Working with Trauma in Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



Working with Trauma in Practice

Phase-based treatment, stabilisation skills, and the evidence-based trauma therapies compared.

Practitioner level · 10 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 Working with Trauma in Practice 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 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.

Contents

How to use this manual 1

Part 1 Part 1: Phase-based treatment and honest stabilisation . . . 3

1. Phase-based treatment and honest stabilisation 4
2. The evidenced therapies compared 10

How to use this manual

Trauma treatment has a map, and clinicians working without it get lost in ways that cost their clients dearly: processing attempted before stability exists, or stabilisation extended so long it becomes avoidance with a clinical name. This course teaches the map and the craft of moving across it, for practitioners treating trauma in real services.

You will study phase-based treatment honestly, including the modern critique of endless phase one, and learn what genuine stabilisation involves and how to know when it is sufficient. You will compare the evidenced trauma therapies, trauma-focused CBT, EMDR, narrative exposure therapy and prolonged exposure, by mechanism, evidence and fit, so referral and treatment choices become formulated rather than habitual. The second module addresses complexity: complex PTSD as ICD-11 defines it, relational trauma's particular signature, and titrated processing, the craft of approaching traumatic material in doses the nervous system can integrate.

Substantial written lessons with key points and clinically applied practice tasks, supported by a study tutor. Ten hours of CPD with around nine 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 practitioner level and carries 10 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

- Assess trauma presentations, including PTSD and complex presentations, with appropriate measures
- Deliver phase-one stabilisation work systematically rather than indefinitely
- Understand the mechanics of trauma-focused CBT, including reliving and updating
- Work with trauma memories at a pace the client's window of tolerance permits
- Manage dissociation in session with grounding, titration and dual awareness
- Plan phase-three reconnection work: grief, meaning and reclaiming a life

PART 1

Part 1: Phase-based treatment and honest stabilisation

Lessons 1 to 5 of the course.

CHAPTER 1

Phase-based treatment and honest stabilisation

Judith Herman's seminal work Trauma and Recovery (1992) gave the field a durable map of recovery that has become the backbone of phase-based trauma treatment. Her three-stage model – safety and stabilisation, remembrance and mourning, and reconnection – was later expanded by researchers such as Dan Siegel, who linked the stages to the neurobiological concept of the window of tolerance, and by evidence-based protocol developers including Edna Foa, Anke Ehlers, and Lori Resick. The contemporary consensus therefore organises trauma work into three functional phases – stabilise, process, and integrate – while insisting that the map be applied flexibly, responsive to the individual's evolving capacity rather than as a rigid timetable.

The first phase, stabilisation, is not a therapeutic luxury but a prerequisite platform on which any destabilising work must rest. It comprises two intertwined strands: external safety and internal regulation. External safety means addressing ongoing threats such as intimate-partner violence, precarious housing, or uncontrolled substance dependence, because therapy cannot outrun an active emergency. Internal regulation involves cultivating grounding fluency, affect tolerance, and the ability to return to the window of tolerance after activation. Grounding techniques – for example, the 5-4-3-2-1 sensory exercise – are taught until the client can reliably shift attention from overwhelming affect to present-moment sensations. Affect tolerance is built by practising paced exposure to low-intensity emotional cues, thereby widening the window's edges. The capacity to re-enter the window after a brief activation is the clinical litmus test for moving beyond phase one.

A common pitfall is the drift into endless stabilisation, which masquerades as preparation but in fact becomes avoidance. The term "honest stabilisation" captures the ethical correction: clinicians must acknowledge when stabilisation is truly required – for example, when a client dissociates for the remainder of a session or resorts to self-harm – and when it has become a holding pattern that stalls progress. Research on straightforward

PTSD, such as the meta-analyses by Watts et al. (2013) and Cusack et al. (2016), demonstrates that trauma-focused interventions like prolonged exposure (PE) and cognitive processing therapy (CPT) are effective without prolonged preparatory phases. Moreover, randomised controlled trials comparing extended stabilisation to immediate trauma-focused treatment have not shown clear advantage for the former. The guideline bodies – NICE (2022) and the ISTSS – recommend trauma-focused therapy as the primary treatment for PTSD, with stabilisation indicated only when specific risk factors or severe symptoms such as active suicidality or severe dissociation are present.

