The Effects of Trauma on Antisocial Behavioral Patterns:

An Adlerian Perspective

A Literature Review

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Abstract

This project will describe the impact of trauma on antisocial behavior patterns and on an individual’s criminal thinking and behaviors. It will discuss how trauma is currently viewed and expressed, what constitutes a traumatic event as well as other definitions of trauma. Current diagnosis for trauma, including post-traumatic stress disorder (PTSD), will be reviewed. Adlerian techniques that have been shown to help address trauma and outcomes of treatment for trauma will be identified. There will be a discussion of how significant events may affect an individual’s lifestyle as an adult and may lead to an individual to struggle with antisocial behavior patterns, including criminal thinking and behaviors. Antisocial behavioral patterns, including current diagnostic criteria, the offender population, recidivism rates, and outcomes of treatment for the offender population will be described. Further, the offender population will be discussed in depth, linking the behaviors expressed as an adult to the experienced trauma as a child or young adult. This project will be in an Adlerian perspective and framework and discussions will include Adlerian viewpoints, integration of Adlerian Psychotherapy, Adlerian techniques that may help in decreasing the antisocial behavior patterns and criminal thinking and behaviors, and include how addressing the traumatic and childhood experiences may help to decrease negative expressions of trauma as an adult.

**Keywords:** trauma, antisocial, offender, Adlerian, criminal, incarceration, core beliefs, early recollections, mistaken beliefs
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The Effects of Trauma on Antisocial Behavioral Patterns:
An Adlerian Perspective

Trauma is an individual’s experience of an event, or repeating events, and is often a result of an overwhelming amount of stress where the individual has struggled to cope. These experiences can eventually lead to serious and long-term consequences. Some of these consequences may include criminal thinking, antisocial behavior patterns, and mental health concerns, including diagnoses like depression, anxiety, and post-traumatic stress disorder (PTSD). Post Traumatic Stress Disorder is described in the 5th ed. of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as “the development of characteristic symptoms following exposure to one or more traumatic events” (American Psychiatric Association [APA], 2013, p. 274). The DSM-5 also mentioned many children may have experienced multiple and co-occurring traumatic events (e.g. physical abuse and witnessing domestic violence). These co-occurring traumatic experiences have been shown to result in reckless and high-risk behaviors leading to accidental injury to self or others or thrill-seeking behaviors (APA, 2013). It is common that these high-risk and reckless behaviors include impulsiveness and criminal and antisocial behaviors.

There have been discussions regarding high rates of childhood and adult trauma in the incarcerated population and those who have struggled with criminal thinking and antisocial behavioral patterns. Individuals who have experienced trauma, including physical, emotional, and sexual abuse, as well as violence experienced in the home or neighborhood, neglect, and abandonment, are known to have predictable, immediate, and significant effects on their personality development. Maschi and Gibson (2012) discussed there is a significant lack of knowledge regarding the relationship between trauma and worldview among offenders with
histories of trauma; however, since then there has been much more information found due to
more recent research. These research studies have focused on the incarcerated population and
have concentrated on the effects of childhood traumas. There are many different therapies and
treatments that have been shown to be successful in addressing these worldviews, negative
thinking, and criminal and antisocial behaviors. Adlerian theory and techniques have also been
shown to be effective in addressing childhood trauma.

Trauma

According to the Substance Abuse and Mental Health Services Administration
(SAMHSA; 2014), trauma can affect individuals of every race, gender, psychosocial
background, and geographic region and “it often ignites the ‘fight, flight, or freeze’ reaction at
the time of the event(s)” (p. 28). Traumatic events may be experienced directly, be a witnessed
event, be an individual’s feelings of being threatened, or be an individual hearing about an event
that affects someone the individual knows. As SAMHSA (2014) mentioned, it is not just the
event that determines whether something is traumatic; it is the individual’s experience of the
event and how the individual interprets the event. According to Smith, Hyman, Andres-Hyman,
Ruiz, and Davidson (2016), the interpretation of a traumatic event included the individual’s
worldview, mistaken core beliefs, and coping abilities. For some people, reactions to traumatic
events are temporary, while others have significant and prolonged reactions that may become
severe with significant mental, emotional, and behavioral consequences (SAMHSA, 2014).
These consequences may include post traumatic stress disorder, substance use, mood disorders,
anxiety disorders, antisocial behaviors, and negative and criminal thinking.

There are different definitions and explanations of trauma and what constitutes a
traumatic event. There can be long-term psychological effects related to trauma. As Armstrong
and Kelley (2009) explained adults who had experienced abuse and neglect as children reported significantly higher rates of almost every type of psychopathology. Smith et al. (2016) also mentioned that many research studies have demonstrated that traumatic experiences are fairly common among clinical and general populations and are associated with many persistent psychological difficulties.

It is important to understand how traumatic events affect individuals, especially those who are incarcerated and have continued to struggle with criminal and antisocial thinking and antisocial behavioral patterns. Sindicich et al. (2014) observed that in the inmate population for both females and males, up to 90% had experienced traumatic events, with most having experienced multiple, or co-occurring, traumas.

Understanding the effects of traumatic experiences on the worldview of criminal offenders can help improve effective interventions to address these effects and other more serious psychological symptoms of trauma (Maschi & Gibson, 2012). According to Maschi and Gibson (2012), every individual is born with positive core beliefs about people being good and the world being fair. When these beliefs are challenged by traumatic experiences, individuals may become negative and sometimes impulsive, criminal, and antisocial.

**Childhood Trauma**

The association between childhood trauma and behavioral problems in adulthood, especially aggressive behaviors, has become more established in the literature. Research has suggested that the timing of abuse (particularly in childhood) and the type of abuse (physical, sexual, emotional) differentially predicts psychopathological symptoms in adulthood (Wolff & Shi, 2012). Ardino (2012) referenced a study conducted in 1989 in which over 900 individuals who experienced abuse before the age of eleven were clearly linked to antisocial behavior. The
study also showed that these children were at a greater risk of being arrested in adolescence and adulthood. In addition, more recent studies have suggested those who have experienced significant trauma and abuse, especially violence and physical abuse, are more likely to be incarcerated.

