

THE BEHAVIOUR INSTITUTE

Diploma in Trauma-Informed Psychotherapy

UNIT 2 • CORE READING 6 OF 6

06

Myths About the Trauma Response

Correcting some persistent, and sometimes harmful, misunderstandings

What This Document Covers

This closing document addresses several persistent myths about the trauma response, many of which trace directly back to the material covered across this unit. Some of these myths are simply inaccurate; others are actively harmful when they shape how survivors are treated, by professionals or by the people around them.

Myth: Freezing Means You Consented, or Weren't Really Afraid

This is among the most damaging myths this unit can address directly, and it connects immediately back to Document 1. Freeze is an involuntary survival response, not a choice, and not evidence of consent or a lack of genuine fear. It is frequently misunderstood in legal, social, and even clinical contexts, with real, harmful consequences for survivors whose response to danger happened to be freeze rather than fight or flight.

Myth: A Real Trauma Response Always Looks Dramatic

As Document 4 covered, hypoarousal can look like flatness, disconnection, or apparent calm — the opposite of the dramatic, visibly distressed presentation many people expect from someone who has experienced trauma. A person presenting as numb, detached, or minimally emotional is not necessarily coping well or unaffected; they may be significantly outside their window of tolerance in the opposite direction from what is commonly expected.

Myth: Severity of the Event Determines Severity of the Impact

As Document 3 demonstrated directly, severity is only one factor among several, and not always the most predictive one. Control, duration, developmental timing, support, and meaning all shape outcome considerably, sometimes more than objective severity does. Dismissing someone's distress because “it wasn't that bad,” or conversely assuming severe distress must follow from an objectively severe event, both miss this more complete picture.

Pause and Consider

Before this unit, would you have recognised hypoarousal — flatness, disconnection, apparent calm — as a genuine trauma response, or would you have read it as someone coping well? What does your own answer suggest about how deeply some of these myths are embedded, even in people who work in helping professions?

Myth: A Strong-Willed or Resilient Person Won't Develop Lasting Symptoms

As Document 5 covered, vulnerability to lasting trauma impact is shaped substantially by factors like genetics, attachment history, allostatic load, and ongoing social context — none of which are meaningfully addressed by willpower or personal strength. This myth places an unfair, and clinically inaccurate, burden of responsibility on survivors, implying that lasting symptoms reflect some personal failing rather than a genuine, physiologically grounded response shaped by many factors outside anyone's conscious control.

Myth: You Can Simply Talk Someone Out of a Trauma Response

As Document 2 established, the amygdala and HPA axis do not respond to logical argument the way the prefrontal cortex does. Telling someone in a state of significant activation that they are safe, however true and however well-intentioned, often has limited effect on the underlying physiological state. Effective response generally requires addressing the nervous system's actual state directly — through grounding, co-regulation, and time — rather than relying on reasoning alone.

Myth: Once the Danger Passes, Recovery Should Be Quick

Given the role of cortisol, which clears the system considerably more slowly than adrenaline, and given the individual differences covered in Document 5, recovery timelines vary enormously and legitimately between people. There is no single, correct timeline against which a survivor's recovery should be measured, and pressure to “move on” faster than a given nervous system is actually able to often does more harm than good.

Why These Myths Persist

Many of these myths persist because they offer a simpler, more comfortable story than the reality this unit has actually described. It is more comfortable to believe that resilience is purely a matter of willpower, or that a calm presentation means someone is fine, or that talking someone through it should be sufficient — because the alternative requires sitting with real physiological and developmental complexity that cannot be resolved quickly or through reassurance alone. Trauma-informed practice asks practitioners to resist that simpler, more comfortable story in favour of a more accurate, if more complicated, one.

Going Further: Recommended Reading

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

- “The Body Keeps the Score” by Bessel van der Kolk — a widely read, foundational account of how trauma is stored in the body, covering much of this unit's territory in considerably greater depth
- “Waking the Tiger” by Peter Levine — the originator of Somatic Experiencing, and a clear, accessible account of the freeze response specifically
- Dan Siegel's original writing on the window of tolerance, including “The Developing Mind”, for those who want to engage directly with the source of Document 4's central concept
- Robert Sapolsky's “Why Zebras Don't Get Ulcers” — a genuinely engaging, accessible account of the HPA axis and chronic stress, for a deeper, non-clinical treatment of Document 2's material

A Few Things to Take With You

- Freeze is not consent, and hypoarousal is not necessarily calm — both are genuine, involuntary trauma responses
- Severity of an event does not reliably predict severity of impact
- Vulnerability to lasting trauma impact is shaped by many factors outside conscious control, not by willpower or personal strength
- Physiological activation generally cannot be resolved through logical reassurance alone
- Recovery timelines vary legitimately and considerably between individuals

Before You Move On

- Having completed this unit, how would you now explain the trauma response, in your own words, to someone with no background in the topic?
- Which myth in this document do you think does the most harm in professional or clinical settings specifically?
- What are you carrying forward into Unit 3, where we turn to PTSD, complex trauma, and dissociation directly?