

Persons With Developmental Disabilities Exposed to Interpersonal Violence and Crime: Strategies and Guidance for Assessment

Ginny Focht-New, APRN, BC, CDDN, Paul T. Clements, PhD, APRN, BC, DF-IAFN, Beth Barol, MSW, PhD, LSW, Martha J. Faulkner, RN, LISW, CFNP, and Kathryn Pekala Service, MS, RNC/NP, CDDN

PURPOSE. *Persons with developmental disabilities are frequently exposed to interpersonal violence and crime, directed at themselves and others, and are in need of specific interventions tailored to their unique needs.*

CONCLUSIONS. *What may be different in comparison to other survivors are the ways therapeutic interventions are adapted so that fears and ongoing concerns can be effectively expressed and addressed.*

PRACTICE IMPLICATIONS. *Persons with developmental disabilities may benefit from a variety of interventions in the treatment of intrapsychic trauma after exposure to interpersonal violence and crime.*

Search terms: *Assessment, developmental disabilities, intellectual disabilities, interpersonal violence, mental retardation, trauma*

Ginny Focht-New, APRN, BC, CDDN, Psychiatric Clinical Nurse Specialist, is Adjunct Professor (Harrisburg campus) and a doctoral student (Chester campus) at Widener University; Paul T. Clements, PhD, APRN, BC, DF-IAFN, is Assistant Professor and Distinguished Fellow—International Association of Forensic Nurses, Old Dominion University, School of Nursing, Norfolk, VA; Beth Barol, MSW, PhD, LSW, is Assistant Professor, Center for Social Work Education, Widener University, Harrisburg, PA; Martha J. Faulkner, RN, LISW, CFNP, is nurse practitioner, Children’s Psychiatric Center—Outpatient Services, University of New Mexico, Albuquerque, NM; and Kathryn Pekala Service, MS, RNC/NP, CDDN, is nurse practitioner, Massachusetts Department of Mental Retardation, Franklin-Hampshire Area Office, Northampton, MA.

Background and Significance

Although there is a significant lack of scholarly literature regarding the traumatic impact of exposure to interpersonal violence and crime in persons with developmental disabilities (DDs), such events are clinically and anecdotally reported to occur at greater rates than the general population (Petersilia, Foote, & Crowell, 2001). Such violent acts include physical assault, sexual assault, robbery, auto theft, burglary, domestic violence, exposure to suicide and homicide, and hate crimes, which occur in a wide variety of locations, such as assisted living centers, group homes, private homes, in transit with Paratransit, parking lots, nursing homes, schools, and in the work place (Abramson, Cameron, & Mastoleo, 2004). Few of these crimes are reported to police, and even fewer are prosecuted because officials hesitate to pursue cases that rely on the testimony of a person with DDs (Department of Justice, 2002). A DD increases vulnerability to intrapsychic reactions for posttraumatic stress disorder (PTSD) in the chaotic postexposure aftermath (McCarthy, 2001).

The term *developmental disabilities*, as defined by the *Developmental Disabilities Act of 1984* (P.L. 98-527),

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indicates a severe chronic disability that (a) is attributable to a mental or physical impairment or a combination of mental and physical impairments, (b) is manifested before age 22, (c) is likely to continue indefinitely, and (d) results in substantial functional limitations in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. When the complexities of having DDs, such as limitations in communication and information processing, are combined with interpersonal violence and crime, it becomes a challenge for the interdisciplinary team to recognize the intrapsychic impact and conduct a comprehensive mental health assessment. Furthermore, therapeutic interventions, other than psychopharmacology, are often not a potential option in anyone with limited verbal communication (Hollins & Sinason, 2000).

The advanced practice psychiatric nurse (APPN) can take the lead in assisting the team to maximize assessment that will guide subsequent treatment when working with people with the challenges of DDs. By adapting traditional approaches, using creativity with flexibility, traumatized persons with DDs can participate in the assessment process, work through the impact of the event, learn to cope, and express their feelings.

