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The American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (APA, 2013) currently understands what it calls "post-traumatic stress disorder" (PTSD), a diagnosis which first appeared in DSM-III (APA, 1980), to involve:

> exposure to actual or threatened death, serious injury, or sexual violence … [the] presence of one or more … intrusion symptoms … persistent avoidance of stimuli associated with the traumatic event(s) … negative alternations in cognitions and mood associated with the traumatic event(s) … marked alterations in arousal and reactivity associated with the traumatic event(s) … [for] more than one month … [causing] clinically significant distress or impairment in social, occupational or other important areas of functioning. (pp. 271-272)

The concept of post-traumatic growth (PTG), which first emerged in the mid-1990s, encompasses many manifestations of post-traumatic "positive change" (Joseph, 2015, p. 180).

This paper offers a person-centred political critique of some directions identified in the current PTSD and PTG research discourses, research discourses which will increasingly effect practitioner and public understandings of PTSD and PTG and which are, therefore, highly political.

Person-centred approaches (PCAs) seem not to always have an entirely clear position in relation to politics. Carl Rogers (for instance, Rogers, 1978) wrote politically, and yet, as Proctor (2006) says, PCAs have been accused of being "individualistic" (p. 1). I speak as an academic/activist sociologist and person-centred psychotherapist-in-training, recognising both unique individuals and their location in the social structures of society, such as power dynamics present in the field of psychopathology.

In this paper, I argue that such power dynamics are evident in individualising and pathologising emerging notions of PTSD being linked to lower resilience (Regel & Joseph, 2010), faulty brains (Bell, 2007), lower intelligence (Bomyea, Risbrough & Lang, 2012), and faulty femininity (Lilly, Pole, Best, Metzler & Marmar, 2009); and that the more person-centred language of PTG is being enabled to develop in similar ways (Joseph, Murphy & Regel, 2012; Joseph, 2015).

Drawing upon neuroscientific contributions which suggest the presence of faulty brains, I contend that what is happening now to PTSD has parallels with how what is currently

understood as “Borderline Personality Disorder” (BPD) has developed (see Shaw & Proctor, 2005), and that this is not being noticed by psychotherapists and wider society. BPD is attracting more public criticism (e.g. Watts, 2016), and, if we are not careful, this particular wheel will need inventing again soon for PTSD.

My feeling is that PCAs need more confidence if they are to intervene in the current PTSD conversation. PCAs do have a place there, as evidenced by practice in this field (e.g. Murphy, Archard, Regel & Joseph, 2013; Murphy & Joseph, 2014; Joseph, 2015); as Proctor (2002) put it: PCAs *can* have the “power of individuals within a group of equals, to suggest and be listened to” (p. 37).

PCAs could insist that incongruence is actually “universal” (Biermann-Ratjen, 1998, p. 114), that no-one at all is fully-functioning, and that what is currently called PTSD is really one incongruence amongst many, rather than a psychopathology encountered by some (deficient) people who need experts to treat them and make them whole again.

Such argumentation would draw clearly upon Rogers’ (1978) contentions that people do not need to be “guided, instructed, rewarded, punished and controlled” because they have the tendency to actualise, “to move towards growth” (p. 8), but, given that PCAs have increasingly sought to enter the psychopathology field on *its* terms rather than person-centred terms, more important to progress in this field is that PCAs themselves become more person-centred, perhaps by revisiting the relevance of existentialism in our work, and by recognising that what some call pathology is merely “an essential reminder of our vibrant and dangerous aliveness” (Deurzen, 2010, p. 238).

The paper starts by introducing psychopathology and its relationship with PCAs. A critical analysis of PTSD is then offered. In the UK, the National Institute for Health and Care Excellence (NIHCE), an organisation which gives “national guidance and advice to improve health and social care” (NICHE, 2005, p. 4), currently recommends trauma-focused cognitive behavioural therapy (T-FCBT) and eye movement desensitisation and reprocessing (EMDR) as psychotherapeutic treatments for PTSD; consequently, they are then explored in comparison with PCAs, which are not mentioned by NICE (2005). Murphy et al. (2013) reveal that PCAs *are* now increasingly available in specialist trauma services in the UK; and Murphy and Joseph (2014) show the efficacy of PCAs with PTSD, declaring the approach a “radical ontology for trauma” (p. 12). This more practice-based material is explored to show that there is an increasingly strong place from which PCAs can intervene into the PTSD conversation in the ways proposed in this paper.

