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 PSTD 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

- An ability to draw on knowledge of levels of dissociation that can occur in PTSD, where the emotional impact of past traumatic events is partially suppressed and its re-emergence causes significant distress:
  - primary dissociation: found in people who (prior to the trauma) had a well-integrated, functioning sense of self, and where there has been a single traumatic event
  - secondary dissociation: found in people with a less integrated sense of self (such as people with a diagnosis of borderline personality disorder) where multiple traumatic events are suppressed, and which break through at different times
  - tertiary dissociation: found in people with a disintegrated sense of self who have experienced multiple traumatic events that have been suppressed
    - an ability to apply this knowledge to formulation and treatment planning (e.g. as an indicator of the need to apply grounding techniques)

- An ability to draw on knowledge of ways that dissociation presents, for example:
  - problems with identity or sense of self
  - closing down experience (loss of function, amnesia, perceptual distortions [e.g. of sounds or smells], depersonalisation, derealisation[1])
  - becoming overwhelmed (e.g. by intrusive images or thoughts)
  - changes in awareness (e.g. not being present, losing track of time, difficulty concentrating or becoming too absorbed)
    - an ability to apply this knowledge to formulation and treatment planning (e.g. as an indicator of the need to apply grounding techniques)

[1] See ‘Knowledge of dissociation’ competences for definitions.