IDENTIFICATION OF TRAUMA SYMPTOMATOLOGY AND CLINICAL MANIFESTATIONS: IMPLICATIONS FOR TRAUMA-INFORMED COUNSELLING

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Abstract
Trauma is pervasive, having a long-lasting diverse impact. It might not always be apparent that someone is suffering from a past traumatic experience. A deeper understanding of the complex symptomatology and clinical manifestations of an individual's traumata is vital to developing appropriate diagnoses and treatments. This study adopted the survey research design to investigate trauma symptomatology and clinical manifestations in the general population in Abia State, Nigeria. Two research questions and two hypotheses guided the study. Data were collected using the Trauma Symptoms and Clinical Manifestation Questionnaire (TSCMQ) from 40 professional counsellors and 20 medical doctors purposively sampled from the study area. Data generated were subjected to analysis using mean and standard deviation for the research questions and t-test for the hypotheses. Findings indicate that counselling and medical professionals identify trauma symptoms like concentration problems, enhanced nervous reactions, avoidance, hypervigilance and sleep problems, loneliness, sadness, interpersonal alienation, diminished pleasure, irritability, deviant behaviour, impulsivity, and somatic complaints, self-injury, suicidal thoughts among others. Specific item differences were observed. Few differences were observed between the professionals in the clinical manifestations of substance abuse, behavioural problems, psychotic symptoms, suicide attempts, physical health problems (sleep difficulties), decreased psychosocial functioning and poor quality of life. The null hypotheses were not rejected. We recommended that the identification of trauma symptoms and clinical manifestations should be included in Counsellor Education programmes where it does not exist. The paper highlighted the implications of the findings.

Keywords: Trauma, Symptomatology, clinical manifestations, trauma-informed care

Introduction

Trauma is perceived as a threat to life or physical and psychological effects that overwhelm an individual's coping mechanisms with lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being (Van Der Kolk, 2015). Continuing, Van

Der Kolk (2015) asserts that trauma affects the individual's brain, mind and body, negatively changing how individuals view themselves and the world around them. Identification of trauma symptoms and clinical manifestation is key to promoting prevention, data-driven investigation, and broad-based trauma interventions (Frydman & Mayor, 2017). Traumatic events impair and complicate developmental tasks that can lead to disruptive behaviours in the future (Frydman & Mayor, 2017). Understanding how traumatic events impact the way one sees the world and being proactive in addressing trauma is the first step in trauma-informed care.

Trauma has been conceptualized differently. Some authors present trauma in general as an identified event or series of events experienced by the individual as physically or emotionally harmful, threatening, or overwhelming. Trauma is seen as an event that overwhelms the ordinary human adaptation to life and the person's sense of control that can lead to maladaptive internalization of the event (Ringel & Brandell, 2012; van der Kolk, 2015). Such maladaptive internalization may result in disturbance to bio-psychosocial functioning, healthy development, and brain performance in regions that are related to emotions, behaviour, and executive functioning (van der Kolk, Ford & Spinazzola, 2019).

According to Kuban and Steele (2011), Little, Aiken-Little, and Somerville (2011), traumatic events also include medical procedures, drowning accidents, house fires, car fatalities, divorce, substance-abusing parents, death, injury, sexual and physical abuse, severe accidents, cancer or life-threatening illness, natural or artificial disasters, war, banditry, COVID-19, kidnapping, terrorism, physical punishment, female genital mutilation/cutting, child labour, prostitution, pornography, bullying, and suicide. Poverty; displacement from homes, and having a parent serving in a war zone are also experiences that were considered traumatic, especially for children (Taylor-Dietz, 2021). From the list of traumatic events above, it is evident that many individuals face traumatic events daily, oblivious of their consequent effects.