According to SAMHSA (2014), 61% of men and 51% of women experienced at least one traumatic event in their lifetime. All types of traumatic events, experienced in childhood or adulthood, significantly predict interpersonal and self-regulation problems (Wolff & Shi, 2012). These problems are likely to affect the thinking patterns of individuals and may result in negative, criminal, and antisocial thinking patterns. Smith et al. (2016) described trauma as the “exposure to an event that is in excess of the normal vicissitudes of life, involving actual or threatened death or injury or a threat to the physical integrity of oneself or others” (p. 1). These events have been shown to have significant and lasting effects on an individual.

Alfred Adler viewed early childhood experiences and memories as important parts of an individual’s lifestyle. One of Adler’s central foci was early recollections as a psychoanalytic treatment approach (Clark, 2002). Early recollections can be an effective way to understand an individual’s lifestyle and “private logic” or beliefs about themselves. Tobin, Wardi-Zonna, and Yezzi-Shareef (2007) explained that Adler believed early recollection interpretations could clearly show an individual’s unique worldview.

Characteristics of the family may be one of the most important influences on a person’s journey to adulthood (Armstrong & Kelley, 2009). Renn (2010) found that accepting the “links between insecure attachment, unresolved childhood trauma, emotional detachment and dissociation, substance misuse, and violent offending behavior was vital in order to work both effectively and with expedition” (p. 9).
Individuals who have experienced traumatic events often experience a disruption in their relationships with others, as well as a shift in their worldview. This disruption can affect everyone around that individual, and SAMHSA (2014) identified family members regularly experience the traumatic stress reactions of the individual family member who was traumatized (e.g., angry outbursts, nightmares, avoidant behavior, symptoms of anxiety, overreactions or under reactions to stressful events). As Smith et al. (2016) discussed, traumatic experiences often disrupt an individual’s ability to form and maintain important interpersonal relationships. They also discussed how traumatic events in childhood may impair development of social learning, coping, and executive functioning including planning, organizing, decision-making, and critical thinking. These skills are necessary to develop and maintain supportive interpersonal relationships in adulthood. Without social support or support of important individuals in a person’s life, many individuals turn to other places to feel safety and belonging, such as gangs, or they isolate themselves.

There is an ability, for some individuals, to rise above a traumatic event regardless of the severity of trauma, and meet challenges with resilience and strength. Not all individuals who experience trauma develop interpersonal problems, which suggests that there are important differences in how individuals evaluate and respond to these experiences (Kaufman, Allbaugh, & Wright, 2017). Differences in how individuals interpret information and experiences results in different points of views, worldviews, and core beliefs. Traumatic events challenge core assumptions and beliefs that the world is safe, other people can be trusted, and the self is capable (Kaufman et al., 2017).
As seen in Figure 1, trauma affects more than one aspect of an individual’s life and is dependent on many different factors including, but not limited to, the characteristics of the individual’s community and specific time in history (era) when the trauma occurred. These different factors influence the individual’s perceptions and processing of the traumatic event (SAMHSA, 2014).

Figure 1. Social-Ecological Model for Understanding Trauma and Its Effects. This figure describes how trauma is influenced by developmental and cultural factors and that factors influence each other (SAMHSA, 2014).
Table 1 describes the different levels of Figure 1 and breaks down each level into characteristics (SAMHSA, 2014).

Table 1.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Age, biophysical state, mental health status, temperament and other personality traits, education, gender, coping styles, socioeconomic status</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Family, peer, and significant other interaction patterns, parent-family mental health, parent’s history of trauma, social network</td>
</tr>
<tr>
<td>Community and Organizational</td>
<td>Neighborhood quality, school system and-or work environment, behavioral health system quality and accessibility, faith-based settings, transportation availability, community socioeconomic status, community employment rates</td>
</tr>
<tr>
<td>Societal</td>
<td>Laws (State and Federal), economic and social policies, media, societal norms, judicial system</td>
</tr>
<tr>
<td>Cultural and Developmental</td>
<td>Collective or individualistic cultural norms, ethnicity, cultural subsystem norms, cognitive and maturational development</td>
</tr>
<tr>
<td>Period of Time in History</td>
<td>Societal attitudes related to military service members’ homecomings, changes in diagnostic understanding</td>
</tr>
</tbody>
</table>

*Note.* Each level is not an all-inclusive list and many not contain all examples of that particular level. (SAMHSA, 2014).
Core Beliefs

Core beliefs are qualities an individual believes are true about him- or herself, others, the world, and the future, regardless of what anyone else thinks, feels, or believes. Core beliefs usually stem from childhood experiences and life circumstances. They are strongly-held, rigid, and inflexible beliefs that are maintained by the tendency to focus on only the information that supports the belief, ignoring evidence that contradicts it (Jacobson, 2013). These beliefs are generally developed during childhood and as adults they are rarely questioned or challenged.

Core beliefs cause individuals to develop specific systems of rules that control behavior. These beliefs, which Adler referred to as mistaken beliefs, have extreme effects on automatic thoughts, especially automatic negative thoughts. As Cuadra, Jaffe, Thomas, and DiLillo (2014) discussed, maltreated children develop distinct maladaptive cognitive processes that involve distorted beliefs about oneself, others, and the environment. These beliefs merge over time and shape how maltreated children later interpret their experiences and react in social situations. Common reactions and responses to traumatic events can include intense and unpredictable feelings, changes in thoughts and behavior patterns, sensitivity to environmental factors, strained relationships, and stress-related physical symptoms (Rowell & Thomley, 2013).