Implications for Assessment

The optimal response to a traumatic event, even in light of otherwise typical affective responses, is to experience no subsequent posttraumatic symptomatology within the initial 3–6 months postexposure (American Psychiatric Association, 2000). This indicates that the person has successfully managed to integrate the traumatic event into their life experience. The person is able to acknowledge the traumatic event and is not compelled to dwell on or avoid it through psychological defenses. The ability to successfully integrate the trauma will depend on several factors, including

appraisal of the situation, previous experiences, and the capacity to process the life event.

If a person is unable to integrate the traumatic event into his or her life history, then an acute PTSD response may ensue. This is identified by a display of intrusive or avoidant behaviors, which may be new behaviors reflective of the traumatic exposure or the reemergence or increased frequency and severity of previously displayed disruptive or disturbing behaviors. Exposure to stressful stimuli may induce a state of hyperarousal and/or numbing, which may cause the victim to experience highly emotional states with lower levels of thinking. This may often be misinterpreted as manipulative behavior, perhaps secondary to a personality disorder, or psychosis. Instead, the ego cannot adapt to the trauma and becomes disorganized, flooded, and overwhelmed, and the person may describe visual and motoric reliving of traumatic events with nightmares and flashbacks that are generally preceded by physiological arousal (Gibson, 2007). Disruptions may affect sensory, perceptual, cognitive, and interpersonal performance levels. Symptoms of sensory disruption can include hyperactivity, headaches, stomach aches, back pain, and nightmares, especially in people with limited verbal ability (Lunskyl & Benson, 2001).

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Perceptual and cognitive disruptions may involve both internal and external cues that produce intrusions of images, auditory, and kinesthetic information associated with the trauma (Miller, Litz, Greif, & Wang, 2001) and may lead to future concerns about repeated

danger (Burgess, Hartman, & Clements, 1995). Symptoms of interpersonal disruption include biphasic response patterns of avoidance and aggression.

The avoidant pattern is characterized by denial of the event. The person may display a lack of energy for learning and living. Avoidant patterns of behaviors, such as an excessive fear of others, may be demonstrated in persons with DDs as worries about who is working specific shifts at an agency or group home, repeating statements about seemingly unrelated events, and an inability to assert or protect oneself. They may appear distant and alienated, with a preoccupied daydreaming quality to their behavior. Phobic mannerisms can be present in their avoidance of cues or situations that trigger unpleasant sensations or memories. Refusals to participate in day programs or work without obvious reasons may occur. A decline in skill development may happen where there had been prior gains. This pattern may also be mistaken for psychotic symptoms, as they may be found talking to themselves, appearing as if they are attending to internal stimuli, seeing something others cannot see, or experiencing seizure activity. Assessment for differential diagnosis is imperative at this juncture.

The aggressive pattern is characterized by acting-out behavior, which may be bold or secret, including aggression toward self, peers, caregivers, and pets (Burgess et al., 1995). There can be testing and breaking of the rules, increased impulsivity, property destruction, or self-injurious behavior, including suicide attempts over seemingly minor conflicts. Diagnostic overshadowing due to the DD results in interpretation of these patterns as manipulative or attention-seeking behavior.

Trauma Learning

When the body and mind become overwhelmed with the traumatic event and can no longer successfully manage the impact upon daily life, trauma learning may occur. This learning can be observed in several presentations. These include reenactment of

the trauma, repetition of the trauma as either victim/victimizer, and displacement of the aggression (Burgess et al., 1995; van der Kolk, 1989).

Reenactment

Reenactment is experienced as recollections of the traumatic event. This may occur as flashbacks that often contain fragmented detail and an intense sensory experience. In persons with DDs, there may be repetitive themes and aspects of the traumatic event expressed via interactions with others, including the onset of previously unobserved behaviors (Burgess et al., 1995) or reemergence or exacerbation of previously observed disturbing behaviors. Frightening dreams may occur with unrecognizable content. The person may fear that the perpetrator will reenact the violence with them just as they did the original victim. Fear surrounding the safety of family and the home environment might also be heightened. In many people with DDs, these manifestations are often mistakenly viewed as simply being challenging behavior rather than demonstrating symptoms of trauma. It is important to be able to distinguish the origin of the behavior in order to develop appropriate treatment to assist the person.

