Trauma-Informed Foundations

THE TALKING THERAPIES UK PRACTITIONER SERIES



Trauma-Informed Foundations

What trauma does to memory, body and trust, and the principles every service should practise.

Foundation level · 6 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

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

Revision 3. This printing was set on 8 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.

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How to use this manual

Trauma rewrites the body's rules before the mind has a say, and services that do not understand this retraumatise the people they exist to help. This course teaches the foundations every practitioner and every service should hold: what trauma actually does to memory, body and trust, and the principles that make practice safe, for clinicians, trainees and anyone in a trauma-facing role.

The first module teaches the mechanism. You will learn why traumatic memory behaves unlike ordinary memory, fragmentary, sensory and present-tense, through the threat cascade and its neurobiology, and then work with the window of tolerance: hyperarousal, hypoarousal, and the band between them where processing and connection are possible. The second module turns understanding into stance: the trauma-informed principles, safety, trustworthiness, choice, collaboration and empowerment, translated from poster language into daily practice, and grounding techniques as psychological first aid you can use the same day.

Full written lessons with key points and immediately usable practice tasks, with a built-in study tutor available throughout. Six hours of CPD, around six months of access, a final assessment, and a personalised certificate on passing.

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 how traumatic memory differs from ordinary memory, and why reminders trigger re-experiencing
- Describe the window of tolerance and recognise hyperarousal and hypoarousal in clients
- Apply the principles of trauma-informed care: safety, trust, choice, collaboration and empowerment
- Teach grounding and stabilisation techniques and judge when they are the priority
- Recognise dissociation on its continuum and respond safely
- Describe the phased model of trauma treatment and each phase's purpose

PART 1

What trauma does

Memory, body and the window of tolerance.

CHAPTER 1

Traumatic memory and the threat cascade

Trauma is not defined by the external event but by the internal overwhelm that exceeds the individual's capacity to cope, integrate and make meaning. When the demand placed on the nervous system outstrips the resources available at the moment of impact, the brain's normal autobiographical encoding processes are interrupted. In ordinary memory, the hippocampal-mediated narrative is constructed, time-stamped and filed, allowing the experience to be recalled as something that happened in the past. In contrast, traumatic encoding, as described by van der Kolk (2014) and Brewin (2010), occurs under extreme threat when the integrating machinery of the medial prefrontal cortex and hippocampus is functionally suppressed. The sensory and affective channels, mediated by the amygdala and periaqueductal grey, record the event at maximal gain, producing a fragmentary, sensory-laden, present-tense memory trace that lacks the 'then' anchor. The result is a memory that is stored as a series of disjointed impressions – smells, colours, bodily sensations and raw affect – rather than a coherent story.

Because the memory is not narrated, it does not serve as a reminder but as a replay. A trigger that shares any of the sensory qualities of the original trauma can activate the stored fragments, causing the survivor to re-experience the event as if it were happening now. This explains the phenomenology of flashbacks, intrusive nightmares and the sudden surge of physiological arousal that many clients describe when confronted with a seemingly innocuous cue. The clinical implication is that the survivor is not choosing to be dramatic; the brain is simply presenting an unintegrated memory in the format in which it was encoded. A single, clearly articulated statement – that the flashback is a memory playback rather than a sign of personal weakness – often provides profound relief, as it reframes the symptom from moral failure to biological inevitability.

The second core mechanism is the threat cascade, a sequence of defensive responses that predates modern cognition. The classic fight-or-flight model,

refined by Porges (2011) into the Polyvagal Theory, recognises three hierarchically organised states: the ventral vagal complex supporting safety and social engagement; the sympathetic mobilisation that prepares the body for fight or flight; and the dorsal vagal complex that initiates shutdown, freeze and collapse when escape is impossible. When an individual perceives an inescapable threat, the nervous system may default to the dorsal vagal response, producing immobility, numbness and a sense of dissociation. This response is not a conscious choice but an evolutionarily conserved survival strategy that can occur within milliseconds, bypassing cortical deliberation.

Peritraumatic dissociation – the feeling of watching oneself from a distance, the distortion of time, the sense of unreality – is a common manifestation of dorsal vagal activation. It protects the organism by limiting the subjective experience of pain and terror, but it also fragments the memory further, reinforcing the sensory-only encoding described earlier. After the threat has passed, the survivor is left with a harsh self-judgement narrative: “Why didn’t I fight? Why did I just lie there?” The therapist’s role is to replace this narrative with a biological explanation, emphasising that the body did exactly what it was hard-wired to do in that moment.

