Wendy Wall: In the Wake of Childhood Trauma

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The sequelae of childhood abuse can be ongoing, particularly when a child experiences abuse over an extended period and the perpetrator is a close family member. The Diagnostic and Statistical Manual (fourth edition, text revision) diagnoses frequently associated with adult survivors of such abuse are posttraumatic stress disorder and borderline personality disorder. The following extended case study explores the appropriateness of these diagnoses for a survivor of protracted physical abuse who met criteria for antisocial personality disorder as well as for posttraumatic stress disorder. The diagnostic category of complex posttraumatic stress disorder is explored for this woman.

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As Wendy Wall, an attractive 32-year-old woman, walked gracefully into her first therapy session, she held herself bolt upright and maintained this posture when seated. She took command of the session even before seating herself, talking about how a recent attempt to write a detailed account of extensive childhood abuse at the hands of her father had triggered intrusive thoughts about the abuse as well as nightmares and insomnia. During her childhood, she was not allowed to leave the house, even to go to school, when her bruises showed. Her father gave her heroin by intramuscular-injection “skin popping” because he liked to watch her stumble around. He bound her feet. He wanted her to be a model and put her on a diet. She was not allowed friends.

Wendy tightly controlled the level of detail of her abuse history but implied she had just scratched the surface. She then curtly stated her diagnosis: posttraumatic stress disorder (PTSD). Not unexpectedly, she made no reference to a personality disorder. However, she did show evidence of antisocial personality disorder in that she abused alcohol and drugs from age 13; she spent time in jail for drug possession, larceny, and assault and battery; and she was on probation in two districts. Because of her drug use and recent incarceration, her two children were in her mother’s custody. Her
children had different fathers, and neither was the man she would refer to as her husband, despite this third man’s being her partner since years before her younger child was born.

This paper explores the relationships between Wendy’s childhood trauma history and her later difficulties via an extended case study that examines her personality disorder features and then reexamines her PTSD diagnosis.

Wendy’s symptoms and behaviors could be framed so that they satisfy criteria for PTSD, although this diagnosis is more geared to the response of a somewhat fully developed individual to an extreme traumatic stressor and not so much to symptoms following chronic trauma to a developing psyche. This chronic trauma differs from examples of trauma delineated in the *Diagnostic and Statistical Manual* (fourth edition, text revision, *DSM–IV–TR*; American Psychiatric Association, 2000), which includes events such as military combat and violent personal assault and, for children, can include developmentally inappropriate sexual experiences with or without actual violence. Wendy reported an extensive physical abuse history, and sexual abuse is not necessary to meet abuse history criteria—although it is suspect because of her father’s drugging her with heroin and binding her feet. Her childhood experience of significant ongoing abuse started by age 6 and continued until at least age 15. In trauma’s wake were three suicide attempts, 20 years where drug abuse was the organizing feature in her life, and a myriad of other difficulties (including spending time in jail).

Numerous studies have implicated childhood trauma as contributing to adult psychiatric conditions, including PTSD (Golier et al., 2003; Teicher, Andersen, Polcari, Anderson, & Navalta, 2003; van den Bosch, Verheul, Langeland, & van den Brink, 2003; Yehuda, Halligan, & Grossman, 2001; Zlotnick, Mattia, & Zimmerman, 2000), with many permutations and combinations of stressors delineated. Several studies have specifically looked at sexual abuse (McLean & Gallop, 2003; Teusch, 2003; Zlotnick et al., 2001); others have considered sexual abuse and physical abuse (Brodsky et al., 2001; Herman, Perry, & van der Kolk, 1989; Rinne et al., 2002; Rinne, Westenberg, den Boer, & van den Brink, 2000; van den Bosch et al., 2003). Disrupted parental care—including emotional abuse, neglect, or separation—has been considered as have sexual and physical abuse (Allen, Coyne, & Huntoon, 1998; Kalsched, 2003; Streeck-Fischer & van der Kolk, 2000; van der Kolk, Perry, & Herman, 1991; Wilkins & Warner, 2001; Zelkowitz, Paris, Guzder, & Feldman, 2001; Zweig-Frank & Paris, 2002). Still other studies consider adult and childhood traumatic experiences (Timmerman & Emmelkamp, 2001; Yen et al., 2002; Zanarini, Ruser, Frankenburg, Hennen & Gunderson, 2000). Lubit, Rovine, DeFrancisci, and Eth (2003) have discussed the effects of various traumatic events on children, such as physical and sexual abuse, natural and technological disasters, transportation accidents, invasive medical procedures, exposure to community violence, violence in the home, assault, and terrorism. Although differing trauma criteria hinder direct comparison of study results, many findings support the hypothesis that Wendy’s difficulties were at least in part sequelae of chronic childhood trauma.

