



# Trauma-Informed Behavior Analysis

Understanding and Responding to Trauma Through a Behavioral Lens

*A Training for Board Certified Behavior Analysts*

# Why This Training?

## The reality:

- Many consumers we serve have trauma histories
- Standard ABA procedures sometimes fail — or backfire
- "Non-compliance" and "aggression" may be survival responses

## This training will:

- Provide a behavioral framework for understanding trauma
- Identify what standard ABA may get wrong with this population
- Offer practical guidance for crisis prevention and response

**This is not about  
abandoning ABA.**

**It's about applying it  
more precisely.**

# What Is Trauma? (A Behavioral Definition)

Trauma is a learning history in which:

- Aversive events were unpredictable and/or inescapable
- The individual had no response available that reliably produced safety
- Neutral stimuli became conditioned as signals for threat
- Survival behaviors were reinforced by escape from or avoidance of harm

**Trauma is not what happened TO them.**

**Trauma is what their nervous system LEARNED from what happened.**

*Trauma is a summary term, not an explanation. Behavior is the data.*

# Respondent Conditioning in Trauma

## Classical/Respondent Conditioning:

Neutral stimulus paired with aversive event → Neutral stimulus becomes conditioned stimulus

### In trauma:

- Sights, sounds, smells, times, places, people present during traumatic events become conditioned stimuli
- These stimuli now elicit physiological threat responses
- This is automatic, not voluntary

### Examples:

Raised voice → fear response

Small room → fear response

Male with beard → fear response

Specific perfume → fear response

**Generalization occurs. The stimuli don't have to be exact matches.**

# Operant Conditioning in Trauma

Behavior that produces escape from or avoidance of aversive events is reinforced.

**In trauma, survival behaviors are reinforced:**

- Aggression → abuser backs off (negative reinforcement)
- Freezing → abuse ends sooner (negative reinforcement)
- Running/hiding → escape from threat (negative reinforcement)
- Compliance → reduced severity (negative reinforcement)

**These behaviors were functional. They worked.**

The problem: These behaviors transfer to new environments where they're no longer adaptive — but they're still in the repertoire, still strong.

# The Smoke Detector Metaphor

A smoke detector can make two errors:

## 1. False negative

Fails to detect fire → Death

## 2. False positive

Detects fire when there isn't one → Annoyance

## Which error is more costly?

A nervous system calibrated by trauma is set to be highly sensitive.

- Better to detect threat that isn't there than miss one that is
- False positives are less costly than false negatives

**The alarm system is working. It's calibrated for a different environment.**

# The Map Metaphor

**Trauma creates a map of the world.**

**The map says:**

- Adults are dangerous
- Asking for help makes things worse
- Calm before the storm — peace predicts violence
- The only person I can rely on is myself

**This map was accurate for the territory they navigated.**

Now they're in new territory, but still using the old map.

**We cannot take away the old map.**

We can only help them build a new one — through new experiences, new contingencies, new learning.

# The Window of Tolerance

Every nervous system has a "window" — a range where learning and social behavior are possible.

## Wide Window:

Can handle more stress, recover quickly, access thinking brain under pressure

## Narrow Window (Trauma):

Small stressors overwhelm capacity, quick to dysregulate, limited access to prefrontal cortex

## The Tunnel Metaphor:

- Wide window = driving through a wide tunnel — room to maneuver
- Narrow window = driving through a narrow tunnel — any wobble hits the wall
- Trauma narrows the tunnel — what used to fit no longer does

**Our goal: Widen the window over time through safety, relationship, and successful coping.**

# What Looks Like Non-Compliance

What we see	What may be happening
Won't follow instructions	Dissociated / can't process language
Ignoring us	Hypervigilant / scanning for threat
Defiance, "testing limits"	Testing whether this adult is safe
Refusal to engage	Freeze response
"Attention-seeking"	Proximity-seeking for safety
Aggression "out of nowhere"	Response to perceived threat we didn't see

**If we treat survival behavior as non-compliance, we will select the wrong intervention.**

# Why "Just Tell Them They're Safe" Doesn't Work

Verbal information doesn't override physiological conditioning.

- The amygdala (threat detection) reacts in milliseconds
- Cortical processing (understanding your words) takes much longer
- By the time they "hear" you, their body has already responded

**You can't talk someone out of a physiological state.**

- "You're safe" is information, but their body has different data
- Their learning history says this environment is dangerous
- Their nervous system believes the history, not your words

**Safety is not established through language. Safety is established through repeated experience.**

# Relationship IS Intervention

## Traditional view:

Build rapport first, then intervene.

