Symptoms and Behavioral Manifestations Associated With Trauma
by Lyle S. Cope, Kathy Markovich and John T. Phillips

Many of us are committed to listening to the people we try to serve. Listening to someone's behavior is not always easy, especially when the person whose behavior puzzles us cannot speak. As a framework, Positive Approaches gives us a way to look carefully at a variety of possibilities; e.g., the impact of the environment, the importance of communication, the impact of clinical issues (mental health, movement differences, addictions, trauma, etc.) and the importance of the supporters to "hanging in there" long enough to see the person through. Very often we are on the outside looking in, trying to get a better sense of someone's reasons for doing what he or she does. This is a time when we have to make "respectful guesses" in order to better appreciate what it is like for someone else.

We are learning that trauma is common in the lives of people who have disabilities. There are behavioral manifestations, signs or symptoms that may indicate that trauma has occurred. We also have to be careful that in developing an awareness of how trauma can affect all of us, we don't start to see it everywhere or begin to over diagnose Post Traumatic Stress Disorder.

The following signs are offered as a guide for anyone interested in learning about the incidence of trauma. One or more signs shouldn't be an automatic confirmation that trauma is the issue. It should simply encourage us to slow down, pay attention, and explore the possibility more carefully, especially if we suspect that trauma has been part of the person's life and if our usual way of supporting people doesn't seem to help.

Mood Instability: Appearing moody, irritable, throwing tantrums, screaming, yelling, changing moods (e.g., appearing comfortable or happy one minute, then becoming sad, angry or terrified the next).

Unexplained Outbursts of Temper: Sudden, unprovoked aggression. Tantrums. Sudden bouts of rage, screaming, throwing things or destroying property. Past or present diagnosis of Intermittent Explosive Disorder, Borderline Personality Disorder, or Impulse Control Disorder.

Depression: Apparently sad. Crying. Loss of interest in activities, things, people. Changes in appetite and sleeping patterns.

Nightmares: Waking suddenly in the middle of the night and looking startled, terrified, confused or agitated. Yelling or crying out while asleep.

Sleep Disturbances: Difficulty falling asleep. Early morning awakening. Frequent waking. Sleepless nights.

Flashbacks: Frequently talking about the past. Becoming angry or fearful, with the reaction being disproportionate to the circumstances. Appearing dazed or confused. Physical changes (e.g., glazed eyes or pseudo seizures). Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. Body memories (e.g., not a conscious recollection of what one is re-experiencing but actually experiencing some of the physical pain). Acting or feeling as if the traumatic event is recurring (includes a sense of reliving the experience, illusions and hallucinations). Intense psychological distress at exposure to internal or external cues (triggers) that symbolize or resemble an aspect of the traumatic event. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Flashbacks can sometimes be misinterpreted as psychotic symptoms.

Hypervigilance: Always looking around the environment. Deliberately staying awake. Avoiding certain places or people. Having persistent fear and anxiety, or being so attentive to the environment that one can't focus on what one has to do. Staying close to staff (clingy). Keeping one's back to the wall. Always needing to see people coming. Not allowing people behind him or her. Getting startled easily, "jumpy." Wearing excessive (multiple) layers of clothing. Knowing where everybody is before walking into a room. Always aware of what's going on. This is someone who can always sense anything happening in a room.

Anxiety and Panic Attacks: Appearing fearful or even terrified. Sudden and unprovoked fear reactions accompanied by somatic or cognitive symptoms: palpitations, pounding heart, or accelerated heart rate; sweating, trembling or shaking; sensations of shortness of breath or smothering; feeling of choking; chest pain or discomfort; nausea or abdominal distress; dizziness, unsteadiness, lightheadedness, or faintness. Derealization (feelings of unreality) or depersonalization (being detached from oneself); fear of losing control or going crazy; fear of dying; numbness or tingling sensations; chills or hot flushes.