Wendy seemed to meet criteria for her diagnosis of PTSD: satisfying both A criteria, more than the requisite one B criterion, three requisite C criteria, the two requisite D criteria, and the E and F criteria (American Psychiatric Association, 2000). She experienced significant injuries—repeated bruising and foot binding, the latter of which required reconstructive surgery—and a threat to her physical integrity (skin popping; Criterion A1). Her responses to these events are uncertain but probably included feelings of helplessness, as she made a suicide attempt at age 10 (Criterion A2). She
had persistent intrusively distressing recollections and nightmares about her abuse (Criteria B1 and B2). She avoided talking about the trauma, avoided contact with her father, and had restricted range of affect (Criteria C1, C2, and C6). She had persistent increased arousal, difficulty falling and staying asleep, and reported irritability (Criteria D1 and D2). She also reported an almost reflex response to hit someone if they tried to give her a hug, which might represent an exaggerated startle response (Criterion D5).

She had other features left unexplained by a PTSD diagnosis, but these grouped quite well under Cluster B personality disorders. Early trauma is often linked with borderline personality disorder (BPD); Wendy, however, showed more features of antisocial personality disorder. This diagnosis might help explain the major disconnect between her constrained, elegant presentation in the room and the reportedly aggressive, tremendously angry and irritable heroin user who stole to support her habit and who committed assault and battery. Wendy had repeatedly performed acts that were grounds for arrest (Criterion A1); she showed impulsivity in many hastily canceled or demanded appointments (Criterion A3); she reported irritability (Criterion A4); and she did not express remorse (Criterion A7) but rather focused on changing behavior to stay out of jail and be reunited with her children. She was well over 18 (Criterion B); some of these behaviors started before age 15 (Criterion C); and behaviors did not occur during the course of schizophrenia or a manic episode (Criterion D). Her behaviors served to get her drugs, and her current focus was on staying out of jail—unlike those with histrionic and borderline personality disorders, who are manipulative to gain nurturance (American Psychiatric Association, 2000). She did show some features of these diagnoses, however, such as shallow expression of emotions and broad-brush presentations (histrionic personality disorder). The people in her life were described at extremes of all good or all bad without presentation of nuanced, complex relationships (histrionic and borderline personality disorders). For example, her father was all bad, and her mother all good; yet, Wendy made no mention of her mother’s lack of protection from her father’s abuse. When spelling out of criteria for a diagnosis of antisocial personality disorder, there is no consideration for childhood factors that might influence its development. Yet trauma interferes with a child-learned ability to regulate arousal, which may lead to problems ranging from learning disabilities to aggression. These children are more vulnerable to act rather than reflect (van der Kolk, Herron, & Hostetler, 1994).

Another diagnostic description, and one that might better explain Wendy’s symptoms and behaviors, would be complex posttraumatic stress disorder (Herman, 1992), which speaks more to the sequelae of extensive, invasive early abuse at the hands of a person in a position of trust. The designation of complex PTSD arose because “the diagnostic categories of the existing psychiatric cannon are simply not designed for survivors of extreme situations and do not fit them well. . . . Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder” (Herman, 1992, p. 118). For chronically traumatized people for whom the trauma occurred before the establishment of a coherent self, such as survivors of chronic childhood physical or sexual abuse, the diagnosis of PTSD does not fit well. The currently articulated diagnostic criteria are derived primarily from survivors of circumscribed traumatic events (Herman, 1992). Viewing symptoms in survivors of extensive trauma as a complex form of PTSD might capture their multitude of symptoms and appropriate degree of felt suffering,
and it might also avoid reliance on Axis II diagnoses, which can be seen as pejorative (Everett & Gallop, 2001; Herman, 1992; McLean & Gallop, 2003; Resick, 2001).