The judgment that guides the transition from phase one to phase two is therefore one of capacity, not comfort. Capacity can be assessed objectively rather than intuited. In the therapy room, a therapist observes whether the client, after a brief activation, can re-ground within a few minutes, resume a coherent dialogue, and maintain a sense of self-ownership over the experience. If the client can do this, they have demonstrated the affect regulation needed for processing. Conversely, if the client remains dysregulated – for instance, exhibiting prolonged dissociation, escalating substance use, or emergent suicidality – the therapist must remain in stabilisation, addressing the concrete risk factors that keep the nervous system locked outside the window.

Phase two, processing, is the core trauma-focused work. It may take the form of imaginal exposure, narrative restructuring, or memory reconsolidation techniques, depending on the modality chosen. The underlying principle is that confronting the traumatic memory in a controlled, therapist-guided manner allows the brain to update the fear network, reducing the pathological salience of the memory. Foa's PE protocol, for example, uses repeated imaginal exposure to diminish conditioned fear responses, while Ehlers and Clark's cognitive model emphasises modifying maladaptive appraisals that maintain the sense of current threat. The therapist's role is to hold a stance of compassionate challenge: the client is invited to "do the hard work" with the reassurance that the therapeutic relationship provides a secure base.

Phase three, integration, moves beyond symptom reduction to address the broader existential and relational consequences of trauma. This stage involves mourning losses, rebuilding a coherent sense of identity, and

fostering reconnection with valued life domains. Techniques may include meaning-making interventions, narrative therapy, and the cultivation of self-compassion. The integration phase is also the point at which clinicians consolidate gains from processing, ensuring that adaptive beliefs and coping skills are generalised to everyday contexts.

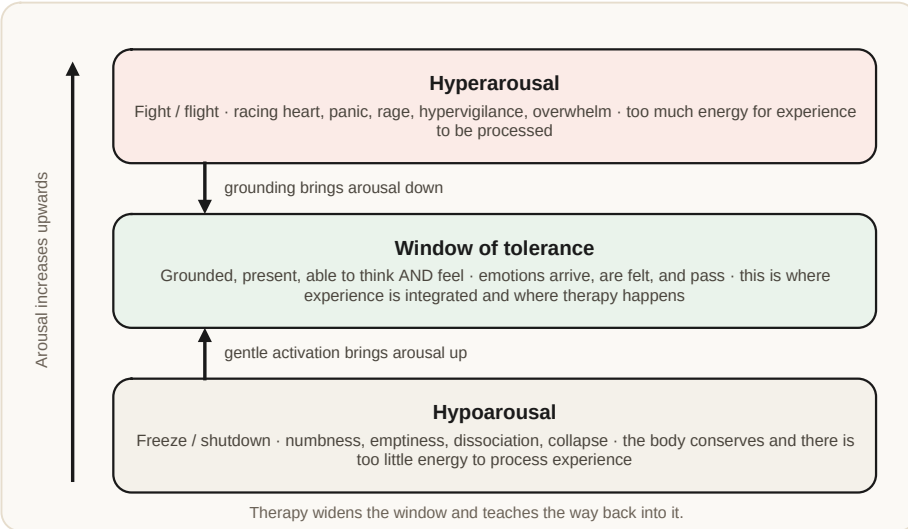


FIGURE 1.1 The window of tolerance

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.

Flexibility is the thread that weaves through all three phases. The map is not a linear conveyor belt but a dynamic landscape. A client may oscillate between phases, requiring revisiting of stabilisation after a particularly destabilising processing session, or may need to linger in integration while navigating new life stressors. The therapist must therefore remain vigilant, continually reassessing the client's capacity to stay within the window of tolerance.

A concrete worked example illustrates how honest stabilisation operates in practice. Sara, a 34-year-old survivor of childhood sexual abuse, presents to a community mental-health service with intrusive memories, hypervigilance, and a PHQ-9 score of 16, indicating moderate depression. In the initial assessment, Sara reports frequent nightmares and a sense that "the past is

always with me," yet she also discloses that she has been able to maintain steady employment and has a supportive partner. The therapist begins by establishing external safety – confirming that Sara's living situation is stable and that she has no current suicidal intent. Internally, the therapist introduces a grounding routine: a brief 3-minute body scan followed by the 5-4-3-2-1 exercise. Over three sessions, Sara practices these techniques, and the therapist observes that after a brief activation (a sudden surge of anxiety when the therapist mentions the word "abuse"), Sara can return to the grounding routine within two minutes and resume the session without dissociation. This observation satisfies the capacity criterion for moving to phase two.