Experiences are considered traumatic if they happen to the individual directly, to their loved ones or to other people around them. DeLore (2016) articulated what might be considered traumatic to include but not limited to experiencing or observing physical, sexual, and emotional abuse; childhood neglect; having a family member with a mental health or substance use disorder; experiencing or witnessing violence in the community or while in the military; natural or artificial disasters and forced displacement; sudden, unexplained separation from a loved one; war or terrorism; poverty, discrimination, and historical trauma. Bridgland, Moeck, Green, Swain, Nayda, Matson, … Takarangi (2021) found sufficient empirical evidence that COVID-19 is a traumatic event that elicits PTSD-like responses and exacerbates other related mental health problems (anxiety, depression, psychosocial functioning).

Again, Pappa, Ntella, Giannakas, Giannakoulis, Papoutsi and Katsaounou (2020) contend that the COVID-19 pandemic, anxiety and fear of contracting the virus, public health instructions, and measures for confinement and social and physical distancing may be traumatic events. They are also likely to increase the risk of multiple traumatic experiences and complex trauma among children and adolescents (Collin-Vézina, Brend, & Beeman, 2020; Guessoum, Lachal, Radjack, Carretier, Minassian, Benoit & Moro, 2020).

Studies validate the deleterious effects of unresolved trauma or adverse childhood experience

(ACE) on future life outcomes, including mental and physical health, social problems, sexually offensive behaviours, and death (Jung, Herrenkohl, Klika, Olivia-Lee, & Brown, 2014; Levenson & Grady, 2016). Research in mental health indicates high correlations between trauma and substance use disorders (SUDs) (Banducci, Hoffman, Lejuez & Koenen, 2014). Histories of traumatic experiences are risk factors for Borderline Personality Disorder (BPD) (Bozzatello, Rocca & Bellino, 2019). Taylor-Dietz (2021**)** found that trauma is a risk factor for developing various behavioural health and substance use disorders. Nevertheless, these effects of trauma may not be in the repertoire of those in the helping profession.

Furthermore, Kuban and Steele (2011) pointed out that children experiencing trauma often view themselves and the world differently, because they lose their ability to make sense of their experiences. Effects of trauma also include dropping out of school, violence perpetration, internalizing problems (posttraumatic stress disorder), alcohol-related problems, and illicit drug use (Voith, Gomoske, & Holmes, 2014). It is necessary to identify the symptoms of trauma and clinical manifestations, which may inform professional practice.

It should be recognized that not all children or adults exposed to potentially traumatic events experience long-term health problems. This may be due to protective factors which help shield individuals from the lasting effects of trauma. Such protective factors include parental knowledge of child development; healthy parent-child attachment; social connections; and social and emotional competence (Austin, Lesak & Shanahan, 2020).

The complex symptoms of individuals who experienced repeated interpersonal traumata and the limitation of current diagnoses for these patients emphasize the need to understand the symptoms of traumatic experiences. Understanding trauma symptoms is needed to develop appropriate diagnoses and treatment. There is ample evidence of a wide range of symptoms experienced by trauma survivors (Resick, Bovin, Calloway, Dick, King, Mitchell, …Wolf, 2012).

Finkelhor, Turner, Shattuck and Hamby (2013) found that four of every ten children reported experiencing a physical assault during the past year. Other reports indicate that more than 60% of youth age 17 and younger have been exposed to crime, violence, and abuse directly or indirectly (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015).

Previous research showed that experiences of different adverse life events might result in different inter-relations of psychological symptoms (Burger, Stroebe, Perrig-Chiello, Scht, Spahni, Eisma & Fried, 2020; Cramer, Borsboom, Aggen, & Kendler, 2012). De Haan, Landolt, Fried, Kleinke, Alisic, Bryant,…Meiser-Stedman (2020) investigated a symptom network of dysfunctional posttraumatic cognitions, posttraumatic stress and depression symptoms of trauma-exposed children and adolescents. Pfeiffer, Sukale, Muller, Plener, Rosner, Fegert,…Unterhitzenberger (2019) found traumatic symptoms as strong or overwhelming emotions, strong physical sensations, difficulty concentrating, nightmares, psychological reactivity, physiological reactivity as well as concentration problems as the most central symptoms.