The language of the Polyvagal-informed body-state map provides a shared, de-shaming framework for both clinician and client. By naming the state – ventral, sympathetic or dorsal – the survivor can articulate their experience without invoking notions of brokenness or moral failure. For example, saying “I went dorsal in that meeting” conveys a specific physiological pattern rather than a vague sense of being “broken”. This shift is clinically powerful because states are mutable; they can be regulated, whereas a label of brokenness suggests permanence.

Consider a concrete worked example. Maya, a 32-year-old teacher, was involved in a severe car collision in which her vehicle was struck from behind while she was stopped at a red light. She reports that, in the weeks following the accident, the sound of a car braking nearby triggers an intense sensation of her heart pounding, a sudden vision of the impact, and an overwhelming urge to flee the scene, even though she is seated safely in a classroom. She also describes episodes of “blanking out” during stressful staff meetings, describing them as “going numb”. In the initial assessment, the therapist administers the PHQ-9 and GAD-7, noting moderate depressive and anxiety

scores, but the primary focus is on the trauma narrative. The therapist explains that during the collision, Maya's brain likely entered a dorsal vagal shutdown because she could not escape the vehicle and the threat was immediate. This shutdown limited her ability to process the event verbally, resulting in a fragmented, sensory memory. The therapist then introduces the three-state map, inviting Maya to label her present-moment experience: the racing heart and urge to flee correspond to sympathetic mobilisation, while the episodes of "blanking out" reflect dorsal shutdown. By externalising the response, Maya is able to say, "My body is reacting with the freeze-collapse system, not that I am weak." Over subsequent sessions, grounding techniques and paced breathing are employed to gently re-engage the ventral vagal system, allowing Maya to integrate the sensory fragments into a coherent narrative. This example illustrates how understanding the threat cascade and memory fragmentation informs both formulation and intervention.

The interplay between fragmented memory and the threat cascade also underpins the development of common trauma-related disorders such as Post-Traumatic Stress Disorder (PTSD) and Complex PTSD (C-PTSD). Ehlers and Clark's (2000) cognitive model posits that persistent re-experiencing arises when the memory is stored in a state-dependent form, and that maladaptive appraisals maintain the sense of current threat. The fragmented, sensory memory provides the raw material for these appraisals, while the dorsal shutdown response reinforces a sense of helplessness. Integrative therapies, whether trauma-focused CBT, EMDR or sensorimotor psychotherapy, aim to transform the sensory fragments into a narrative that can be temporally situated, thereby reducing the propensity for involuntary replay.

It is essential to convey to survivors that the freeze and collapse responses are not choices but automatic survival biology. The language of "choice" can inadvertently reinforce shame, as the survivor may internalise the belief that they failed to act. By reframing the response as an involuntary, evolutionarily conserved mechanism, clinicians provide a compassionate corrective to the self-critical narrative. This reframing is not merely a rhetorical device; it aligns with neurobiological evidence showing that the periaqueductal grey and dorsal vagal complex are activated within 200-300 milliseconds of threat detection, well before conscious deliberation can occur.

In practice, the de-shaming power of the body-state map can be harnessed in psychoeducation sessions. The therapist may begin by inviting the client to notice their current physiological state, guiding them through a brief body scan that distinguishes between ventral calm, sympathetic arousal and dorsal shutdown. When a client recognises a dorsal pattern, the therapist can normalise it by stating, “Your nervous system has entered the shutdown mode that protects you when escape is impossible. It is not a sign of weakness.” This simple acknowledgement often elicits a visible relaxation response, as the client feels understood and no longer alone in their experience.

The therapeutic journey following this initial psychoeducation does not resolve the trauma in a single session, but it establishes a crucial foundation. By providing a clear, biologically grounded explanation of why memories are fragmented and why the body may freeze or collapse, the clinician equips the survivor with a language that reduces shame and opens the door to further work such as exposure, narrative reconstruction, and somatic regulation. The moment a client can articulate, “My flashback is a memory that was stored in fragments because my brain shut down,” they have taken a decisive step away from self-blame towards self-compassion.

Finally, it is worth noting that the concepts presented here are supported by a robust evidence base. Functional neuroimaging studies demonstrate reduced hippocampal activation and heightened amygdala response during trauma recall, consistent with fragmented encoding. Polyvagal research, including the work of Porges and colleagues, confirms the hierarchical activation of ventral, sympathetic and dorsal pathways in response to threat. Clinical trials of interventions that target these mechanisms, such as EMDR and sensorimotor psychotherapy, show significant reductions in PTSD symptom severity, underscoring the practical relevance of understanding traumatic memory and the threat cascade.

