Understanding and Stabilising After Trauma

THE TALKING THERAPIES UK SELF-HELP SERIES



Understanding and Stabilising After Trauma

A six-module psychoeducational programme for adults with trauma-related difficulties, focused on understanding trauma responses and developing stabilisation skills before any processing work

A self-help workbook · 6 modules · about 6 weeks

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

Copyright © 2026 Talking Therapies UK. All rights reserved.

The moral right of the author has been asserted. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publisher, except for brief quotations in a review, and except that the purchaser may copy or print the worksheets for their own use.

First edition, 2026.

This workbook accompanies the Understanding and Stabilising After Trauma programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 6. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

Contents

How to use this workbook **1**

Part 1 Understanding Trauma Responses **5**

1. Welcome to the programme 6
2. What trauma is, clinically 7

How to use this workbook

If you have experienced something traumatic, or have been carrying something difficult from earlier in your life that you now suspect was traumatic, this programme is designed to give you a working understanding of what trauma is, why it affects the body and mind in the ways it does, and what helps in the period before you access trauma-focused therapy. The programme is not therapy. It does not attempt to process traumatic memories, work through the traumatic event, or change what happened. The work it does is the work that comes before that: understanding what is happening in your body and mind, learning to recognise when you are outside the range where ordinary thinking and feeling are accessible, and developing the stabilisation skills that allow trauma-focused work to be done effectively if and when you access it. What this programme is. A six-module psychoeducational programme aligned with the stabilisation phase of phase-based trauma treatment, drawing on the work of Judith Herman, Marylene Cloitre, Pat Ogden, and others in the trauma field over the past three decades. The programme covers what trauma responses actually are physiologically and psychologically, the window of tolerance model that describes the range of states in which you can think and feel normally, grounding and stabilisation skills for returning to that window when you are outside it, the body-level foundations of sleep and nutrition and movement that support recovery, the markers that tell you it is time to access trauma-focused therapy, and a daily practice plan for the holding period before treatment begins. What this programme is not. It is not trauma-focused therapy. Trauma-focused therapy, whether trauma-focused CBT, EMDR, or one of the relational longer-duration approaches for complex trauma, requires a trained therapist for sound clinical reasons. Reactivating traumatic memory in the present tense, with the affective intensity that the techniques generate, requires a clinical relationship that can manage arousal, prevent or interrupt dissociation, and hold the patient through experiences that often involve substantial distress. Without that holding, the work can re-traumatise rather than process, particularly for adults with complex trauma histories, significant dissociative tendencies, or comorbid difficulties. This programme therefore explicitly avoids any technique that asks you to describe, focus on, or process the content of traumatic memories. The work it does is the work of stabilisation, which is a necessary foundation for processing but which is also valuable in its own right. Who this programme is for. Adults who are experiencing trauma-related difficulties (intrusive memories, flashbacks, nightmares, hypervigilance, avoidance, emotional numbing, difficulty trusting, difficulty sleeping) and who are either waiting for trauma-focused therapy, considering accessing it, or for whom it is not currently the right step. Adults who have completed a course of trauma-focused therapy and want a structured stabilisation practice for the maintenance phase will also find the programme useful. Adults whose trauma history is well-managed but who want to understand what they have lived through may find the psychoeducational content valuable. Who this programme is not for. Adults who are currently in acute crisis (acute suicidal ideation, recent hospital admission, active psychosis, severe dissociation) should be in active clinical care rather than working with self-paced material. Adults whose primary difficulty is something other than trauma (depression without trauma history, OCD, eating difficulties, relationship distress) should use the relevant programme rather than this one. Adults with significant complex trauma backgrounds, including childhood developmental trauma extending across years, are likely to need the structured stabilisation work

supported by a clinician rather than self-paced; the programme can be useful adjunctively but is not sufficient on its own. Important safety note. The content of this programme is designed to be tolerable. The exercises avoid any direct focus on traumatic content. If at any point in the programme you find that the material is bringing up traumatic memory in a way that overwhelms you, please pause the programme and contact the practice or your GP. Some adults find that even psychoeducational material about trauma surfaces material that has been pushed down for years; this is not unusual and is a marker for needing trauma-focused therapy support rather than for continuing alone. If at any point you experience suicidal thoughts or thoughts of harming yourself, please contact Samaritans on 116 123, text SHOUT to 85258, your GP, or NHS 111. The trauma is not what would kill you; the loneliness of unprocessed trauma can become unbearable, and crisis services are the right contact at those moments.

This workbook is the written form of the Understanding and Stabilising After Trauma programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module's teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 6 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

What this workbook will help you to do

- By the end of this module you will have a working understanding of what trauma is in clinical terms, recognise the major categories of trauma response, understand why the body and brain respond as they do, and have located your own experience roughly within the territory.
- By the end of this module you will understand the window of tolerance model, recognise hyperarousal and hypoarousal states in your own experience, and have begun to identify your personal indicators of being in or out of the window.

- By the end of this module you will have practised the standard grounding techniques and identified which work best for you in each state.
- By the end of this module you will understand why the body's foundations matter particularly during trauma recovery, will have identified your own current state across the four foundations, and will have a brief realistic plan for protecting them.
- By the end of this module you will know the markers that indicate it is time to access trauma-focused therapy, the major evidence-based approaches and their differences, and how to navigate the routes into care in the UK system.
- By the end of this module you will have an integrated daily practice plan combining foundations, grounding skills, and window-of-tolerance awareness, and you will have written it in a form you can actually follow during the waiting period.