## Trauma-informed view:

**The relationship IS the intervention.**

## Why relationship is therapeutic:

- Disconfirms learning history ("this adult is different")
- Provides safety cues that lower arousal
- Creates context for new learning

**You cannot borrow trust in a crisis.**

The relationship you build in calm moments is what you have to work with when things get hard.

# What Makes Relationship Safe

Safety in relationship is built through:

## Predictability

Doing what you said you would do

## Responsiveness

Noticing and responding to their signals

## Repair

When rupture happens, coming back and fixing it

## Respect for autonomy

Allowing choice; respecting "no" when possible

## Non-contingent positive regard

You are not only nice when they comply

**Safety is demonstrated, not declared. Every interaction is data they're collecting about you.**

# Adults as S-Deltas for Approach

## Typical development:

- Adults provide safety, comfort, resources
- Child learns: Adults = good things
- Adults become SDs for approach behavior

## After trauma/neglect:

- Adults provided pain, unpredictability, or nothing
- Child learns: Adults = danger or disappointment
- Adults become S-deltas (or SDs for avoidance)

## Reconditioning is required.

Through repeated safe experiences, you can shift from S-delta to SD for safety.

**This takes time. There are no shortcuts.**

# Hidden Antecedents

When staff say "nothing happened" before a crisis — something happened.

## Hidden antecedent categories:

**Sensory:** Noise, smell, lighting, temperature, texture

**Environmental**  
: Room layout, crowding, blocked exits

**Relational:** Tone, proximity, who's present

**Body state:** Hunger, fatigue, pain, illness

**Temporal:** Time of day, anniversaries, day of week

**Internal:** Memories, thoughts, conditioned emotional responses

**Standard A-B-C captures the last 30 seconds.**

The actual antecedent trail may have started hours or days earlier.

**Wrong antecedent identification = wrong intervention = no behavior change.**

# Hidden Antecedents: Sensory Triggers

**Sensory stimuli paired with trauma become conditioned triggers:**

- A specific perfume or smell (matched an abuser)
- Fluorescent light flickering (unpredictable, dysregulating)
- A door slamming down the hall (not even in the room)
- Someone's tone of voice — not yelling, just a specific tone
- Being touched from behind or unexpectedly
- Certain textures (restraint, rough handling)
- A song or sound that was playing during traumatic event

**These don't have to make sense to us.  
They made sense during the trauma.**

# Hidden Antecedents: Environmental & Relational

## Environmental Shifts:

- New person entering room
- Unfamiliar staff covering
- Schedule change (even positive)
- Room rearrangement
- End of preferred activity approaching

## Relational/Social Cues:

- Staff talking quietly to each other
- Someone frowning (not at them)
- Staff seeming stressed or rushed
- A peer escalating across the room
- Being looked at too long

## Key insight:

Trauma-affected consumers are exquisitely attuned to environmental and social threat cues. They're reading the room constantly — and they're often reading it more accurately than we realize.

# Hidden Antecedents: Body State & Temporal

## Body State (Often Missed):

- Hungry (but didn't say anything)
- Tired / slept poorly / nightmares
- Pain (headache, stomach, sensory)
- Illness coming on
- Overstimulated from earlier activity

## Time-Linked Triggers:

- Anniversary of traumatic event
- Time of day associated with abuse
- Day of week (custody exchange)
- Season (winter = when it happened)
- Holidays approaching

*They may not consciously know it's an anniversary or trigger time.*

## Ask:

"What was their baseline when they arrived?"

"What happened in the last hour, not just the last minute?"

"What's happening in their life outside of session?"

# The Antecedent Trail: Example

## What we document:

*"Consumer was asked to transition to table.  
Consumer hit staff."*

## What actually happened:

- Didn't sleep well (body state)
- Mom cancelled visit yesterday
- Room was loud this morning
- Worked with unfamiliar staff
- Asked to transition during preferred
- Staff stood too close

**The hitting wasn't caused by the transition request.**

The transition request was the last straw on an already overloaded system.