Repetition

During this stage of the trauma learning process, behavioral patterns are generally noted in interactions with others. The behavioral repetition of the trauma may be played out in either the role of the trauma victim or the role of the victimizer. Repetition of the trauma in the role of the victimizer is a major cause of aggression and violence. It can be suggested that traumatized persons with DDs will attempt to act out the dynamics of the event on others who are usually smaller and weaker in an attempt to gain a sense of control or mastery over the trauma that originally happened. They may also have fantasies of injuring or even killing the perpetrator, especially if they were personally victimized or if the victim was someone emotionally close to them, such as a housemate, parent, caregiver, or sibling (Burgess et al., 1995).

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Displacement

During the displacement stage, behaviors and thoughts of the trauma are elaborated symbolically. The elaboration may manifest itself as a dream or fantasy, including symbolic representations of the violent act. Ultimately, this symbolic elaboration may lead to psychotic reactions that have patterns of the original trauma embedded in them and may be acted out with significant force.

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Implications for APPNs

When a person is unable to link ongoing, self-defeating, disrupting cognitions, emotions, and behaviors to the original trauma, there is no resolution or integration, and the underlying fear persists. This leads to an inability to use new experiences to develop and grow. Instead, the flexibility of the person to discriminate new information may be lost, and the person is either numb to the new information, hyperalert, or may perceive it as dangerous (Burgess et al., 1995).

As evident in the myriad symptoms that can occur after a traumatic event, exposure to interpersonal violence clearly places persons with DDs at risk for PTSD and is typically expressed via disruptive symptoms and behaviors. Although there is a large foundation of literature that examines assessment for PTSD in persons who have been exposed to trauma and abuse of various types, there is a paucity of research specific to people with DDs exposed to interpersonal violence and crime. There is a need for research specific to this type of exposure supported by the pervasive nature of

violence in the United States, and the APPN is uniquely prepared to provide sensitive and comprehensive intervention and, subsequently, to provide guidance to the interdisciplinary treatment team.

Promoting Mental Health and Adaptive Coping

Until relatively recently, it was widely believed that people with DDs could not recognize or understand trauma and loss and, consequently, did not experience the sequelae (Clements, Focht-New, & Faulkner, 2004). For people with significant cognitive disability, it was even assumed that they would not remember or be affected by trauma (Pease, 2000). Traumatic events, by virtue of the sudden imposition of loss of control and inequity of power, inherently represent a loss to the survivor, and the sequelae do ensue (even if without a clear understanding of the relation to the traumatic event). There has been a bias in the field that persons with DDs do not have a full range of feelings; however, clinical experience has now been validated with a significant expansion in the extant scientific and anecdotal literature that acknowledges that people with DDs do have full emotional capacities (Arthur, 2003).

Levels of understanding, coping, and adaptation are related to cognitive development. Many persons with DDs have not had the opportunity to “learn a language” with which to express their feelings; so loss and fear may be expressed through physical symptoms, such as incontinence, complaining of a “stomach ache,” or more often, through negative behaviors, such as apathy, self-injury, or aggression. These behavioral symptoms may be attributed to pathology or to the DD diagnosis itself (again diagnostic overshadowing), with consequent attention given to the symptoms of the behavior. Thus, treatment considering the cause (i.e., sequelae related to trauma from exposure to interpersonal violence and crime) is often neglected. As a result, these individuals often have much higher levels of complicated trauma because their fears and losses are not openly acknowledged, socially supported, or publicly mourned (Lavin & Doka, 1999).

Family and other caregivers need to become better informed about trauma and how to support and provide opportunities and ways for people with DDs to express their needs and feelings. The emotional needs and issues of caregivers (and their own personal history of intrapsychic trauma) play an important part in the provision of this support and also need to be addressed. There may be conflicts between caregivers and families in their beliefs on the recognition of such trauma and any subsequent interventions, which require careful acknowledgement and a plan for conflict resolution.

Persons with DD need concrete explanations of the "event," and they benefit greatly from help in "finding their voices" or ways to tell the story; particularly, regarding the truth about the painful event and assistance to achieve a sense of safety, well-being, and connection to the world. Interventions based on the individual's expressive ability and cognitive development, like pictures and drawing, may be beneficial (Clements, Benasutti, & Henry, 2001). Other suggestions that may help the person include psychotherapy, particularly group work (Arthur, 2003); avoidance of programming that re-evokes a traumatic event and, again, psycho-education (including stress-reduction techniques and approaches for crisis intervention); and programmatic and/or community-based support for staff and family (Pease, 2000).