In sum, the essence of this lesson is twofold: traumatic memories are stored as fragmented, sensory, present-tense impressions because the integrating brain regions are suppressed during overwhelming threat, and the freeze-collapse response is an automatic survival strategy mediated by the dorsal vagal complex. By employing a shared body-state map, clinicians can de-shame these experiences, allowing survivors to replace the narrative of personal failure with a biologically accurate story of resilience. This

reframing lays the groundwork for all subsequent trauma-focused work, fostering a therapeutic environment where the survivor feels seen, understood and empowered to move towards integration.

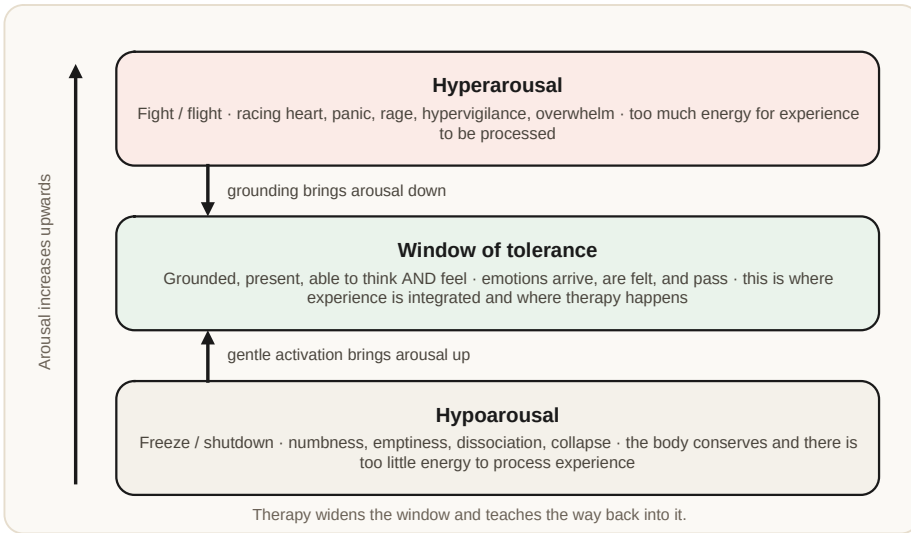


FIGURE 1.1 The window of tolerance

Siegel's window of tolerance describes the zone of arousal within which experience can be processed and integrated. Trauma narrows the window: survivors are thrown into hyperarousal (fight/flight) or hypoarousal (shutdown) by reminders. Therapy widens the window and teaches the return journey.

Points worth keeping

- Traumatic memory: fragmented, sensory, present-tense
- Freeze and collapse are survival biology, not choices
- A shared body-state map de-shames symptoms

PRACTICE TASK

Write three sentences explaining to a survivor why their body froze, in language that removes the shame.

CHAPTER 2

The window of tolerance

The window of tolerance has become the central organising image for clinicians working from a trauma-informed perspective, and this lesson equips you to use it with the same precision that a carpenter uses a calibrated ruler. The window of tolerance is the band of nervous-system arousal within which a person can experience, think, feel and relate without becoming overwhelmed or disengaged. When a client is operating inside this window, emotional material can be processed, memories can be integrated, and therapeutic learning can occur. The experience is characterised by a sense of being present, a capacity to attend to internal cues, and the ability to maintain a coherent narrative of events. Above the window lies a state of hyperarousal, driven by the sympathetic branch of the autonomic nervous system. The client may feel panic, rage, racing thoughts, a sense of being flooded, or a physical sensation of heat and tension. Below the window is hypoarousal, mediated by the dorsal vagal complex, in which the client may feel numb, dissociated, foggy, or deadened, as if the body has dropped into a low-energy shutdown. Both extremes represent states in which the brain's capacity for information processing is compromised; the former by an excess of activation that outpaces the prefrontal cortex, the latter by a withdrawal of activation that limits the flow of sensory data to cortical networks.