McLean and Gallop (2003) used the designation complex PTSD in studying effects of childhood trauma. They found complex PTSD and BPD diagnoses significantly higher in a group of 65 women aged 19–64 who reported early- versus late-onset abuse. Pervasive deleterious effects from abuse occurring in the early stages of formation of the self seem to lend support to the diagnosis complex PTSD.

Complex PTSD is not in the DSM–IV–TR, even though many experienced clinicians see a need for a diagnosis that goes beyond simple PTSD (Herman, 1992). At the present, however, existing DSM–IV–TR diagnoses are the major means of delineating symptoms and behaviors and are important for effective communication about clients. Simple PTSD and an Axis II diagnosis in line with DSM–IV–TR criteria could help in identification of defense mechanisms, interpersonal dynamics, risk factors, and treatment design; though, the term complex PTSD could better and less judgmentally speak to the pervasive nature and far-reaching sequelae of early and ongoing childhood abuse.

Herman (1992) defined complex PTSD by seven criteria, which were presented as descriptive, as Herman did not specify how many might be required for diagnosis. From what was known of Wendy’s history, she fit most of these criteria. First, there must be a history of subjection to totalitarian control over a prolonged period of months to years. Examples are hostage situations, prisoners of war, concentration camp survivors, and survivors of some religious cults. Examples closer to Wendy’s experience are subjection to totalitarian systems in domestic life, such as domestic battering, childhood physical and sexual abuse, and organized sexual exploitation. Wendy had a history of repeated physical abuse spanning at least 9 years, and she clearly met this criterion.

Alterations in affect regulation—including persistent dysphoria, self-injury, and explosive anger-form the second criterion, which she seemed to satisfy. She had a consistent restricted dysphoric affect covering reported feelings of tremendous angry. She kept her anger under firm control but relayed one instance of explosive anger, when she assaulted a police officer.

Third are alterations in consciousness, including amnesia, hypermnesia, transient dissociative episodes, depersonalization/derealization, and reliving experiences with either intrusive PTSD symptoms or ruminative preoccupation. She had intrusive recollection of details of abuse, which emerged after trying to write a detailed history of her abuse. She did not seem to experience dissociation.

The fourth criterion for complex PTSD addresses alterations in self-perception. This may include a sense of helplessness or paralysis of initiative. A sense of shame, guilt, or self-blame may predominate, as may a sense of defilement or stigma. There may be a complete sense of difference from others: specialness, aloneness, a sense that no one will understand, or a nonhuman identity. What is known of Wendy’s history does not allow us to say she definitively meets this criterion, but she may have a sense of difference from others in a sense of aloneness. Although she did not specifically say she felt alone, she exuded a sense of aloneness, detachment, and estrangement in that the therapist felt walled off and disconnected from her.

A fifth criterion is alterations in perception of the perpetrator, including preoccupation with the relationship with the perpetrator and perhaps a preoccupation with revenge, unrealistic attribution of the perpetrator’s total power, idealization or paradoxical gratitude, sense of special or supernatural relationship, or
acceptance of the perpetrator’s belief system. Wendy sought her father out when she was in her 20s, and when she found him, he reintroduced her to heroin. It became her drug of choice. They used heroin together for awhile, probably until her second suicide attempt 6 months later. There is in this story a sense of a special, though temporary relationship and an acceptance of his way of life, if not his belief system. Wendy’s consistent abuse of substances from age 13 until the present, when she was at least partially motivated to be abstinent by a desire to stay out of jail, demonstrates adoption of her perpetrator’s way of life.

The sixth criterion Herman (1992) delineated was alterations in relations with others, including isolation and withdrawal, disruption in intimate relationships, repeated search for a rescuer, persistent distrust, and repeated failures of self-protection. Wendy withheld a lot of information about herself, which might be viewed as withholding herself and tending toward isolation and withdrawal. Referring to the minimal information she gave to one of the many therapists involved with her mother and children, she said, “She knows what she needs to know.” This behavior might also be evidence of a persistent distrust.

The last criterion for complex PTSD that Herman (1992) delineated is alteration in systems of meaning, such as loss of sustaining faith or a sense of hopelessness and despair. Wendy was a nonpracticing Catholic who maintained a firm disbelief in God or any higher power. She did not reveal whether this was a change from a previous belief system, but her lack of belief in God separated her from other halfway house residents, from those in the recovery movement, and from her own family.