Healing components of trauma include a supportive, safe environment, physical health assessment and care, stress reduction/stress management techniques, protection from treatment paradigms with overwhelming participant burden, facilitation to live as normal a life as possible, opportunities to make lasting relationships, and having meaningful use of the day. These, coupled with the opportunity to tell the trauma story safely with acceptance, if so moved, build a sense of powerful self.

Pivotal to the healing is the biopsychosocial environment. The key people in this approach are the supporters who should be known as "social therapists." According to Barol (2001), the social therapist is a person who is in close and supportive contact with another person. The role of the person, family member, caregiver, teacher,

nurse, etc., is not as relevant here as the intention and manner in which the person carries out his or her relatedness with the person. Social therapists are not trained, licensed healthcare providers, rather caregivers who provide an important role in socializing the patient (Barol).

People with DDs usually live with continuous psychosocial assaults against their sense of self and are often surrounded by people who think of them as being "other," "different," and "less than." They learn lessons throughout their lifespan in response to these attitudes and experiences. Externally, the behaviors that these people evidence seem maladaptive, dysfunctional, and "weird." Social therapists are intent on relaying to persons with DDs that they have unconditional value in their eyes. Therapists, by being effective and caring role models, work in the best interests of the persons with DDs, by assisting them to develop skills to make and maintain relationships and to problem solve through social situations. Persons with DDs also will learn to develop skills and expertise to acquire status and mastery in their own environments.

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Assessment Using Biographical Timeline

In the human services field, particularly in work with persons with DDs, the past 30 years have reflected a movement to focus exclusively on the here-and-now element of practice. This stance was assumed with good intentions, as there was a dawning awareness that many of the challenging behaviors shown by people with DDs could be changed through behavioral

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modification techniques—notably punishment paired with reward. It was initially posited that dwelling on the past was counterproductive, intending to allow people to have fresh starts with their new support staffs.

For many people with DDs, whose behaviors were directly related to living in negative circumstances, moving to behavioral management (now called positive behavioral support) from behavioral modification was enough to produce dramatic changes in behavior. However, for the rest of these people, these approaches were not sufficient. Some people changed for periods of time and then reverted back to reacting with challenging behaviors. Others continued on with their challenging behaviors without change. However, it was clear that there was something more occurring than *here-and-now* response to the stimulus of the environment.

Utilizing examination of an individual's past for clues, biographical timelines can provide insight regarding challenging behaviors in relation to ongoing small traumas and subsequent interpersonal trauma or criminal events (Barol, 2001; Barol, Gelo, & Joyce, 2002). The biographical timeline is used to educate the support team to the issues, intrapsychic wounds, and missed opportunities that occurred in a person's life, which, in turn, build empathy among the interdisciplinary team members for the person's perception of the traumatic event and the offender. This can mobilize resources and create a healing environment by addressing the specific needs that have been identified through the individual's biography.

Persons with DDs respond well to a broad range of therapeutic modalities, including Gestalt, Cognitive Behavioral, Reality Therapy, and Music Therapy, among others (Focht-New, 2004). Eye Movement Desensitization and Reprocessing is also emerging as an effective treatment with some people with DDs as part of a treatment paradigm (Seubert, 2005).

Relatively few therapists, however, feel confident in providing therapy for these individuals due to the overshadowing of the DD label (Focht-New, 2004). Interestingly, when we have shown groups of therapists a biographical timeline, absent of the diagnosis of DD,

therapists have come up with very good treatment plans and feel confident in their effectiveness to help. When we add back in the DD factor, they tend to feel more confident in their ability to help given the context of the biography.

While it is helpful and important to have therapists involved with people with PTSD, people with DDs do best when they are in an environment where the social therapists and other support persons are tuned in and able to deal directly with issues as they arise. The following case example illustrates this point.

