

Different Types of Trauma

Understanding different experiences, responses and pathways towards healing

Trauma is not one single experience. Two people can live through similar events and respond very differently, while experiences that are minimised by others can have a profound effect on the person living through them. This guide explores major trauma categories, the emotions and body responses that may follow, and ways of finding safety and support without reducing a person to a label.

A message from Space to Breathe Therapy

You do not have to prove that an experience was 'bad enough' before you are allowed to acknowledge its impact. Understanding the type and pattern of trauma can be useful, but the most important questions are: what happened to you, what did it mean to you, what is happening now, and what would help you feel safer?

Trauma is about impact, not competition

A traumatic response can develop when an experience overwhelms a person's ability to cope or leaves them feeling unsafe, powerless, trapped or profoundly threatened. Trauma can be sudden or cumulative, interpersonal or accidental, recent or historical. Some people develop PTSD or complex PTSD; many do not. Distress should be understood in context rather than diagnosed from a checklist alone.

Common factors that shape impact

- Age and developmental stage when the experience occurred.
- Whether the threat was one-off, repeated or ongoing.
- Whether another person caused the harm, especially someone trusted or depended upon.
- The degree of control, escape, support and protection available.
- Previous adversity, loss or trauma.
- Physical injury, pain, disability or medical treatment associated with the event.
- Social responses afterwards - being believed, blamed, supported, isolated or pressured.
- Culture, identity, neurodivergence, sensory processing, communication needs and access to appropriate care.

1. Acute or single-incident trauma

Acute trauma can follow a single overwhelming event such as a serious accident, assault, fire, disaster, sudden medical emergency, frightening birth experience or witnessing severe harm. The nervous system may remain on high alert after the danger has passed.

Possible responses

- Intrusive memories, nightmares or flashbacks.
- Avoiding reminders, places, conversations or activities.
- Startle responses, panic, irritability or difficulty sleeping.
- Feeling unreal, detached or emotionally numb.
- Repeatedly replaying 'what if' or 'if only' thoughts.
- Fear that the event will happen again.

Personal perspective - Sam

"After the accident everyone kept telling me how lucky I was. I knew they meant well, but I did not feel lucky. I felt frightened all the time. The first useful thing anyone said was that my body had not yet caught up with the fact that the danger was over. I stopped trying to force myself to be normal and started rebuilding confidence in very small steps." **This is a composite perspective.**

2. Chronic and repeated trauma

Chronic trauma describes repeated or prolonged exposure to distressing experiences. This may include domestic abuse, repeated bullying, ongoing violence, prolonged medical treatment, captivity, exploitation, chronic instability or living for long periods in threatening environments. When danger is repeated, survival strategies can become deeply embedded.

A person may become highly watchful, minimise their own needs, expect danger, struggle to trust calm situations, or find it difficult to recognise what safety feels like. Recovery often requires attention not only to memories but also to current relationships, practical safety, boundaries, identity and the body.

3. Complex and developmental trauma

Complex trauma often refers to repeated interpersonal trauma, particularly where escape was difficult and the person depended on those around them. Developmental trauma describes the impact of adversity during important stages of childhood development. These concepts overlap, but they are not interchangeable with a formal diagnosis.

Possible longer-term themes

- Difficulty regulating intense emotions or recovering after stress.
- Persistent shame, guilt, worthlessness or a harsh inner critic.
- Dissociation, memory gaps or feeling disconnected from the body.
- Fear of abandonment alongside difficulty trusting closeness.
- People-pleasing, appeasing, over-responsibility or difficulty saying no.
- Identity confusion and uncertainty about personal needs, preferences or boundaries.
- Strong reactions to criticism, conflict, rejection or loss of control.

Important clinical distinction

Complex PTSD is a recognised diagnosis in ICD-11 and includes core PTSD symptoms alongside persistent difficulties with emotion regulation, negative self-concept and relationships. Not everyone with repeated trauma meets diagnostic criteria. Assessment should be individual and professionally undertaken.

4. Attachment and relational trauma

Trauma occurring within relationships can affect expectations of closeness, trust, dependency and conflict. Experiences may include abuse, coercive control, betrayal, neglect, inconsistent caregiving, abandonment, exploitation or repeated emotional unsafety. The person may simultaneously want connection and fear it.

