

THE BEHAVIOUR INSTITUTE

Diploma in Trauma-Informed Psychotherapy

UNIT 3 • CORE READING 1 OF 6

01

Understanding PTSD

From nervous system response to diagnosable clinical picture

What This Document Covers

Unit 2 covered what happens in the nervous system during and after a threatening event. This document takes that biology and maps it onto the formal clinical picture of Post-Traumatic Stress Disorder — the specific, recognised pattern of symptoms that can develop when that system does not fully settle back down.

What PTSD Actually Requires

PTSD is not simply “having been through something traumatic.” It is a specific, diagnosable pattern of symptoms, falling into four clusters, all connected to a specific traumatic exposure, persisting for more than one month, and causing real, significant distress or impairment in daily functioning.

Cluster One: Intrusion

Unwanted, involuntary re-experiencing of the traumatic event — intrusive memories, nightmares, flashbacks in which a person may feel as though the event is genuinely happening again, and intense psychological or physical distress when exposed to reminders of the event.

Cluster Two: Avoidance

Persistent effort to avoid anything connected to the trauma — avoiding thoughts, feelings, conversations, people, places, or activities that serve as reminders. This cluster connects directly to the flight response covered in Unit 2, extended from the moment of threat into an ongoing, deliberate life pattern.

Cluster Three: Negative Alterations in Cognition and Mood

This cluster covers a broad range of changes, including an inability to recall key aspects of the event, persistent negative beliefs about oneself or the world (“I am fundamentally unsafe,” “no one can be trusted”), distorted blame directed at oneself or others, persistent negative emotional states, diminished interest in previously meaningful activities, feelings of detachment from others, and an inability to experience positive emotion.

Cluster Four: Alterations in Arousal and Reactivity

This cluster maps most directly onto the hyperarousal territory covered in Unit 2 — irritability or angry outbursts, reckless or self-destructive behaviour, hypervigilance, an exaggerated startle response, difficulty concentrating, and sleep disturbance.

Pause and Consider

Before reading this document, which of these four clusters would you have most readily associated with PTSD? Which is the least well known publicly, and why do you think that particular cluster tends to be the most overlooked?

Onset and Course

PTSD symptoms most commonly begin within the first three months following a traumatic event, but this is not universal. Delayed-onset presentations, in which the full diagnostic picture does not emerge until six months or more after the event, are well recognised and covered in real depth in Document 5. The course of PTSD also varies considerably — some people experience a relatively contained episode that resolves within months, others experience a more chronic, persistent course lasting years, and some experience a pattern of symptoms that recede and later resurface, sometimes prompted by an unrelated later stressor.

A Story to Make This Real

Consider a composite scenario drawn from patterns seen repeatedly in trauma-focused practice. A client, “Sofia,” 38, survived a serious workplace fire, escaping without physical injury. In the months that followed, Sofia began experiencing vivid, unwanted memories of the event, particularly the smell of smoke, which could trigger a memory so vivid she described briefly feeling as though she was back inside the building.

Sofia began avoiding her workplace's kitchen entirely, where the fire had started, going out of her way to avoid the smell of anything burning, including declining invitations to barbecues. She noticed herself becoming persistently irritable with her family, sleeping poorly, and finding herself unable to concentrate on tasks she had previously managed easily. She also noticed, with some confusion, that she had stopped enjoying activities she had once found genuinely engaging, and felt a persistent, vague sense that the world had become a more dangerous place than she'd previously believed.

Mapped against the four clusters covered in this document, Sofia's presentation is a clear, relatively classic picture: intrusion (the vivid memories, triggered by smell), avoidance (the kitchen, the barbecues), negative alterations in cognition and mood (the loss of interest, the shifted belief about danger), and arousal and reactivity (the irritability, the sleep disturbance, the concentration difficulty). Recognising the full pattern, rather than treating each symptom as a separate, disconnected problem, made a considerable difference to how her subsequent treatment, covered in Unit 4, was approached.

Why the Full Picture Matters

It is common, including among professionals without specific trauma training, to focus heavily on the intrusion cluster — flashbacks and nightmares — as the defining feature of PTSD, while underweighting the other three clusters. This can lead to missed or delayed diagnosis in people whose presentation is dominated by avoidance, mood changes, or arousal symptoms, without prominent flashbacks. A genuinely trauma-informed assessment holds all four clusters in view, rather than searching primarily for the most publicly recognisable symptom.

What's Next

This document covered PTSD arising from a single, identifiable traumatic event. The next document turns to a related but importantly distinct presentation: Complex PTSD, arising from prolonged or repeated trauma, and carrying additional features beyond the four clusters covered here.

A Few Things to Take With You

- PTSD involves four symptom clusters: intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity
- Symptoms must persist for more than one month and cause genuine distress or functional impairment
- Onset is most common within three months, but delayed onset of six months or more is well recognised
- The course of PTSD varies considerably between individuals — from relatively contained to chronic and persistent
- Effective assessment requires attention to all four clusters, not primarily the most publicly recognisable symptom of intrusive flashbacks

Before You Move On

- Looking at Sofia's story, which cluster do you think would have been easiest to miss if a clinician was focused primarily on asking about flashbacks?
- How does understanding the four clusters change how you might structure an initial assessment conversation?
- What connection do you see between this document's four clusters and the trauma responses covered in Unit 2?