PSYCHOPATHOLOGY AND PTSD: CRITIQUES AND CONNECTIONS

Lemma (1996) stated that “psychopathology generally refers to patterns of maladaptive behaviour and states of distress which interfere with some aspect of adaptation” (p. 1), and Joseph and Worsley (2005) wrote that “psychopathology refers to the study of unusual, distressing and dysfunctional psychological conditions” (p. 1).

Notions of a condition being considered unusual clash with Murphy et al.’s (2013, p. 435) observation that PTSD diagnoses are “increasingly common”, and references to maladaptive behaviour obscure how people are much more than one of their perceived behaviours.

Furthermore, “diagnostic heterogeneity” (Kroes, Whalley, Rugg & Brewin, 2011, p. 526) needs to be recognised. Curwen and Ruddell (2008) explain that a process of “ruling out” happens, and “when all other diagnoses in the differential diagnosis have been ruled out the

correct diagnosis is presumed to remain" (p. 16). As Lemma (1996) said, there is "mystery" (p. 1) here.

Not all diagnosis is led by psychiatry, though; PTSD first appeared in 1980 with reference to war veterans (Humphreys & Joseph, 2004). Veterans wanted this diagnosis, so that they would be entitled to access treatment (Burstow, 2005, p. 430). Following feminist lobbying in the 1980s and early 1990s (Humphreys & Joseph, 2004, p. 561), in DSM-IV (APA, 1994), PTSD encompassed abuse survivors (Burstow, 2005, p. 432), whose pain also needed to be acknowledged in a public way.

As such, diagnosis can be meaningful. A client of Rutherford (2007) saw the term PTSD as "an anchor amidst her experience of disintegration" (p. 160). Harper and Speed (2014), however, point to diagnosis leading to a "devalued [identity]" (p. 40).

PCAs have been viewed as having "little or no relevance" (Joseph & Worsley, 2005, p. 1) to psychopathology. Joseph and Worsley (2005) feel that PCAs have been "isolated" from psychiatry, causing marginalisation (p. 1). They feel that "we have a duty to understand our psychological and psychiatric colleagues" (Joseph & Worsley, 2005, p. 2). This is indeed very important, and, indeed, reading Freeth (2007) (a psychiatrist and psychotherapist) may prompt empathy with psychiatrists; Freeth (2007) says that psychiatrists "are expected to take responsibility" and "condemned for being controlling" (p. 102).

Perhaps most compelling from the psychiatry literature, in my view, is what is termed "post-psychiatry". Tseris (2013) explains this as aiming "to grapple with issues of context and meaning, challenging the primacy of biological explanations and yet not denying that mental distress is an embodied experience" (p. 161). This suggests some common ground with PCAs, for as Sanders and Tudor (2001) say, PCAs can make a "specific contribution to the [psychopathology] debate in viewing personality as a process rather than as a structure" (p. 153). Tudor and Worrall (2006), for instance, offer a vignette in which a woman client who "describes alienation from her species [humans]" comes alive when birds fly past the window, enabling her therapist to "refocus on her vitality and authenticity" (p.159).

Joseph (2005) carefully explores how person-centred personality processes, behaviour and defence can be applied to PTSD. Joseph (2005) feels that: "PTSD symptoms are ... another way of talking about ... the breakdown and disorganisation of the self-structure" (p. 192). People experience a "denial to awareness of existential experiences" (p. 192), and "trauma shows us the limits of the human condition" (p. 194). PTSD intrusion/avoidance symptoms can be understood as the person "[attempting] on the one hand, to accurately symbolise in awareness their experience (intrusion) and on the other, to deny their experiences and hold onto their pre-existing self-structure (avoidance)" (Joseph, 2005, p. 194). While Joseph (2005) accounts for the diagnosis of PTSD in a way that can be followed by PCAs, that should not mean that PTSD itself should be accepted uncritically by PCAs; we need to look more deeply at the implications of embracing PTSD as it is currently constructed.