DeLore (2016) also identified common signs of unresolved trauma as:

1. Anxiety or panic attacks that occur in what would be considered typical situations
   A feeling of shame; an innate feeling that they are worthless, or without importance

2. Suffering from chronic or ongoing depression
3. Avoiding people, places, or things that may be related to the traumatic event.
4. Flashbacks, nightmares, and body memories regarding the traumatic event.
5. Addiction and eating disorders in an attempt to escape or numb negative emotions.
6. Sleeping issues, as well as trouble going to sleep or staying asleep
7. Suffering from feelings of detachment, or feeling "dead inside" (This is perhaps the most devastating of the signs because it creates a feeling of loneliness and isolation)
8. Dissociation leads to disconnect in situations and conversations
9. Hypervigilance (a constant feeling of being on guard)
10. Suicidal thoughts or actions
11. Uncontrollable anger; acting on it
12. Self-harm, cutting, and mutilation
13. Not being able to tolerate conflicts as they once would have
14. Unexplained or irrational fears of people, places, or things.

Knowledge of the possible signs and symptoms of trauma may equip practitioners with facts that might lead to evolving treatment parameters that will reduce re-traumatisation.

Trauma can manifest physically and emotionally. Iachini, Petiwala and DeHart (2016) and Sajnani, Jewers-Dailley, Brillante, Puglisi, and Johnson (2014) identified the manifested trauma symptoms as self-isolation, aggression, attention deficit and hyperactivity. Others include paleness, lethargy, fatigue, headaches, stomach problems, sexual dysfunction, poor concentration and a racing heartbeat. Such victims may have anxiety or panic attacks and are unable to cope in certain circumstances. Some familiar emotional manifestations of trauma include denial, anger, problem concentrating, sadness and emotional outbursts (Wang, Cotton, Duval, Tamburrino, Brickman, … Liberzon, 2016).

Some sources of trauma are rape, domestic violence, natural disasters, severe illness or injury, the death of a loved one, witnessing an act of violence, and plagues such as COVID-19. Nothing good comes from ignoring trauma symptoms. It only causes the trauma to go deeper, metastasising like cancer. In addition to intensification and greater frequency of trauma symptoms, untreated trauma often leads to self-medicating with prescription and illicit drugs, as well as excessive alcohol consumption.

The theoretical underpinning of this study represents a paradigm shift in how professionals perceive and treat survivors of trauma. Trauma-based paradigm refrains from viewing survivors' poor functioning as resulting from sickness, weakness, or deficiencies in moral character. It reframes from viewing survivors as psychologically and physically weak, instead, in need of healing and help (van der Kolk, 2015). Contemporary trauma theory (CTT) provides a theoretical framework for understanding the impact trauma has on a person's functioning. It is based on the following central properties: dissociation, attachment, reenactment, long-term effect on later adulthood and impairment of emotional capacities. This theory is relevant as victims of trauma display compromised ability to regulate their moods and their emotional responses as adults, including the ability to identify emotions in self and others, to understand emotions, and to self-regulate, leading to internalizing and externalizing problems that may require intervention.

Trauma-Informed Care (TIC) is an approach that focuses on understanding, recognising and responding to the effects of the many and varied types of trauma. There is a body of empirical evidence that trauma is pervasive and that the impact is broad and diverse. The effects are profound and life-shaping (Jung, Herrenkohl, Klika, Olivia-Lee, & Brown, 2014; Levenson & Brady, 2016). However, it might not always be apparent that someone is suffering from a past traumatic experience, which can lead to symptoms being judged and misunderstood as character flaws or moral failures. By addressing the impact of trauma and facilitating healing, behavioural health providers not only build trust more reliably and deliver better services but also reduce the chance that a vulnerable client is re-traumatised.

Trauma-informed care is based on the following underlying assumptions: recognize the signs and symptoms of trauma in clients, families, staff and others who are involved; realize the widespread impact of trauma and understand the potential paths for recovery; respond by fully integrating knowledge about trauma into policies, procedures and practices; and resist re-traumatization (R^4).