# Procedures That May Be Contraindicated

Specific trauma histories may contraindicate specific procedures:

History	Potentially Contraindicated
Food insecurity	Food as reinforcer
Sexual abuse	1:1 without oversight, some physical prompting
Neglect/abandonment	Attention extinction, planned ignoring
Physical abuse	Time out, physical prompting without consent
Law enforcement history	Punishment hierarchies

**These aren't universally wrong — but they require risk-benefit analysis with trauma histories.**

# Why Standard ABA Sometimes Fails

Standard ABA may fail with trauma-affected consumers because:

- 1 Incorrect function identification** — Survival behavior isn't escape-maintained in the typical sense
- 2 Unidentified aversive stimuli** — Triggers we don't see
- 3 Relationship insufficient** — Procedures require trust that hasn't been built
- 4 Window exceeded** — Demands exceed current capacity
- 5 Procedure is itself triggering** — Physical prompting, proximity, 1:1 attention

**The science is not wrong.  
The application may be incomplete without understanding  
learning history.**

# Teaching a Dysregulated Nervous System Is Unsafe

## At high arousal:

- Social behavior is not available to be learned or emitted
- Demands for social responding increase physiological load
- This directly contributes to escalation

## The sequence matters:



**Teaching social skills to a dysregulated nervous system is not ineffective — it is unsafe.**

# Compliance Is Not the Target

**During crisis, compliance is not your target behavior.**

## Compliance requires:

- Prefrontal cortex online
- Trust that following instructions is safe
- Low threat perception
- Physiological regulation

## Treating compliance as the goal during crisis:

- Increases demand when tolerance is lowest
- Confirms you are a source of threat
- Directly escalates the crisis

**During trauma-related  
escalation:**

**None of these are present.**

**Compliance is the outcome of effective intervention, not the intervention itself.**

# Crisis Prevention & Response

Practical tools for de-escalation

---

# Control Is the Operant Variable

Control means the consumer can:

- Move without being blocked
- Leave without being pursued
- Choose their distance from others
- Predict adult behavior
- End interactions without punishment

**These are observable  
environmental  
conditions.**

**Loss of control = Loss of response options = Escalation**

When the only available response is aggression, you'll get aggression.

**You cannot remove all response options and then be surprised by aggression.**



*You do not need to convince them you are safe.*

*You need to stop demonstrating that you are a threat.*

# Stop Proving Threat

## Threat signals (what to stop):

- ✗ Standing over them (dominance)
- ✗ Blocking exits (trapping)
- ✗ Moving toward (pursuit)
- ✗ Loud voice (aggression signal)
- ✗ Repeated directives (control)
- ✗ Sustained eye contact (predator behavior)

**Remove these and you stop functioning as an aversive stimulus.  
The nervous system settles when the environment stops threatening.**

# The Lid Flip

## Dan Siegel's Hand Model:

*Make a fist with thumb tucked inside fingers.*

**Thumb = survival brain**

(threat detection)

**Fingers = thinking brain**

(reasoning, language)

**Regulated:**

Fingers cover thumb

**Escalated:**

Lid flips — survival brain in charge

**When the lid is flipped, you're talking to the thumb.**

The thumb doesn't process language.

The thumb doesn't reason.

The thumb survives.

**Wait for the fingers to come back  
down.  
Then talk.**

# Crisis Is Not Managed With Language

At high arousal, language functions as:

- Additional stimulation (more to process)
- Social pressure (requiring a response)
- Threat signal (tone, volume)
- Evidence of monitoring (being watched)

Even "supportive" language fails:

"You're okay" — invalidating

"Calm down" — a demand

"Take a deep breath" — instruction

**During acceleration and peak: Words are gasoline.**

**Safety is demonstrated through behavior,  
not explained through language.**

# Thermostat, Not Thermometer

## Thermometer:

*Reflects the temperature*

Consumer escalates → Staff escalates

Consumer yells → Staff talks louder

## Thermostat:

*Sets the temperature*

Consumer escalates → Staff stays calm

Consumer yells → Staff gets quieter

**Your regulated nervous system can regulate theirs.**

But only if you stay cool when they're hot.

**Co-regulation before self-regulation.  
Your regulated presence IS the intervention.**

# Staff Self-Regulation

**You cannot co-regulate if you are dysregulated.**

## Signs you are escalating:

- Heart rate increasing
- Voice getting louder or faster
- Moving closer or faster
- Feeling frustrated, angry, or scared
- Thinking "they need to stop this"

## What to do:

- Notice it — awareness first
- Slow your breathing
- Drop your shoulders
- Soften your face
- Tag out if needed

**Your body speaks louder than your words.**

They will detect your activation even if you try to hide it. If you're dysregulated, step back — your presence is making it worse. It's not failure to tag out. It's good clinical judgment.

