# Trauma-Informed Practice for Therapists

THE TALKING THERAPIES UK PRACTITIONER SERIES



# Trauma-Informed Practice for Therapists

## Integrating evidence-based approaches to support survivors in therapeutic work

Practitioner level · 10 hours of continuing professional development

**TALKING THERAPIES UK**

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First edition, 2026.

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

Revision 2. This printing was set on 2 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-Informed Practice for Therapists – intermediate is a six-hour CPD course designed to equip clinicians with the knowledge and skills required to work safely and effectively with survivors of traumatic experience. Drawing on the NICE guideline NG116, ISTSS recommendations and contemporary research in trauma-focused CBT, EMDR and attachment-based therapy, the programme blends neurobiological insight with practical application.

Foundations of Trauma invites participants to explore the multifaceted nature of trauma, its prevalence, and the profound impact on the brain and body. Through case vignettes and evidence-based models of the stress response, learners gain a nuanced understanding of how trauma alters cognition, emotion and behaviour, laying the groundwork for informed intervention.

Core Principles of Trauma-Informed Care examines the six guiding principles – safety, trustworthiness, peer support, collaboration, empowerment and cultural, historical and gender sensitivity. Participants learn to embed these principles into the therapeutic alliance, recognising how each principle reshapes assessment, rapport building and treatment planning in a trauma-sensitive context.

Evidence-Based Interventions compares the main trauma-focused therapeutic models, including trauma-focused CBT, EMDR and attachment-based approaches. The module offers structured overviews, key techniques, contraindications and integration strategies, enabling clinicians to select and adapt interventions that best match client presentations and therapeutic goals.

Putting It All Together in Practice translates theory into day-to-day work. Learners practise applying safety protocols, collaborative goal setting and self-care routines, using role-play and reflective exercises. The session emphasises maintaining therapeutic boundaries, managing vicarious trauma and sustaining resilience in clinical practice.

On completion, participants will be able to assess trauma exposure, embed trauma-informed principles into every session, select and deliver evidence-based interventions, and monitor both client and clinician wellbeing. The course promises a richer therapeutic relationship, improved treatment outcomes and a sustainable, self-aware practice, delivered within a CBT framework and accredited for 6 CPD hours, suitable for therapists, counsellors and psychotherapists seeking to deepen their expertise in trauma-informed care.

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

- Identify the neurobiological and psychological impacts of trauma on clients.
- Apply the six key principles of trauma-informed care to assessment and treatment planning.
- Select and adapt evidence-based interventions such as TF-CBT and EMDR for diverse client needs.
- Demonstrate strategies for maintaining therapist safety and managing vicarious trauma.

- Integrate trauma-informed documentation and referral pathways within a multidisciplinary setting.

PART 1

# Foundations of Trauma

*Explore what trauma is, how it affects the brain and body, and the prevalence of trauma exposure.*

CHAPTER 1

# Defining Trauma and Its Types

Trauma is a profoundly personal experience that emerges when an individual perceives an event or series of events as threatening to their physical or psychological integrity, and feels a loss of control over the situation. The defining feature of trauma is therefore not the objective severity of the incident—whether it involved a car crash, a natural disaster or a single act of violence—but the subjective sense of danger, helplessness and the perceived inability to recover. This distinction is central to trauma-informed practice because the same incident can be catastrophic for one person and relatively benign for another, and conversely, a seemingly minor event can be devastating for someone with particular vulnerabilities or pre-existing conditions. In clinical work, the focus must therefore be on the impact of the event on the client's functioning and well-being, rather than on the event's objective characteristics.

The literature has long recognised that trauma exposure can be categorised along a spectrum that reflects both the temporal pattern of exposure and the interpersonal context. The most widely accepted typology distinguishes three primary categories: acute, chronic and complex trauma. Acute trauma refers to a single, discrete event that overwhelms the individual's coping resources. Classic examples include a motor-vehicle collision, a sudden loss of a loved one, or an unexpected violent assault. The hallmark of acute trauma is the rapid onset of intense symptoms—intrusive memories, hyper-arousal, avoidance—that may resolve over weeks or months with adequate support. The therapeutic response to acute trauma is often brief and focused, employing trauma-focused cognitive-behavioural therapy (TF-CBT) or eye movement desensitisation and reprocessing (EMDR) to process the memory and reduce avoidance.

