Understanding Trauma and PTSD

THE TALKING THERAPIES UK PRACTITIONER SERIES



Understanding Trauma and PTSD

The cognitive behavioural understanding of post-traumatic stress

Foundation level · 6 hours of continuing professional development

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 a purchaser of the accompanying course may print a single copy for their own study.

First edition, 2026.

This manual accompanies the Understanding Trauma and PTSD course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 4. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 What trauma does 3

1. Understanding post-traumatic stress 4
2. The cognitive behavioural model of PTSD 9

How to use this manual

This comprehensive six-hour introductory course provides clinicians and trainees with a rigorous, evidence-based exploration of post-traumatic stress through the lens of Cognitive Behavioural Therapy. Rooted in the principles outlined in the practice's Comprehensive PTSD and Complex PTSD Recovery Guide, this module moves beyond surface-level definitions to examine the profound impact trauma has on an individual's memory, physiology, and core beliefs. You will gain a deep understanding of the cognitive behavioural model that explains why symptoms persist, analysing the intricate interplay between intrusive memories, hyperarousal, and avoidance behaviours. The curriculum covers the diagnostic picture with precision, distinguishing between standard PTSD and Complex PTSD as defined by ICD-11, ensuring you can accurately identify and conceptualise client presentations. Beyond conceptualisation, this course places a critical emphasis on the preparatory work essential for effective trauma therapy. You will study the therapeutic stance required to work with trauma survivors, learning how to establish safety and build a foundation of trust before engaging in any processing work. The module details the importance of stabilisation techniques and psychoeducation, explaining why these elements are non-negotiable prerequisites for successful trauma-focused interventions. By mastering these foundational skills, you will learn to assess client readiness, manage potential triggers, and create a secure environment that facilitates recovery. This course serves as the vital gateway to advanced trauma interventions, equipping you with the necessary theoretical knowledge and practical grounding to handle complex cases with confidence and competence.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at foundation level and carries 6 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to

supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Explain the cognitive model of PTSD, including memory disorganisation and appraisals
- Describe the ICD-11 distinction between PTSD and complex PTSD
- Recognise re-experiencing, avoidance, threat and dissociative phenomena in presentations
- Explain why avoidance maintains PTSD and what that implies for treatment
- Deliver psychoeducation about trauma responses that normalises without minimising
- Describe the evidenced trauma-focused therapies and the NICE recommendations

PART 1

What trauma does

Trauma's effect on memory, body and belief, and the diagnostic picture.

CHAPTER 1

Understanding post-traumatic stress

Post-traumatic stress disorder represents a profound disruption to the body's natural alarm system, a state where the mind's emergency machinery, designed to function for minutes during a crisis, remains activated for years, months, or even decades. To understand PTSD, one must first abandon the notion that it is a sign of weakness or a failure of character. Instead, it is a biological and psychological adaptation gone awry, a maladaptive response to an event that was, by definition, outside the range of ordinary human experience. The presentation of PTSD is not random; it is organised into recognisable clusters that serve as a clinical roadmap. A clinician who understands these clusters can often hear the diagnosis in a client's ordinary speech long before any questionnaire or diagnostic interview confirms it, recognising the subtle shifts in tone, language, and affect that betray the underlying trauma.

The first cluster, re-experiencing, is the signature of the disorder. These symptoms are intrusive, unwanted, and vivid. They arrive unbidden, often triggered by cues that bear a sensory resemblance to the original event. This is not merely remembering; it is a sensory invasion. A survivor of a car crash does not recall the crash; they smell the fuel, hear the shattering glass, and feel the seatbelt digging into their chest. Nightmares are common, often replaying the event or themes related to it. At the extreme end of the spectrum are flashbacks, which collapse time entirely. In a flashback, the survivor is not recalling the trauma; they are re-living it, present-tense, with the body fully enlisted in the memory. The clinical marker across all re-experiencing symptoms is the quality of 'nowness' described by Ehlers and Clark, a sense that the trauma is happening right now rather than having happened in the past. This sense of immediacy is what makes trauma memory so distinct from ordinary autobiographical memory.