In the newest DSM, DSM-5 (APA, 2013), "Anxiety Disorders have been redistributed into three ... classifications [including] Trauma- and Stressor-Related Disorders" (Reichenberg, 2014, p. 35). This renders PTSD more descriptive. Even in previous DSMs, PTSD was "one of only a few diagnoses ... whose symptoms [were] attributed to situational causes alone" (Hodges, 2003, p. 409). This way of seeing has obscured a more important point made by Hodges (2003) that: "PTSD ... cannot be conceptualised as a 'normal' response to trauma and simultaneously be called a 'disorder'" (p. 411). Indeed, Burstow (2005) explores whether PTSD responses are 'disordered' at all. She says "it is unclear what makes … responses symptoms of a disease, it is not even clear that these are unfortunate or unwise responses. It depends

on the context" (p. 434). Furthermore, DSM-5 (APA, 2013) introduces three new symptoms to PTSD diagnosis, including: "persistent and distorted cognitions that lead the person to blame self or others" (Reichenberg, 2014, p. 48). This seems ripe for an implication that anything that happens to an individual is their own responsibility.

Regel and Joseph (2010) say "there are no 'right' and 'wrong'" (p. 3) trauma reactions. This feels untrue as they also say "some people may be less resilient" (p. 1). Furthermore, as research starts to identify types of intrusive thoughts, a position is now being reached where there are right and wrong intrusive thoughts: "brooding is thought to impede cognitive processing ... reflection is thought to facilitate cognitive processing" (Stockton, Hunt & Joseph, 2011, p. 85). While it is very important to explore the nuances of PTSD, in order to fully understand its dynamics, there is some pathologising here; for people cannot easily choose which intrusive thoughts to entertain, and it is likely to be distressing/stigmatising to learn that one's intrusive thoughts are of the wrong sort.

PTSD has a gendered nature: "men tend to experience more traumatic events than women, but women often tend to experience higher impact of events" (Regel & Joseph, 2010, p. 22). Hodges (2003) notes that PTSD is "deemed pathological because it persists" (p. 414): women's emotional distress has a history of being viewed as tiresome (Chesler, 2005). Lilly et al. (2009), in a study of 157 female police officers and 124 female civilians, note how "peritraumatic dissociation is one of the strongest correlates of PTSD" (p. 767), but that women police, for whom "the cost of openly expressing fear and helplessness may be great" (p. 772), experience less peritraumatic dissociation and less PTSD than female civilians. Lilly et al. (2009) want to "design interventions" to change civilian women (p. 772). This way of thinking provides a contemporary example of some women being perceived as faulty and in need of fixing by experts with interventions; of it being some women's own fault that they responded to trauma in particular ways; if only they were more like men…

Although Regel and Joseph (2010) identify many "pre-trauma risk factors" (p. 25), intelligence is appearing in the PTSD discourse. Bomyea et al. (2012) link "lower intelligence prior to trauma exposure [to] PTSD development" (p. 634); "one hypothesis is that those with higher intelligence are better able to use effective problem solving strategies to cope with symptoms" (p. 634). More research is said to be needed (Bomyea et al., 2012), but this argument has potential to pathologise groups with a higher prevalence of PTSD – women and particular ethnic minority groups (e.g. Perez Benitez, Zlotnick, Gomez, Rendon & Swanson (2013) study Latinos) and it in fact already stigmatises anyone experiencing PTSD as potentially lacking intelligence.

Similarly, Kroes et al. (2011) say that studies have explored "brain variation" and have found "abnormalities" which are "similar to those implicated in major depressive disorder, raising the question of whether they ... reflect common difficulties, for example in emotion regulation" (p. 525); Bell (2007) makes it clearer: "it is still unknown whether smaller hippocampal volume predispose persons to PTSD or whether it is an effect of the disorder" (p. 29).