It is difficult to achieve trauma-informed care without understanding the symptomatology and clinical manifestations of trauma survivors. There is a need for trauma symptoms and clinical manifestations to be identified and specified in literature to serve as a guide for professional practice. This underscores the relevance of the present study on the identification of trauma symptomatology and clinical manifestations as perceived by professional counsellors and medical doctors.

Statement of the Problem

The effects of traumatic experiences are pervasive with a long-lasting impact on the individual and can be so severe as to interfere with an individual's ability to live everyday life. Professional help may be needed to assist the victims to deal with the stress and dysfunction caused by the traumatic event and to restore the individual to a state of emotional well-being. Symptoms and clinical manifestations are not easily discernible. It is not apparent that someone is suffering from a posttraumatic experience, leading to symptoms being judged and misunderstood as character flaws or moral failures. It is expedient to identify the symptoms and clinical manifestations of those who experience posttraumatic events. This information may provide practitioners with vital clues towards identifying clients suffering from past traumatic events, which will adequately guide them to select relevant intervention strategies and avoid re-traumatization. The problem of this study, therefore, is to identify the symptoms and clinical manifestations of trauma as perceived by professional counsellors and medical doctors.

Research Questions

What are the perceived signs and symptoms of traumatic experiencesfi
What are the clinical manifestations of traumatic experiencesfi

Hypotheses

$H0_1$ Counsellors' perceptions of traumatic signs and symptoms do not significantly differ from those of medical doctors.

$H0_2$ There is no significant difference between the perceptions of counsellors and medical doctors on the clinical manifestations of traumatic experiences of patients.

Methodology

This study adopted the descriptive survey research design. Participants were 40 professional counsellors and 20 medical doctors purposively sampled from Umuahia in Abia State, Nigeria, with more than ten years of post-qualification experience. The instrument for data collection was the "Trauma Symptoms and Clinical Manifestation Questionnaire" (TSCMQ), with 33 items. It is a five-point Likert-type scale ranging from strongly agree to strongly disagree with values ranging from 5 to1. The decision rule is three and above as acceptable mean and 2.99 and below as not accepted. It has two clusters. Cluster A deals with the signs and symptoms of trauma made up of 21 items, while cluster B deals with the clinical manifestations of trauma with 12 items. The instrument was validated by three experts, two in Guidance and Counselling and one in Measurement and Evaluation. The reliability index of 0.83 was established using Pearson's Product Moment Correlation which was suitable for the study. Data collected were analysed using mean and standard deviation for the research questions and t-test for the hypotheses at a 0.05 level of significance.

Results

Research Question One: What are the perceived signs and symptoms of traumatic experiencesfi

Table 1: Mean and Standard Deviation of Perceived Signs and Symptoms of Traumatic Experience

	Cluster A: Signs And Symptoms	Counsellors			Medical doctors		
		$\overline{X}$	SD	Decision	$\overline{X}$	SD	Decision
1	Nightmares around the traumatic event	4.57	0.95	Accept	3.45	0.77	Accept
2	Poor memory	4.00	0.87	Accept	3.75	0.45	Accept
3	Difficulty concentrating	4.33	0.77	Accept	4.00	0.86	Accept
4	Disorientation	4.08	0.97	Accept	4.25	0.78	Accept
5	Mood swings	3.47	1.18	Accept	2.75	0.95	Accept
6	Avoidance of the activities that could trigger memories of the event	4.38	0.72	Accept	3.85	1.05	Accept
7	Social isolation	4.09	1.10	Accept	3.45	0.77	Accept
8	Feeling of loneliness	3.80	1.05	Accept	3.25	0.82	Accept
9	Lack of interest in previously enjoyed activities	4.40	0.76	Accept	4.05	0.95	Accept
10	Easily startled	3.66	1.32	Accept	4.20	0.76	Accept
11	Tremendous fatigue	3.19	0.85	Accept	4.30	0.88	Accept
12	Racing heartbeat	4.50	0.76	Accept	4.24	0.50	Accept
13	Being often on edge	4.70	0.82	Accept	4.05	0.85	Accept
14	Sleep problems	3.25	0.77	Accept	3.75	0.76	Accept