Following re-experiencing comes avoidance, the second cluster. This is the understandable, albeit maladaptive, survival strategy of the mind. Avoidance manifests in two distinct forms: external and internal. Externally, the survivor avoids people, places, conversations, objects, and activities that remind them of the trauma. Internally, they avoid thoughts, feelings, or

conversations associated with the event. This internal avoidance is often more insidious; it can manifest as emotional numbing, a flattening of affect where the person feels detached from themselves or others, or a complete inability to recall key details of the event. The survivor may tell the story fluently in a voice from which all feeling has been drained, effectively dissociating from the emotional content even as they speak the words.

The third cluster, hyperarousal, represents the body's persistent contribution to the disorder. It is the state of perpetual readiness, the nervous system stuck in the 'on' position. Symptoms include an exaggerated startle response, sleep disturbance, difficulty concentrating, and irritability or outbursts of anger. Hypervigilance is the constant scanning of the environment for threats, a state that makes even mundane activities, such as shopping in a supermarket, exhausting and fraught with danger. This cluster is often what brings a client to clinical attention, as it impacts their functioning and relationships more immediately than the intrusive memories.

The fourth cluster, negative alterations in mood and cognition, completes the modern diagnostic picture. This encompasses persistent negative emotional states, such as fear, horror, anger, guilt, or shame. It includes a distorted self-concept, viewing oneself as completely ruined, incompetent, or permanently damaged. The world is re-appraised in absolutes; nowhere is safe, and no one can be trusted. This cluster is critical for treatment planning, as shame and guilt are often the most resistant elements to change.

To understand why trauma memories behave this way, we must look at the neurobiology of memory. The account this course builds upon is rooted in the cognitive model of PTSD, which posits that extreme stress fundamentally alters how memory is encoded and stored. Ordinary autobiographical memory is elaborated and contextualised; it is woven into the life story, time-stamped, and retrievable deliberately. It has a beginning, middle, and end. Peritraumatic encoding, however, is different. During the trauma, attention narrows to survival-relevant fragments. The stress hormones released during the event privilege sensory and emotional channels over the contextualising ones. What is stored is powerful, fragmentary, and poorly integrated with everything the person knows. The result is a memory that is strong in sensation and weak in context. It lacks

the time-stamp that would tell the alarm system that the event has already happened and is over. Consequently, these memories are triggered associatively by anything resembling their fragments, leading to the intrusive symptoms described earlier.

The body's role in this process is inseparable from the memory fragmentation. Trauma responses are whole-organism events involving the fight, flight, and freeze responses. However, the freeze response, or tonic immobility, is particularly clinically significant. Tonic immobility is a brainstem reflex, a physiological shutdown that occurs when escape is impossible. Many survivors misinterpret this freezing as complicity or cowardice, hanging self-blame on a biological reflex that was not a decision. Understanding this distinction is vital for therapeutic work, as it helps to dismantle the survivor's internalised shame.

The classification of PTSD has evolved, and the current gold standard in the UK is the ICD-11. ICD-11 has sharpened the diagnostic architecture in ways this pathway adopts. PTSD is defined by three core elements: re-experiencing in the here and now, deliberate avoidance, and a persistent sense of current threat expressed in hypervigilance and startle, following exposure to an extremely threatening or horrific event. However, ICD-11 also recognises Complex PTSD, a distinct sibling diagnosis. Complex PTSD requires the same core PTSD symptoms plus three disturbances of self-organisation: affect dysregulation, persistent negative self-concept, and relational disturbance. This diagnosis typically follows prolonged or repeated trauma from which escape was difficult, such as childhood abuse or captivity. The third course in this pathway is devoted to this complex presentation.

Two boundary disciplines are essential to keep in mind when assessing trauma reactions. Not everything that happens after a traumatic event is PTSD. Depression, substance misuse, and normal grief have their own shapes and frequently co-occur with trauma. Furthermore, not every reaction to trauma is a disorder. Most people exposed to trauma recover naturally within weeks, which is why the diagnosis requires a duration of symptoms and significant impairment. This is why treatment respects natural recovery rather than pathologising every response.