Dissociative Experiences: Appearing non-responsive to the environment. Having unexplained (inexplicable) "bouts" or episodes of anger; having "rage attacks." Inexplicable episodes of screaming, throwing things or destruction of property. Abrupt physical assault (often on people one likes). Being extremely afraid (terrified) of people one knows and trusts at times. Having periods of time when the person doesn't remember what she or he has done. During that period of time acting like a totally different person, making people call him or her by a different name, having a different facial expression and sometimes demonstrating skills others didn't know she or he had. Calling someone known by a different name. Appearing unfocused, not with it, sometimes behaving as if somewhere else. Unable to respond to people during the experience. Not remembering what one did (black outs) or how one got somewhere. Talking about past painful (and traumatic) events without any emotions. Inability to recall an important aspect of a traumatic event.

Avoidance: Efforts to avoid thoughts, feelings or conversations associated with trauma. Efforts to avoid activities, places or people that arouse recollections of the trauma

(these may appear as unusual phobias or, for example, avoiding the doctor's office, a former place where the person lived, touching certain types of clothing, certain rooms, sounds, smells, etc). Markedly diminished interest or participation in significant activities. Feeling of detachment or estrangement from others.

Inability to Experience Pleasure: Never laughing or smiling. Loss of interest in programs, work, meals, friends. Withdrawn and isolated. Restricted range of affect (unable to have loving feelings).

Unexplained Grief Reactions: Weeping for no reason. Apparently inconsolable.

Hopelessness: Appears completely disinterested in what, or if, anything happens to him or her. Appears non-responsive to environment, activities and relationships. Sense of a foreshortened future (the person does not expect to have a career, significant relationships or a normal life span).

Poor Concentration: Unable to attend to tasks. Decreased work performance. Appearing unfocused, not with it. Suspected to suffer from petite mal or temporal lobe activity.

Alcohol, Substance Abuse, and Other Addictions: Attempts to drink aftershave, mouthwash or other products. Appears to misbehave intentionally to get emergency medication. Asks for an injection. Increase in number of cigarettes smoked or cups of coffee consumed. Increase in self-injurious behaviors.

Food Consumption Disturbances: Always hungry, stealing food, refusing to eat. Weight gain and weight loss. Increased pica. Presence of gagging and vomiting.

Suicidal Thoughts and Attempts: Talks of dying. States that he or she would be "better off dead." Severe self-injurious behavior, jumping in front of a car, throwing oneself down a flight of stairs, cutting or slashing oneself with glass, swallowing dangerous objects or items.

Sexual Problems: Promiscuity, excessive masturbation, and exhibitionism. Sexually victimizing others. Identified as a "bed hopper." Sexual phobias. Not permitting genitalia to be washed. Perceived vulnerability (e.g., the person always seems to associate with others who are likely to use or abuse her or him), poor judgment or "repeated bad choices." Increased risk taking.

Desire to Hurt or Mutilate Oneself: Self-injurious behaviors, cutting, burning, scratching, picking, biting, rubbing, swallowing, etc.

Poor Self-Esteem, Shame, Guilt: Negative self-statements, "I am no good," "I can't do anything right," "No one loves me," etc.

Chronic Muscle Tension: Appearing tense or edgy, having sharp and quick movements. Increased blood pressure.

Unexplained Physical Discomfort: Always asking to see a nurse or a doctor. Suffering from pain that can't be explained or treated medically. Appearing restless. The person reports vague complaints of pain or not feeling well. The person is often described as manipulative or simply as displaying "attention seeking behavior." Constantly needing to be around others.

Headache, Stomach Ache, Dizziness: Complaining of headache or stomachache. Holding head or stomach. Asking for Tylenol. Falling, stumbling and requiring someone to hold on to while walking. Again, the person is described and perceived as manipulative or deliberately misbehaving.

Associated Features: The following is a series of features commonly associated with people who have been affected by trauma. Again, each one alone doesn't tell us much, and many of them could be explained by a variety of factors, including trauma.

