoms consist of persistent physical symptoms that often defy medical explanation. They may include digestive symptoms, chronic pain, cardiopulmonary symptoms, chronic pelvic pain, conversion symptoms, irritable bowel syndrome, headaches, "acid" stomach, and sexual symptoms (not specified by Luxenberg et al.). Many traumatized individuals have overactive sympathetic and parasympathetic nervous systems, which over time cause the body to react like a car that is constantly having the gas and the brakes applied at the same time (Franklin Cardiovascular Associates, PA, 2021). The body wears out prematurely under these conditions.

Clinicians who have worked with AASOs in inpatient settings are aware that they often have multiple ill-defined physical complaints that may not respond to medical treatment (e.g., digestive symptoms, chronic pain, headaches). These complaints are not necessarily manifestations of hypochondria or a need for attention. Rather, they may be long-term effects of repeated early traumatic experiences, which have compromised the body's ability to cope with stress.

Some research has shown however, that the impact of somatic symptoms as related to sexual offending is not statistically significant. A large study (Miccio-Fonseca, 2001, $N = 656$) compared sex offenders, victims, and family members who were neither offenders nor victims (adults and youth). There were no differences between the sex offenders and the other groups on any of 58 somatic variables examined in the study. However, the sex offenders were significantly different on a constellation of mental symptoms (i.e., feeling depressed, feeling shame, easily distracted, feeling lonely, poor concentration, feeling alone, poor judgment, difficulty thinking clearly, acting impulsively, difficulty making decisions, inability to plan ahead, withdrawal from others, decrease in sexual interest, outbursts of anger). The researcher concluded, "The findings suggest that male sex offenders may have something distinctive going on in their brains from that of others" (p. 109).

Disturbances in Meaning Systems

Luxenberg et al. (2001) assert that individuals with severe trauma histories often fail to find meaning in the things that usually give life a sense of purpose. They are often alienated from any system of spiritual belief ("How could God have let this happen to me?"). Their view of human relationships is adversarial. They often see relationships as a power struggle and think that everyone is out for themselves. This may be accompanied by a profound sense of learned helplessness and a pervasive decreased sense of competence. It is not unreasonable to postulate that AASOs who have experienced severe trauma may compensate for this learned helplessness (feeling powerless) through control seeking abusive behaviors, including sexual offending.

Summary

This article described six symptom clusters formulated by Luxenberg et al. (2001) that are seen in individuals who have complex trauma. The clusters (i.e., affect dysregulation/poor impulse control, disturbances in attention and consciousness, disturbances in self-perception, disturbances in interpersonal relationships, somatization, and disturbances in meaning systems) provide a trauma-informed template that has potential application to individuals who are sexually abusive. Professionals who evaluate AASOs who have experienced severe trauma might consider incorporating this template in their assessments.

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Lucinda A. Lee Rasmussen, Ph.D., LCSW, Associate Professor, San Diego State University School of Social Work, San Diego, CA

Jay Adams, Ph.D., Clinical Psychologist, Sex offender treatment specialist and SVP defense evaluator, Paso Robles, CA.

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