To fix these mechanisms in mind, let us hold them against one concrete case. Consider Elias, a thirty-two-year-old former firefighter referred for

anxiety and irritability. Elias presents as tense, unable to sit still, and constantly checking his phone for messages. He reports broken sleep and difficulty concentrating at work. He does not volunteer the trauma; he simply says he is ‘on edge’ and ‘can’t switch off.’ His avoidance is subtle; he refuses to visit the city centre where his station was located and avoids news reports about fires. Every cluster is present, but none are obvious at first glance. His re-experiencing is masked by his hyperarousal; he is jumpy and irritable, which he interprets as general anxiety. His avoidance of the city centre is rationalised as a dislike of crowds. His mood is flattened, described as ‘numb.’ It is only when a clinician asks the listening guide question, ‘What was the worst thing that happened to you?’ that the mask slips. Elias pauses, his voice drops, and he describes the smell of burning rubber that haunts him in supermarkets and the visual of the collapsed roof that appears when he closes his eyes. He admits he has never told anyone about the roof collapsing because he feels responsible for the lives lost. Here, the clusters are revealed: the intrusive smell and image (re-experiencing), the refusal to go to the city (avoidance), the jumpiness and sleeplessness (hyperarousal), and the numbness and self-blame (mood alteration). Nothing in his initial presentation said trauma until the clusters were listened for.

The toll of untreated PTSD is significant, eroding sleep, health, work, and relationships. It often doubles down through the substances used to manage it and carries an elevated suicide risk. Yet, it remains one of the most treatable conditions in the clinic once reached. The clusters are the listening guide that finds the diagnosis the person has learned not to mention. The next lesson will assemble these observations into the cognitive model that makes treatment rational.

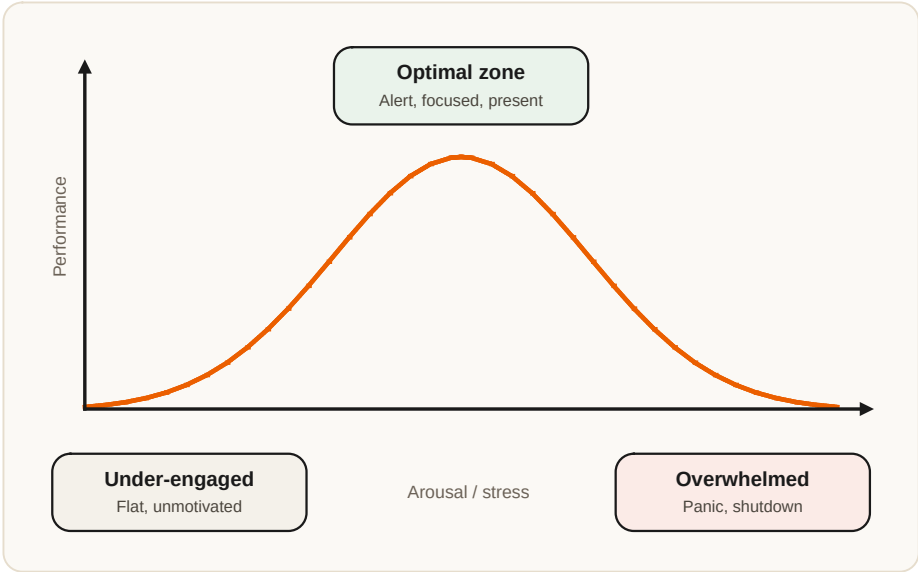


FIGURE 1.1 The arousal–performance curve

The Yerkes–Dodson relationship: performance rises with arousal up to an optimum, then collapses as arousal becomes overwhelm. Clinically it explains why some activation helps engagement while panic prevents it, and why grounding aims for the middle of the curve, not the bottom.

Points worth keeping

- Re-experiencing, avoidance, hyperarousal, mood
- Why trauma memories intrude and fragment
- The body's role in trauma
- PTSD and complex PTSD in ICD-11

PRACTICE TASK

List the ICD-11 symptom clusters and one example of each.