Ross (2011) identified that an individual’s core beliefs underlie their automatic thoughts. She recognized six different categories of core beliefs, including defectiveness, feeling unlovable, abandonment, helplessness and powerlessness, entitlement, caretaking, responsibility, and self-sacrifice. Defectiveness, Ross explained, encompass beliefs about feeling flawed, inferior, or incapable. These result in thoughts such as “I’m worthless” and “I’m not good enough” (para. 3). She goes on to describe feelings of loneliness and not belonging resulting in feeling unlovable which result in automatic thoughts such as “I’m not loveable” and “I’m alone”
Abandonment describes an individual’s assumption that they will lose anyone they form emotional bonds with. This may result in thoughts including “I’m unimportant” and “people I love will leave me” (Ross, para. 5). She continued to explain that thoughts like “I’m weak” and “I can’t change” were related to feelings of helplessness and powerlessness. These generally resulted in individuals assuming that they lack control and cannot handle anything successfully or independently (para. 6). Entitlement beliefs, according to Ross, are related to an individual feeling special, making demands, and engaging in behaviors that disregard effects on others. These often could result in thoughts such as “I can do no wrong” and “I’m superior” (para. 7). Lastly, she identified “caretaking, responsibility, and self-sacrifice” as describing beliefs such as feeling responsible for the happiness of others. These usually resulted in thoughts such as “I have to do everything perfectly” and “my needs are not important” (para. 8).

There are usually common themes in an individual’s core beliefs, resulting in common thoughts, which lead to specific behaviors. Since core beliefs are so deeply rooted in the personalities of individuals, they are seldom obvious and are difficult to identify, challenge, and change. Maschi and Gibson (2012) explained that when an individual experiences trauma, they may perceive the world as unfair and feel that they lack personal control over their life circumstances. They then consequently respond to the world accordingly, which may include criminal thinking and offending. Maschi and Gibson suggested most serious consequences brought on by traumatic events and negative worldviews are maladaptive behavioral responses, predominantly criminal behavior.

Mistaken Beliefs

Adler described core beliefs as being driven by experiences in childhood. As Lingg and Kottman (1991) explained, mistaken beliefs are faulty conclusions made from the viewpoint of a
child, usually when the child is stressed and seeking to find a sense of belonging in their world. It is well known that children are great at seeing everything around them; however, they may not have the understanding, knowledge, and experience to interpret the real meaning of an event. As Dreikurs and Soltz (1964) suggested “children are expert observers but make many mistakes in interpreting what they observe. They often draw wrong conclusions and choose mistaken ways in which to find their place” (as cited in Lingg & Kottman, 1991, p. 2).

Adler viewed mistaken beliefs as the primary reason for psychological problems which interfered with an individual’s healthy growth and development. Mistaken core beliefs are established at a young age and follow a person unquestioned throughout their life. By challenging a mistaken core belief Adler believed people could be shown where their personal approach to life was getting in the way and preventing them from living a full life.

**Posttraumatic Stress Disorder (PTSD)**

Post Traumatic Stress Disorder (PTSD) is the result of significant traumatic event. Kaufman et al. (2017) stated that “the degree to which a traumatic event challenges or disrupts core beliefs regarding the world, other people, and the self, is associated with adjustment problems and increased risk for adverse outcomes including depression and posttraumatic symptoms” (p. 2). As Ford and Hawke (2012) emphasized, witnessing or having exposure to a traumatic event, especially abuse or violence, may put youth at a higher risk for problematic aggression, delinquency, failure in school, substance use disorders, and adult criminality. They went on to explain that these outcomes are usually preceded by emotional, cognitive, and behavioral dysregulation. In addition, Wilson, Berent, Donenberg, Emerson, Rodriguez, and Sandesara (2013) referenced a study of about 900 juvenile detainees in Chicago, where about
92% reported experiencing at least one traumatic event. In addition, 84% experienced more than one traumatic event, which is significantly higher than the national sample.

**DSM-5 PTSD Criteria**

The *DSM-5* criteria for PTSD significantly differed from those in the *DSM-IV-TR*. In the *DSM-5* (APA, 2013), PTSD is identified under a new chapter “Trauma- and Stressor-Related Disorders” (p. 265) and is no longer classified as an anxiety disorder. In addition, the *DSM-5* more clearly defined a traumatic event and gave specific examples of experiencing or witnessing a traumatic event (Houston, Webb-Murphy, & Delaney, n.d.).

According to Houston et al. (n.d.), symptom clusters changed by splitting one cluster, “avoidance and numbing,” into two different clusters to include “avoidance (Criterion C)” and “negative alterations in cognitions and mood (Criterion D)” (p. 2). Houston et al. (n.d.) noted two new symptoms were added to Criterion D, including “distorted blame of self or others for causing the traumatic event or for resulting consequences, and persistent (and often distorted) negative beliefs and expectations about oneself or the world” (p. 2). One last major change from the *DSM-IV-TR* to the *DSM-5* was the acute and chronic specifications being removed and replaced with time-specific diagnoses (Houston et al., n.d.).

**Shock**

Alfred Adler described trauma as “shock symptom” (Ansbacher & Ansbacher, 1956, p. 287). He discussed when an individual is forced to confront a problem when they are not ready to cope, they respond with a “shock reaction” (Ansbacher & Ansbacher, 1956/1964, p. 287) that matched their life style, especially when the life style supported their mistaken beliefs (Ansbacher & Ansbacher, 1956/1964). This “shock” may trigger certain psychological symptoms, such as the criteria for a PTSD diagnosis. In Adlerian Psychotherapy, it is important
to understand how these symptoms are used by the individual and how the symptoms individuals 
experience are viewed as the “smoke covering the fire of inferiority feelings” (Stein & Edwards, 
a certain amount of time, but eventually their private logic and mistaken beliefs will be 
challenged by reality. This challenge will most likely eventually lead to a “shock” and then 
possibly to the development of symptoms similar to PTSD.

According to Hjertaas (2013), Adler believed a struggling individual developed 
symptoms not because they experienced something, but instead due to a “failing in the style of 
life” (p. 2). Hjertaas (2013) also believed Adler understood the connection between complicated 
events, both in childhood and later in life, and how the interpretation by the individual, with their 
unique worldview, built their lifestyle. Adler affirmed the determination of humans to modify 
their weaknesses into strengths. He also saw how each individual’s unique expressions stemmed 
from their childhood beliefs.