Case Example

Ralph (pseudonym) was abandoned by his abusive and neglectful mother when he was 11 years old. Throughout his life he had witnessed multiple episodes of domestic violence perpetrated upon his mother by her many boyfriends and he had been subsequently beaten during his mother's episodes of rage. One night, she dropped him off at a local group home and never came back. Ralph lived in the group home for 4 years without seeing or hearing from his mother. He was a highly anxious and occasionally aggressive young man. One day Ralph received a card in the mail. He asked his house parent (social therapist) to read the card to him. She told him that it was an Easter Card (He was excited!). When she opened the card, a five-dollar bill dropped out (He was even more excited! He grabbed up the money), and then she read the card to him: "Happy Easter, Love MOM!"

Ralph instantly dropped the money and fell to the floor. He rolled up in the fetal position and groaned and whimpered. He was clearly distraught. His house parent bent down near him and said, "Ralph, you have power here. You can do whatever you want; you can keep the money, keep the card, throw away the money, throw away the card, keep the money and throw away the card. It is all up to you."

Ralph jumped up, picked up the money, and said, "Throw away the card," and went upstairs to his room. The social therapist, knowing Ralph's biography

and about the intense abuse that he had experienced both as witness to his mother's abuse and direct recipient at the hand of his mother, was able to meet Ralph empathetically when he received the card. She was able to offer him options that left him with a feeling of empowerment with regard to his mother. While it wasn't a "cure," Ralph was better able to talk about his feelings and showed more mastery over his impulses after that incident. It is this type of "on-the-spot" counseling, based on historo-biographical mental health assessment, that is pivotal to unraveling the lessons of trauma and promoting healing.

Palliative Psychopharmacology

In conducting a psychopharmacological evaluation of the person with DD, a comprehensive assessment of the person's individual and family psychiatric and medical history is essential, as it provides insight into dynamics that might additionally impact current symptomatology. When meeting with the individual (and their caregiver), it is important to stress the treatment goals of pharmacotherapy as reducing PTSD symptoms, improving resilience to stress and quality of life, and reducing further disability and comorbidity (Davidson, Stein, Shaley, & Yehuda, 2004). Special consideration regarding communication deficits must be given. If the person's verbal or cognitive skills prevent them from communicating verbally, their emotional, affective, and behavioral status can be realized from direct observation of the person alone and by questioning supportive caregivers and/or guardians. A thorough history of previously or currently prescribed psychotropic medications is essential, as well as the dates they were prescribed, the symptoms that were targeted, the response of the symptoms to the medication, and any possible side effects experienced. To ensure that there are no underlying medical causes that could be causing or contributing to current symptoms and behaviors, it is essential that the person had a physical examination within the past year or in many situations just prior to the evaluation.

In prescribing psychotropic medications to the person with DDs who also has PTSD after exposure to interpersonal violence or crime, it is important to target the presenting complaint and symptom constellation.

Which Medication to Choose?

The pathophysiology of the development of PTSD is multifactorial, but the pharmacology specifically targets the dysregulation that occurs in the noradrenergic and serotonergic neurotransmitter systems (Ellingrod & Barnett, 2005). In prescribing psychotropic medications to the person with DDs who also has PTSD after exposure to interpersonal violence or crime, it is important to target the presenting complaint and symptom constellation. Three major symptom clusters are seen in individuals who have PTSD: reexperiencing phenomena of the trauma, avoidance and numbing phenomena, and hyperarousal. Flashbacks, recurrent nightmares, and psychotic-like symptoms characterize the reexperiencing cluster. Avoidance of stimuli and memories of the trauma, depression, and a sense of foreshortened future typify the avoidance and numbing cluster. An increase in autonomic nervous system discharge with ensuing difficulties in sleep, concentration, anger and aggression, anxiety, depression, and insomnia distinguish the hyperarousal cluster. It is critical to differentiate between those symptoms that were precipitated by the traumatic event and symptoms present prior to the event that have reemerged or been exacerbated by the event. An example of this would be the behavior of stereotypical head banging that had previously been eliminated but now reoccurs or

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increases in intensity or frequency subsequent to the traumatic event.

