Contact us

BACP and BACP Healthcare Team welcome your queries on healthcare counselling and psychotherapy related issues. To get in touch, please email us at healthcare@bacp.co.uk or telephone 01455 883 300 (ext 331) to leave a message for a member of the team. Please remember to quote your membership number.

Contribute to HCPJ

HCPJ welcomes feedback, original articles and suggestions for features and themes for future issues. Please send your emails, views and opinions to hcpj.editorial@bacp.co.uk

Editorial

Revisions to the mental health bible of diagnosis – the American Psychiatric Association Diagnostic and Statistical Manual (DSM) – have progressively widened the gateway to the diagnosis of post-traumatic stress disorder (PTSD) over the past 30 years, making it more likely that therapists will treat traumatised clients. This trend looks set to continue, aided and abetted in the UK by the National Institute of Health and Clinical Excellence (NICE) and the Improving Access to Psychological Therapies (IAPT) programme.

The development is a bit of a double-edged sword, writes Stephen Joseph. On the one hand, it has meant increasing resources available to care for those afflicted by trauma, and an increasing interest in trauma research. On the other, it can lead us to lose sight of important truths: in particular, that the vast majority of people exposed to trauma do not develop PTSD, but conversely often report positive changes. The flip side is that the main determinants of PTSD become the individual vulnerabilities that people bring to their experience – personality development, ineffective ways of coping and inadequate support systems.

From this perspective, it is clear that addressing underlying emotional and social issues will be of central importance to recovery for many, perhaps most, clients. Effective approaches are likely to involve a lot more joined-up working than many counsellors and psychotherapists have been used to, of the sort described by David Murphy in his article on the value of multidisciplinary working in the field. IAPT services, working optimally, could play a major facilitative role here in terms of signposting and support.

Along with inappropriate service design, deeper emotional issues that underlie maladaptive coping strategies in response to trauma doubtless account for why many people with complicated trauma-related issues often end up being passed from one professional to another, or falling through gaps in the healthcare services and so receiving no help at all. Chris Purnell makes a persuasive case for professionals continuing to bear in mind individual attachment strategies in such contexts. Particularly useful also are his pointers on how to recognise attachment styles, and make sure that an appropriate approach is offered that ties in with clients' needs.

Psychological debriefing is arguably at the opposite end of the spectrum of trauma interventions. It was a relief to read, in Stephen Regel's piece, that this '...has been consistently and misleadingly viewed as a form of psychological treatment' – giving rise to a lot of confusion and a misapprehension that 'counselling doesn't work' for those who are suffering from psychological trauma. Stephen Regel also touches on social support being a major protective factor following trauma, and mentions, along with Stephen Joseph, the more positive changes that can arise from an experience of trauma, including an enhanced sense of personal resilience.

Martin Alderton's article on CCP's work with critical incident debriefing following large and smaller scale traumatising incidents ties in nicely with this. Once again, the focus is on health and wellbeing rather than on pathology, and the CCP programme of care includes non-clinical and clinical contacts (with the non-clinical, 'defusing' element providing practical as well as emotional support). All rather encouraging.

Penny Gray
Editor