Chronic trauma, in contrast, involves repeated or prolonged exposure to a single type of stressor. This can take the form of ongoing physical or emotional abuse, persistent exposure to community violence, or living in a war zone for an extended period. Symptoms of chronic trauma are typically more diffuse, characterised by pervasive anxiety, hyper-vigilance, a sense of entrapment and a chronic feeling of threat. The chronicity of the exposure

erodes the individual's sense of safety and can lead to a pervasive sense of hopelessness. Treatment for chronic trauma usually requires a longer-term approach that prioritises the development of coping skills, the establishment of a sense of safety and the gradual introduction of trauma-specific processing.

Complex trauma represents the most severe and multifaceted form of exposure. It is characterised by exposure to multiple, varied, and often interpersonal traumatic events that occur over an extended period, usually involving a failure of the primary caregiver or attachment figure. Judith Herman's seminal work, *Trauma and Recovery*, and Bessel van der Kolk's *The Body Keeps the Score* provide a comprehensive framework for understanding complex trauma. Symptoms are broader and more pervasive, including identity disturbances, dissociation, affect dysregulation, and chronic relational difficulties. Complex trauma often requires a phased approach that begins with safety, stabilisation and the rebuilding of a coherent sense of self before trauma-specific interventions can be introduced.

A common misconception is that trauma is synonymous with post-traumatic stress disorder (PTSD). While PTSD is a recognised diagnostic outcome of trauma exposure, many individuals who experience trauma do not meet the full criteria for PTSD yet continue to suffer significant distress. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD-11) both acknowledge that trauma can manifest through a range of diagnoses, including depression, anxiety disorders, substance use disorders and somatic syndromes. In practice, clinicians should therefore assess for trauma history even when the presenting problem does not appear to be a classic PTSD case. Screening tools such as the PHQ-9 for depression and the GAD-7 for anxiety can be useful adjuncts to trauma-specific measures, helping to capture the broader impact of trauma on mental health.

Another pervasive myth is that trauma is only relevant to those who have experienced violence or disaster. In reality, any event that threatens an individual's sense of safety, autonomy or identity can be traumatic. The concept of "subjective threat" articulated by Foa and colleagues emphasises that the perception of danger, rather than the objective danger itself, is what determines the traumatic response. Examples of non-violent traumatic

events include the sudden loss of a loved one, a severe medical diagnosis, a traumatic miscarriage or even the abrupt termination of a long-term relationship. The key factor is the perceived threat to one's core self and the inability to process the event in a supportive environment.

The distinction between acute, chronic and complex trauma is not merely academic; it informs the therapeutic approach. For acute trauma, brief, focused interventions such as TF-CBT or EMDR are often sufficient. Chronic trauma typically requires longer-term work to build coping skills and address the pervasive sense of threat. Complex trauma necessitates a phased approach that prioritises safety, stabilisation and the rebuilding of a coherent sense of self before trauma-specific processing can occur. This phased approach aligns with the principles of trauma-informed care as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA): safety, trustworthiness, choice, collaboration and empowerment.

In a trauma-informed therapeutic relationship, the clinician must be attuned to the client's subjective experience and adapt the intervention accordingly. The therapist's role is to create a safe, predictable environment that fosters trust and empowers the client to take an active role in their recovery. The use of structured assessment tools, such as the Clinician-Administered PTSD Scale (CAPS) or the Trauma History Questionnaire (THQ), can help to clarify the type and severity of trauma exposure, but should always be supplemented by a careful exploration of the client's narrative and subjective experience.

The neurobiological underpinnings of trauma provide a biological context for the psychological phenomena described here. The polyvagal theory, proposed by Stephen Porges, explains how the autonomic nervous system responds to threat, shifting from a state of social engagement to one of fight, flight or freeze. This physiological shift underlies many of the symptoms seen in trauma, such as hyper-arousal, dissociation and affect dysregulation. Understanding these mechanisms can help clinicians to explain the client's experience, normalise their reactions and tailor interventions that target the underlying neurobiological processes.

The dual-representation theory, developed by Brewin and colleagues, posits that traumatic memories are stored in two distinct systems: a verbally accessible memory system and a perceptually detailed, non-verbal system. Trauma-focused CBT and EMDR aim to integrate these two systems,

reducing the vividness and emotional intensity of intrusive memories. This theoretical framework underscores the importance of processing the traumatic memory in a safe, controlled manner, rather than attempting to suppress or avoid it.