Selective serotonin reuptake inhibitors (SSRIs) are first-line agents in the treatment of PTSD (Ellingrod & Barnett, 2005) due to their efficacy in all symptom clusters (Anis, Kohn, Henderson, & Brown, 2004) and their low side-effect profile. These agents include fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram, and escitalopram. Serotonin-2 (5HT₂) antagonist nefazodone and trazodone are antidepressants but have the favorable side effect of sedation, which can help alleviate insomnia and/or nightmares. Antihypertensive agents, such as propranolol, guanfacine, and clonidine, can reduce hyperarousal as well, but they must be used cautiously as these can cause postural hypotension and sometimes sleep disturbances. Severe PTSD symptoms can include extreme internal disorganization, which may present as severe dysregulation of emotions, perception, and behavior. Auditory and/or visual hallucinations and paranoia may be present along with debilitating anxiety. Although typical neuroleptics have been used frequently in the past, they will not be addressed in this article due to the more favorable side-effect profile of atypical neuroleptics.

Atypical neuroleptics, such as risperidone, olanzapine, and quetiapine, have been beneficial for rapid reduction of psychosis, aggression, and extreme anxiety. Quetiapine is particularly sedating and, therefore, helpful if the individual has difficulty getting to sleep or maintaining sleep. Benzodiazepines have been utilized in extreme cases of trauma-related panic, but must be used cautiously due to their addictive potential. In treatment of persons with refractory PTSD, anticonvulsants, such as valproate, carbamazepine, and oxcarbazepine, may help stabilize rapidly shifting moods or aggression. Miscellaneous medications, such as buspirone, are used less commonly but can be helpful in some cases of unmanageable anxiety.

Selective serotonin reuptake inhibitors have a fairly benign side-effect profile but can cause nausea, vomiting, diarrhea, and headache, as well as sexual side effects.

Nefazodone and trazodone have the side effect of sedation. Nefazodone has had a recent black-box warning regarding hepatotoxicity (Bristol-Myers Squibb, 2001), and trazodone can cause the unwanted problem of priapism. Antihypertensive agents, such as propranolol, guanfacine, and clonidine, can cause postural hypotension, headache, dizziness, dry mouth, and sometimes nightmares. Atypical antipsychotics have a much reduced chance but not absent occurrence of extrapyramidal symptoms, risk for tardive dyskinesia, and neuroleptic malignant syndrome. Anticonvulsants all carry the risk of life-threatening Stevens-Johnson syndrome rash, and carbamazepine induces its own and concurrent drug metabolism. This is only a cursory list of the most common side effects, and it is incumbent upon the prescribing practitioner to thoroughly know the mechanism of action, duration of effect, and side effects of these psychotropic medications.

Prescribing Guidelines

Prior to prescribing psychotropic medication, it is important to determine if the person with DDs is able to understand the medication's indications, alternatives, benefits, risks, and side effects. Assessment of the individual's capacity to understand and give informed consent to treatment should be evaluated on an individual basis. If unable to understand and give consent, the parent, caregiver, or guardian should be included in the decision-making process and given much needed education regarding the medication. Someone that knows the person well and with whom they feel comfortable (social therapist) should also accompany the person to the psychopharmacology assessment in order to provide a comprehensive evaluation. Written and verbal information regarding the medications that is clear, concise, and free of jargon should be given to the individual (and their caregiver if needed) at the appropriate developmental level, along with a picture of the medication. This enables the individual and their support person to

make best use of the intervention and subsequently receive the greatest benefit. It is also important to discuss the nature of psychotropic medications in treating psychiatric disturbances and to explicitly review that it may take time to find just the right medication for the person with DDs. Additionally important to include in the conversation should be a review of the length of time for the desired effect to occur, particularly related to reduction of important trauma-related disruptive symptoms, such as hyperarousal, sleep, mood disturbance, or flashbacks. Although some medications may initially sedate and calm the individual within the first few days of administration, it is usually not until much later, usually weeks and sometimes months, that they will receive the full benefit. Discussing the benefits, alternatives, risks, and possible side effects of the medications thoroughly and early on assists in adherence to the agreed-upon treatment. It is key to partner with the individual and caregivers in the management of medication within the parameters of the environment and supports, and it is also vital that the use of medication be paired with environmental and other therapeutic supports.