# The SLOW Protocol

**S**

## **Space**

Increase distance. Don't crowd. Step back, not forward.

**L**

## **Lower**

Lower your voice. Lower your body. Slow your movements.

**O**

## **Options**

Provide choices. Include escape. "You can take a break."

**W**

## **Wait**

Give processing time. Say it once, then wait. Tolerate silence.

**SLOW is not a script. It's a stance.**

# Proxemics: Physical Distance Matters

Distance communicates safety or threat:

## Intimate (0-18")

Reserved for trusted people. Entering uninvited = threat.

## Personal (18"-4ft)

Conversation distance. Still feels close during crisis.

## Social (4-12ft)

Professional distance. Safer during escalation.

## Public (12ft+)

Minimal threat. May be needed during peak crisis.

**During escalation: Increase distance. What feels "too far" to you is often "just right" to them.**

# What Staff Get Wrong

## Common errors during crisis:

- ✗ Talking more — explaining, reasoning, repeating
- ✗ Moving closer — approaching to "help"
- ✗ Adding people — "getting backup"
- ✗ Increasing demands — "just do this one thing"
- ✗ Matching escalation — getting louder, faster
- ✗ Blocking exits — standing in doorways

**These feel helpful. They are not.  
Every one escalates rather than de-escalates.**

# The 7 Stages of Escalation

Escalation follows a predictable pattern:

- 1 Calm** — Regulated, learning available
- 2 Trigger** — No longer baseline
- 3 Agitation** — Warning signs, still accessible
- 4 Acceleration** — Escalating, losing thinking brain
- 5 Peak/Crisis** — Survival brain only
- 6 De-escalation** — Coming down, fragile
- 7 Recovery** — Depleted, returning to baseline

**Your response must match the stage. What works at Stage 3 fails at Stage 5.**

# Stage 1: Calm

## Consumer presentation:

- Regulated nervous system
- Engaged, responsive
- Can learn, follow directions, interact

## What you do:

- Teach replacement behaviors
- Build relationship (NCR)
- Practice coping skills BEFORE needed
- Make trust deposits

## This is when you work.

Everything you do here — building relationship, teaching skills, establishing predictability — is what you'll have to draw on in crisis. The calm work prevents the crisis work.

# Stage 2: Trigger

## Consumer presentation:

- Something shifted — no longer baseline
- May be subtle: pause, change in expression
- Trigger may be visible or hidden

## What you do:

- Remove or modify trigger if possible
- Acknowledge: "That was loud."
- Lower demands proactively
- Offer break before they need to ask

**This is your highest-leverage moment.**

Catch it here and you may prevent escalation entirely. Miss it and you're playing catch-up. Train staff to notice the small shifts — not just the obvious ones.

# Stage 3: Agitation

## Consumer presentation:

- Difficulty staying on task
- Increased motor activity, pacing
- Whining, complaining, arguing
- Visible tension, voice changes

## What you do:

- SLOW begins here
- Give more space
- Reduce your language
- Offer choices: "You can take a break..."
- Validate: "This is hard."

✗ Do NOT try to convince or coax compliance.

✗ Do NOT debrief or process. Just stabilize.

**Still accessible — thinking brain is partially online.  
This is your last good intervention window.**

# Stage 4: Acceleration

## Consumer presentation:

- Yelling, screaming
- Throwing, property destruction
- Physical aggression, SIB
- Cannot problem-solve or reason

## What you do:

- SLOW fully engaged — max space, min words
- SILENCE begins — 5 words max, once, wait
- Remove dangerous objects
- Remove audience — one adult only
- Do NOT block exits

**Do not raise your voice to be heard. Do not add demands.**

**The window for verbal intervention is closing.  
Prepare for Stage 5.**

# Stage 5: Peak/Crisis

## Consumer presentation:

- Maximum intensity
- May not recognize familiar people
- Not tracking language at all
- Operating on survival only

## What you do:

- SILENCE — don't talk
- ONE ADULT — others out
- DO NOT block, approach, or stand over
- Wait for de-escalation

**You don't prove safety. You stop proving threat.**

**This is the moment of highest risk  
and lowest influence.**

# Stage 6: De-escalation

## Consumer presentation:

- Intensity decreasing
- May cry, withdraw, become quiet
- Still fragile — can re-escalate easily

## What you do:

- Still minimal language
- Practical offers only: "Water's there."
- Allow regulation behaviors (stimming)
- Do NOT process yet

**They are NOT regulated yet. They're regulating.**

**Common mistake: "Now that you're calm, let's talk about what happened."**

This re-escalates. Their nervous system is settling. Don't activate it again. Wait.