The following worked example illustrates how the type of trauma informs assessment, formulation and intervention. Consider a 32-year-old woman named Sarah who presents with intrusive memories, nightmares and a pervasive sense of hyper-vigilance. She reports that her symptoms began after a car accident in which she was the sole survivor. The accident was a single, sudden event, and she has not experienced any other traumatic incidents. Sarah's symptoms are intense, but she reports that they have gradually lessened over the past six months, although she still experiences occasional flashbacks and a heightened startle response.

In this case, Sarah's experience is best characterised as acute trauma. The single, discrete event triggered a classic post-traumatic stress response. The fact that her symptoms have reduced over time suggests that she has engaged in some form of natural recovery, but the persistence of intrusive memories and hyper-arousal indicates that she would benefit from trauma-focused CBT or EMDR. The therapeutic focus would be on processing the traumatic memory, reducing avoidance, and developing coping strategies for hyper-arousal. A structured assessment using the CAPS would confirm the presence of PTSD symptoms, while the PHQ-9 and GAD-7 would help to gauge the extent of comorbid depression and anxiety.

Contrast this with a client named Ahmed, a 45-year-old refugee who has lived in a war zone for eight years, experiencing daily bombings, loss of family members and ongoing displacement. Ahmed's symptoms include chronic anxiety, a sense of entrapment, and difficulties with trust and attachment. This presentation aligns with chronic trauma, and treatment would need to address the pervasive threat, build safety and trust, and gradually introduce trauma-specific processing. A phased approach would begin with psychoeducation about the neurobiology of stress, followed by the development of coping skills such as grounding techniques, and only after a period of stabilisation would trauma-specific interventions be introduced.

A third scenario involves a young boy named Liam, who has been in foster care since the age of four following repeated physical and emotional abuse

by his biological parents. Liam's symptoms include dissociation, identity confusion, and a pervasive sense of shame. This pattern reflects complex trauma, requiring a phased approach that prioritises stabilisation, safety and the reconstruction of a coherent sense of self before trauma-specific interventions. In Liam's case, the therapist would first focus on building a secure therapeutic alliance, teaching emotion regulation skills, and addressing attachment difficulties before moving on to trauma processing.

These examples demonstrate how the type of trauma informs the assessment, formulation and choice of intervention. The key is to remain attuned to the client's subjective experience and to adapt the therapeutic plan accordingly. In practice, this means routinely assessing for trauma history, recognising the spectrum of trauma responses, and tailoring interventions to the specific type of trauma exposure.

In summary, defining trauma and its types is foundational for any trauma-informed practice. It clarifies the nature of the client's experience, dispels common myths, and guides the selection of appropriate therapeutic strategies. Clinicians should routinely assess for trauma history, recognise the spectrum of trauma responses, and tailor interventions to the specific type of trauma exposure. The next lesson will explore the neurobiology of stress and memory, providing a biological context for the psychological phenomena described here.