CHAPTER 2

The cognitive behavioural model of PTSD

The cognitive behavioural model of post-traumatic stress disorder, most influentially articulated by Anke Ehlers and David Clark, offers a comprehensive account of why intrusive recollections, avoidance, hyperarousal and negative alterations in cognition and mood persist long after the traumatic event has ended. At its core the model proposes that PTSD is maintained by three interlocking mechanisms: a poorly elaborated trauma memory, threatening appraisals of the trauma and its sequelae, and a repertoire of maintaining behaviours that function as safety-seeking strategies. Each mechanism reinforces the others, creating a self-sustaining cycle that resists spontaneous remission and that can be targeted systematically in trauma-focused cognitive behavioural therapy.

A poorly elaborated trauma memory differs fundamentally from ordinary autobiographical memory. In everyday remembering, an event is encoded with contextual details — temporal order, spatial layout, causal links and an integrated narrative — allowing the recollection to be experienced as a past event that is distinct from the present moment. In PTSD, however, the memory remains fragmented, dominated by sensory fragments such as vivid visual images, sounds, smells or bodily sensations, and it lacks the temporal and contextual tags that would situate it firmly in the past. This deficit in elaboration means that when a cue resembling any element of the trauma is encountered, the memory is retrieved involuntarily and experienced as a here-and-now reliving, often termed a flashback. The work of Brewin, Dalgleish and Joseph on dual representation theory complements this view by distinguishing between verbally accessible memories and situationally accessible memories, the latter being the sensory-perceptual traces that drive intrusive re-experiencing. Ehlers and Clark argue that the failure to integrate the trauma memory into the broader autobiographical knowledge base prevents the natural process of emotional processing described by Foa and Kozak, whereby repeated, controlled exposure to the memory leads to habituation and the updating of threat-related meanings.

Threatening appraisals constitute the second pillar of the model. Following the trauma, the individual generates a set of negative interpretations

concerning the event itself, its immediate consequences and its implications for the self, the world and the future. Typical appraisals include beliefs such as “the world is entirely dangerous”, “I am permanently damaged”, “the trauma proves that I am incompetent” or “another catastrophe is inevitable”. These appraisals are not merely passive thoughts; they actively shape attention, interpretation and memory retrieval, biasing the person towards threat-related information and away from safety signals. The appraisals also give rise to intense emotions — fear, shame, guilt, anger — which in turn reinforce the sense of current threat. Importantly, the model distinguishes between appraisals of the trauma memory (e.g., “the flashback means I am losing my mind”) and appraisals of the trauma sequelae (e.g., “my avoidance means I am weak”). Both categories fuel the maintenance cycle, and both are amenable to cognitive restructuring within therapy.

The third mechanism, maintaining behaviours, encompasses a wide range of overt and covert strategies that the person employs to reduce the distress triggered by trauma reminders. These safety-seeking behaviours include avoidance of places, people, conversations, media or internal cues associated with the trauma; hypervigilance and scanning for danger; substance misuse to dampen arousal; thought suppression; and the use of rituals or compulsive checking. While each behaviour provides short-term relief, it prevents the individual from confronting the feared stimulus in a way that could disconfirm the threatening appraisal. For example, avoiding a road where a car accident occurred blocks the opportunity to experience that the road is now safe, thereby preserving the belief that “driving is fatal”. Similarly, suppressing intrusive thoughts paradoxically increases their frequency, a phenomenon documented by Wegner’s ironic process theory. The net effect is a reinforcement of the fear structure and a perpetuation of the poorly elaborated memory, because the memory never receives the corrective information that would allow it to be contextualised and integrated.

A concrete worked illustration can clarify how these three mechanisms interact in a single case. Consider a 34-year-old paramedic, referred to here as Ms. A, who attended a major incident in which a building collapsed, resulting in multiple fatalities. During the event she was trapped for several hours, exposed to the sounds of screaming, the smell of dust and the sensation of crushing pressure. In the weeks that followed, Ms. A reported recurrent, vivid flashbacks in which she re-experienced the heat on her skin and the sound of collapsing masonry, but she could not recall the sequence

of her own actions, the arrival of colleagues, or the moment she was rescued. This memory is poorly elaborated: it consists of isolated sensory fragments without a coherent narrative timeline, and it is triggered by seemingly innocuous cues such as the sound of a siren or the smell of concrete dust.