15	Chronic muscle pain	3.55	0.89	Accept	4.45	1.05	Accept
16	Sexual dysfunction	4.45	0.78	Accept	3.82	0.77	Accept
17	Irritability	4.40	0.92	Accept	4.00	0.97	Accept
18	Compulsive behaviour	3.10	0.84	Accept	3.88	0.76	Accept
19	Emotional numbing	4.50	0.77	Accept	4.20	1.10	Accept
20	Guilt feelings	3.45	1.05	Accept	2.80	0.89	Accept
21	Feeling anxious	4.65	0.88	Accept	3.56	0.65	Accept
	Total	**4.00**	**0.49**	**Accept**	**3.81**	**0.45**	Accept

Table 1 shows that professional counsellors and medical doctors identified all the items in the table as signs and symptoms of traumatic experiences. The means above 3.00 were seen in all the items, with the overall mean of 4.00 SD 0.49 for professional counsellors and 3.81 SD 0.45 for medical doctors.

HO_1 Counsellors' perceptions of traumatic signs and symptoms do not significantly differ from those of medical doctors.

Table 2: The T-test Analysis of the Mean Difference in the Perceptions of Professional Counsellors and Doctors of Traumatic Signs and Symptoms

Groups	N	$\overline{X}$	SD	df	t.cal	t.critical	Remark
Counsellors	40	4.00	0.40	2	1.6636	1.96	Not significant
Medical doctors	20	3.81	0.45	58			

The result of the t-test above shows that the calculated t value is 1.6636 with 58 degrees of freedom is less than the critical value of 1.96, which is not statistically significant. The hypothesis is thus not rejected.

Research Question Two: What are the clinical manifestations of traumatic experiencesfi

Table 3: Mean and Standard Deviation of Perceived Traumatic Clinical Manifestations

	Cluster B: Clinical Manifestations	Counsellors			Medical Doctors		
		$\overline{X}$	SD	Decision	$\overline{X}$	SD	Decision
22	Substance abuse	3.91	1.11	Accept	4.05	0.55	Accept
23	Behavioural problems	3.58	1.44	Accept	3.88	0.78	Accept
24	Sleep difficulties	3.91	1.04	Accept	4.00	1.05	Accept
25	Self-destructive behaviour	3.50	1.11	Accept	3.75	0.77	Accept
26	Suicidal ideation	3.75	1.08	Accept	4.45	0.49	Accept

27	Sexual dysfunction	4.08	0.75	Accept	3.75	0.85	Accept
28	Decreased psychosocial functioning	3.92	0.86	Accept	3.25	0.66	Accept
29	Anxiety	4.41	0.76	Accept	4.55	0.92	Accept
30	Headaches	4.58	0.49	Accept	4.65	0.85	Accept
31	Lethargy	4.25	0.72	Accept	3.36	1.11	Accept
32	Poor concentration	4.30	0.74	Accept	3.45	0.86	Accept
33	Racing heartbeat	4.00	0.81	Accept	4.41	0.92	Accept
	TOTAL	**4.02**	**0.31**	**Accept**	**3.96**	**0.45**	**Accept**

Table 3 above shows that both counsellors and medical doctors accepted all the items as clinical manifestations of traumatic experiences with slight variations. Mean scores were above the acceptable mean of 3 points.

HO_2: There is no significant difference between the perception of counsellors and medical doctors on the clinical manifestations of traumatic experiences of patients.