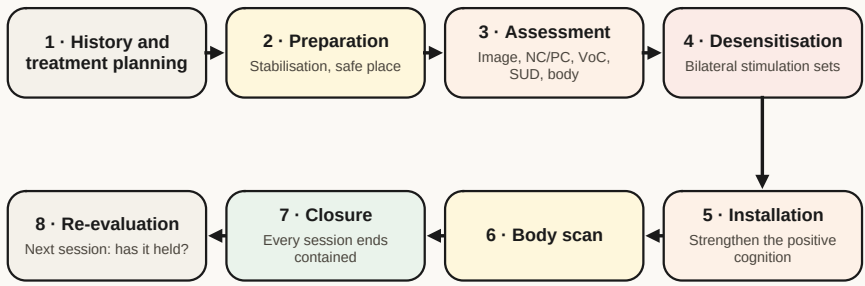
In the processing phase, the therapist employs a modified PE protocol. Sara is guided to create a trauma narrative, describing a specific incident from age nine in vivid detail. The therapist monitors physiological markers – heart rate and self-reported distress on a 0-10 scale – ensuring that Sara remains within her window. After each imaginal exposure, Sara engages in the previously learned grounding routine, reinforcing the newly formed safety net. Over eight weekly sessions, Sara's subjective units of distress (SUDs) decline from an initial 8 to a final 2, and her PTSD Checklist for DSM-5 (PCL-5) score drops from 48 to 22, reflecting clinically significant improvement.

Following processing, the integration phase focuses on rebuilding Sara's narrative identity. The therapist invites Sara to explore how the abuse has shaped her beliefs about self-worth and trust, and together they co-construct a revised story that acknowledges the trauma while highlighting Sara's resilience and current values. Sara also engages in a values-guided activity plan, re-connecting with a hobby of painting that she had abandoned. By the end of treatment, Sara's PHQ-9 score falls to 7, indicating mild depression, and she reports a renewed sense of agency and hope.

Contrast this with the case of Mark, a 42-year-old veteran who presents with severe PTSD (PCL-5 = 68), ongoing alcohol dependence, and a recent suicide attempt. In Mark's assessment, any discussion of his combat experiences triggers immediate dissociation, and he reports that "the world feels like it's falling apart" when he tries to talk about the trauma. The therapist recognises that Mark's capacity to return to the window after activation is absent; he remains dysregulated for the duration of the session. Accordingly,

the therapist prioritises phase one work: arranging a safe housing placement, coordinating with a substance-use specialist, and intensively teaching grounding and affect-regulation skills over a six-week period. Only once Mark demonstrates the ability to re-ground within five minutes after a brief activation does the therapist consider moving to processing. This honest appraisal prevents premature exposure that could exacerbate Mark's destabilisation and respects the ethical imperative to do no harm.

The lesson, therefore, is that phase-based treatment, when practised honestly, provides a clear direction without devolving into a waiting room. Stabilisation is a genuine capacity-building endeavour, not an indefinite postponement of processing. The therapist's responsibility is to assess, with observable behavioural markers, whether the client can re-enter the window after activation, and to use that assessment to guide the timing of trauma-focused work. By doing so, clinicians honour both the scientific evidence that supports early trauma-focused interventions and the lived reality of clients whose nervous systems may be temporarily unable to tolerate the demands of processing. The map remains indispensable, but only when it is wielded with flexibility, transparency, and a steadfast commitment to moving the client forward rather than keeping them in a perpetual state of preparation.



Phases 3–6 repeat per target memory; the client's own processing does the work.

FIGURE 1.2 The eight phases of EMDR

Shapiro's standard protocol moves through eight phases. Preparation and history-taking do the stabilising groundwork; assessment activates the target memory with its image, cognitions and body sensation; desensitisation applies bilateral stimulation until distress falls; installation and body scan consolidate; closure and re-evaluation keep every session safe and cumulative.

Points worth keeping

- Phases: stabilise, process, integrate, flexibly
- Stabilisation builds capacity; endless stabilisation is avoidance
- The criterion: can they return to the window after activation?

PRACTICE TASK

List three observable signs that a client has enough stability to begin processing work.