# Stage 7: Recovery

## Consumer presentation:

- Exhaustion
- May show shame, guilt, embarrassment
- Returning to baseline

## What you do:

- Return to routine — don't hover
- Brief: "That was hard. Glad you're here."
- No consequences right now
- Processing hours/days later if at all

## How you respond now matters.

Don't treat them as broken. Don't interrogate. Don't lecture. Simply return to normal — which demonstrates the relationship survived.

The landing matters as much as the crisis.



*If a crisis escalates in your presence,  
something is off in the system — not the  
consumer.*

# Examine the System

## Possibilities:

- Relationship foundation is insufficient
- You are functioning as a threat stimulus
- Your behavior is escalating rather than de-escalating
- Environmental conditions are wrong

**The consumer's behavior is data about your system, not evidence of their pathology.**

**Before concluding "treatment resistant," examine your own stimulus function.**

# The BCBA's Role During Crisis

## Your presence often carries:

- Evaluative stimulus control ("supervisor is watching")
- Authority signals (power differential)
- Less daily pairing history than RBT

**For trauma-affected consumers, these may elevate arousal.**

## **If the RBT is signaling safety effectively:**

- There may be no behavioral reason for you to enter
- Support from outside — clear environment, handle logistics
- Your job may be to stay out

**Question to ask: "Is my presence helping or making this worse?"**

# After Crisis: Timing Matters

## Immediately after (Recovery):

Return to routine, minimal language  
No processing, no consequences

## Hours later (if regulated):

Brief: "Earlier was hard. How are you now?"  
Follow their lead

## Next day or later:

Processing IF appropriate and IF they consent  
Consequences: delayed, logical, connected to repair

**Repair, don't interrogate.**

# Relationship Repair

## What repair IS:

- Acknowledging what happened without shame
- Demonstrating the relationship survived
- Simple: "That was hard. We're okay."

## What repair is NOT:

- Interrogation: "Why did you do that?"
- Forced apology: "You need to say sorry."
- Conditional reconnection

**The repair teaches:  
Relationships survive rupture.**

*For some consumers, this is novel information.*

# Building a Debrief Culture

After significant incidents, debrief with staff:

- What worked? What didn't?
- What did we miss in the antecedent trail?
- What could we do differently next time?
- How are YOU doing after that?

## NOT:

"What did you do wrong?"  
"Why didn't you...?"

## YES:

"What can we learn?"  
"How can we support you?"

**Punitive debriefs make staff defensive and dysregulated.  
Supportive debriefs build competence and regulation.**

# Measuring Success Differently

## Don't only measure:

- Frequency of problem behavior
- Compliance rates

## Also measure:

- Recovery time — How quickly to baseline?
- Communication — Do they tell you when climbing?
- Stage reached — Stopping at 3 instead of 5?
- Approach behaviors — Seeking staff for support?

## Progress may look like:

*"Crises still happen, but they're shorter, less intense, and they tell us when they're starting to escalate."*

**That's success.**

# Training Your RBTs

## Core concepts:

- 1 Trauma is learning history — Same principles, different awareness
- 2 Nervous system drives crisis behavior — Not volitional
- 3 Relationship is foundation — They're either SD for safety or threat
- 4 Their regulation matters — Thermostat, not thermometer
- 5 Less is more during crisis — Space, silence, waiting

Teach SLOW concretely.  
Practice it. Role-play silence.

Debrief after crisis —  
supportive, not punitive.

RBTs who feel supported stay regulated longer.

# Key Quotes

"You don't prove safety — you stop proving threat."

"Crisis de-escalation is not something you say. It's something you stop doing."

"If crisis escalates in your presence, something is off in the system — not the consumer."

"Compliance is the outcome, not the intervention."

"The consumer's behavior is data about your system, not evidence of their pathology."

"Your regulated presence IS the intervention."

The order is non-negotiable:



**You cannot skip steps.**

If you try to teach before regulation, you will fail.

We are not just managing behavior.

We are:

- Providing corrective relational experiences
- Reconditioning stimuli paired with threat
- Building new learning history alongside the old
- Teaching nervous systems that some adults are safe

**This is behavior analysis applied to trauma. Same science.  
Different awareness.**

**The work is slow. The work is hard.  
The work matters.**

Thank you.