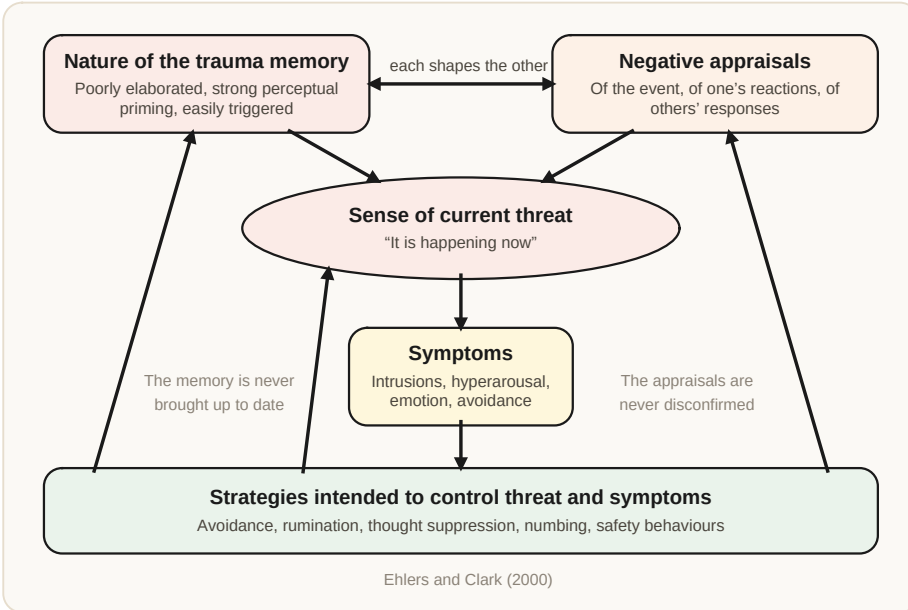


FIGURE 2.1 The cognitive model of PTSD

Ehlers and Clark: post-traumatic stress persists when the trauma memory is poorly elaborated and strongly cued, and appraisals of the event or its aftermath generate a sense of CURRENT threat. Memory and appraisal shape each other, which is why neither yields on its own. The strategies that follow, avoidance, rumination, numbing and safety behaviours, each relieve distress briefly, and each then feeds the threat directly as well as preventing the memory and the appraisals from changing.

From these fragments Ms. A derived a set of threatening appraisals. She concluded that "I am fundamentally unsafe wherever I go", that "my training was useless and I am incompetent", and that "the flashbacks mean I am losing my mind and will never work again". These appraisals generated intense fear, shame and a pervasive sense of hopelessness, which she attempted to manage through a constellation of maintaining behaviours. She avoided the ambulance station, refused to attend debriefings, stopped driving past the site of the collapse, and began drinking heavily each evening to blunt the night-time intrusions. She also engaged in mental safety-seeking

by repeatedly telling herself “I must not think about the building”, a thought-suppression strategy that paradoxically increased the frequency of the intrusive images.

In therapy, the clinician would first map this maintenance cycle using the Ehlers and Clark formulation, making explicit the links between the fragmented memory, the catastrophic appraisals and the avoidance and suppression behaviours. The treatment plan would then target each component: imaginal reliving and narrative writing to elaborate the trauma memory, cognitive restructuring to test and modify the threatening appraisals, and behavioural experiments — such as graded exposure to the ambulance station and controlled driving past the collapse site — to disconfirm the belief that the environment is irredeemably dangerous. Throughout, the therapist would monitor symptom severity using validated measures such as the PHQ-9 and GAD-7, and would attend to the broader social context captured by the Social GGRRAAACCEEESSS framework, ensuring that issues of gender, race, sexuality and occupational identity are integrated into the case formulation. By systematically dismantling the three maintaining mechanisms, the model predicts a reduction in re-experiencing, avoidance and hyperarousal, and a restoration of a coherent autobiographical narrative in which the trauma is remembered as a past event rather than relived as a present threat.