Support should avoid recreating powerlessness. Predictability, consent, transparent boundaries, choice and repair after misunderstandings are especially important.

Reflection

Relationships and safety

I feel safest with people who: _____
I notice myself becoming unsafe when: _____
A boundary I would like to practise is: _____
Something I want others to understand is: _____

5. Medical trauma

Medical trauma can arise from serious illness, emergency treatment, invasive procedures, intensive care, frightening symptoms, pain, loss of bodily control, traumatic birth, diagnostic uncertainty, or experiences of not being heard or believed. The body itself may become a reminder of danger.

Appointments, smells, alarms, needles, bodily sensations, hospitals or waiting for test results can trigger intense responses. Trauma-informed healthcare includes clear explanations, consent, choices where possible, sensory adjustments and acknowledging previous difficult experiences.

6. Traumatic bereavement

Bereavement can become intertwined with trauma when a death is sudden, violent, unexpected, witnessed, medically distressing or surrounded by disturbing circumstances. A person may experience ordinary grief alongside intrusive images, avoidance, guilt, fear or a sense of unreality.

Grief and trauma can coexist

The goal is not to remove grief. Support may involve helping the person remember the whole relationship and life of the person who died, rather than being dominated by the circumstances of the death.

7. Secondary and vicarious trauma

People can be affected through repeated exposure to the trauma of others. This can occur in therapists, emergency workers, healthcare staff, social care, police, journalists, advocates, carers and family members. Vicarious trauma can alter beliefs about safety, trust and the world; secondary traumatic stress may include symptoms resembling direct trauma responses.

Protective practice includes supervision, manageable workloads, boundaries, recovery time, peer support and organisational responsibility. Self-care should not be used to excuse unsafe systems or excessive exposure.

8. Collective, community and identity-related trauma

Trauma can occur across communities through war, displacement, terrorism, disaster, racism, hate crime, persecution, discrimination, poverty, community violence or repeated social exclusion. The impact may be personal and collective at the same time.

Culturally responsive support should not assume that individual therapy is the only route to healing. Community, spirituality, activism, family, cultural practices, practical justice and belonging may all be important.

9. Workplace trauma

Work can become a source of trauma after serious incidents, assault, repeated bullying, harassment, discrimination, unsafe practice, moral injury, exposure to death or suffering, or prolonged organisational threat. Returning to work may reactivate fear even when the original incident is over.

Support may include occupational health, reasonable adjustments, phased return, changes to duties, trauma-informed management, union or HR support where appropriate, and psychological care.

10. Cumulative and 'small t' experiences

People sometimes use the informal phrase 'small t trauma' for experiences that may not involve a single catastrophic event but accumulate through repeated humiliation, rejection, instability, exclusion or emotional injury. The phrase can be useful conversationally, but it is not a clinical diagnosis. Repeated experiences can have significant effects and should not be dismissed simply because each event looks minor in isolation.

A useful question

Instead of asking, 'Was this traumatic enough?', try asking, 'What did this experience teach my mind and body about safety, myself, other people and the future?'

Feelings, emotions and survival responses

Trauma responses can move rapidly between fear, anger, grief, shame, numbness, relief and hope. They can also show up as actions rather than words.

- **Fight:** anger, defensiveness, argument, urgency or feeling ready to protect yourself.
- **Flight:** escape, avoidance, overworking, constant activity or difficulty being still.
- **Freeze:** blankness, immobility, inability to decide or feeling stuck.
- **Fawn/appease:** agreeing, placating, over-explaining or abandoning your own needs to reduce perceived danger.
- **Shutdown/collapse:** withdrawal, exhaustion, numbness or reduced capacity after prolonged overwhelm.

Message tracker

What is my system communicating?

Situation or reminder: _____
Emotion(s): _____
Body sensations: _____
Thought/message: _____
Urge or survival response: _____
Intensity 0-10: _____
What helped even slightly: _____

Grounding in the present

- Orient to the room: name the place, date and time of day.
- Notice three things that show the present is different from the traumatic event.
- Feel a steady surface beneath your feet, back or hands.
- Use a familiar sensory support - warmth, cool water, a texture, quiet, movement or weighted pressure if personally helpful.
- Choose one next action rather than solving everything at once.

