

THE BEHAVIOUR INSTITUTE

Diploma in Trauma-Informed Psychotherapy

UNIT 1 • CORE READING 6 OF 6

06

Myths About Trauma-Informed Care

What the popular version gets wrong, and what to say when someone pushes back

What This Document Covers

As trauma-informed language has become widespread — in schools, workplaces, and clinical training — it has also become genuinely misunderstood in some fairly consistent ways. This closing document addresses the most common myths directly, closing out Unit 1 before we move into the neuroscience of trauma itself in Unit 2.

Myth: Trauma-Informed Care Means No Rules or Consequences

As Document 2 covered directly, this is one of the most persistent and damaging misunderstandings. Trauma-informed care doesn't remove structure, boundaries, or consequences — the treatment centre case study in that document showed structure and trauma-informed practice working together, not in opposition. Safety, the very first of the six core principles, actually depends on predictable structure. What trauma-informed care changes is how consequences are applied — with voice, transparency, and curiosity about underlying causes — not whether they exist at all.

Myth: It's Just Being Nice or Gentle

Trauma-informed practice can look gentle, and often is, but reducing it to simple niceness misses the substance underneath it entirely. It's a structured framework grounded in specific principles and, as Document 3 covered, a genuine evidence base. A service can be extremely warm and friendly while remaining poorly trauma-informed — for instance, still relying on rigid, non-negotiable rules that remove all client choice, however kindly those rules are delivered.

Myth: It Only Matters for People With Severe, Obvious Trauma

As Document 5's universal precautions concept made clear, trauma-informed practice is built around the working assumption that trauma may be present even when it isn't visible, diagnosed, or disclosed. Given the prevalence data from Document 3's ACE study, a genuinely trauma-informed default benefits the majority of people passing through any given service, not a small, identifiable minority.

Myth: Being Trauma-Informed Means You're Providing Trauma Treatment

This is the exact distinction Document 4 was built to address directly. Being a trauma-informed practitioner or service is not the same as delivering trauma-specific treatment. A trauma-informed general counsellor, GP, or teacher is doing something genuinely valuable — but it is not, on its own, equivalent to trained, targeted trauma processing work.

Pause and Consider

Which of these myths, if any, matched something you believed — or something you've heard a colleague or friend say — before starting this unit? What do you think drives that particular misunderstanding specifically?

Myth: Trauma-Informed Care Is a One-Time Training, Not an Ongoing Practice

A single staff training session on trauma-informed principles, however well delivered, does not make a service genuinely trauma-informed on its own. As Document 1 established, this is a cultural and operational shift affecting an entire organisation — physical environment, policies, hiring practices, supervision structures, and day-to-day decision-making — not a credential earned once and then set aside. Services that treat it as a box-ticking exercise rather than an ongoing practice tend to see the language adopted without the substance following.

Myth: It's a New, Unproven Trend

As Document 3 demonstrated, trauma-informed care rests on a research foundation stretching back decades, alongside a considerably longer history of clinical observation predating even that. While the specific language and formalised frameworks have become more widespread relatively recently, the underlying insight — that adversity shapes behaviour and health in measurable, significant ways — is well-established, not a passing fad.

Why These Myths Matter

Getting this right matters beyond simple accuracy. Services and individual practitioners who adopt trauma-informed language without genuinely engaging with its substance risk two real problems: doing a disservice to the people they're meant to help, who may be told they're receiving trauma-informed care that doesn't actually reflect the principles covered in this unit, and undermining the credibility of the whole framework for genuinely sceptical colleagues, who reasonably push back when “trauma-informed” appears to mean little more than a poster on a wall.

Going Further: Recommended Reading

None of the following is required, but if this unit has genuinely interested you, these are worth your time:

- “The Deepest Well” by Nadine Burke Harris — written by a physician whose clinical work directly informed the modern trauma-informed care movement, covering the ACE study's real-world clinical implications in accessible detail
- SAMHSA's “Concept of Trauma and Guidance for a Trauma-Informed Approach” — the original, freely available framework document underlying much of what's covered in Document 2
- “What Happened to You?” by Bruce Perry and Oprah Winfrey — a widely accessible book built directly around the reframe covered in Document 1, useful both for practitioners and for a general audience
- The original ACE Study publications (Felitti et al., 1998) — worth reading in the original for anyone who wants to engage directly with the foundational research covered in Document 3

A Few Things to Take With You

- Trauma-informed care does not mean removing rules, consequences, or structure — it changes how those things are applied

- It is a substantive framework grounded in principles and evidence, not simply a matter of being nice or gentle
- Its relevance extends to everyone, not only people with known or severe trauma histories
- Being trauma-informed and delivering trauma-specific treatment are related but genuinely distinct things
- It is an ongoing organisational and clinical practice, not a one-time training or a passing trend

Before You Move On

- Having completed this unit, how would you now explain trauma-informed care, in your own words, to a sceptical colleague?
- Which of the six principles from Document 2 do you feel most confident applying already? Which will take the most conscious effort?
- What are you carrying forward into Unit 2, where we turn to the neuroscience of trauma itself?