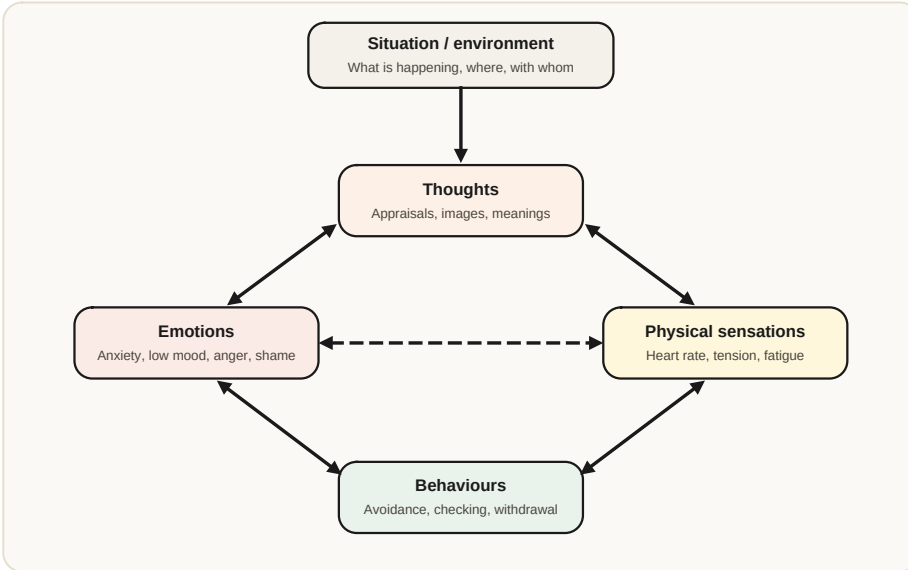



**FIGURE 1.1 The five areas model**

*Greenberger and Padesky's five areas ("hot cross bun") model: a situation is processed through thoughts, emotions, physical sensations and behaviours, and every element influences every other. Change introduced at any point, most often at thoughts or behaviours, alters the whole system.*

## Points worth keeping

- Trauma is defined by the subjective sense of threat and loss of control, not by the objective severity of an event.
- Acute trauma is a single, discrete event; chronic trauma involves repeated or prolonged exposure; complex trauma involves multiple, varied interpersonal events over time.
- Many individuals who experience trauma do not meet PTSD criteria; trauma can manifest through a range of diagnoses such as depression, anxiety and somatic syndromes.
- Misconceptions include equating trauma solely with violence or disaster; any event threatening core self-integrity can be traumatic.
- The type of trauma informs assessment, formulation and intervention strategy, requiring a tailored, phased approach.
- Clinicians should routinely assess trauma history and remain attuned to the client's subjective experience to guide treatment.

**PRACTICE TASK**

*Over the next week, conduct a brief trauma screening with a client who presents with anxiety or depression. Use a structured, non-judgemental approach to identify any acute, chronic or complex trauma exposure. Document the type of trauma, key symptoms and any immediate safety concerns, and reflect on how this information will shape your therapeutic plan.*

CHAPTER 2

# Neurobiology of Stress and Memory

Trauma is not merely a psychological event; it is a profound neurobiological disturbance that reshapes the brain's stress circuitry and the very architecture of memory. When a person confronts a threat that overwhelms their coping capacity, the central nervous system launches a coordinated response that begins in the hypothalamus and radiates through the pituitary, adrenal glands, and brainstem. The hypothalamic-pituitary-adrenal (HPA) axis releases corticotropin-releasing hormone (CRH), which stimulates the pituitary to secrete adrenocorticotropic hormone (ACTH). ACTH in turn drives the adrenal cortex to produce cortisol, the primary glucocorticoid that modulates neuronal excitability and gene expression across the brain. Simultaneously, the locus coeruleus, the brain's principal source of norepinephrine (NE), is activated, releasing NE into widespread cortical and limbic targets. These neurochemicals prime the organism for a fight, flight or freeze response, but they also alter the functioning of the amygdala, hippocampus and prefrontal cortex (PFC), the triad that governs emotional salience, contextualisation and executive regulation.

The amygdala, a small almond-shaped structure in the medial temporal lobe, is the brain's alarm system. Acute stress heightens amygdala responsiveness, a phenomenon first described by Phelps and colleagues in the early 2000s. The amygdala tags incoming sensory information as emotionally salient, thereby enhancing its consolidation. This tagging is mediated by synaptic plasticity mechanisms that involve the interaction between the amygdala and the hippocampus. The hippocampus, responsible for binding events to their spatial and temporal context, is exquisitely sensitive to cortisol. Moderate cortisol levels can facilitate hippocampal long-term potentiation, but chronic or excessive exposure, as seen in prolonged trauma, impairs neurogenesis and dendritic arborisation, reducing the hippocampus's capacity to encode contextual details. The result is a memory that is vivid for its emotional core yet fragmented for the surrounding narrative.

The PFC normally exerts top-down regulatory control over the amygdala, dampening emotional reactivity and supporting executive functions such as

planning, perspective-taking and threat appraisal. Stress hormones suppress PFC activity, weakening this regulatory loop. Consequently, the individual may experience intrusive recollections that feel automatic and uncontrollable, because the PFC is less able to inhibit amygdala-driven retrieval. The dorsal anterior cingulate cortex (dACC), which monitors conflict and error, can become over-active, contributing to hypervigilance and a heightened sense of threat even in safe environments. This neurobiological picture aligns with the “hyper-arousal” component of the trauma-related symptom cluster described in the DSM-5 and the “hyper-responsive amygdala” model advanced by McEwen and Sapolsky.