The diagnosis complex PTSD seems a more apt description of Wendy’s behaviors and character features than simple PTSD and antisocial personality disorder, and it is far more likely to engender understanding and warmth on the part of therapists and other treatment providers than would traditional diagnoses. Even Wendy’s apparent lack of remorse for criminal activity might be understood as identification with the perpetrator.

However, one must ask whether these diagnoses are equivalent and whether a diagnosis of complex PTSD would wield enough explanatory power to explain an Axis I diagnosis as well as a Cluster B personality disorder. Survivors of childhood abuse often accumulate three diagnoses with negative connotations: somatization disorder, borderline personality disorder, and multiple personality disorder, which is now called dissociative identity disorder (Herman, 1992). The common denominator of these is childhood trauma, and they might be best understood as variants of complex PTSD, which may incorporate features of these diagnoses in a nonpejorative diagnosis (Herman, 1992). The features delineated in Herman’s descriptive criteria for complex PTSD seem to address at least some of the features of these three diagnoses. The presence of antisocial personality disorder features seems invident in the diagnostic description; furthermore, if an applicable variant of complex PTSD diagnosis were defined, the diagnosis might not communicate the essential features of such a person’s presentation, defenses, and needs as clearly as the Axis II diagnosis. An in-depth examination of the sequelae of childhood trauma may help answer this question.

Effects of trauma are physiological as well as psychological, thereby resulting in altered neurodevelopment (Lubit et al., 2003; Teicher et al., 2002) and hormonal dysregulation (Rinne et al., 2002; Rinne et al., 2000; van der Kolk, 1994; Zelkowitz et al., 2001). Trauma is stored in somatic memory and expresses itself in biological stress-response alterations, where intense emotions at the time of past trauma lead to chronic alterations in physiologic stress responses. The body can therefore misinterpret
innocuous stimulus in terms of reliving the trauma and as potential threat (van der Kolk, 1994; van der Kolk, Hostetler, et al., 1994).

Prolonged severe trauma, especially in childhood, often leads to a chronic inability to modulate emotions (van der Kolk, Hostetler, et al., 1994), and problems with affect regulation are likely to lead to impulsive behavior, interpersonal violence, and drug use (Streeck-Fischer & van der Kolk, 2000). Such difficulties in affect regulation are characteristic of personality disorders, particularly BPD, and many have found significant correlations between childhood trauma and Axis II diagnosis (Brodsky et al., 2001; Golier et al., 2003; Herman et al., 1989; Johnson et al., 2003; Lubit et al., 2003; McLean & Gallop, 2003; van den Bosch et al., 2003; van der Kolk et al., 1991; Yen et al., 2002; Zlotnick et al., 2001).

Numerous studies have related early trauma to BPD. Herman, Perry, and van der Kolk (1989) found a high incidence of childhood abuse (81%) in 55 patients who had BPD. The findings revealed that borderline pathology correlated positively with physical and sexual abuse and with witnessing domestic violence. Van der Kolk, Hostetler, Herron, and Fisler (1994) found BPD highly correlated with childhood history of severe abuse and neglect, although 10% of those with BPD were shy and frightened as children and reliably had no trauma history. In a study of 362 young adults aged 18 to 35, a diagnosis of BPD was correlated with dissociation, and dissociation was correlated with childhood traumas of witnessing sexual violence, caretaker neglect, and sexual abuse (Zanarini et al., 2000). The severity of personality disorder was found to be associated with severity of trauma; early-age trauma, assaulitve type of trauma, and multiple types of trauma were associated with increased severity of personality disorder in a study of 668 adults aged 18–45 with personality disorders (Yen et al., 2002). Childhood abuse has been linked to self-harm, including potentially lethal behavior. Brodsky et al. (2001), in a study of 136 adults, reported that those with childhood abuse had significantly higher aggression and impulsivity, as well as an earlier age of suicide attempt, than those without abuse; furthermore, suicide attempts and a history of abuse were positively associated with a diagnosis of BPD. Van der Kolk et al. (1991), in a study of 74 adults aged 18–39, found childhood trauma and neglect were associated with self-destructive behavior, including suicide attempt and cutting.

