



TRAUMA, NERVOUS SYSTEM & TRAUMA-INFORMED SUPPORT

Avoiding Retraumatisation

Recognising how environments, systems and interactions can recreate threat or powerlessness — and reducing avoidable harm.

The key idea

Retraumatisation is more specific than ordinary distress. Trauma-informed practice aims to reduce avoidable recreation of threat, helplessness or other significant elements of previous traumatic experiences.

What retraumatisation means

Retraumatisation describes a situation in which an experience, interaction or environment evokes aspects of earlier trauma strongly enough to cause renewed distress or a sense of threat. The term should be used carefully: distress, disagreement or discomfort are not automatically retraumatisation.

Trauma reminders and triggers

A trauma reminder can be sensory, relational, situational or internal. Sounds, smells, touch, loss of control, particular words, medical procedures or power dynamics may resemble aspects of an earlier experience. Responses vary widely and are not always predictable.

Avoiding assumptions

Trauma-informed practice does not require professionals to guess a person's trauma history or interpret every reaction through a trauma lens. Ask about needs and preferences where appropriate, and avoid pressuring someone to disclose experiences they do not need or want to discuss.

Key distinction

Trauma-informed practice aims to reduce avoidable harm without assuming that every person has trauma or that every difficult reaction is caused by trauma.

Choice, consent and control

Where genuine choices are available, making them clear can reduce unnecessary loss of control. Consent should be sought where required, and people should know what will happen before touch, examination, questioning or other potentially intrusive procedures whenever circumstances allow.

Predictability and preparation

Explaining what will happen, in what order, approximately how long it may take and what options exist can reduce avoidable uncertainty. If plans change, communicate this rather than expecting the person to simply adapt without explanation.

Power and coercion

Services may hold significant power through legal authority, access to treatment, safeguarding responsibilities or control of resources. Some restrictions may be necessary or lawful, but unnecessary coercion, threats or humiliation can increase distress and undermine safety.

Language and communication

Use clear, respectful language and avoid unnecessarily graphic or blaming questions. Communication should be accessible, with interpreters, AAC, Easy Read, visual information, extra processing time or other adjustments where needed.

Touch and bodily autonomy

Do not assume that touch intended as reassurance will feel reassuring. Explain why touch or physical contact is needed, seek consent where appropriate and possible, and respect preferences about positioning, personal space and who is present.

Recognising escalating distress

Changes in speech, movement, attention, breathing, responsiveness or communication may indicate increasing distress, but there is no single universal trauma response. Check in rather than assuming what a behaviour means.

Grounding and regulation

Grounding strategies can help some people reconnect with the present, but they are not universally helpful. Offer rather than impose them, and allow the person to identify what supports regulation for them.

Important to remember

A strategy that helps one person may increase distress for another. Grounding and regulation techniques should be offered with choice and adapted to the individual.

After difficult or restrictive events

Following restraint, emergency intervention, safeguarding action or another highly distressing event, a later review can help identify what happened, what the person experienced and what might reduce harm in future. Timing and participation should be appropriate to the individual.

Repair

Trauma-informed practice does not mean interactions will never go wrong. When trust has been disrupted, repair can involve acknowledging what happened, listening to the person's experience, apologising where appropriate, correcting misinformation and agreeing practical changes. Repair should focus on accountability and future safety rather than pressuring the person to reassure the professional.

Example

A patient becomes visibly distressed before a procedure. Rather than assuming refusal or non-compliance, the clinician pauses, explains each step, checks what the patient wants to know, offers available choices about positioning and support, and agrees a signal for stopping where clinically possible.

Practical check

Could any part of this process unnecessarily remove control, surprise the person or recreate a harmful power dynamic? Have choices and limits been explained? Is communication accessible? Is touch necessary and appropriately consented to? If distress increases, is there a plan for pausing, adapting or reviewing what happened?

References & Further Resources

These resources provide useful starting points for further reading about trauma-informed practice, safer care and evidence-based support following traumatic experiences.

NHS England

Provides national resources relevant to trauma-informed care, patient experience, safeguarding, restrictive practice and improving safety within health services in England.

NICE

Publishes evidence-based guidance for conditions including post-traumatic stress disorder. This helps distinguish trauma-informed service principles from trauma-specific assessment and treatment.

SAMHSA

Its widely cited trauma-informed framework emphasises safety, trustworthiness, collaboration, empowerment and attention to practices that may contribute to retraumatisation.

UK Trauma Council

Provides evidence-informed resources on trauma and traumatic bereavement, particularly in relation to children and young people, with accessible material for professionals and families.

How to use these resources

Reducing the risk of retraumatisation should sit alongside current professional standards, safeguarding, consent and capacity requirements, accessibility duties, risk management and condition-specific evidence-based care. Trauma-informed practice does not replace necessary treatment or lawful protective action.