Trauma-informed practice

What CRPO expects, why trauma matters, the principles, what it looks like in session, how to respond to a disclosure and what to write down, with peer-reviewed sources.

Study aid, not legal advice. Last verified against the official sources linked below on 11 November 2026.

1 What CRPO expects

- Competency **1.2g**: integrate knowledge of the impact of trauma on psychological functioning.
- Consent is ongoing, and a client may withhold or withdraw it at any time (**3.2.4**, 3.2.5).
- Trauma work is paced by the client's **readiness, safety and consent**, not by the technique.
- When the need is beyond your competence, consult, take it to supervision or refer (**2.1.5, 2.1.6**).

2 Why it matters

- Adverse childhood experiences are common and show a **graded relationship** with adult health risks (Felitti et al., 1998, Am J Prev Med 14(4):245-258).
- With **four or more**, the strongest links are to problematic drug use and to violence against others or oneself (Hughes et al., 2017, Lancet Public Health 2(8):e356-e366).
- Services can **retraumatize**, above all through 'power-over' relationships and a lack of trust (Sweeney et al., 2018, BJPsych Advances 24(5):319-333).

3 The principles

- **Safety**: physical, emotional, cultural and gender safety, defined with the client.
- **Trustworthiness and transparency**: openness and respect, because many survivors met secrecy and betrayal.
- **Collaboration** and mutuality: work with the client, not on them.
- **Empowerment, choice and control**: strengths and adaptations before symptoms.
- **Context**: culture, history and gender shape what trauma means and what helps.
- Ask "**What happened to you?**" rather than "What is wrong with you?" (Sweeney et al., 2018).

4 In session

- **Say what will happen** and why; the client sets the pace and can pause or stop.
- **Watch for overwhelm** or dissociation; slow down, ground in the present, and return control.
- **Offer choices**: where to sit, the door, the camera, what to talk about first.
- No pressure for details: the story is told when, and as far as, the client chooses.
- **Close gently**: check how the client is leaving, and agree the next contact.

5 When someone discloses

1. Say that telling you was a good thing.
2. Do not dig for the details.
3. Ask whether they have told anyone before, and how that went.
4. Ask whether it is connected to what they are struggling with now.
5. Check that they are safe now.
6. Offer trauma-specific support, or a referral to it.
7. Check how they are at the end of the session, and offer a follow-up.

6 What to write down

- Only what care needs: PHIPA **s. 30 (2)** bars collecting or using more health information than is reasonably necessary.
- Key facts in the **client's words**, not graphic detail; their choices about pace and consent; safety checks; referrals.
- Mandatory **reports still apply**, for a child in need of protection or sexual abuse by a regulated health professional, and are recorded.
- Write as if the client will read it, because they may.

Ask what happened, not what is wrong: safety, choice and pace belong to the client. Disclosure steps adapted from Read et al. (2007), as set out by Sweeney et al. (2018).

Official sources: CRPO Entry-to-Practice Competency Profile (1.2g) and CRPO Standard 3.2: Consent and PHIPA, s. 30 (2). Condensed from Foundations and Therapeutic Process. Independent study aid, not legal advice, not affiliated with CRPO or COMPASS.