

THE BEHAVIOUR INSTITUTE

Diploma in Trauma-Informed Psychotherapy

UNIT 1 • CORE READING 2 OF 6

02

# The Core Principles

*Turning the trauma-informed reframe into something practitioners can actually do*

## What This Document Covers

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The previous document introduced the core philosophical shift behind trauma-informed care. This document sets out the practical principles that put that shift into action — the widely referenced framework, developed by SAMHSA, that most trauma-informed services and training programmes still build from today.

## Six Principles, Not a Checklist

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SAMHSA's framework identifies six key principles of a trauma-informed approach. It's worth holding these as genuinely interconnected, rather than a checklist to tick off one at a time — in real practice, they constantly overlap and reinforce one another.

### 1. Safety

Both physical and psychological safety, throughout an entire service, for everyone involved — clients and staff alike. This includes obvious things like a secure, calm physical environment, but extends to psychological safety: predictability, clear expectations, and an absence of the kind of unpredictable authority that can itself feel threatening to someone with a trauma history.

### 2. Trustworthiness and Transparency

Operations and decisions are conducted with transparency, with the explicit goal of building and maintaining trust. This means being honest about what will happen in a session, what information will be shared and with whom, and following through consistently on what's said — since inconsistency, even well-intentioned inconsistency, can itself be experienced as unsafe by someone whose trust has previously been badly broken.

### 3. Peer Support

Recognising the value of people with lived experience of trauma or adversity as a genuine source of support and connection for others going through something similar. This principle has driven the growth of peer support worker roles across mental health and addiction services, built on the understanding that connection with someone who has “been there” can do something a purely clinical relationship sometimes can't.

### 4. Collaboration and Mutuality

A genuine levelling of power differences between staff and clients, recognising that healing happens in relationships and in the meaningful sharing of power and decision-making. This doesn't mean abandoning clinical expertise or professional boundaries — it means actively working against the kind of rigid, one-directional authority structure that can replicate the powerlessness many trauma survivors have already experienced.

### 5. Empowerment, Voice, and Choice

Individual strengths are recognised, built upon, and validated, and new skills are developed as necessary. People are supported in developing self-advocacy skills, and are given genuine choice and control wherever possible — including, importantly, the choice to decline. Even small elements of restored choice (which chair

to sit in, which topic to start with, whether to make eye contact) can matter considerably for someone whose trauma involved a profound loss of control.

## 6. Cultural, Historical, and Gender Issues

The framework actively moves past cultural stereotypes and biases, offers services that are responsive to the racial, ethnic, and cultural needs of the people served, and recognises and addresses historical trauma — acknowledging that trauma is not experienced identically by everyone, and that some populations carry additional layers of collective, intergenerational, or systemic trauma that a genuinely trauma-informed approach cannot ignore.

### Pause and Consider

*Of these six principles, which do you imagine would be hardest to implement consistently in a real, busy service — understaffed, time-pressured, working within existing institutional rules? Why do you think that particular one is often the first to slip?*

## A Story to Make This Real

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Consider a composite drawn from patterns seen across residential addiction treatment settings. A treatment centre had, for years, operated a strict rule: any resident missing a scheduled group session without prior approval would lose privileges for 48 hours, applied uniformly regardless of the reason given.

On paper, the rule existed for good reasons — consistency, structure, and encouraging genuine engagement with treatment. In practice, staff noticed a recurring pattern: a small group of residents, disproportionately those with documented histories of childhood neglect or abuse, would occasionally miss sessions during weeks that coincided with unannounced visits from family members, or changes to the usual staff roster.

Applying the six principles directly to this pattern reframed the situation considerably. Rather than treating the missed sessions purely as a compliance issue requiring uniform sanction, staff began asking, individually and without judgement, what had made attending difficult that day — restoring a degree of voice and choice that the blanket rule had previously removed entirely. For several residents, the answer involved a genuine, trauma-related response to unpredictability or unfamiliar authority figures — exactly the kind of safety and trust issue the framework is built to address, not punish.

The centre didn't abandon structure or consistency — both remained genuinely important. What changed was the addition of a brief, collaborative check-in before any sanction was applied, giving residents a meaningful voice in a process that had previously been entirely one-directional. Missed-session rates in the affected group dropped substantially over the following months, not because expectations had been lowered, but because the response to difficulty had become genuinely trauma-informed rather than simply punitive.

## Why This Isn't Simply “Being Nice”

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It's worth naming directly, since this is a common misreading covered again in Document 6: none of these six principles are about lowering expectations, removing consequences, or treating trauma as an excuse for any and all behaviour. Safety, structure, and clear boundaries remain genuinely essential — in fact, principle one depends on them. Trauma-informed care asks practitioners and services to hold structure and compassion together, not to trade one for the other.

## What's Next

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The next document turns to the research foundation underneath this entire framework — the Adverse Childhood Experiences (ACE) study, and how a single, now-famous piece of research reshaped how an entire field understands the relationship between early trauma and lifelong health.

## A Few Things to Take With You

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- SAMHSA's framework identifies six interconnected principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues
- These principles work together, not as a checklist to apply one at a time

- Restoring even small elements of genuine choice and voice can matter considerably for someone whose trauma involved a profound loss of control
- Trauma-informed care holds structure and compassion together — it does not mean abandoning boundaries or consequences

## Before You Move On

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- Which of the six principles do you think is most often overlooked in services you're familiar with, professionally or personally?
- In the treatment centre example, what allowed staff to maintain structure while still genuinely restoring some voice and choice to residents?
- How would you explain, in your own words, the difference between trauma-informed care and simply lowering expectations or removing consequences?