Memory processing under trauma is not simply a matter of stronger encoding; it also involves alterations in the way memories are stored. Animal studies have shown that high levels of NE during a stressful event can shift memory storage from the hippocampus to the amygdala, producing what is termed “emotional memory” that is less dependent on contextual cues. In humans this manifests as flashbulb-type memories: vivid, sensory-rich fragments that are recalled with intense affect but lack coherent chronology. When trauma is repeated or ongoing, the brain may adopt dissociative strategies, compartmentalising the experience into separate memory networks that are difficult to integrate. This can lead to the phenomenon of “memory fragmentation” where the client recalls isolated sensory impressions, emotions or bodily sensations without a clear narrative thread.

The neurobiology of stress also explains why trauma survivors often display avoidance. The PFC’s diminished capacity to re-appraise threat cues means that reminders of the trauma are interpreted as imminently dangerous, triggering the sympathetic nervous system. The resulting physiological arousal—elevated heart rate, rapid breathing, muscle tension—reinforces avoidance behaviours through negative reinforcement. Over time, the neural pathways that support safety learning become weakened, while those that encode threat remain potentiated. This is the neurobiological substrate of the avoidance symptom cluster and the “fear-learning” model of trauma.

Understanding these mechanisms is essential for therapeutic work. Interventions that aim to modulate arousal, such as grounding techniques, paced breathing or slow rhythmic movement, can help restore balance between the sympathetic and parasympathetic branches of the autonomic nervous system. By reducing NE and cortisol spikes, the therapist creates a

window in which the PFC can re-engage, allowing the client to approach distressing material with greater cognitive control. This is the neurobiological rationale behind the “window of tolerance” model, which describes the optimal zone of arousal for processing traumatic memories. The window is not a fixed range but a dynamic zone that can be expanded through regulation skills.

Memory reconsolidation offers another therapeutic lever. When a memory is retrieved, it becomes labile and can be updated before it is stored again. Pharmacological studies have shown that blocking protein synthesis during this window can weaken the emotional charge of the memory. In psychotherapy, the analogue is to guide the client into a state of moderate arousal, retrieve the target memory, and then introduce corrective information or new emotional experiences. Techniques such as Eye Movement Desensitisation and Reprocessing (EMDR) or trauma-focused cognitive behavioural therapy (TF-CBT) aim to harness this reconsolidation window, allowing the memory to be re-encoded with reduced threat value. The reconsolidation window is typically considered to last from a few minutes to a few hours after retrieval, a period during which the memory trace is vulnerable to modification.

A concrete worked example illustrates how these concepts translate into practice. James, a 42-year-old man, presents with recurrent nightmares and flashbacks of a childhood assault. Neurobiologically, his amygdala remains hyper-responsive to cues reminiscent of the assault (for instance, the sound of a particular type of doorbell), while his hippocampal contextual binding is compromised, leading to fragmented recollections. In the initial sessions, James reports feeling “flooded” when discussing the assault, with a racing heart and trembling hands. The therapist first establishes safety by teaching paced breathing and a body-scan grounding exercise, thereby lowering sympathetic arousal and allowing the PFC to regain some regulatory influence. Once James can remain within his window of tolerance, the therapist gently invites him to visualise a specific flashback while maintaining the grounding technique. The therapist then asks James to notice any new, present-moment information that contradicts the old belief that “the world is always unsafe”—for example, the fact that he is now in a secure therapeutic space with supportive staff. By pairing the retrieval of the traumatic memory with this corrective experience, the therapist facilitates reconsolidation, gradually integrating the memory into a broader, less

threatening narrative.

It is also important to recognise that trauma can affect implicit memory systems. Procedural learning, conditioned fear responses and somatic sensations may persist even when explicit recall is limited. Clients may report “body memories”—tightness in the chest, a knot in the stomach—without being able to articulate the associated event. Somatic-oriented approaches, such as sensorimotor psychotherapy, work directly with these non-verbal traces, using movement, touch or breath to discharge stored arousal. From a neurobiological perspective, these interventions aim to down-regulate the autonomic nervous system and promote integration between the limbic system and cortical networks.