Although childhood trauma is often studied in relation to the personality disorder BPD, significant relationships have been found for other personality disorders, such as antisocial personality disorder (Golier et al., 2003; Lubit et al., 2003; Resnick, 2001). Lubit et al. (2003) related that intense, negative emotions resulting from trauma interfere with subsequent development of empathy and prosocial behavior. Furthermore, PTSD has been associated with antisocial personality disorder in upward of 43% of men and 15% of women (Resnick, 2001). Incidence of antisocial personality disorder was found to be significantly greater with the childhood trauma of bereavement than without (Golier et al., 2003). Sequelae of childhood trauma have been associated with impulsive behavior, illegal drug abuse, and interpersonal violence (Brodsky et al., 2001; Streeck-Fischer & van der Kolk, 2000; van der Kolk, Herron, & Hostetler, 1994)—behaviors forming three criteria for antisocial personality disorder (American Psychiatric Association, 2000). Streeck-Fischer and van der Kolk (2000) reported that physical abuse and neglect are associated with the highest rates of arrest for violent offenses and for development of antisocial personality disorder. Timmerman and Emmelkamp (2001), in a study of 39 male forensic patients and 192 male prisoners aged 20 to 70, found that over 75% of the cases

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involved a history of trauma and that emotional abuse and borderline pathology were significantly associated with dissociation. The childhood abuse Wendy experienced is then a clear, plausible contributing cause to her subsequent development of behaviors and symptoms that meet criteria for antisocial personality disorder.

In examining precursors to Wendy’s adult behaviors and symptoms, neglect may be as important as abuse. Neglect was investigated as a precursor to BPD before sexual or physical abuse and may have characterized an atmosphere where abuse could occur (van der Kolk, Hostetler, et al., 1994). Van der Kolk et al. (1991) found that neglect was the most powerful predictor of persistent self-destructive behavior in a group of 74 subjects with personality or bipolar II disorders. While childhood trauma contributed heavily to self-destructive behavior, lack of secure attachments maintained it.

Secure attachment is critical to the growing child, and a lack of secure attachments deeply affects the quality of interpersonal relationships (Kalsched, 2003; Mitchell, 2000; Winnicott, 1971). Kalsched, who based his theoretical approach on Winnicott and others, described how the child experiences inordinate anxiety, loss of parts of self, and lack of integrative mediating and containing functions unless there is good enough mothering. The child then works to organize primitive defenses around this anxiety to make meaning, defend against experiencing anxiety, and protect remnants of the true self. The child cannot give up primitive protective behaviors until he or she learns how to feel secure and competent (Streeck-Fischer & van der Kolk, 2000).

Secure attachment protects the child from adverse effects of stressful situations. The infant’s and the mother’s heart-rate curves parallel each other, and the mother has the capacity to modulate physiological arousal, reinforcing attachment with a smooth alteration between increasing and decreasing arousal. In the absence of secure attachment bonds, the child is missing critical defenses against pathology induced by traumatization (van der Kolk, Herron, et al., 1994) and may not develop an adequate biological framework for dealing with future stress (Streeck-Fischer & van der Kolk, 2000).

Lack of an adequate biological framework for dealing with stress could be a helpful context for understanding drug abuse, which is common in those who endured childhood abuse and neglect (Streeck-Fischer & van der Kolk, 2000; Teusch, 2003; van der Kolk, Hostetler, et al., 1994), as was certainly true for Wendy. Drug use may be a means of self-soothing when there are inadequate defenses against arousal; it also serves to numb and to offer protection from memories, as well as to decrease inhibition against expression of anger.

A lingering question about Wendy’s childhood trauma history is her relationship to her mother and her mother’s role while her father inflicted abuse. Wendy did not report neglect, but one wonders about this, as her mother clearly did not protect her. Wendy said that her mother had a history of alcohol problems and separated from Wendy’s father when Wendy was 16. Wendy said that she admired her mother’s strength and that she and her mother had a really good relationship. But the only details Wendy seemed able or willing to give about this relationship were that her mother bought a house so that Wendy and her children could live with her, that her mother was caring for the children, and that she was going to buy Wendy a car. These details appear two-dimensional, which could speak more to Wendy’s trauma history than to her relationship with her mother. Abused children have been found to have a marked impairment in their ability to describe their affect states in words (van der Kolk, Hostetler, et al., 1994). If her mother was numbed by alcohol during
Wendy’s early years—or if she, like Wendy, was a captive of abuse within the home—she may not have been emotionally available to engage in the mother–child dance of smooth alteration between increasing and decreasing arousal that facilitates the young child’s capacity to modulate physiological arousal and to protect against traumatic life events (van der Kolk, Herron, et al., 1994).

