## 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:

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

## Knowledge of dissociation

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| 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) |

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| 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 |

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| 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) |

## Knowledge of the Adaptive Information Processing (AIP) model

- An ability to draw on knowledge of the AIP model, which proposes that:
  - there is an innate physiological system designed to assimilate disturbing experiences by linking them with existing memory networks (resulting in an adaptive resolution and a psychologically healthy integration)
  - the operation of the AIP system can be disrupted by a trauma or other adverse life experience, such that perceptions:
    - are stored not in the normal associative memory system but in a way that does not allow them to connect to the more adaptive information networks
    - remain in a 'state-dependent' form that can be triggered by internal or external cues (and so give rise to the symptoms of PTSD and other disorders)
  - bilateral stimulation paired with focusing on the trauma or adverse experience enables memories to be reprocessed and adaptively stored (shifting from implicit/non-declarative memory to explicit/declarative memory and from episodic to semantic memory systems)
  - as the memory moves from a dysfunctional to a functional form:
    - there is an adaptive shift in all components of the memory, including the sense of time and age, symptoms, reactive behaviours and sense of self
    - the negative manifestations of the memory dissipate, and the positive ones become more vivid