**Treatment of Trauma**

Many people will experience a traumatic event at some point in their lives, and many will 
recover from that trauma with time, especially with the support of family and friends. For 
others, the effects of trauma are long lasting causing an individual to live with deep emotional 
pain, fear, confusion, or PTSD, far after the traumatic event has passed. The support, assistance, 
and guidance of a mental health professional is essential in healing from trauma and PTSD. It is 
also important to create increased awareness of trauma in organizations through educating all 
staff members, including those who have indirect and direct contact with individuals struggling 
with trauma.
Trauma usually disrupts an individual’s natural state of mind and freezes an individual in a state of hyperarousal and fear. As suggested by Robinson, Smith, and Segal (2017) identified different things that could help in the treatment of trauma, including:

- Exercising.
- Connecting to others (ask for support, participate in social activities, reconnect with old friends, join a support group, volunteer, make new friends).
- Self-regulate (mindful breathing, sensory input, staying grounded, feel feelings).
- Taking care of health needs (get plenty of sleep, avoid mood altering substances, eat a well-balanced diet, reduce stress).

**Trauma Informed Care**

Key components of trauma informed care for those providing it include individuals needing to feel connected, valued, informed, and hopeful. The connection between childhood trauma and adult psychopathology is understood and acknowledged by all staff (Muskett, 2014). She added that staff should work in encouraging, mindful, and empowering ways with individuals, their family and friends, and any other social services to help promote and protect the independence and self-sufficiency of the individual. According to SAMHSA (2014) in a “a trauma-informed perspective” an individual’s behaviors and trauma-related symptoms are their greatest attempt to manage and cope with their traumatic experience. Muskett (2014) stated that:

Successful implementation of trauma informed care includes (i) active leadership support, role modelling, and engagement in trauma informed principles; (ii) data collection; (iii) rigorous debriefing and prevention-focused analysis of events that do occur; (iv) trauma informed education and skill development of staff; (v) use of a range of assessments (e.g. trauma, risk, and strengths identification) and tools to teach self-
management of illness and emotional regulation; and (vi) involvement and inclusion of consumers at all levels of care. (p. 53)

SAMHSA (2014) identified the concept of a trauma informed approach needing to include realizing the widespread impact of trauma, recognizing the signs and symptoms of trauma in clients, families, staff, and others involved in responding, by fully integrating knowledge about trauma into policies, procedures, and practices, while seeking to actively avoid re-traumatization.

In discussing this concept further, Robinson, Smith and Segal (2017) recognized how others may struggle with those who have been effected by a traumatic event, including family and friends. They encouraged others to be patient and understanding, to offer support, to be open for discussion with a loved one who is ready to talk, to help a loved one relax and not isolate, and not to take trauma symptoms personally.

**Early Recollections**

A counselor or therapist obtains early recollections, or early memories, to gain understanding and knowledge of an individual’s lifestyle and core beliefs. Clark (2002) described that understanding a client’s conceptualization of life helps to guide treatment planning and utilizing specific interventions in the counseling process. Adler’s premise was “there are no chance memories; what we remember from our early childhood is reflective of what we believe now” (Tobin et al., 2007, p. 2). Adler went on to show that the interpretation of early recollections could illuminate the individual’s unique outlook on life and affect their lifestyle (Tobin et al., 2007).

Lingg and Kottman (1991) described the collection process for obtaining early recollections starts by the therapist or counselor asking the client to become relaxed, close their
eyes, take a few deep breaths, and get as comfortable as possible. According to Tobin et al. (2007), the client is asked for a set of early recollections (early memories), usually at least three. Lingg and Kottman (1991) described the individual is to be made aware each of their recollections should have taken place before eight years of age. The individual is encouraged to experience those memories and explain what happened from the perspective of being there at that age. Lingg and Kottman (1991) explained each memory is then transcribed verbatim and the client’s emotions and feelings are identified in relation to the experiences at that time. The counselor or therapist may ask the client to imagine themselves stepping into that moment as an adult and identify emotions and feelings they are experiencing. The client may also be asked which moment during the early recollection stood out the most, and to identify feelings and emotions during that specific moment (Tobin et al., 2007). Gaining an understanding of the development of the client’s core or mistaken beliefs through early memories is an important part of obtaining early recollections (Lingg & Kottman, 1991). Therapists and counselors can then help the client in re-orientating their beliefs by examining their early recollections (Tobin et al., 2007).

**Criminal Thinking and Behavior**

The examination of criminal behavior is multifaceted. Within the field of psychology, it is viewed from several domains, including human development, perception, learning, cognition, memory and information processing, motivation, emotion, history, philosophy, as well as clinical, applied, social, community, biological, and physiological psychology (Andrews & Bonta, 2010). *The Psychology of Criminal Conduct* by Andrews and Bonta (2010) “seeks a richer and deeper understanding of criminal behavior and insist that the analysis of criminal behavior consider biological, personal, interpersonal, familial, and structural/cultural factors as
well as consider the individual in particular immediate situations and in the broader social context” (p. 34).

According to Andrews and Bonta (2010) as presented in their book, *The Psychology of Criminal Conduct*, there are four different definitions of criminal behavior including legal, moral, social, and psychological ones. These are described as:

- **Legal**: Criminal behavior refers to actions that are prohibited by the state and punishable under the law.

- **Moral**: Criminal behavior refers to actions that violate the norms of religion and morality and are believed to be punishable by supreme spiritual beings.

- **Social**: Criminal behavior refers to actions that violate the norms of custom and tradition and are punishable by the community.

- **Psychological**: Criminal behavior refers to actions that may be rewarding to the actor but that inflict pain or loss on others. That is, criminal behavior is antisocial behavior (p. 11).

The authors further identify their “working definition” of criminal behavior as “antisocial acts that place the actor at risk of becoming a focus of the attention of criminal justice professionals within the juvenile and/or adult justice systems” (Andrews, & Bonta, 2010, p. 12).