Such material on brains has parallels with some research exploring BPD – also a psychopathology disproportionately applied to women (see Shaw and Proctor, 2005); women diagnosed with BPD are pathologised as being faulty, for instance being declared manipulative of others (Watts, 2016). Berdahl (2010) explains that "functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) [have been used] to gain some insight into how the BPD brain works" (p. 177) and that "studies do converge on the

general impression that the BPD brain has some sort of dysfunction in limbic and prefrontal areas" (p. 177).

This research introduces a notion of the "BPD brain"; and the research mentioned above starts to suggest the "PTSD brain". This is highly problematic, for it has potential to locate the trigger for a perceived psychopathology in the being of the person affected rather than in the trauma that the person has experienced, rendering PTSD no more neutral than BPD. Machizawa-Summers (2007), for instance, already questions the reality of people diagnosed with BPD, saying "it is important to assess whether the BPD patients' perceptions of parental behaviours and traumatic experience are coloured by their pre-existing psychological problems or whether these negative childhood experiences facilitate development of borderline pathology" (p. 271). This parallel alone should prompt caution in embracing the PTSD discourse.

Joseph (2005) says that person-centred theory enables understanding of PTG: "as the client comes more to develop a self-structure that is congruent between self and experience, they should also become more fully functioning and able to engage in organismic valuing" (p. 197). However, drawing upon Harper and Speed (2014), it is clear that such progress is built upon "deficit" (p. 41). Indeed, current research into PTG does highlight personal deficiency: Joseph et al. (2012) report that "greater PTG is associated with ... emotional stability; extraversion; openness to experience; optimism; and self-esteem" (p. 320). Likewise, there is an "optimum" level of PTSD needed for PTG: "moderate" (Joseph et al., 2012, p. 320), for then "the individual's assumptive world has in some way been challenged, triggering the intrusive and avoidant experiences, but the person remains able to cope ... and engage sufficiently in the necessary cognitive processing needed to work through" (Joseph et al., 2012, p. 320). Thus, even a concept that feels positive contains traps for the unwary – notions that people did not experience sufficient PTG because they lacked particular, currently-prized, personal qualities to begin with.

Overall, PTSD originally appeared to be a helpful diagnostic classification (Burstow, 2005), but the current direction of the PTSD discourse, and the PTG discourse which has followed it, starts to have problematic elements, particularly when a strong parallel with BPD is recognised.

PCAs are well-placed to offer a critique of the current discourses because PCAs recognise and could much more clearly insist that incongruence is actually "universal" (Biermann-Ratjen, 1998, p. 114), rather than a psychopathology encountered by some (deficient) people who need fixing by experts. But PCAs can only intervene into the debate if they have a place there. The next section explores treatments for PTSD and how PCAs are positioned amongst them.

TRAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY, EYE MOVEMENT DESENSITISATION AND REPROCESSING, AND PERSON-CENTRED APPROACHES

As indicated above, the UK's National Institute for Health and Care Excellence (NICE) (2005) proposes trauma-focused cognitive behavioural therapy (T-FCBT) or eye movement desensitisation and reprocessing (EMDR) for PTSD (and medication but says it "should not be used as a routine first-line treatment for adults" (p. 4)).

T-FCBT implicitly holds a position of personal deficit. Techniques include "exposure": "prolonged imaginal exposure requires the individual with PTSD to vividly imagine the trauma for prolonged periods" (Harvey, Bryant, & Tarrier, 2003, p. 502); "cognitive restructuring",

which “involves teaching patients to identify and evaluate the evidence of negative automatic thoughts” (Harvey et al., 2003., p. 503); and “anxiety management training” (Harvey et al., 2003, p. 503). Burstow (2005), above, made clear that the “context” matters in deciding if “fear” is “unwise” (p. 434). Tseris (2013) feels “standard CBT strategies” can “offer only superficial and inadequate support” (p. 160) for interpersonal trauma; “re-traumatisation” is also possible via “exposure” (Seidler & Wagner, 2006, p. 1512).

