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Trauma-Informed Approach: Who Made It Happen, Why It Was Needed, and How It Was Shaped.

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1. Introduction

What would you prefer: being asked 'What is wrong with you?' or 'What is happening?'. If you preferred the latter, you have chosen a Trauma-Informed question. Given today's multicultural and multigenerational society in which psychological trauma survivors abound, Elliot et al. (2005) inform us that the Trauma-Informed Approach aspires to upgrade all service delivery (medical, community, business, education, etc.) to neuroscience knowledge, on the assumption that service providers can benefit from understanding trauma's impacts on nervous systems, behaviors, and relationships, while becoming aware of their own roles in creating psychologically safe environments that promote autonomy and respect client agency. Switching from asking 'What is wrong with you?' with a desire to fix, to asking 'What is happening?', followed by attentive listening paired with an open mind, is not just a mere vocabulary change, it is a paradigm shift from natural sciences towards human sciences. See Appendix A for a real-life example.

The author of this paper aims to understand how the Trauma-Informed Approach developed, and why it was needed, by exploring two men who have experienced, researched and promoted that paradigm shift: Carl Rogers and Bessel Van der Kolk. This paper will cover their socio-historic context, their professional activities related to this approach, who inspired them, what they chose to do differently, and why. Then, this author will conclude by analyzing what they had in common, and whether the Trauma-Informed approach is still relevant today.

2. Carl Rogers (1902-1987)

As Evans (1975) writes, Rogers began as a child behavior therapist in the mid 1920's, and quickly became critical of short-term behavior-shaping via sole environment manipulation, preferring to nurture whole individual potential by getting to know the kids personally. During the mid-1940's, while at the University of Chicago, he scientifically researched the efficiency of diverse psychotherapy methods, which led him to prove that psychologists could do psychotherapy too, and not just psychiatrists; this had never been demonstrated before (APA(a), 2024). Interestingly, this happened during an important historic period that saw the defeat of eugenics-loving Nazi Germany, who

twisted Darwin's theories by applying artificial selection to humans while committing holocaust in the process. Surprisingly, in 1946, after the war had ended, the American Psychological Association elected eugenics specialist Henry E. Garrett for president (APA(b), 2024). This is revealing of eugenics' influences in psychology at the time. Thus, when Carl Rogers obtained the APA presidency in 1947, a 180 degrees shift occurred towards humanistic approaches (APA(a), 2024). According to Evans (1975), once president, Rogers advocated for client agency and confidentiality, and opened the APA to clinical psychologists, thereby definitely defeating psychiatry's monopoly on the matter. Later, in the 1960, 70's and 80's, amongst many other projects, he founded the Center for Studies of the Person to investigate individual potential, and facilitated encounter groups in polarized communities worldwide until his passing in 1987 (APA(a), 2024). Throughout his long career, Rogers stayed true to his first humanist hunches, and dedicated himself to understanding what beneficial conditions could unleash the untapped potential of human beings.

Evans (1975) writes that Rogers popularized 'client-centered' psychotherapy, promoting the ideas of unconditional positive regard, acceptance, understanding, and safety in relationships, having observed that only with these favorable conditions could human beings access their own free will, sense of responsibility, flexibility, and creativity, all of which was needed to solve their own problems and to flourish. Moreover, Rogers was concerned by the detrimental impact of ethics based on absolutes of right or wrong, preferring instead a pragmatic "… situational ethics where right and wrong are relative to the situation …" (Evans, 1975, p.101). Through his American lens, he judged situational ethics more adequate for fast-shifting modern times compared to the simpler, traditionally-comforting absolutes of right versus wrong. Furthermore, because Rogers refused to become an idol, and to rigidly hold on to his ideas, his general guidelines could be adapted by diverse groups worldwide, and a vast number of people from all walks of life could learn the art of improving themselves and their relationships.

Philosophy-wise, Evans (1975) writes that Rogers was influenced by "… Otto Rank's preoccupation with the 'will' [namely] how the development of autonomy introduced a type of self-determinism that Freud did not emphasize", hence he took a step away from Freudian thought early on (p. xxiv). Moreover, Evans adds that self-determinism was aligned with another of Roger's influences: Kierkegaard's existentialism. For Kierkegaard, humans were "… understood as 'spirit', and that spirit must become itself through a process [of] on-going synthesis of contrasting fundamental characteristics: the finite and the infinite, the temporal and the eternal; the necessary and the possible" (Lippitt et al., 2024, para 21). Therefore, by understanding and allowing the conditions for this dynamic process of becoming to unfold, Rogers clearly applied Kierkegaard. Yet, when interviewed by Evans (1975), he claimed that above all else, it is his psychotherapy patients, group therapy participants, students and colleagues that taught him most about what becoming human entails.