**Antisocial Personality**

According to Andrews and Bonta (2010) antisocial personality styles and behaviors are accurate predictors of criminal behavior. Social and home environments contribute to the development of antisocial behavior and it is shown that “parents of troubled children have high levels of antisocial behaviors themselves” (Black, 2016, para. 6). Child abuse has also been linked with antisocial behaviors, with many individuals growing up with neglectful, and
sometimes violent, antisocial parents. As Chamberlain and Moore (2002) cite, several studies have documented that severe antisocial behaviors in adolescence led to extremely poor adult adjustments. They went on to discuss males who were antisocial adolescents were more likely to engage in criminal activities as adults and females were more at risk for behaviors such as internalizing disorders, early pregnancy, and high use of social services. Research conducted by Armstrong and Kelley (2009) demonstrated that early childhood trauma and maltreatment were strong precursors to adult antisocial behavior patterns and psychopathology. Cuadra et al. (2014) mentioned that “in attempting to regain power and control, victims of maltreatment may identify with their abusers, exhibit limited empathy toward others, disregard others’ wants and needs, and form beliefs that rationalize or condone behaving in an overtly aggressive or manipulative manner” (p. 2).

**DSM-5 antisocial personality disorder criteria.** The DSM-5 (APA, 2013) states that “the essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood” (p. 645). Individuals who are diagnosed with antisocial personality disorder do not conform to social norms, do not respect lawful behavior, and repeatedly perform acts that are grounds for arrest. They may also display a pattern of impulsivity, repeatedly lie, con others, and are frequently deceitful and manipulative in order to gain personal profit or pleasure (APA, 2013).

The DSM-5 antisocial personality disorder diagnostic criteria F60.2 (APA, 2013, p. 659) are the following:

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.

2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.

3. Impulsivity or failure to plan ahead.

4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.

5. Reckless disregard for safety of self or others.

6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.

7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

**Treatment for Criminal Thinking and Behavior**

Suggestions made by Andrews and Bonta (2010) for treatment of criminal thinking and behavior include taking responsibility, developing prevention skills and techniques, leading productive and prosocial lives, Cognitive Behavioral Therapy (CBT), identifying risk factors and triggers, being non-judgmental, and addressing criminal thinking errors. According to Andrews and Bonta (2010), some early types of treatment included probation and parole, institution-based, capital punishment, psychotherapy, and non-institutionalization; however, more knowledge and
information has been obtained to identify best practices for the treatment of criminal thinking and behavior.

Specific cognitive-behavioral approaches have been shown to be effective with offenders to address criminal thinking and behavior. These have been designed as cognitive-restructuring, coping skills, and problem solving therapies. They include Aggression Replacement Training (ART), Moral Reconation Therapy (MRT), Reasoning and Rehabilitation (R&R and R&R2), Relapse Prevention Therapy (RPT), and Thinking for a Change (T4C) (Milkman & Wanberg, 2007). Along with the therapies listed, addressing criminal thinking errors, traumatic events, and core beliefs can be effective.

**Criminal Thinking Errors**

Offenders tend to take what are otherwise common thinking errors to the extreme and then develop them into patterns of behavior that continually victimize and harm others. The list of the more common thinking errors includes: closed minded thinking, victim stance, good person stance, lack of effort, lack of interest in being responsible, lack of time perspective, fear of fear, power thrust, uniqueness, and ownership attitude (Loebig, 2014). The list below is comprised of common thinking errors is correlated with corrective thoughts:

- Closed minded thinking – not receptive, not self-critical, no disclosure, good at pointing out other’s faults, lying by omission.
  - Correction: active listening, self-criticism, regular disclosure.
- Victim stance – blame others, views self as a victim.
  - Correction: blame self, take personal responsibility for every action and outcome.
• Good person stance – focuses only on positive attributes of self, fails to acknowledge destructive behavior, builds self up at other’s expense.
  o Correction: self-disgust and balanced self-perception.
• Lack of effort – unwilling to do anything thought of as boring or disagreeable, “I can’t” meaning “I won’t.”
  o Correction: push self to do the difficult.
• Lack of interest of being responsible – does not use past as learning tool, expects others to act immediately on demands, decisions on assumptions, not facts.
  o Correction: develop goals, learn from the past.
• Lack of time perspective – does not use past as learning tool, expects others to act immediately on demands.
  o Correction: develop goals and learn from the past.
• Fear of fear – irrational fears (many) but refuse to admit them, fundamental fear of injury or death, profound fear of put down, when held accountable experiences “zero state” – feels worthless.
  o Correction: use fear as a guide.
• Power thrust – compelled need to be in control of every situation, uses manipulation and deceit, refuses to be dependent unless situation can be taken advantage of.
  o Correction: put oneself in another’s position, identify how others are being controlled.
• Uniqueness – different and better than others, expect others to meet failures, super-optimism, quits at the first sign of failure.
  o Correction: understand commonalities with others.
Ownership attitude – perceives all things, people, objects of possessions, no concept of ownership or rights of others, sex for power and control—not intimacy.

- Correction: understand the negative ripple effect of possessive behavior.

These criminal thinking errors are similar to thinking distortions or cognitive distortions. They are thoughts or ways of thinking that are negative, twisted, and distort healthy thinking. They are irrational and change a person’s perception of self, others, and the world.

**Cognitive Behavioral Therapy (CBT)**

Cognitive Behavioral Therapy (CBT) has as a goal to help individuals change their patterns of thinking and behavior that have become problematic and cause difficulties in their lives. According to Martin (2016), CBT is successful in changing attitudes and behaviors because it focuses on thoughts and core beliefs. It also focuses on how cognitive processes are connected to behaviors as a way of coping and dealing with emotional concerns.

Cognitive Behavioral Therapy is problem-focused to treat specific concerns and the therapist’s or counselor’s role is to help the client in obtaining and practicing effective strategies and techniques to address their thinking and achieve their goals. It differs from other types of therapy because treatment sessions have a structure, including the individual describing specific problems and goals and they work towards these throughout sessions. Another difference is how progress may be made with homework the individual assigns hi- or herself. One last important difference is that CBT “favors a more equal relationship” between the client and therapist (Martin, 2016, p. 6).

