

01

What Is Trauma-Informed Care?

A shift in the question we ask, from “what’s wrong with you?” to “what happened to you?”

What This Document Covers

This course begins not with a specific therapy technique, but with something broader: a way of thinking about people that changes almost everything downstream of it. Trauma-informed care isn't one intervention among many — it's a shift in the basic question a practitioner, or an entire service, asks when someone in front of them is struggling.

The Question That Changes Everything

For most of the history of clinical practice, the implicit question asked of someone presenting with difficult behaviour, chaotic relationships, or apparent non-compliance with treatment has been some version of: what's wrong with this person? Trauma-informed care proposes a different starting question: what happened to this person?

This isn't simply a softer or more sympathetic way of phrasing the same idea. It's a genuinely different diagnostic and clinical stance. "What's wrong with you" looks for pathology located inside the individual — a disorder, a deficit, a character flaw. "What happened to you" looks for an adaptive response to overwhelming experience — behaviour that made sense, and may still make sense, given what someone has actually lived through.

Where This Came From

Trauma-informed care as a formal framework developed largely from the 1990s onward, gaining significant momentum through the work of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States, alongside a growing body of research — which we'll cover in depth in Document 3 — demonstrating just how common trauma actually is, and how significantly it shapes long-term health and behaviour.

It emerged partly as a direct response to a recurring pattern noticed across mental health, addiction, and social services: services designed with good intentions were, in practice, frequently re-traumatising the very people they were meant to help — through rigid rules, coercive procedures, a lack of choice or control, and environments that inadvertently replicated the powerlessness of the original trauma.

Not a Technique — a Framework

One of the most common early misunderstandings, which we'll return to directly in Document 6, is treating trauma-informed care as a specific therapy someone can be trained in and then simply apply. It isn't. It's closer to a lens, or an organisational culture, that shapes how care is delivered across an entire service — from the way a receptionist greets someone, to how a treatment plan is developed, to the physical layout of a waiting room.

This means trauma-informed care can, and ideally does, sit underneath any specific therapeutic modality — CBT, psychodynamic work, EMDR, or any other approach covered later in this course — rather than competing with them. A clinician can deliver excellent CBT within a trauma-informed frame, or deliver

technically competent CBT within a frame that is, inadvertently, re-traumatising. The technique alone doesn't determine which.

Pause and Consider

Think of a time you interacted with a service — medical, educational, administrative, anything — that left you feeling unheard, powerless, or unsafe, even if nothing overtly wrong happened. What made it feel that way? Now think of an experience that felt genuinely respectful and safe, even under difficult circumstances. What was actually different?

A Story to Make This Real

Consider a composite scenario drawn from patterns seen repeatedly across addiction and mental health services. A woman, “Rachel,” 34, arrives twenty minutes late to her third appointment at a community mental health service, visibly agitated, and initially reluctant to make eye contact with the receptionist.

Under a traditional service model, this might be logged simply as “poor engagement” or “non-compliance,” with a note that continued lateness could affect her continued access to the service. The underlying assumption, often not stated but present in the response, is that Rachel isn't taking her treatment seriously enough.

Under a trauma-informed model, the same behaviour prompts a different set of questions before any judgement is formed. What might make travelling to, and entering, this particular building difficult for Rachel? Is there something about waiting rooms, or being observed, or fixed appointment structures, that could be genuinely activating for someone with her history — which the service may not yet fully know? Rather than assuming poor motivation, a trauma-informed response holds open the possibility that the lateness and visible agitation are, themselves, meaningful information.

In this composite case, a gentle, non-judgemental conversation eventually revealed that Rachel had experienced a home invasion two years earlier, and found being watched while waiting in an open, exposed area of the clinic — in view of the street-facing window — to be quietly, persistently distressing, though she'd never mentioned it, partly from not wanting to seem “difficult.” A small, practical adjustment — offering her a seat away from the window, and a few minutes' flexibility around her arrival time — made a meaningful, measurable difference to her ability to actually engage with treatment.

Nothing about Rachel's diagnosis or treatment plan needed to change for this shift to matter. What changed was the question being asked about her behaviour, and, as a direct result, the response that behaviour received.

What's Next

This document has introduced the core reframe — from “what's wrong with you” to “what happened to you.” The next document sets out the specific principles that put this reframe into practice: what trauma-informed care actually looks like, structurally, once you move past the underlying philosophy.

A Few Things to Take With You

- Trauma-informed care shifts the core clinical question from “what's wrong with you” to “what happened to you”
- It developed largely from the 1990s onward, partly in response to services inadvertently re-traumatising the people they aimed to help
- It is a framework or lens, not a specific technique — it can sit underneath any therapeutic modality
- Behaviour that looks like poor engagement or non-compliance can often be better understood as an adaptive response to past experience

Before You Move On

- Think of a time you judged someone's behaviour without knowing their history. Would knowing more have changed how you interpreted it?
- Why do you think “what happened to you” can feel like a genuinely difficult question for a service or a practitioner to build itself around, compared to “what's wrong with you”?
- What's one small, practical change — in a workplace, a classroom, a clinic — that could make an environment feel safer for someone with an unknown trauma history?