CHAPTER 2

The evidenced therapies compared

The first-line trauma-focused interventions that dominate contemporary guidelines – Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and Eye Movement Desensitisation and Re-processing (EMDR) – may look very different on the surface of a session, yet they are united by a single therapeutic spine. At the heart of each model lies the controlled re-engagement with the traumatic memory until that memory is updated. The underlying claim, now supported by a substantial body of experimental and clinical work, is that traumatic memories are stored in a fragmented, present-tense form that continues to generate threat predictions. When the memory is activated within the client's window of tolerance and paired with information that contradicts the original prediction – for example, that the client survived, that the world is not wholly dangerous, that the client is not intrinsically defective – the memory can be reconsolidated in a more adaptive form. In other words, the therapeutic aim is not to erase the memory but to rewrite its emotional and cognitive script so that it no longer dominates the client's present experience.

The shared spine can be described in three interlocking steps. First, the therapist guides the client into a state of safety and establishes a clear window of tolerance, often using grounding techniques and physiological monitoring. Second, the client is invited to bring the target memory into conscious awareness, either through imaginal reliving, written narrative, or dual-attention tasks. Third, the therapist introduces corrective information – new learning, compassionate self-statements, or behavioural evidence – while the memory remains active, thereby creating the conditions for memory updating. Across TF-CBT, PE, CPT and EMDR, the specific route to that updating differs, as do the emphases on narrative, exposure, cognition or bilateral stimulation, but the mechanistic core remains constant.

In TF-CBT, the model articulated by Ehlers and Clark (2000) identifies two maintaining processes: a disjointed, sense-making deficit in the memory itself and maladaptive appraisals that arise from that deficit. The therapist works with the client to produce a detailed written account of the trauma,

encouraging the client to add temporal and contextual markers that give the memory a “time-stamp”. This narrative work is complemented by cognitive restructuring, where stuck points such as “I am permanently damaged” are challenged and replaced with balanced alternatives. The signature “updating” manoeuvre in TF-CBT involves identifying the “hotspot” – the worst moment of the trauma – re-activating it in session, and then deliberately pairing it with the client’s current knowledge that they are safe now. The result is a memory that retains factual detail but loses its terror-laden affect.

Prolonged Exposure, as systematised by Foa and colleagues (2005), leans heavily on the exposure component of the spine. The client engages in repeated imaginal reliving of the trauma, often recording the narrative and listening to it between sessions, while also confronting avoided external situations (in-vivo exposure). The original formulation of PE emphasised habituation – the gradual reduction of fear as the memory is revisited. More recent accounts, however, foreground inhibitory learning (Craske et al., 2008), suggesting that new safety information is learned alongside the original fear memory, creating a competing memory trace rather than merely diminishing the original response. The therapist’s role is to maintain a stance of compassionate curiosity, ensuring the client remains within their tolerance window while the exposure proceeds.

Cognitive Processing Therapy, developed by Resick and colleagues (2002), adopts a lighter touch on the memory itself and a heavier focus on cognition. The client writes an impact statement and then a detailed trauma narrative, but the narrative is not repeatedly revisited in the same way as in TF-CBT or PE. Instead, the therapist guides the client through a systematic identification of “stuck points” – maladaptive beliefs about safety, trust, power, esteem and intimacy – and then works to modify these beliefs using Socratic questioning and evidence-based disputation. For clients who find direct reliving overwhelming, CPT offers a pathway to the same updating process by first reshaping the interpretive framework that gives the memory its power. The memory is still activated, but the emphasis is on the cognitive restructuring that follows.

EMDR, pioneered by Shapiro (1989), introduces a dual-attention stimulus that appears to accelerate the updating process. The client holds the traumatic memory in mind while simultaneously tracking a therapist-guided

bilateral stimulus – most commonly rapid eye movements, but also auditory tones or tactile taps. The dominant working-memory account (Baddeley, 2003) proposes that the simultaneous load on the visuospatial sketchpad reduces the vividness and emotional intensity of the memory, thereby facilitating reconsolidating with new, corrective information. Neuroimaging studies have shown reduced amygdala activation and increased prefrontal engagement after successful EMDR sessions, supporting the notion that the memory is being re-encoded in a less threatening form. While the necessity of eye movements per se remains debated (e.g., van den Hout & Engelhard, 2012), the overall evidence base for EMDR as a delivery system for memory updating is robust.