Therapists and counselors use CBT techniques to help individuals challenge their distorted thinking patterns and replace these with more realistic, positive, and effective thoughts.
These techniques may be used to help individuals replace maladaptive behaviors and become more open minded, mindful, and aware of how thinking distortions affect their behaviors.

**Thinking for a Change (T4C)**

_Thinking for a Change (T4C)_ uses a combination of approaches to increase an offender’s awareness of self and others. It integrates cognitive restructuring, social skills, and problem solving skills. It also teaches offenders an introspective process for examining their ways of thinking as well as their feelings, beliefs, and attitudes (Milkman & Wanberg, 2007). This approach allows offenders to learn how to report on situations that could lead to criminal behavior and identify risky thoughts, attitudes, and beliefs, including core beliefs and mistaken beliefs. It is comprised of 25 lessons that build on each other, which is ideally delivered twice per week. “The program is designed to be provided to justice-involved adults and youth, males and females…by corrections professionals in prisons, jails, detention centers, community corrections, probation, and parole settings” (National Institute of Corrections, 2016, para. 3).

**Criminality and the Connection to Trauma**

There is a significant connection between trauma and criminality, criminal thinking, and criminal and antisocial behavioral patterns. As Honorato, Caltabiano, and Clough (2016) found, when trauma survivors are held back or prevented from healing, they may suffer with self-destructive behaviors, including substance use, revenge, harm towards others, and other criminal thinking, often leading to criminal justice system involvement. It seems that the more violent the crime, the more difficult it proves to re-establish a trusting relationship. Among criminal offenders, there have been high levels of traumatic experiences documented consistently.

According to Wolff and Shi (2012), childhood and adult trauma rates are high among incarcerated persons. A study completed by Stimmel, Cruise, Ford, and Weiss (2014) found that
86% of the participants reported exposure to at least one traumatic event and 71% had multiple types of traumatic events. Maschi and Gibson (2012) suggested that incorporating trauma and stress management programming into criminal justice settings, especially prisons, would help in addressing possible adverse psychological reactions.

According to Levenson (2014) it was clear that childhood adversity was closely related to adult criminality, especially interpersonal violence. She went on to discuss that more exposure to adverse events increased the likelihood of mental health concerns and serious involvement in substance use and criminality. Studies have shown that childhood maltreatment has pronounced negative effects on mental health. Trauma and childhood maltreatment can lead to disruption in relationships and other psychological problems, including low self-efficacy, lack of positive life tasks, and difficulties with processing social norms and social information (Kim, Park, & Kim, 2016).

Trauma can interfere with a child’s ability to “empathize, decreases appropriate social skills, impulse control, ability to self-regulate, and contributes to the development of a poor future orientation” (Murray, Glaser, & Calhoun, 2013, p. 2). It is also mentioned by Courtney and Maschi (2012) that maladaptive patterns seen after traumatic experiences can be aggressive and self-destructive and affects regulation and impulse control, which are two major components that can lead to many illegal behaviors.

It can be concluded that having multiple traumatic experiences decreases an individual’s ability to form secure attachments and relationships with others placing them at an increased risk for criminal behavior. As cited by Kim et al. (2016) there have been a substantial number of studies that have suggested childhood maltreatment greatly increased the risk of criminality in adolescence and adulthood. In their research Cuadra et al. (2014) found “as expected, overall
child maltreatment experiences were positively and significantly associated with overall adult criminal behavior” (p. 6).

According to Courtney and Maschi (2012), close to 93% of juvenile or adult offenders reported a history of being a victim or witness to violent acts, including physical or sexual assault occurring during childhood and/or adulthood. Maschi and Gibson (2012) went on to report:

The most common type of trauma exposure among young and older adult offenders was living in a violent neighborhood (89% and 65% respectively). However, young offenders were significantly more likely to report living in a violent neighborhood and witnessing this type of physical assault. In contrast, older adult offenders were significantly more likely to report experiencing the death of a family member, having a life-threatening illness, and experiencing a disaster than their younger counterparts. (p. 8)

Significant recent research has been conducted regarding how child maltreatment and early victimization is linked to, and resulted in, adverse psychological concerns and behavioral outcomes, including at a societal level with criminal behaviors and adult criminal offending. According to Cuadra et al. (2014) connections have been found between engagement in aggressive and antisocial behaviors and the self-serving attitudes, thoughts, or beliefs that offenders utilize to rationalize or justify their own actions. As discussed by Honorato, Caltabiano, and Clough (2016) there are common courses followed by traumatized individuals from childhood to adolescence and early adulthood, resulting in incarceration. These researchers explained some of the impact of trauma and the lack of support resulted in substance abuse to mask the traumatic events, an act of spontaneous violence, triggering uncontrollable anger, leading to violence and incarceration.
As recommended by Armstrong and Kelley (2009), for those who work with offenders, it is important to understand that childhood trauma and maltreatment may be the root cause of their adult antisocial behaviors. In a study conducted by Cuadra et al. (2014) the findings suggested it may be beneficial for those working in correctional settings, or with the offender population in the community, to address the increased risk of offending associated with a history of child maltreatment, while considering and keeping in mind that criminal behavior is not an inevitable outcome of early abuse or neglect.