Regel and Joseph (2010) explain that T-FCBT is about: “helping the sufferer challenge and change problematic thoughts and meanings” (p. 52). Harvey, Bryant and Tarrier (2003) explain this begins with “psycho-education”, which aims “to legitimise the trauma reaction, to help the patient develop a formulation of their symptoms, and to establish a rationale for treatment” (p. 502). The idea of “legitimising” (Harvey et al., 2003, p. 502) feels respectful, but Guilfoyle (2008) also notes how CBT “patronises” (p. 198). He also says that “CBT’s complicity with contemporary power arrangements is ... blatant” – the intention is for people to return to work quickly (p. 197). (See also Royal College of Psychiatrists, 2015).

EMDR may be an alternative, although not for everyone – Tarquinio et al. (2012) report excluding participants with “health issues, neurological disorders, eye disorders/pain, dissociative disorders, etc.” (p. 207), and Coffeng (2004), a Focusing-Oriented therapist, notes that a client’s PTSD “had become worse after a treatment with EMDR” (p. 284).

While T-FCBT requires an instrumental therapeutic alliance (Polak et al., 2012, p. 4), EMDR “[lets] the process of therapeutic change organically unfold” (p. 402). However, protocol is what is figural in understandings of EMDR for PTSD (Marich, 2012, p. 405), again positioning clients as objects upon whom to practice interventions.

Pilgrim (2009) observes that current guidance about treatments for PTSD “is informed by evidence, but not all evidence is being used” (p. 336). The “common factors” approach, as outlined by Hubble et al. (2010, p. 35-39), draws attention to “client and extratherapeutic factors”, “the therapeutic relationship/alliance” and “therapist factors”; Hubble, Duncan, Miller and Wampold (2010) observe that “it is no longer a matter of which therapeutic approach is best. Rather, it is about showing that a treatment, conducted by a given therapist with a particular client at a specific time and place, yielded positive results” (p. 39).

Benish, Imel and Wampold (2008) conducted a meta-analysis of a range of psychotherapies and demonstrated that “bona fide psychotherapies produce equivalent benefits for patients with PTSD” (p. 746), but the meta-analysis did not include PCAs. As Joseph (2015) observes: “practitioners of the PCA are marginalised in clinical practice because of the perception that they lack the knowledge or skills to work with traumatised individuals” (p. 180). PCAs need to be more visible, and increasingly they are becoming so.

Murphy and Joseph’s (2014) experience is that PCAs step in when T-FCBT/ EMDR have failed: people go “‘through the system’ several times” with a focus upon “symptoms” (as described above) and are “missed ... as a person” (p. 5). Tseris (2013) argues that interpersonal trauma needs more than “standard CBT” (p. 160). Murphy and Joseph (2014) suggest that “clients who have experienced neglect, abuse or domestic violence especially benefit from the genuine warmth and prizing of the social environment created in person-centred therapy” (p. 90). This is respectful rather than explicitly about personal deficit. PCAs are not entirely distinct, however: exposure therapies also require “accurate symbolisation” and “what PCT adds is ... that there is no need ... to push the client because the client will be intrinsically motivated to increase congruence between self and experience” (Joseph, 2005, p. 196). PCAs allow for individual differences more respectfully than behavioural approaches (Joseph, 2005).

Nonetheless, the PTSD discourse can sometimes lead PCAs away from "the uniqueness of the experience" (Schmid, 1998, p. 75), and into the realms of potential "power over" ("domination, coercive authority" (Proctor, 2002, p. 37)), almost bringing PCAs alongside some ways of conceptualising CBT/EMDR; but there is also sensitivity/creativity in current PCAs for PTSD, allowing for an arising of "power-from-within … an inner strength" (Proctor, 2002, p. 37).

Murphy and Joseph (2014) adopt a "principled non-directive approach" (p. 3) which is very respectful – but in one instance I felt that their focus on not responding to the question of a client diagnosed with PTSD (when she seeks reassurance) (Murphy & Joseph, 2014, p. 8-9) drew to mind Totton's (2012) point that "there are many subtle ways in which the therapist can imply that they know better than the client" (p. 29). I contrast this with Hawkins (2014) – although her client is experiencing flashbacks, Hawkins (2014) does not deploy the term PTSD (p. 20): she fully connects, person to person. Is there something about the absence of the language of PTSD that enabled this, I wonder?