Head-to-head randomised controlled trials have repeatedly demonstrated that TF-CBT, PE, CPT and EMDR produce broadly comparable reductions in core trauma symptoms as measured by instruments such as the PTSD Checklist for DSM-5 (PCL-5), the PHQ-9 for depressive symptoms and the GAD-7 for anxiety. Meta-analyses by Watts et al. (2013) and Bisson et al. (2019) report effect sizes in the large range (d?0.80-1.00) for each of these modalities, with no single approach emerging as superior across heterogeneous samples. NICE (2022) therefore recommends TF-CBT and EMDR as first-line treatments in the UK, while the American Psychological Association's guidelines (2021) add PE and CPT to the roster of evidence-based options. The practical implication is that the therapist's choice should be guided not by a hierarchy of efficacy but by three client-centred criteria: preference, tolerability and formulation.

Preference is the most powerful predictor of treatment adherence. When a survivor is offered a clear, jargon-free description of each modality – for example, "TF-CBT involves writing a detailed account of what happened and then testing the thoughts that arise from it", "PE asks you to repeatedly imagine the worst part of the event while also confronting things you have been avoiding", "CPT focuses on the beliefs that the trauma has left you with", and "EMDR uses eye movements while you hold the memory in mind" – the survivor can make an informed choice that aligns with their sense of agency. Studies have shown that when clients feel they have chosen the therapy, dropout rates fall dramatically (Schnurr et al., 2007).

Tolerability concerns the client's capacity to engage with the core mechanisms of a given therapy at the present stage of recovery. A client

who experiences overwhelming dissociation or severe affect dysregulation may struggle to produce a coherent written narrative, making TF-CBT or PE initially intolerable. For such clients, CPT's emphasis on cognition or EMDR's less verbally demanding dual-attention task can provide a gentler entry point. Conversely, a client who craves structure and a sense of order over the chaotic recollection may find the narrative-driven approach of TF-CBT or the systematic exposure hierarchy of PE more reassuring.

Formulation refers to the therapist's conceptualisation of the client's maintaining factors. If the formulation highlights pervasive guilt and shame – for instance, a survivor who believes "I am to blame for what happened" – a cognitive-focused approach such as CPT or the cognitive restructuring component of TF-CBT may be most efficient. When the formulation foregrounds behavioural avoidance – the client has stopped attending social gatherings, driving, or looking at photographs because the memory triggers panic – an exposure-oriented approach like PE or the in-vivo component of TF-CBT may be indicated. In practice, many clinicians adopt a hybrid stance, drawing on the shared spine while tailoring the route to the client's unique presentation.

To illustrate how these principles operate in a real-world setting, consider the case of Maya, a 32-year-old teacher who survived a single-incident sexual assault three years ago. Maya presents with intrusive images, hypervigilance, avoidance of public transport, and persistent self-blame ("I should have fought back"). Her PHQ-9 score is 14, indicating moderate depression, and her GAD-7 is 12, reflecting moderate anxiety. In the initial assessment, Maya expresses a strong desire to avoid talking about the assault in detail, yet she is motivated to regain confidence in using the bus to travel to work.

The therapist begins by explaining the four evidence-based options, using plain language and a visual decision aid. Maya indicates that the idea of "talking about it over and over" feels frightening, but she is intrigued by the notion of "changing the way she thinks about herself". The therapist therefore proposes starting with CPT, acknowledging that the narrative component will be brief and that the focus will be on identifying and challenging the stuck points of guilt and shame. In the first session, Maya writes an impact statement and together with the therapist identifies three primary stuck points: "I am responsible for the assault", "I am weak", and

“People cannot be trusted”. Over the next six weeks, the therapist guides Maya through Socratic questioning, encouraging her to examine the evidence for and against each belief, and to generate balanced alternatives such as “The assault was the perpetrator’s choice, not mine”. Throughout, the therapist monitors Maya’s affective tolerance, using grounding exercises and the PHQ-9 and GAD-7 to track symptom change.