**Effective Therapies and Treatments**

Trauma and PTSD are two of the most common reasons people seek counseling or therapy. The most effective form of treatment for healing from the effects of trauma is psychotherapy. This type of therapy can help individuals make sense of their traumatic experiences and feelings, develop plans to stay safe, learn healthy coping skills, and connect with support and other resources (Pollock, TeBockhorst, Bell, Larsen, & Pimputkar, 2017). As stated in Briere, Agee, and Dietrich (2016)

Although modern single-trauma-focused exposure therapies can be helpful in the treatment of many instances of Post-Traumatic Stress Disorder (PTSD), those suffering from PTSD and other difficulties associated with more complex trauma scenarios might benefit from interventions that address multiple traumas and multiple outcomes. Although it is possible that emotional processing of a single traumatic event can, to some extent, generalize to the effects of other types of traumas, therapy may be more helpful to the extent that it also includes cognitive interventions, interpersonal therapy, affect skills training, and psychodynamic/relational interventions that address broader difficulties associated with a complex trauma history. (p.444)
According to Pollock et al. (2017), other commonly used therapies for treatment of trauma are CBT and eye movement desensitization and reprocessing (EMDR); however, there are many other therapies not mentioned. Depending on the nature of the trauma and the specific needs of the individual, one approach may be more suitable than others; however, building on an individual’s existing resources and encouraging and fostering an individual’s strengths are key steps in working with individuals who have struggled with trauma and PTSD.

As discussed by Milkman and Wanberg (2007), changing antisocial attitudes and feelings, reducing current antisocial peer associations, promoting familial affection, communication, promoting identification and association with anti-criminal role models, increasing self-control, self-management, and problem-solving skills, replacing skills of lying, stealing, and aggression with more prosocial alternatives can help reduce risk of recidivism of criminal thinking and behavior. For offenders, addressing trauma in an appropriate manner by looking at an individual’s core beliefs and mistaken beliefs, and utilizing early recollections to do so, may also help in the reduction of recidivism.

Substance Abuse and Mental Health Services Administration (SAMHSA; 2014), identified “approaching [trauma] survivors with genuine respect, concern, and knowledge increased the likelihood that the caregiver can (1) answer questions about what survivors may be experiencing, (2) normalize their distress by affirming that what they are experiencing is normal, (3) help them learn to use effective coping strategies, (4) help them be aware of possible symptoms that may require additional assistance, and (5) provide a positive experience that will increase their chances of seeking help if they need it in the future” (p. 161-162).

Also noted by SAMHSA (2014), therapists and counselors can help clients who have experienced traumatic events by providing integrated treatment that combines different
therapeutic models. These could help in targeting symptoms and disorders, as well as acknowledge how disorders interact with each other. Ford and Hawke (2012) shared successful therapies include clients to have:

- stable residence
- safety from further trauma exposure
- several months of regular meetings with a trained trauma specialist mental health professional
- secure, supportive contact with people who reliably provide practical and emotional support during the therapy and in daily life

**Adlerian Psychotherapy**

“The overall goal of Adlerian psychotherapy is helping an individual develop from a partially functioning person into a more fully functioning one” (Stein, & Edwards, 1998, p.11) and Alfred Adler described that “human beings live in the realm of meanings” (Stein, & Edwards, 1998, p. 2). Adler’s holistic understanding of an individual’s creative solutions to overcoming feelings of inferiority and insecurity in order to meet essential needs to have significance and belonging has seemed to stand the test of time (Millar, 2013). Millar (2013) emphasized several central Adlerian concepts including control, connection, meaning, and a sense of worth and belonging. From an Adlerian viewpoint, without social embeddedness, or without a feeling of belonging to a social group, coping with trauma in a valuable manner is more difficult (Strauch, 2001).

As discussed by Stein and Edwards (1998), Adler viewed the first five years of life as essential in the development of personality. He believed an individual’s perception is limited as there will always be differences in realities from person to person. Stein and Edwards (1998)
also mentioned Adler stated all behavior was purposeful, determined, and directed at moving
toward a final goal. To quote Adler, “If clients have goals that are on the useless side of life,
then their emotions will also serve these goals. Frequently, emotion is used to avoid

According to Cuadra, et al. (2014), it has been suggested that individuals who are
exposed directly or indirectly to violent or abusive experiences (e.g., sexual and physical abuse,
witnessing domestic violence) early in their development may be more likely to accept matching
attitudes and beliefs emphasizing the reinforcing qualities of violence, and engage in offensive or
abusive behaviors later in life. Many individuals that experience negative traumatic events are
likely to develop negative thinking patterns which may lead to negative and criminal behaviors.

Identifying Core Beliefs

As explained by Stein and Edwards (1998), Adler believed that an individuals’ behaviors
were not always guided by reality but were guided instead by a fiction based upon what they
believed to be the truth. As Hjertaas (2013) identified, Adler viewed traumatic events as the
inability to cope with the difficulties of life and for a clinician to be able to help an individual,
they would need to “determine carefully how much the preexisting lifestyle is playing a role and
how much the traumatic event (or lesser psychic shock) affects the individual’s core beliefs
about self, others, and life, recognizing that each case would be unique to these regards” (p. 3).

As explained by Courtney and Maschi (2012) “93% of criminal offenders” have
experienced a traumatic event (p. 73). They reported that in a “nationally representative sample
of approximately 984,000 state prisoners of all age groups, about one out of five reported being a
victim of violence (i.e., physical and/or sexual assault) multiple times throughout the life course”
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(p. 1). These experiences have been linked to psychological reactions, including internal dialogue and negative messages to be defensive (Courtney & Maschi, 2012).

A common place to start in identifying core beliefs and addressing criminal thinking errors is by writing down all of the negative and criminal thoughts that come to mind throughout a day and then reviewing what has been written to find common themes, common criminal thinking errors, and common mistaken core beliefs (Milkman & Wanberg, 2007). Kaufman et al. (2017) suggested that examining core beliefs to find meanings may be more important in predicting outcomes than the specific types of thoughts and cognitions, which then lead to actions and specific behaviors. Adler (as cited in Ansbacher & Ansbacher, 1956/1964) suggested behaviors are usually goal-directed and stem from mistaken core beliefs. Adler invited the therapist or counselor to understand the individual’s behavior as goal-driven and holistic, in terms of their lifestyle and their future goals (Ansbacher & Ansbacher, 1956/1964).

In discussing group work, Levenson (2014) encouraged counselors and therapists to promote a group climate in which members establish acceptable norms regarding peer support and confrontation, model compassionate interactions, practice effective communication skills, and encourage respectful peer confrontation, as it can help individuals to change distorted thinking and encourage increased engagement in the group.