The scientific foundations of the window of tolerance rest on the work of Stephen Porges and his Polyvagal Theory, which describes how the ventral vagal complex supports social engagement and co-regulation when the nervous system is within the optimal arousal range. When the ventral vagal brake is intact, the client can attend to the therapist, negotiate affect, and integrate new learning. When the system is pushed above the ventral vagal capacity, the sympathetic fight-or-flight circuit dominates; when it falls below, the dorsal vagal immobilisation response takes over. Bessel van der Kolk's research on the neurobiology of trauma further demonstrates that repeated exposure to threat narrows the window of tolerance, making even mundane stressors appear threatening, and that the brain's predictive coding mechanisms become hyper-sensitive to cues that have previously signalled

danger (van der Kolk, 2014). In practical terms, trauma narrows the bandwidth of the window and makes the exit points – the early signs that a client is slipping out of the window – more abrupt and less predictable.

Understanding the window of tolerance is not an abstract intellectual exercise; it is a core clinical skill that informs every decision you make in the consulting room, from the pace of questioning to the selection of grounding techniques. The first principle is to work within the client's window. When a therapist pushes a client into hyperarousal, the client's attention is hijacked by the flood of limbic activation, and the prefrontal cortex cannot organise the experience into a coherent narrative. The client may relive the trauma in a fragmented, sensory-laden fashion that is not integrated, leading to re-traumatisation rather than healing. Conversely, when a client is in hypoarousal, the therapist's words may be heard but not registered; the client appears disengaged, yet the nervous system is in a protective shutdown that prevents new information from being encoded. In both cases, therapeutic work stalls.

The second principle is that the window can be widened, but the process must be gradual and titrated, much like progressive overload in physical training. Research on exposure therapy and affect-focused psychodynamic work shows that repeated, controlled exposure to mildly activating material, followed by rapid return to regulation, expands the capacity of the ventral vagal system to tolerate higher levels of arousal without tipping into flood or collapse (Foa & Kozak, 1986; Schauer & Elbert, 2010). The therapist's role is to calibrate the dose of activation, monitor the client's physiological signals, and ensure that each activation episode is followed by a period of safety and grounding. Over time, the client's window expands, allowing for deeper processing of traumatic memories and greater flexibility in emotional regulation.

The third principle is the early detection of exit signs. Each person develops a unique signature of the moment when the nervous system begins to slip out of the window. In hyperarousal, the signs may include a rapid increase in speech tempo, a clenched jaw, a tremor in the hands, or a sudden sharpening of the gaze. In hypoarousal, the signs may be a slowing of speech, a glazed look, a softening of the voice, or a verbal cue such as "I'm fine" delivered in a flat tone. Recognising these cues in real time enables the therapist to intervene before the client is fully flooded or shut down.

Intervention may involve a grounding exercise, a brief pause, or a shift in focus to a sensory anchor, thereby restoring the client to the centre of the window where processing can resume.

To illustrate how these principles operate in practice, consider the following worked example. Maya, a 32-year-old woman, presents for therapy after a series of childhood sexual assaults and a recent car accident. She scores 18 on the PHQ-9, indicating moderate depression, and 12 on the GAD-7, reflecting significant anxiety. In the initial session, Maya describes the accident in vivid detail, her voice trembling, her eyes darting around the room. As she speaks, you notice her breathing becoming shallow, her hands clenching into fists, and her speech accelerating. These are classic hyperarousal exit signs. You pause, gently ask her to place her feet flat on the floor, and guide her through a three-step grounding sequence: noticing the texture of the carpet, feeling the weight of her body in the chair, and listening to the hum of the air-conditioning. Within a minute, her breathing slows, her fists relax, and her speech returns to a measured pace. You then return to the narrative, but this time you limit the exposure to a single sensory fragment – the sound of the crash – and immediately follow it with a grounding cue. Over the next several sessions, you repeat this titrated exposure, each time extending the length of the narrative by a few seconds, while always ensuring that Maya returns to a regulated state before moving on. After eight weeks, Maya's window has visibly widened: she can discuss the accident for ten minutes without signs of flood, and she reports feeling more capable of handling everyday stressors. Her PHQ-9 score drops to 10, and her GAD-7 to 6, reflecting the therapeutic impact of working within and gradually expanding the window of tolerance.

The practical application of the window of tolerance extends beyond the therapist's chair to every point of contact within a trauma-informed service. Reception staff, intake coordinators, and peer support workers all benefit from recognising the signs of arousal and responding with safety-oriented interventions. For instance, a receptionist who observes a client's hands trembling as they hand over paperwork can offer a brief moment of privacy, invite the client to sit, and provide a calming object such as a stress ball. This simple act prevents the client from being thrust into a hyperarousal state before the therapeutic encounter even begins.