After four weeks, Maya reports that her self-blame has softened but that the vivid image of the assault still flashes when she steps onto a bus. At this juncture, the therapist revisits the shared spine and suggests a brief EMDR protocol to target the residual image. Maya consents, appreciating that EMDR does not require her to narrate the event in detail. In a series of three EMDR sessions, Maya holds the intrusive image in mind while following the therapist’s hand movements. The bilateral stimulation reduces the vividness of the image, and the therapist introduces the corrective cognition “I am safe now”. By the end of the EMDR phase, Maya’s PCL-5 score has dropped from 48 to 32, and she reports being able to board the bus without panic.

Maya’s case demonstrates how a therapist can move fluidly between modalities while remaining anchored to the shared spine of memory updating. The initial preference for a cognition-focused approach respected her tolerability limits; the subsequent brief EMDR intervention addressed a residual sensory memory that remained resistant to cognitive work alone. The formulation – guilt-driven beliefs plus a specific avoidance behaviour – guided the sequencing of interventions, and the outcome measures (PHQ-9, GAD-7, PCL-5) confirmed clinically significant improvement.

The evidence base does not support a third, passive route that many services inadvertently adopt: maintaining a supportive stance without ever approaching the traumatic memory. While empathy, validation and psycho-education are essential components of any therapeutic relationship, they do not, on their own, produce the memory updating required for lasting symptom remission. The comparative table of first-line therapies therefore carries a single, unifying lesson – every therapy that works does so by deliberately engaging the memory and allowing it to be revised.

For the intermediate practitioner, the professional obligation is threefold. First, acquire a thorough, experiential understanding of TF-CBT, PE, CPT and EMDR so that you can describe each modality honestly, including the typical session structure, the expected emotional intensity and the duration of

treatment. Second, integrate the client's expressed preference, observed tolerability and formulation into a shared decision-making process, recognising that preference predicts retention and that tolerability may shift over the course of therapy. Third, deliver the chosen modality with fidelity to its core mechanisms – the shared spine of memory re-engagement and updating – while remaining vigilant for signs that the client has moved out of their window of tolerance, ready to pause, stabilise and re-establish safety before proceeding.

In sum, the four first-line trauma-focused therapies are not competing brands but parallel routes that converge on a common mechanistic destination. Their outcomes are broadly comparable, as demonstrated by robust meta-analytic data; the decisive factor in clinical practice is the fit between the survivor's preferences, their capacity to tolerate the core work, and the therapist's formulation of maintaining processes. By honouring this fit and by steadfastly guiding the memory towards an updated, less threatening representation, the practitioner upholds the evidence-based mandate to move beyond mere kindness and towards genuine healing.

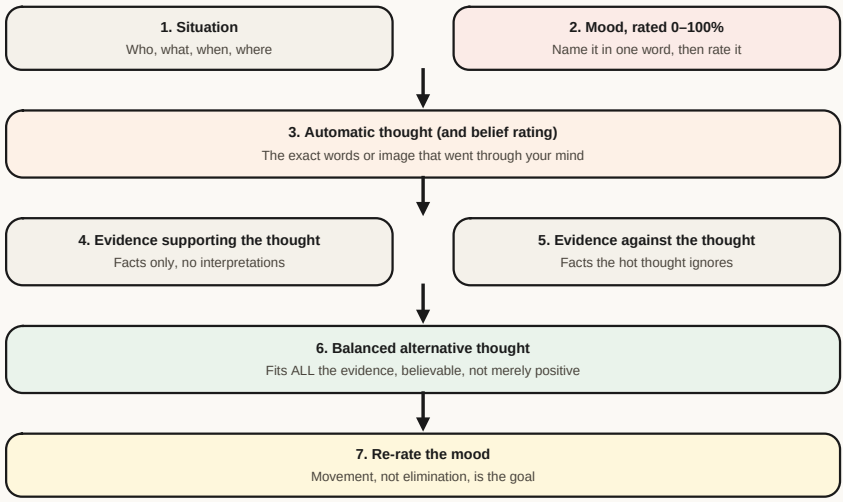


FIGURE 2.1 Working through a thought record

The classic seven-column thought record as a sequence: capture the situation and mood, catch the automatic thought, weigh the evidence on both sides, build a balanced alternative, and re-rate the mood. The learning is in the discipline of evidence before reassurance.

Points worth keeping

- Shared spine: re-engage the memory until it updates
- TF-CBT, PE, CPT, EMDR: broadly comparable outcomes
- Choose by preference, tolerability, formulation

PRACTICE TASK

For a client terrified of talking through details, note which first-line option you would present first, and why, in two sentences.