PART 1

Understanding Trauma Responses

What trauma is, what the difference is between normal stress response and traumatic stress, and why the body responds the way it does

CHAPTER 1

Welcome to the programme

Trauma is one of the most carefully studied and most commonly misunderstood areas in clinical psychology. The popular image of trauma centres on dramatic single events: combat, serious accidents, violent assault. These events are traumatic, but they are only one corner of a wider clinical picture. Trauma in the clinical sense includes a much broader range of experiences: prolonged childhood abuse or neglect, witnessing violence, medical emergencies, the sudden death of a loved one, traumatic birth, prolonged exposure to threat, the cumulative effect of repeated boundary violations, and the experiences that arise from being in caregiving roles where you regularly encounter the suffering of others. Whether something counts clinically as trauma depends less on what happened in absolute terms and more on what it did to the system: whether the experience overwhelmed the person's capacity to process it, whether it left lasting changes to threat-detection and emotional regulation, and whether the person is now living in a way that is shaped by the event rather than free of it.

This programme is for adults who are living with the effects of one or more traumatic experiences. It does not require that you have a diagnosis of PTSD. It does not require that you have a single identifiable traumatic event. It does not require that you can talk about what happened. The work of the programme can be done by adults who know exactly what their trauma was, by adults who suspect they have trauma but are not sure what, and by adults who have been told by a clinician that what they have been experiencing is trauma-related but who do not yet have a clear personal sense of what that means.

A practical note before we begin. The programme is psychoeducational and stabilising. It does not attempt to process traumatic memories. The reason is simple: processing traumatic material safely requires a trained clinician's presence to manage arousal, prevent or interrupt dissociation, and hold the patient through what can be intensely distressing experiences. Doing this work alone or with a self-paced programme is at best ineffective and at worst harmful, particularly for adults with complex trauma histories. The work this programme does is the work that comes before processing: understanding, recognising your own states, developing stabilisation skills, and tending to the body's foundations. That preparatory work is valuable in itself, and it is the foundation on which trauma-focused therapy is built when you access it.

If at any point in the programme the material surfaces traumatic memory or affect that feels overwhelming, please pause and contact the practice or your GP. Some adults find that even psychoeducational material brings up things that have been pushed down for years; this is not unusual and indicates that trauma-focused therapy with a clinician is the right next step.

CHAPTER 2

What trauma is, clinically

The clinical definition of trauma has evolved substantially over the past forty years. The current understanding, broadly shared across the major diagnostic frameworks, holds that a traumatic event is one in which a person directly experiences, witnesses, or learns about actual or threatened death, serious injury, or sexual violence, in a way that overwhelms the person's normal capacity to process and integrate the experience. The standard diagnostic categories that arise from traumatic exposure are Post-Traumatic Stress Disorder (PTSD), Acute Stress Disorder for the early phase, Adjustment Disorders for less severe presentations, and Complex Post-Traumatic Stress Disorder (CPTSD) for the cumulative effects of prolonged or repeated trauma, particularly in childhood.

PTSD is defined by four symptom clusters that together create the characteristic clinical picture. Re-experiencing covers the intrusive memories, flashbacks, nightmares, and emotional reactivations of the traumatic content. Avoidance covers the active or passive ways the person stays away from reminders of the trauma, including places, people, activities, conversations, and internal states. Negative alterations in cognition and mood cover the changes in how the person sees themselves, others, and the world: distorted blame, persistent negative emotional states, loss of interest, feelings of detachment, inability to experience positive emotion. Arousal and reactivity changes cover the body-level changes: irritability, hypervigilance, exaggerated startle, problems concentrating, sleep disturbance.

CPTSD, formally recognised in ICD-11 in 2019, captures additional features that arise from prolonged or repeated trauma, often beginning in childhood. The three additional features are difficulties with affect regulation (intense and labile emotions, difficulty calming once activated), negative self-concept (deep beliefs that one is bad, worthless, defective, contaminated), and interpersonal difficulties (difficulties forming or sustaining close relationships, distrust, alternating closeness and distance). CPTSD is more common in adults with childhood abuse, prolonged institutional abuse, prolonged domestic violence, war and torture, and prolonged caregiving for severely impaired relatives. The distinction between PTSD and CPTSD matters for treatment: PTSD is typically treated with shorter-duration trauma-focused therapy whereas CPTSD usually requires longer-duration phase-based work.

You do not need to map your own presentation precisely against these diagnostic categories at this stage. The categories are useful for understanding the landscape; the precise differential is the work of clinical assessment if you access it.

Not all difficult experiences are clinically traumatic. The body is well-designed to handle even substantial stress and most people recover from most difficult events without developing a trauma-related disorder. The factors that predict whether an event becomes traumatic include the severity of the event, the person's prior history (previous trauma, childhood adversity), the availability of social support afterwards, and the meaning attached to the event. Two people exposed to the same event can have very different outcomes; this is not because one is weaker than the other but because the same event lands in different systems.