

Knowledge of trauma

An ability to draw on knowledge that although diagnostic criteria vary in their detail, post-traumatic stress disorder (PTSD):

is defined as a disorder that follows exposure to an extremely threatening or horrific event, or series of events

consists of three core elements:

1) re-experiencing vivid intrusive memories (flashbacks) or nightmares that involve re-experiencing in the present, accompanied by fear or horror

2) marked internal avoidance of thoughts and memories, or external avoidance of activities or situations reminiscent of the traumatic event(s)

3) hyperarousal (a state of perceived current threat in the form of hypervigilance or an enhanced startle reaction)

An ability to draw on knowledge that diagnostic criteria for PTSD indicate that symptoms should persist for several weeks and interfere with normal functioning

An ability to draw on knowledge that:

acute trauma refers to PTSD in response to a single traumatic event

chronic trauma refers to a traumatic event that is repeated and prolonged (e.g. domestic violence, child abuse, bullying)

complex PTSD reflects exposure to varied, multiple and prolonged traumatic events, often of an invasive interpersonal nature, and is characterised by symptoms of PTSD as well as disturbances of self-organisation, including:

emotional dysregulation

interpersonal difficulties

negative self-concept

An ability to draw on knowledge that traumatic events that do not lead to a diagnosis of PTSD can also have an adverse impact on mental health

An ability to draw on knowledge of treatment guidelines for PTSD (e.g. National Institute for Health and Care Excellence and Scottish Intercollegiate Guidelines Network guidance)

An ability to draw on knowledge about the neurobiological impact of repeated traumatic experiences in childhood and its implications for treatment, including:

that hyperarousal (e.g. extreme fear, anger, guilt, shame) or hypoarousal (numbing, derealisation, depersonalisation) are adaptive responses that reflect the child's efforts to maintain a relationship with abusive caregivers (which is essential for their biological survival)

that hyperarousal and hypoarousal in response to threat shuts down prefrontal cortical functioning, limiting the analysis and processing of information (and that treatment needs to operate within a 'window of tolerance', i.e. when the person is neither hyper- or hypoaroused)

An ability to draw on knowledge that comorbidity of PTSD with other mental health disorders is common

An ability to draw on knowledge that trauma can result in different levels of symptom complexity, related to:

the duration and severity of trauma to which the person has been exposed
the resilience of the person

Knowledge of dissociation

An ability to draw on knowledge of symptoms/signs of dissociation to recognise its presence, for example:

depersonalisation (feeling that one's body is unreal, changing or dissolving; out of body experiences; appearing 'spaced out')

derealisation (the world appears unreal or distorted, e.g. objects changing shape, size or colour, or other people appearing like robots)

dissociative amnesia (not being able to remember incidents, experiences or important personal information)

identity confusion (feeling uncertain of who one is)

identity alteration (recurring switches between states of how a person experiences their role or identity, or more dramatic shifts in how a person presents [e.g. different voice, posture, priorities, behaviour, thinking pattern, etc.] that others may notice)

An ability to draw on knowledge that prolonged chronic trauma is likely to lead to a greater propensity to dissociate

An ability to draw on knowledge that dissociation occurs on a spectrum, ranging from dissociative episodes (such as occur in single-event PTSD) through to increasing fragmentation of personality containing separate emotional self-states and, in its extreme form, separate identities

An ability to draw on knowledge that because work with individuals with severe and chronic dissociation will be challenging, practitioners should work within the limits of their competence and experience, and within the parameters of the service context (e.g. the number of sessions routinely available)