In the therapeutic relationship, the window of tolerance also informs the

pacing of interventions such as Cognitive-Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and Somatic Experiencing. CBT protocols that begin with behavioural activation must first ensure that the client can tolerate the mild increase in physiological arousal that activity brings. EMDR practitioners use the “safe space” phase to stabilise the client before bilateral stimulation, thereby anchoring the experience within the window. Somatic Experiencing explicitly tracks the pendulation between activation and de-activation, a process that mirrors the gradual widening of the window described earlier. Across all modalities, the therapist’s attunement to the client’s arousal state remains the common denominator of success.

A further nuance is the role of the therapist’s own nervous system in co-regulation. Polyvagal Theory emphasises that the ventral vagal complex is socially mediated; when the therapist maintains a calm, regulated presence, the client’s nervous system is more likely to stay within the window. This phenomenon, often described as “the therapist’s nervous system as a safety cue,” has been documented in studies of therapist-client physiological synchrony (Koole & Tschacher, 2016). Consequently, therapists must attend to their own self-regulation, employing practices such as mindfulness, breath work, or brief body scans between sessions to ensure they are not inadvertently transmitting hyperarousal or hypoarousal to the client.

The final element of the window of tolerance framework is the recognition that the window is not static; it fluctuates across the day, across contexts, and in response to internal and external stressors. A client may be comfortably within the window during a quiet morning session, yet find the same material overwhelming in the evening after a demanding workday. Therefore, assessment of the window should be ongoing, using both verbal check-ins (e.g., “How are you feeling in your body right now?”) and non-verbal observation. Some clinicians augment this observation with physiological measures such as heart-rate variability (HRV) monitoring, which provides an objective index of vagal tone and can help to fine-tune the therapist’s sense of where the client’s window lies.

In summary, the window of tolerance offers a parsimonious yet richly detailed map of the client’s capacity for processing trauma. By working within the window, gradually widening it through titrated exposure, and

learning the early exit signs unique to each client, clinicians can transform what might otherwise be a chaotic flood of affect into a manageable, integrative therapeutic experience. The window reframes behaviours that might be misread as resistance, aggression, or disengagement as adaptive states of the nervous system, thereby fostering compassion and precision in clinical practice. As you move forward in this course, keep the image of the window in mind: it is the lens through which every therapeutic decision is filtered, the compass that guides the pacing of exposure, and the safety net that catches the client when they begin to slip. Mastery of this concept is the foundation upon which all subsequent trauma-informed skills are built, and it equips you to provide care that is both scientifically sound and deeply humane.

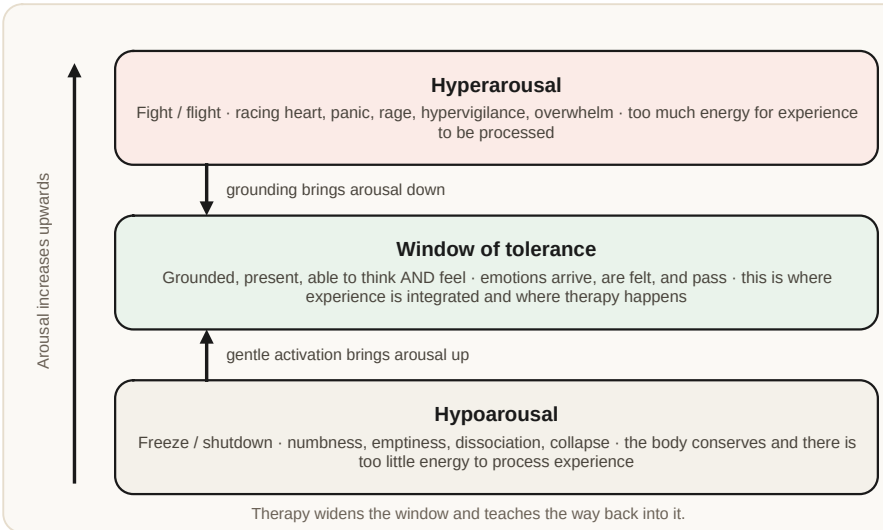


FIGURE 2.1 The window of tolerance

Siegel's window of tolerance describes the zone of arousal within which experience can be processed and integrated. Trauma narrows the window: survivors are thrown into hyperarousal (fight/flight) or hypoarousal (shutdown) by reminders. Therapy widens the window and teaches the return journey.

Points worth keeping

- Within the window: processing possible
- Above: hyperarousal; below: shutdown
- Work within, widen slowly, learn the exit signs

PRACTICE TASK

Map your own window: two personal signs of moving above it, two of dropping below, and one thing that returns you.