- Ambivalence
- Very compliant, always wanting to please others
- Self-destructive and impulsive behaviors
- Sleeping with clothes on
- Incontinence or "bed wetting"
- Constipation
- Poor hygiene, making oneself "ugly"
- Wanting to have things a certain way (obsession or compulsion)
- Need to be in control
- Ritualized behaviors
- Hoarding
- Eating disorders
- Loss of previously sustained beliefs
- Having a hard time dealing with failures
- Hostility
- Difficulty making decisions
- Uncontrolled fear
- Feelings of ineffectiveness
- Feeling victimized
- Feeling permanently damaged
- Feeling constantly threatened or unsafe
- Feeling powerless to create change
- Feeling out of control
- Social withdrawal
- Impaired relationships with others, difficulty trusting others
- Making "false accusations"

Furthermore, we are learning that people who have been affected by trauma often have many commonalities in their histories. Psychiatric medications have frequently been tried with them. Often people have a vague and unclear psychiatric diagnosis (if any at all), but more commonly will have a collection of different diagnoses over the years. Frequently, their behaviors were unintentionally attributed to their developmental disability. They typically have a long history of placements, referrals, and comprehensive behavioral interventions, and many consultations have been arranged over time. If positive results were found, they were short term and were not generalized to the rest of the person's life. Many people have a severe reputation of being manipulative, aggressive, explosive and assaultive. Many have also spent a lot of time in restrictive settings (seclusion and restraints). The following vignettes are offered as typical examples of people with whom the authors have worked, and for whom past unresolved trauma has affected the persons' present. These examples are by no means meant to be comprehensive case histories; rather, they are intended to give rise to images of people whom you may be supporting, and to spur inquiry and team discussion about the potential effects of each person's past and current experiences.

People should also become familiar with Robert Sovner's framework to help translate symptoms of mental health issues into behavioral manifestations, especially since so many of these symptoms can also occur when someone has a mood disorder. Several of Sovner's works are listed in the Bibliography.

Hal P.

Hal P. is a 40-year-old man who spent 30 years of his life in a state center for persons with mental retardation. His home life, prior to coming to the center, was abusive. He fell from a second story window on more than one occasion, and the second time he required surgery. There is also a very strong suspicion that he was sexually abused prior to his admission to the center. It is known that during his stay at the center, he was around other men who were bigger and who engaged in sexual activity with him. Though he appeared to be a willing participant in these activities and there is no evidence to suggest coercion (Over Compliant), it is very clear that he suffered feelings of guilt about engaging in this behavior (Shame).

Hal displayed many behaviors at the center that illustrate some of the symptoms of trauma. He would stay up late at night watching TV and then get up in the morning and go to programming with no difficulty. He would not sleep during the day (Sleep Disturbance, Avoidance). If he saw a public service announcement on TV dealing with child abuse, he would become extremely distraught and talk about how bad it is to abuse a child (Flashbacks). There were also occasions when he would become defensive and not allow staff to wash his genitals, insisting that, "It's not nice to 'queer' someone" (Sexual Problems). Sometimes he would use pipe cleaners or hangers to insert in his penis. At these times he would say, "It's dirty" (Desire to Hurt or Mutilate Oneself, Shame).

Hal's story illustrates some of the symptoms and associated features that may present in those who have suffered from trauma. Given Hal's early life experiences and those he had at the center, it is highly probable that he did suffer the effects of trauma, and much of what we saw as challenging and bizarre behaviors were indicative of this. Fortunately for Hal, many staff liked him and supported him. The social relationships that he forged with paid staff were key to his overcoming his history and minimizing its impact on his everyday life. Hal's friendly nature made it very easy for others to listen to his sometimes painful stories and to want to stay with him. Hal is now living in the community in close proximity to his sister. The staff who currently support him truly like him and work diligently to make his life enjoyable. He is very content and is living his life in the context of relationships with people who support him and provide him with more enjoyment.

Margy H.

Margy H. is a 43-year-old woman who has resided in two state centers and two group homes over the past 34 years of her life. As a child, she had problems at her family home with her brothers and sister. She was placed in a state center at the age of nine. She was later transferred to a second facility, and from there to a group home. Her experiences in the group home were marred by violence and neglect, resulting in her transfer to another group home with similar results. She then was re-admitted to the second center. But subsequently she was transferred back to the original center, when the second one closed.

Margy has a long history of challenging behaviors that were not helped by behavioral interventions. The litany of attempts to change her behaviors met with little or, at best, short-lived success. Given her unstable history with frequent moves, it is easy to believe that she has suffered trauma. However, her case is complicated by the fact that she does have physical problems and a definitive mental health diagnosis. Her team works hard to separate these factors so that her treatment is optimized.