Use of Early Recollections

Adler said that

There are no chance memories; out of the incalculable number of impressions which meet an individual he chooses to remember only those which he feels, however, darkly, to have bearing on his situation. Thus his memories represent his “Story of My Life”; a story he repeats to himself to warm him or comfort him, to keep him concentrated on his
goal and to prepare him by means of past experiences so that he will meet the future with
an already tested style of action. (Adler, 1958, p. 73)

Within the Adlerian theory, recurring images of the traumatic experience, also known as
flashbacks, may act like an early recollection and may send a message to the self of the dangers
of life and possible inadequacies to meet the dangers (Hjertaas, 2013). As Stein and Edwards
(1998) stated:

Children who have been neglected, rejected, or abused have not experienced love and
cooperation. They do not know what it means to feel a positive connection to others and,
as a result, often feel isolated and suspicious. When faced with difficulties, they tend to
overrate these difficulties and to underrate their own abilities. To make up for what they
did not receive as children, they may feel entitled to special consideration or
compensation. They may want others to treat them well but do not feel an obligation to
respond in turn. (p. 8)

Adler pointed out it is important not to move toward processing the traumatic memories
until stabilization and safety is well established; otherwise, there is a danger of retraumatization
(Millar, 2013). In order to help an individual feel stable and safe, Millar (2013) mentioned
assessing and assuring the following:

• Safety in the client’s present life circumstances and the basic needs of food,
  accommodation, and finances assured

• Sufficient social support structures identified, such as from family, friends, and other
  agencies

• Identification and encouragement of the resourceful and creative aspects of the
  client’s lifestyle
• Identification of and building on external resources that offer the client respite, such as meaningful leisure activities, exercise, and special “anchors” or “oases”
• Strategies to support the client to gain his or her own control in regulation of distressing symptoms, such as flashbacks and nightmares
• Establishment of a positive therapeutic relationship

The feeling of safety and stabilization will allow an individual to start working at a cognitive level and addressing lifestyle concerns, including utilizing early recollections. As Millar (2013) reported, without having safety and stabilization, especially with complex cases where the individual has poor resilience and minimal social support, there is a danger of decompensation and retraumatization. As Armstrong and Kelley (2009) described:

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 experiences to occur and create new adaptive coping skills for the offender. (p. 9)

The vital piece to the success of an approach lies not in the examination of traumatic experiences, but in the understanding that perception and past learning history guides behavior (Prather, 2007). Early recollections can be used to promote insight into an individual’s thinking patterns and behaviors by reflecting on a client’s self-image, views of the world (core beliefs), and how they interact with others. Gathering early recollections can help a counselor or therapist
begin to understand the client’s struggles, attitudes, hopes, and behaviors, as well as their goals, mistaken beliefs, and lifestyle.

As identified by Lingg and Kottman (1991), one of the goals of counseling is to identify basic mistakes and bring them to the client’s awareness. It is the counselor’s responsibility to discover those early, mistakenly developed beliefs, and to help the client see how those ideas are false and how they can interfere with effective social and personal functioning (Lingg & Kottman, 1991). It is important for a therapist or counselor to be able to help the client identify mistaken core beliefs by examining early recollections, as well as to introduce creative ways to help a client gain insight into their life style.

As explained by Maschi and Gibson (2012), cognitive therapies have been shown to reduce recidivism among adult and juvenile offenders. They also discussed innovations in the form of cognitive restructuring group work, which includes the use of dreams and imagery, and shows potential in processing both trauma among incarcerated offenders. This information about imagery and dreams can be easily linked as described as a form of early recollections.

**Conclusion**

A traumatic experience has, or multiple traumatic experiences have, can have different definitions and levels of severity. Each individual will interpret a stressful event, or events, in a different way, with some being able to cope well with the experience and others having long lasting effects on their lives. Some of these long-lasting effects could be mental health concerns (including PTSD), substance use, isolation and withdrawing, antisocial behaviors and thinking, resulting in some instances in incarceration.

Many children have experienced traumatic events including maltreatment, neglect, abandonment, physical, emotional, or sexual abuse, and violence towards others. As a result,
they developed their own set of beliefs about themselves, others, and the world. A significant number of these individuals develop antisocial thinking resulting in incarceration.

There is a significant correlation between childhood traumatic event(s) and behavioral concerns in adulthood resulting in antisocial thinking and behavior. These concerns and behaviors affect more than just the individual. They can affect everyone around them, including family, friends, and their communities. As Levenson (2014) explained:

Trauma informed care can be integrated into common program models or theories of practice, including relapse prevention, cognitive behavioral therapy, the Good Lives Model and Risk/Needs/Responsivity models. Trauma informed care simply delivers clinical services in a way that recognizes the prevalence and impact of early trauma on behavior across the lifespan. (p. 10)

The core beliefs that are developed through childhood are rarely questioned or challenged; however, it can be done so with some therapies. Many individuals within the offender population continue to struggle with their cognitive distortions and errors throughout adulthood. Adler described these thinking distortions as mistaken beliefs and developed techniques to address and challenge these mistaken beliefs by obtaining early recollections. These beliefs are also deeply rooted, hard to identify, and even harder to change; however, when individuals struggle with a traumatic experience(s), utilizing Adlerian techniques and viewing them with an Adlerian framework may help in identifying these beliefs and thinking distortions.

Adler viewed early childhood experiences and memories as important parts of an individual’s lifestyle. He focused on understanding an individual holistically. Being able to analyze and understand early recollections appears to help in the reduction of criminal and negative thinking patterns and behaviors.
Criminal thinking and behaviors are those actions which place individuals at risk of being involved in the criminal justice system, as well as an indicator of recidivism. It has been shown that an individual with antisocial behaviors has had at least one traumatic experience while growing up, with most children experiencing abuse of some kind. In addition, some individuals grew up with antisocial and criminal parents; therefore, being exposed to this lifestyle at an early age. Many research studies have shown childhood trauma and maltreatment are significant precursors to adult antisocial behavioral patterns.
References