The empirical support for this model is substantial. Randomised controlled trials of trauma-focused cognitive behavioural therapy, which operationalises the Ehlers and Clark formulation, consistently demonstrate large effect sizes for PTSD symptom reduction across diverse populations, including military veterans, survivors of sexual assault and emergency-service personnel. Meta-analyses by Bisson et al. and by the National Institute for Health and Care Excellence confirm that interventions targeting memory elaboration, appraisal modification and behavioural avoidance are the active ingredients of effective treatment. Moreover, neuroimaging studies have shown that successful therapy is associated with increased hippocampal activation during memory retrieval and decreased amygdala reactivity to trauma cues, providing a biological correlate of the psychological processes described by the model.

In summary, the cognitive behavioural model of PTSD articulated by Ehlers and Clark provides a parsimonious yet richly detailed account of symptom

persistence. It identifies a poorly elaborated trauma memory, threatening appraisals, and maintaining safety-seeking behaviours as the three mutually reinforcing mechanisms that keep the disorder alive. The model guides a structured, evidence-based therapeutic approach that seeks to elaborate the memory, re-evaluate the appraisals, and eliminate the behaviours that prevent disconfirmation of threat. The worked example of Ms. A illustrates how these mechanisms manifest in clinical practice and how a formulation-driven intervention can interrupt the maintenance cycle, offering a clear pathway from theory to effective treatment.

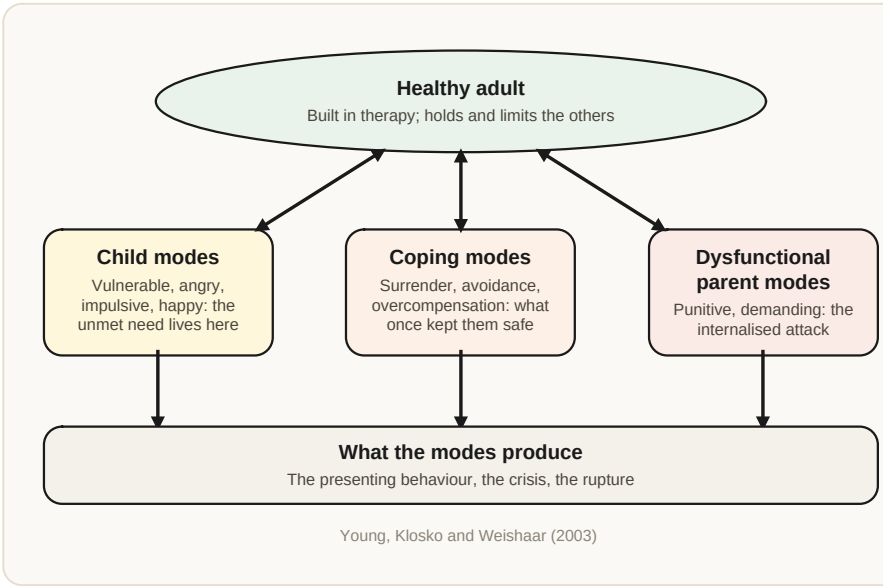


FIGURE 2.2 Schema modes

Schema therapy describes a mode as the emotional state and coping response active at a given moment. Grouping the modes makes the work in the room legible: the child modes carry the unmet need, the coping modes are what once kept the person safe, the internalised parent modes carry the attack, and the healthy adult, built over the course of therapy, is the part that eventually holds and limits the other three. What presents in the consulting room is the product of the three mode classes, which is why the crisis is read as a mode and not as a diagnosis.

Points worth keeping

- The Ehlers and Clark model in brief
- Poorly elaborated trauma memory
- Threatening appraisals of the trauma and its sequelae
- Maintaining behaviours and safety-seeking

PRACTICE TASK

Map one client's maintaining behaviours onto the model.