An examination of Wendy’s defense mechanisms might shed light on her capacity to modulate arousal and deal with life stressors. One of the defenses that Wendy was observed to use was repression in that traumatic memories were withheld from consciousness until she attempted to write her history. Repressed memory and projection are characteristic of many trauma survivors—as are dissociated memory, denial, splitting, and displacement—and may serve in development of traumatic amnesia (Whitfield, 1998). Although Wendy took control in every observed situation, she seemed to use projection when she painted others as controlling (a defense mechanism itself; Sadock & Sadock, 2003). She seemed to use intellectualization when she used recovery movement vocabulary and images—for example, “I think that’s my addictive personality talking.” She may have been using isolation, a splitting or separating of an idea from the repressed affect that accompanies it, as she talked about painful situations while expressing little painful affect. While she remained poised and contained during sessions, even when shedding tears, she drew the therapist in with descriptions of the crises and pathos of her life. These instances seemed less to establish a relationship and share meaning than for the therapist to hold the affect, a use of projective identification as described by Jureidini (1990). Through her drug use, Wendy may have been using primitive acting-out defenses, as she chronically gave in to impulses that might have served to numb and self-sooth her to avoid tension arising from painful affect and memory. This combination of narcissistic (projection), immature (acting out), and neurotic (controlling, isolation, intellectualization, repression) defenses without mature defense mechanisms (Sadock & Sadock, 2003) speaks to the complexity of her biological, psychological, and cognitive problems yet gives hope for successfulness in treatment.

Treatment would need to address the pervasive nature of her difficulties and address issues of safety, stabilize aggressive impulses, promote mastery experiences, and compensate for developmental deficits (Streeck-Fischer & van der Kolk, 2000). Although Wendy presented with a wish to avoid processing traumatic memories, they might be judiciously approached at a later time. Sensitive treatment would also include awareness that small disruptions might be seen as repetition of prior hurt and abandonment (van der Kolk, Hostetler, et al., 1994). Treatment would be subject to possible influences of past trauma on family members (Yehuda et al., 2001), as was evident with Wendy.

Within 8 weeks of treatment, Wendy’s husband died of an overdose (at a time when she thought he was safely contained in jail), and then an older brother committed suicide. The sudden, unexpected death of a loved one is a major stressor and the most common precursor to PTSD across genders (Yehuda, 2002). Added to these were other recent stressors: difficulties with the legal system, a struggle to abstain from drug use, incarceration, separation from her children, and her dealing with effects of childhood abuse. For any one of the major stressors occurring during the past year, she would be at the third level on the stress-crisis continuum described by Burgess and Roberts (1995), in which interventions would focus on bolstering her network of relationships and could include cognitive–behavioral therapy (to assist with information processing).
and pharmacotherapy (to deal with long-term physiological symptoms). Because multiple traumatic crises in the previous few months were added to cumulative crises that are not yet well resolved, she could be at the seventh level of stress–crisis, a complex level of crisis. This course of events is an example of the complex, ongoing difficulties in the lives of childhood trauma survivors and how these influence presentation and treatment considerations.

Perhaps no single diagnosis can speak to the complexities of the sequelae of childhood trauma. The environments in which the trauma is perpetrated, the age of the child, elemental features of the abuse and its duration, and a myriad of mediating factors affect presentation of the adult survivor. It is important to remember that response to trauma is complex and individual. Most children exposed to traumatic events never develop PTSD (Teicher et al., 2002). Some develop a BPD, an antisocial personality disorder, some other personality disorder, or a drug abuse disorder; and some may never even interact with the mental health system. Those who do, however, may present with features that are difficult to understand and difficult to treat. A diagnosis of complex PTSD might help in understanding, instead of blaming, and might help in developing appropriate treatment modalities as long as the complexities of adult presentation are taken into account.

References


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