Recovery: different pathways for different people

There is no single trauma recovery programme that suits everyone. Recovery can involve practical safety, medical rehabilitation, therapy, medication for associated symptoms, peer support, community, legal advocacy, grief work, relationships, creative expression, spiritual practices, movement, occupational support and rebuilding daily routines.

Evidence-based psychological treatments

For PTSD, trauma-focused CBT and EMDR are among the established treatments recommended in UK guidance for appropriate presentations. Treatment choice should consider the person's preferences, age, symptoms, comorbidities, safety, accessibility and readiness. Trauma processing should not be forced simply because someone has disclosed trauma.

Recovery does not mean forgetting

A meaningful recovery may look like having more choice, feeling safer in your body, sleeping better, being able to remember without being overwhelmed, reconnecting with people, returning to activities, setting boundaries, or discovering a future that is not organised entirely around danger.

My recovery map

Safety - Support - Meaning - Future

One thing that helps me feel safer: _____
One person/service I can contact: _____
One trigger I understand better now: _____
One boundary that protects my recovery: _____
One part of myself I want to reconnect with: _____
One hope for the next month: _____

Supporting a partner, family member or friend

- Believe the person's account without demanding details.
- Ask whether they want listening, practical help, company or space.
- Avoid telling them how they 'should' feel or how quickly they should recover.
- Respect choices and boundaries; trauma often involves loss of control.
- Learn their signs of overload and preferred ways to communicate.
- Encourage professional help when distress is persistent, severe or affecting safety, while avoiding coercion unless immediate safeguarding requires action.
- Look after your own wellbeing too; supporters can become exhausted or distressed.

Books and UK support

Books to explore

- **Trauma and Recovery** - Judith Herman. A foundational exploration of trauma, safety, remembrance and reconnection.
- **The Body Keeps the Score** - Bessel van der Kolk. A broad mind-body overview; some case material may be intense.
- **What My Bones Know** - Stephanie Foo. A memoir exploring complex trauma and recovery.
- **Anchored** - Deb Dana. Accessible nervous-system-oriented reflections; best treated as optional psychoeducation rather than a diagnostic model.
- **What Happened to You?** - Bruce D. Perry and Oprah Winfrey. A conversational exploration of adversity and understanding behaviour through context.

Places to seek information or help

- NHS - PTSD information, GP support and urgent mental health routes.
- Mind - mental health information, helplines and local services.
- Samaritans - emotional support on 116 123 when struggling to cope.
- Victim Support - independent help for people affected by crime.
- Rape Crisis England & Wales - specialist sexual violence support.
- Refuge / Women's Aid - domestic abuse information and support.
- Combat Stress - specialist mental health support for UK veterans.

Urgent safety

If you or somebody else is in immediate danger, call 999 or attend A&E.; If you are struggling to stay safe, seek urgent NHS mental health support, contact 111 where appropriate, or call Samaritans on 116 123.

Clinical notes

This guide is psychoeducational and should not be used to diagnose trauma-related disorders. Clinicians should assess current threat and safeguarding, suicide/self-harm risk, dissociation, substance use, sleep, physical health, medication effects, neurodevelopmental needs, traumatic brain injury, psychosis, grief and social context. Symptoms can overlap with anxiety, depression, panic, chronic pain, neurodivergent overwhelm and medical conditions.

Where PTSD or complex PTSD is suspected, use current diagnostic frameworks and NICE guidance. Treatment should be delivered within professional competence. Establish consent, goals, safety and stabilisation needs before detailed trauma processing. Avoid assuming that a client who can describe an event is ready for exposure-based work.

For neurodivergent clients, consider sensory triggers, interoception, alexithymia, communication differences, executive functioning, literal language and the possibility that shutdown, loss of speech or avoidance may reflect overload rather than unwillingness.

Closing message

Understanding the type of trauma can provide language and direction, but no category can contain the whole person. Your reactions make more sense when they are understood in the context of what you

have lived through. Healing can begin with awareness, continue through understanding and safety, and gradually create room for connection, growth and a future that feels more like your own.

Space to Breathe Therapy