Standing out from many of his contemporaries and predecessors, Rogers criticized the positivist medical model. As Evans (1975) writes, he found it too "cynical, negative and externally determined", and instead believed that the mental health practitioner's role in society

was to "… improve the intellectual and psychological health of its members [via] the development of an optimistic, self-determined, positive philosophy about human existence …" (p. xxvi). Furthermore, Evans notes that the popularity of Skinner's reward-punishment operant conditioning from the 1950's to the 1980's may have sparked some psychological reactance in Rogers, his uneasiness with strict behaviorist views of fueling the development of his non-directive style. Thus, Rogers doubted that asking 'What is wrong with you?' was really suited for human affairs as he was skeptic of Skinner's linear worldviews. He preferred systems-thinking, as he observed that one presenting issue may hide many inter-related dynamics, and he dared to take the hermeneutical lens that looked deeper into how the therapist's own attitudes could unknowingly contribute to patient's outcomes. To quote Rogers himself during Evan's interview in 1975: "… the basic difference between a behavioristic and a humanistic approach to human beings is a philosophical choice" (p.131). Thus, Rogers proposed to raise awareness about which paradigm practitioners adopted, and how their philosophical choice guided their professional actions. While the positivist model raised doctors onto pedestals, Rogers stepped down to meet people where they were are at, admitting not knowing everything, and being all ears for the clients who were the true experts of themselves. Although often being the odd one in the room, Rogers wasn't entirely alone, as we shall see next.

3. Bessel Van der Kolk (1943 –)

In his book The Body Keeps the Score (2014), Van der Kolk writes that he learned psychiatry at Harvard, and started working at the Boston Veterans Administration Clinic (VA) in 1978, only five years after US troops left Vietnam, and almost three decades in the deinstitutionalization movement. He spent most of his career understanding the impacts of psychological trauma on the human brain, nervous system, psyche, and relationships, and exploring possible treatments. He supported the introduction of the previously dismissed Post-Traumatic Stress Disorder (PTSD) diagnostic in the DSM-III, he researched both conventional (medications and psychotherapy) and alternative treatments (yoga, theater, neuro-feedback, etc.) for trauma survivors, he studied childhood developmental issues, he founded the Trauma Centre where he worked for almost 40 years while also teaching psychiatry at Boston University. According to his website (2020), after a period of internal political turmoil, Van der Kolk transferred over to the Trauma Research Foundation where he still works today.

Van der Kolk (2014) writes that he was inspired by Pavlov's often-forgotten research on the Reflex of Purpose, which reports that humans have a fundamental drive for purpose, for organizing around meaning, and for utilizing emotions to ignite a self-determined momentum. Also, he reports having enjoyed Darwin's overlooked work The Expression of Emotions, which describes body-brain bidirectional systems during moments of emotional excitation. Eventually, that Darwinian hunch evolved into Porge's Polyvagal theory, another of Van der Kolk's all-time favorites, which revealed how being seen and heard relaxes and reassures, or how being ignored or dismissed enrages and discourages, therefore highlighting the importance of quality relationships on the health of our nervous systems. Furthermore, Maier and Seligman's (1967) animal research on inescapable shock was a revelation because, as Van der Kolk

(2014) himself reports, it confirmed that the development of learned helplessness indeed happens when one cannot escape a traumatic experience, and it validated that stress and on-guard attitudes persist long after the threat has passed. Therefore, as Rogers suggested, providing conditions where safety, agency and autonomy reigns makes total sense. Van der Kolk reports to have creatively synthesized all of the above, realizing that psychological trauma affects people from all ages and walks of life, and that public policy changes at the federal level could have a much larger impact on society than one-on-one therapy. So, in 1998, after decades of lobbying, the US Senate passed a Van der Kolk-inspired bill to create the National Child Traumatic Stress Network (NCTSN), connecting hundreds of diverse organizations offering Trauma-Informed care for families, psychological first aid trainings, and multiculturally adapted local mental health supports. No doubt, Rogers would have wholeheartedly applauded this.

As he himself writes, Van der Kolk (2014) dared to do things differently right from his first study in the late 1970's, by asking Vietnam veterans the Trauma-Informed question: 'What happened?'. Listening to veteran's stories simply had never been done so systematically in scientific research. What prompted him to design this study was Kardiner's first-hand accounts of World War I's traumatized soldiers in his book Traumatic Neuroses of War (1941), but even more so his own and psychiatry's sheer ignorance of the subject; a 40 year-gap in medical literature that he resolved to fill with new research.