Finally, the therapist must be aware of the bidirectional relationship between stress physiology and therapeutic alliance. A client who perceives the therapist as unsafe may experience heightened amygdala activation, which can manifest as mistrust or withdrawal. Conversely, a therapist who models calm regulation can signal safety to the client’s nervous system, supporting the development of a secure attachment-like bond. This relational safety is a prerequisite for any memory work, because it ensures that the client can stay within the window of tolerance long enough for reconsolidation processes to occur.

In summary, trauma reshapes the brain’s stress circuitry, amplifying amygdala signalling, impairing hippocampal contextualisation, and suppressing prefrontal regulation. These changes produce vivid, emotionally charged but fragmented memories that are prone to intrusion and avoidance. Stabilisation techniques that lower sympathetic arousal restore the window of tolerance, allowing the prefrontal cortex to re-engage and support memory processing. When a traumatic memory is retrieved in a regulated state, reconsolidation can be harnessed to update the memory trace, reducing its threat value and facilitating integration. By grounding the neurobiological mechanisms in clinical practice, therapists can design interventions that are both evidence-based and deeply resonant with the lived experience of trauma survivors. This lesson equips clinicians with a nuanced understanding of the neurobiology of stress and memory, enabling them to apply stabilisation and reconsolidation techniques with precision and compassion.

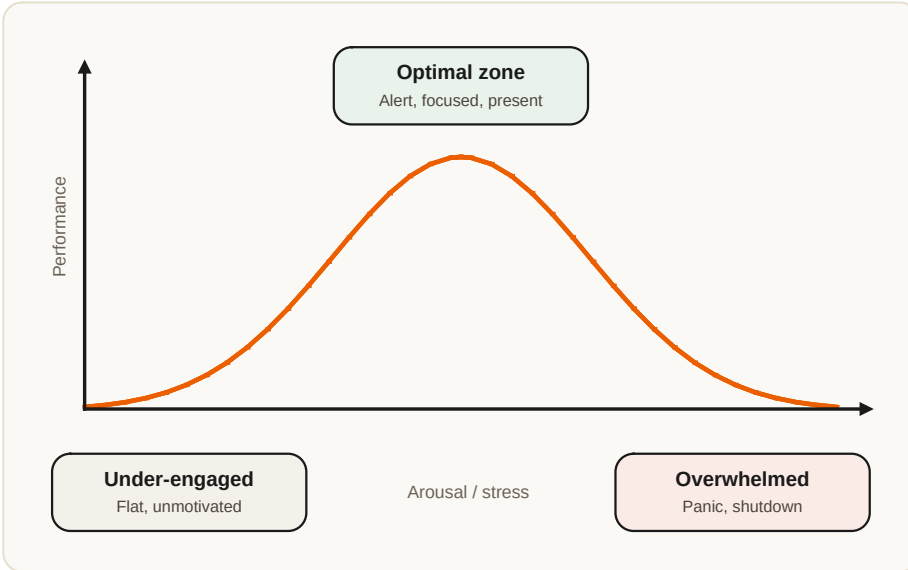



**FIGURE 2.1 The arousal–performance curve**

*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

- Trauma activates the HPA axis and locus coeruleus, releasing cortisol and norepinephrine which heighten amygdala activity and impair hippocampal contextualisation.
- Hyper-responsive amygdala and suppressed prefrontal cortex produce intrusive, emotionally vivid but fragmented memories and reduce the ability to regulate threat cues.
- Stabilisation techniques that lower sympathetic arousal restore the window of tolerance, allowing the prefrontal cortex to re-engage and support memory processing.
- Memory reconsolidation occurs when a traumatic memory is retrieved in a regulated state; therapeutic approaches such as EMDR and TF-CBT aim to update the memory's emotional charge.
- Implicit somatic memories persist outside conscious recall; somatic-oriented interventions help discharge stored arousal and integrate body sensations with narrative memory.

- A secure therapeutic alliance signals safety to the client's nervous system, facilitating the neurobiological conditions needed for effective trauma processing.

**PRACTICE TASK**

*Over the next week, conduct a brief grounding routine (e.g., 5-minute paced breathing followed by a body-scan) at the start of each client session. After each session, note any client cues (physiological, verbal or behavioural) that indicate the client was within, below or above their window of tolerance, and reflect on how the grounding exercise influenced those cues.*