One day, a staff person was praising her and giving her a reward for her good behavior at the work site. She was smiling and then suddenly lunged across the table and bit another individual (Unexplained Outbursts of Temper). There have been other times when she would begin crying, crawl into a corner, suck her thumb and curl up in a fetal position (Social Withdrawal, Depression). She will often become upset and bite her hand and pound her head against the wall (Desire to Hurt or Mutilate Oneself).

As mentioned above, Margy has a mental health diagnosis and physical problems. This makes providing her with effective treatment difficult. However, her team is working hard to define areas and deal with individual problems as they arise. Given her history, trauma is certainly another factor that must be taken into account.

Patty T.

Patty T. is a 52-year-old woman with a profound developmental disability. She was admitted to a state center when she was only four years of age, upon the advice of her family's doctor. On the day she was admitted she was brought to the center and dropped off by her parents, who had previously agreed to have no contact with her for six weeks in order to allow her to adjust to her new surroundings. Patty was placed in a living area with 35 other children with limited staff. One can only imagine the raucous environment caused by 36 children vying for the attention of only two caregivers. Patty was dropped off in the midst of this mêlée and responded to it as any four year old child would. She was terrorized. She screamed and cried. She stomped her feet and pounded her fists. In frustration she slapped both hands on the sides of her head. She ran frantically about the area among the other children. And when one of the other children bumped into her, Patty pushed her down and kicked her. The very first entry in Patty's record indicated that she spent her first night in her new residence with "her hands tied behind her back." From that initial entry on, Patty's record has a multitude of examples describing how she was restrained, "tied to the bench." Several entries even depict how another child injured Patty while she was in mechanical restraints.

Patty would sleep only several hours a night (Sleep Disturbance) and would often awaken attempting to hurt herself. She began to spend more and more time in mechanical restraints because of an increasing number of tantrums (Unexplained Outbursts of Temper), which were characterized by intense self-injurious behavior (Self-Destructive Behavior, Suicidal Attempts). She would pound her head on hard tile floors, corners of doorframes and furniture. She often severely injured herself and anyone who was trying to keep her safe. Staff would literally weep because of her suffering and their inability to comfort her. There was nothing that seemed to console her. She would rarely laugh or smile (Inability to Experience Pleasure). And it was only after Patty grew older and had spent many years with several specific staff members that she began to bond with them (Impaired Relationships, Difficulty Trusting Others).

Patty's story not only exemplifies how difficult it is to support people who have survived traumatic histories, but it gives a small glimpse into how emotionally difficult it can be for staff and how vital it becomes to be able to "hang in there." In the long run, it was those long-time coming relationships that proved to be Patty's greatest support. With time, staff began to notice things that she seemed to enjoy--simple things like having her hair brushed and being sung to. Patty began to show favored status to certain staff. She would seek out these people and allow them to rub her arms and hands. She would smile at them and laugh if they tickled her. Patty has been restraint-free for the past six years.

Ann J.

Ann J. was an attractive 20-year-old woman of slender build with a moderate developmental disability. Ann and I met in 1989, in the state center where I worked, after she had been remanded on an emergency interim basis in lieu of a more suitable

living arrangement. She had been removed from her family home as a result of long-term sexual victimization by her father. She had endured abuse by her father and then, against her expressed wishes, she found herself living in a loud and chaotic setting away from all the people and things familiar to her. At this young age, Ann had already been diagnosed with the following: Autism, Childhood Schizophrenia, Psychotic Disorder NOS, Intermittent Explosive Disorder, Epilepsy and Borderline Personality Disorder. Her medication history was equally diverse, with clinical trials having little or short-lived effects on her presenting symptoms. Upon her admission, her mood would fluctuate rapidly, going from greeting new people with smiles to weeping and promising she would "be a good girl" if she could go home (Mood Instability, Guilt). Quite simply, she was terrified and alone.