However, Van der Kolk soon discovered that trauma was taboo, as he writes facing rejection on his following research grant proposal because the VA did not find PTSD relevant for its organization (2014). Moreover, during the pharmacological revolution of the 1980-90's, while teaching psychopharmacology at the Massachusetts Mental Health Center, Van der Kolk writes of humbly realizing that while medications did financial wonders for doctors and helped close mental institutions, they numbed symptoms without addressing deeper issues, and did not cultivate the patient's own autonomy nor improve its relationships, with high costs for families and local communities. Thus, he concluded that "no doctor can write a prescription for friendship and love", and this realization motivated him to advocate for the pairing of natural sciences with humanistic approaches (Van der Kolk, 2014, p.83). Therefore, Van der Kolk writes that his team at the Trauma Center spent much time understanding each patient deeply before considering potential multifaceted treatments, the one-pill-fits-all model not being in their organizational culture. Moreover, he postulated hermeneutically, that what may appear as 'wrong' behaviors are often failed attempts at voicing needs, or at trying to be heard, and what is often seen as 'problems' are actually awkward 'solutions' for those who do them. Therefore, for Van der Kolk, the whole human being picture included mind and relationships, not just the body, and asking 'What is happening?' was a way to access that bigger picture.

In conclusion, although both Rogers and Van der Kolk were first educated in natural sciences, they each realized that the 'What is wrong with you?' worldview was maladapted for human systems. In each their own socio-historical contexts, they switched to 'What is happening?', humbly admitting ignorance, and trusting that accepting, safe and compassionate environments were what human beings needed to resolve their own dialectic tensions. Without giving up in face of adversity and resistance to change, nor

succumbing to peer pressures, nor falling for pharmaceutical fads, they took the commitment to humanistically complete the gap left by positivism's flaws, to trust their own critical thinking while breaking taboos, and to use empiricism at the service of humanity, while not forgetting the role of ethics in mental health. Today, with the phoenix of eugenics rising from its ashes worldwide, on-going atrocious wars, natural catastrophes, domestic violence, etc., not only Trauma-Informed trainings are still relevant, but are needed more than ever. Rogers and Van der Kolk have shown us the way with persistence and courage. Let's continue to walk in their footsteps, if we are to be optimistic about the future.

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Appendix A

What follows is a real-life example showing the power of asking 'What is happening?'. While working as a support worker in a 'dry' homeless shelter (i.e. no drugs or alcohol consumed on site) in downtown Victoria, British-Columbia, part of my job description was to escort out anyone found intoxicated, and/or help them find a place in another shelter whenever possible.

In the specific case discussed here, there were suspicions that a male resident may have been intoxicated, so a social worker asked me to make closer observations then report back. When I saw the suspected man, he had just tumbled down the stairs. I approached, greeted him, and after checking in to make sure he was okay, I asked 'What is happening?', then listened attentively. He complained of being dizzy and tired. I did not notice slurred speech, alcohol or drug smell, or any sign of intoxication. However, I observed that he was wearing crooked bifocal glasses with shattered lenses. I asked him: 'How long ago did your glasses break?' He said that happened a year before, when he had been beaten up on the first day that he became homeless, and he had been seeing triple ever since.

After we parted, I wrote a report of my observations to the social worker. In the following days, with the man's consent, the social worker booked an eye exam. Finally getting to a clinic meant a lot to him. When the glasses arrived a few weeks later, I accompanied him for pick up. Immediately after he put them on, his face lit up, he stood up and danced joyously without falling. On his way back to the shelter, he walked straight and fast. Soon he began to read again and ride a bicycle. He applied to become a volunteer, which eventually gave him references, which in turn got him a paid job and within a few months, a place to call home.

Homelessness is now a thing of the past for this man. Yet, all I did was to ask a few Trauma-Informed questions, write a report, accompany him. He chose to go to his exam, chose his frames,

picked them up, volunteered, read, rode his bike, got a job, kept it long enough to save enough money, and got his own place. If I had asked ‘What’s wrong with you?’ chances are the interaction would not have gone so smoothly, and chances are I would not have learned about his needs. In the worse case, he would have been labeled unruly, flagged in the shelter database, and sent back on the street or ping-pong endlessly between organizations. Who knows how long it would have taken him until he got new glasses?

My manager hailed this as a success story, but in my point of view, we were not done. I argued that small change well-done can have big effects, and suggested to include basic vision issues questions in the entry intake form, in order to systematically repeat this story countless times. So, the intake form was indeed changed, and since then, dozens more got eye care, and most of those are no longer homeless. This proves that long-standing institutions can look at their own structures, ask ‘What is happening?’, and be curious about how the designs of their own service delivery systems impacts the outcomes of the people are going through them. This experience thought me what Rogers and Van der Kolk also had realized: being curious with one another can literally unlock ‘the process of becoming’. I believe that Trauma-Informed Approach in service-delivery across the range of all human affairs could be part of the solutions for many of society’s woes, homelessness being one of them.