Table 4: The T-test Analysis of the Mean Difference in the Perception of Professional Counsellors and Doctors of Clinical Manifestations of Traumatic Experience

Groups	N	$\overline{X}$	SD	df	t.cal	t.critical	Remark
Counsellors	40	4.02	0.31	2	0.6054	1.96	Not significant
Medical doctors	20	3.96	0.45	58			

The t-test analysis in Table 4 shows that the calculated t value is 0.6054 with 58 degrees of freedom, showing that the difference is not significant leading to the non-rejection of the null hypothesis at a 0.05 level of significance.

Discussion of Findings

The result of research question one shows that most of the symptoms listed in the questionnaire were accepted as signs and symptoms of post-experience of trauma. They are nightmares, poor memory, difficulty concentrating, disorientation, avoidance, racing heartbeat, sexual dysfunction, irritability, and anxiety, among others. The result is in line with De Haan *et al*. (2020) and Pfeiffer *et al*. (2019), who found symptoms like intense or overwhelming emotions, intense physical sensations and difficulty concentrating as the most central. The current findings corroborate that of DeLore (2016), who identified common signs of unresolved trauma as anxiety or panic attacks, feeling of shame, chronic or ongoing depression, nightmares, addiction and eating disorders, sleeping issues, loneliness, isolation, dissociation, hypervigilance, suicidal thought among others. Participants in the present study might have observed similar symptoms during their professional duties.

Regarding the second research question, clinical manifestations of trauma include substance abuse, behavioural problems, sleep difficulties, suicidal ideations, sexual dysfunction, headaches, and poor

concentration, among others. This result is in line with those of Iachini et al. (2016) and Sajnani et al. (2014), who identified lethargy, fatigue, headaches, stomach problems, sexual dysfunction, suicidal tendencies, poor concentration and a racing heartbeat, among others, as clinical manifestations of post-traumatic experiences.

The two hypotheses analysed were not rejected. This is an indication that our result did not provide sufficient empirical evidence to conclude that professional counsellors and medical doctors surveyed do not significantly differ in their perceptions of the symptoms and clinical manifestations of trauma.

Implications for Trauma-Informed Counselling

Germane to trauma-informed counselling practice is the ability to work flexibly and attend to trauma issues. The primary implication of the findings of this study for trauma-informed counselling practice is not to wait for explicit problems related to traumatic experiences to emerge before addressing trauma in the sessions but to follow a model of prevention-assessment-intervention proactively. Counsellors are in a unique position to disseminate trauma-informed materials to students, staff and the community in a preventative manner. Signs, symptoms and clinical manifestations of past traumatic experiences so identified will equip both practitioners and victims of the root of their challenges.

Another implication is the need to develop qualitative behavioural assessment using the identified signs, symptoms and clinical manifestations. Using relevant skill sets and instruments within a trauma-informed model will help to identify those in need who may be reluctant or resistant to explicitly ask for help.

Identifying trauma symptoms and clinical manifestations will adequately equip counsellors to provide individuals with targeted, trauma-informed interventions based on previous knowledge of individual trauma and through overall assessment.

Limitations

Certain limitations should be considered when interpreting this study. Firstly, due to the small sample size (60), it should be interpreted with caution as this may not be sufficiently representative to be generalisable to a broader population. Secondly, the questionnaire is a self-report questionnaire and so is not devoid of individual bias inherent in such questionnaires. Thirdly, we used the same instrument for both counsellors and medical doctors with different practical and theoretical orientations. However, the identified limitations do not invalidate the findings of the study that has been added to the body of knowledge of trauma-related issues that are widespread in the general population.

Recommendations

Based on the findings of the study, we made the following recommendations:

1. Counsellor educators should emphasise on trauma-informed counselling approach by highlighting the signs, symptoms and clinical manifestations of post-traumatic experiences and their impact on their education programmes.
2. Counselling Curriculum planners should ensure that Trauma-related issues are part of the curriculum of counsellor education programmes if not already there. This has become

expedient considering the widespread nature of traumatic events in the environment.

3. Professional counsellors should embark on education and information dissemination on the signs and symptoms of trauma and the need for individuals experiencing such symptoms to access help early to avoid its devastating effects.

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