Ann first got my attention when I entered the living area in which she was assigned, because she approached me and then would not leave my side. However, despite her close proximity, she did not try to talk to me or even catch my eye; rather, her eyes continually darted around the room toward the origin of even the slightest sound (Hypervigilance, Feeling Unsafe). Ann would spend most of her day away from the others in her living area, crying much of the time (Depression). She began to make accusations of physical and sexual abuse, typically identifying the largest or loudest staff member present as the perpetrator. Each accusation was investigated thoroughly and discovered to be unfounded (Making False Accusations). She would not enter her bedroom in the dark, and if she awoke in a darkened room she would scream, running from the area (Nightmares, Avoidance). Ann's personal hygiene began to deteriorate. According to her mother, Ann loved to take long hot showers and was extremely thorough in washing herself. However, upon admission Ann would often refuse to shower. Even on the rare occasion when she could be convinced to shower, she would not wash her genital area (Poor Hygiene, Sexual Phobia). Ann also started to refuse meals, losing twelve pounds in a month's time. Moreover, she began to refuse to take her medications, which were administered with applesauce or pudding (Food Consumption Disturbance). The more insistent staff would become in trying to get her to take her medication, the more determined she became not to take it, at times resulting in physical assaults (Unprovoked Outbursts of Temper). In fact, whenever staff would tell her to do something, she would resist. Certain staff persons were able to gain her co-operation by taking what one staff described as a "low pressure sale of the idea" approach rather than telling her what she had to do (Need To Be in Control). The staff's understanding and empathy were deeply challenged by Ann's false accusations, and the reputation she was gaining for being spoiled, manipulative and obstinately uncooperative.

Ann's responses to the situation in which she found herself were, in retrospect, understandable--even predictable. I specifically note the "in retrospect," because at the time we were first supporting Ann, the people who worked directly with her, myself included, were unaware of her history of abuse. Ann's mother, with administrative support, wanted that rather sensitive information kept quiet in order to protect Ann from any embarrassment. We learned of Ann's history during meetings that followed a rather troublesome event. As a result of refusing to take her anti-convulsant medications, and

the altercations which sometimes ensued, it was decided that she would be given medications in an intramuscular form if she continued to refuse the oral dose. The next time Ann refused to take her medications, the nurse was prepared to administer a shot; however, a favored staff person was able, at the last minute, to convince Ann to take the drug orally. During the meeting the following morning, we discussed what would have been entailed had we found it necessary to give Ann her medications intramuscularly. The debate centered around the risk of her not having her anticonvulsant medication versus the risk of physically injuring Ann in the process of administering the injection. There was a prolonged silence as we faced images of physically restraining Ann, lowering her pants and giving her an injection. That silence was broken when the social worker, in tears, told us of Ann's sexual abuse, conjuring images that too closely resembled what we had nearly done to her the night before.

Ann's story provides good examples of the behavioral manifestations of trauma, and it also clearly identifies how important it is for staff to have an awareness of these possible effects and to be mindful of them. Moreover, Ann's story gives yet another look into how emotionally difficult it can be for staff to support trauma survivors and how crucial it becomes to be able to listen to what people are telling us.

As we previously stated, many of us are committed to listening to the people we are trying to serve. Listening to someone's story, told either through words or behaviors, is not always easy. It is especially difficult when that story touches our own emotions. Trauma, by its nature, affects the person directly experiencing the traumatic event; however, it can collaterally affect a person witnessing another's trauma. It is possible for these collateral traumatic effects to plague staff who bear witness to another's trauma by listening to her or his painful stories. Therefore, it becomes essential to the effectiveness of the supports offered, for the members of the team to support each other. Ann only stayed at the state center for about three months before she was placed in a community setting near her mother.

It is the authors' sincere hope that these vignettes will serve to illustrate how the symptoms of trauma can manifest in individuals who have developmental disabilities. More importantly, we hope that they will spark discussion within teams struggling to support someone whose behavior is puzzling, about possible reasons why the person does what she or he does. It is precisely during this time when a team is the most perplexed by the person they strive to support, that it is vitally important for that team to make "respectful guesses." Powerlessness, fear, isolation, and loss form the core of the subjective experience of trauma. Therefore, empowerment, safety, understanding, and empathetic relationships must be at the heart of supporting the victim of trauma. Positive Approaches provide the ideal person-centered framework on which to build a truly supportive and healing environment.

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