What I feel matters most in the person-centred field now is not how incongruence may be mapped to PTSD to explain, in person-centred terms, a psychopathology encountered by some people (but not others) for individual reasons – which can then be approached in person-centred ways. Instead, we should properly recognise that the fully-functioning person who is "never really endangered by new experience [and has] no need to defend against any form of self experience" (Biermann-Ratjen, 1998, p. 114) does not exist and never will. As such, we can fully embrace the idea that everyone has a psychopathology of some sort or another, and one (PTSD included) is not better or worse than another. We can then enter the psychopathology debate on humane, equalising terms, rather than on psychopathology's own often-objectifying terms of disorder and deficit. PCAs already do recognise that people can be "trusted" (Rogers, 1978, p. 8), that they can flourish in a "growth-promoting climate" (Rogers, 1978, p. 9) which offers empathy, unconditional positive regard and congruence. We need to say that more confidently, and share more evidence of PCAs' effectiveness, as precursors to challenging psychopathology's language. This may be difficult for some PCA researchers and practitioners who engage with psychopathologies as currently understood, but it is consistent with the theory, philosophy and practice of our encounters with people. Indeed, as we gain confidence in this field, we may start to draw more explicitly upon the existential aspects of the philosophy underpinning our practice, and look more widely into existentialism. Personally, I very much appreciate the British School of Existential Analysis founder, Deurzen (2010), when she states that what some call "pathology" is merely "an essential reminder of our vibrant and dangerous aliveness" (p. 238). My feeling is that this is a conceptualisation that might be accepted more by PCAs.

"New form[s] of communication" (Totton, 2012, p. 107) are important in the work envisaged in this paper, and Warner's (2005, 2014) research is invaluable, unless her ideas of difficult process become co-opted into diagnosis (Tudor & Merry (2002, p. 8) link "difficult process" and "personality disorders"). Difficult process is, for Warner (2014), "descriptions of some common client experiences rather than diagnostic categories" (p. 122). Some PTSD experiences feel consistent with difficult process. There is a long-term project here, for as Warner (2005) says, "if, as PC theorists, we are able to clarify ... an overall model of health and pathology, we may also be able to increase our effectiveness in critiquing and offering constructive alternatives to current systems of mental health services" (p. 91).

CONCLUSION

As Humphreys and Joseph (2004) note, “some aspects of the PTSD discourse are developed and others disregarded” (p. 564). In this paper, instances have been shown where there is as yet insufficient recognition of the individualising/pathologising nature of some current PTSD and PTG discourses – emerging notions of lower resilience (Regel & Joseph, 2010), faulty brains (Bell, 2007), lower intelligence (Bomyea et al., 2012), faulty femininity (Lilly et al., 2009) and personal deficits (Joseph et al., 2012). Some troubling parallels with the development of the BPD discourse have been shown.

I have argued that PCAs need to be more politically aware and engaged, more willing to influence the direction of the PTSD conversation than to seek permission to listen to it. PCAs are increasingly showing their relevance to PTSD and can increasingly claim a place alongside more established psychotherapies for PTSD, acquiring the “power of individuals within a group of equals, to suggest and be listened to” (Proctor, 2002, p. 37). I have suggested how this power may be used to good effect, by challenging discourses which feel problematic.

Williamson (2010) argues that intimate partner violence (IPV) can lead to “responses” which “mimic” PTSD; she says that “we know far too little to assume that ... [IPV] ... inevitably results in a diagnosable psychiatric condition, as opposed to creating confusion” (p. 1416). It may eventually be that PCAs will reject the term PTSD altogether, and call for others to do likewise. Certainly, arguments against the label BPD are currently gathering pace in a public psychotherapy (see Watts, 2016, for instance).

In the meantime, as PTSD can be helpful to people making meaning of symptoms, it does feel appropriate to seek to work with PTSD. PCAs are a refreshing alternative in this field to forms of psychotherapy where experts seek to help stigmatised others. But let us always keep a critical eye upon research findings and their implications.

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