Finally, drug interactions are possible when prescribing psychotropic medications to persons with DDs because multiple-drug regimens are common in this population, probably due to the frequent coexistence of medical and psychiatric disorders. Many individuals may be on antiepileptic agents to manage comorbid seizure disorders; therefore, it is important to assess for possible drug interactions prior to prescribing and to make every effort to avoid polypharmacy with psychotropic medications.

Sociopolitical Implications for Assessment

In the United States, the Victim Rights Movement of the 1970s and 1980s resulted in the creation of many programs dedicated to assist victims of crimes. The local, state, and federal governments passed laws establishing certain rights for victims. These rights may vary from state to state depending on the legislation

adapted by each state and the available resources within. Unfortunately, these foundational rights and significant services may be often overlooked for victims of violence who have DDs. However, the national Office for Victim Assistance reminds that anyone can be a victim of crime, and it subsequently offers helpful hints for victims of violence and their families and caregivers (which apply both to people with and without DDs) (see sidebar).

Summary

In conclusion, persons with DDs are exposed to more violence and exposed more often than people in the general population. They experience all the same reactions and symptoms that everyone does; the difference is in the interpretation of the experience and the expression of symptoms relative to trauma learning and PTSD.

With assessment that adapts to the person's disability and some creative ideas, such as using the biographical timeline, the individual can be supported therapeutically by the entire interdisciplinary team. The team must include the individual, the family or primary caretakers, the psychiatric nurse—when involved, and most importantly the “social therapists” who carry through therapeutic interventions via their relationships in the home environments. In addition, there are a variety of therapies that, when used in combination with medications, will address PTSD in people with DDs.

The APPN is a key member of the team who can guide recognition of symptoms of PTSD, assist in organizing information to be communicated to the prescribing physician/nurse, and provide therapy. With everyone working together to support the individual with DDs, there is a great chance of helping the person to achieve their own success after exposure to interpersonal violence and crime.

Author contact: gfocht@aol.com, with a copy to the Editor: mary@artwindows.com

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Tips for Coping

These are some ideas that may help victims cope:

1. Find someone to talk with about how you feel and what you are going through. Keep the phone number of a good friend nearby to call when you feel overwhelmed or feel panicked.
2. Allow yourself to feel the pain.
3. Keep a journal (*this can be adapted to include narrative, drawings, artwork, etc.).
4. Spend time with others but make time to spend alone.
5. Take care of your mind and body. Rest, sleep, and eat regular healthy meals.
6. Reestablish a normal routine as soon as possible, but don't overdo.
7. Make daily decisions. This will help to bring back a feeling of control over your life.
8. Exercise, though not excessively, and alternate with periods of relaxation.
9. Undertake daily tasks with care. Accidents are more likely to happen after severe stress.
10. Recall the things that helped you cope with trying times and loss in the past, and think about the things that give you hope. Turn to them on bad days.

Things to avoid:

11. Be careful about using alcohol or drugs to relieve emotional pain. Becoming addicted not only postpones healing but creates new problems.
12. Make daily decisions, but be careful to avoid making life-changing decisions in the immediate aftermath, since judgment may be temporarily impaired.
13. Don't blame yourself—it wasn't your fault.
14. Your emotions need to be expressed. Try not to bottle them up.

For some victims and families of victims, life is forever changed. Life may feel empty and hollow. Life doesn't "mean" what it used to. Part of coping and adjusting is redefining the future. What seemed important before may not be important now. Many victims find new meaning in their lives as a result of their experience. It is important to remember that emotional pain is not endless, and that it will eventually ease. It is impossible to undo what has happened, but life can be good again in time.

For family and friends of a victim of crime:

1. Listen carefully.
2. Spend time with the victim.
3. Offer your assistance even if they haven't asked for help.
4. Help with everyday tasks like cleaning, cooking, caring for the family, and minding the children.
5. Give them private time.
6. Don't take their anger or other feelings personally.
7. Don't tell them they are "lucky it wasn't worse"—traumatized people are not consoled by such statements.
8. Instead, tell them that you are sorry such an event has occurred to them, and you want to understand and help them.

(Federal Bureau of Investigation Victim Assistance, n.d.)

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