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Trauma-informed care practices in psychiatric wards: a comprehensive review of strategies for reducing restraint use and enhancing patient trust

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Abstract:

Trauma is highly prevalent among individuals admitted to psychiatric inpatient facilities, with a substantial proportion of patients reporting histories of childhood adversity, interpersonal violence, neglect, sexual abuse, military combat, forced displacement, or other psychologically distressing experiences. These traumatic exposures frequently influence emotional regulation, interpersonal relationships, treatment adherence, and behavioural responses during psychiatric hospitalization. Conventional inpatient practices, including coercive interventions such as physical restraint, mechanical restraint, seclusion, and involuntary medication administration, may unintentionally reactivate traumatic memories, intensify psychological distress, and compromise therapeutic engagement. Consequently, trauma-informed care (TIC) has emerged as a transformative framework that seeks to recognise the widespread impact of trauma while fostering safety, dignity, collaboration, empowerment, and recovery-oriented psychiatric services (Substance Abuse and Mental Health Services Administration et al., 2014).

Trauma-informed care extends beyond individual clinical interventions and represents an organisational philosophy integrated into policies, workforce education, environmental modifications, communication strategies, and multidisciplinary clinical decision-making. Rather than asking "What is wrong with the patient?", trauma-informed approaches encourage healthcare professionals to consider "What has happened to the patient?", thereby shifting psychiatric care from symptom control toward understanding behavioural responses within the context of traumatic life experiences (Sweeney et al., 2018). This paradigm has gained increasing international recognition because evidence suggests that trauma-informed inpatient services are associated with reductions in restraint use, decreased seclusion episodes, fewer aggressive incidents, improved staff confidence, enhanced patient satisfaction, and stronger therapeutic alliances (Azeem et al., 2015).

The implementation of trauma-informed care is particularly relevant in psychiatric wards where patients often experience heightened emotional vulnerability, impaired coping mechanisms, severe mental illness, and acute behavioural disturbances. Restrictive practices intended to maintain safety may inadvertently reinforce fear, mistrust, and psychological harm, thereby delaying recovery and increasing the likelihood of repeated crises. Trauma-informed strategies emphasise de-escalation techniques, collaborative safety planning, respectful communication, shared decision-making, sensory modulation, peer support, and environmental adaptations that reduce perceived threats while preserving patient autonomy whenever clinically feasible (Isobel et al., 2021). Such interventions contribute not only to immediate crisis prevention but also to long-term improvements in patient engagement, trust, and treatment adherence.

This review synthesises current evidence regarding trauma-informed care practices implemented within psychiatric inpatient settings, with particular emphasis on their effectiveness in reducing restraint utilisation and strengthening patient trust. The review discusses the epidemiology of trauma among psychiatric populations, theoretical foundations of trauma-informed care, mechanisms underlying trauma-related behavioural responses, evidence supporting

organisational transformation, barriers to implementation, staff education, leadership responsibilities, policy implications, and future research priorities. Collectively, available literature indicates that trauma-informed psychiatric services can substantially improve both patient-centred outcomes and workplace culture when supported by comprehensive organisational commitment, continuous professional development, and evidence-based clinical practice (Bryson et al., 2017; Wilson et al., 2017).

Keywords:
Trauma-informed care; psychiatric nursing; restraint reduction; patient trust; mental health nursing; therapeutic relationship; inpatient psychiatry; recovery-oriented care.

1. Introduction:

Psychiatric inpatient units provide specialised care for individuals experiencing acute mental illness, behavioural crises, severe emotional distress, or significant impairment requiring intensive therapeutic intervention. Although these settings are designed to promote stabilisation and recovery, many patients admitted to psychiatric wards possess extensive histories of psychological trauma that profoundly influence their emotional responses, interpersonal interactions, coping mechanisms, and treatment engagement. Trauma may result from childhood abuse, domestic violence, sexual assault, armed conflict, discrimination, neglect, natural disasters, medical trauma, or repeated exposure to threatening environments. Studies consistently demonstrate that trauma exposure is substantially higher among psychiatric populations than in the general community, making trauma-informed approaches increasingly essential within contemporary mental health services (Substance Abuse and Mental Health Services Administration et al., 2014).

Historically, psychiatric care has frequently relied upon restrictive interventions including physical restraint, mechanical restraint, seclusion, and involuntary treatment to manage aggressive or high-risk behaviours. While these interventions may occasionally be necessary to prevent immediate harm, they are associated with considerable ethical, psychological, and physical consequences for both patients and healthcare professionals. Restrictive practices have been linked to fear, humiliation, re-traumatisation, injuries, diminished therapeutic relationships, increased staff burnout, and reduced patient satisfaction. Importantly, individuals with previous traumatic experiences often perceive restraint as a continuation or repetition of earlier abuse, resulting in heightened distress and long-lasting psychological consequences (Huckshorn et al., 2005).

Recognition of these adverse outcomes has prompted a global movement towards trauma-informed care within psychiatric services. Trauma-informed care is not merely a clinical technique but rather a comprehensive organisational framework that recognises trauma as a widespread public health issue influencing patient behaviour, emotional regulation, physical health, and engagement with healthcare systems. Instead of interpreting challenging behaviours solely as symptoms of psychiatric illness, trauma-informed approaches encourage clinicians to understand behavioural responses as adaptive survival mechanisms that developed following traumatic experiences. This perspective promotes empathy, collaborative care planning, patient empowerment, and respectful communication while reducing reliance on coercive interventions (Sweeney et al., 2018).

The conceptual foundations of trauma-informed care are built upon six core principles established by the Substance Abuse and Mental Health Services Administration: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment with choice, and sensitivity towards cultural, historical, and gender-related factors (Substance Abuse and Mental Health Services Administration et al., 2014). These principles encourage healthcare organisations to redesign policies, clinical environments, workforce education, and leadership strategies to minimise re-traumatisation while supporting recovery. Within psychiatric wards, trauma-informed care extends from admission assessments and nursing communication to crisis intervention, environmental design, multidisciplinary teamwork, discharge planning, and quality improvement initiatives.

Growing international evidence demonstrates that hospitals implementing trauma-informed organisational change frequently experience substantial reductions in physical restraint and seclusion episodes without compromising patient or staff safety. Simultaneously, improvements have been reported in therapeutic alliance, patient trust, staff morale, patient participation in treatment planning, and overall quality of psychiatric care (Azeem et al., 2015; Bryson et al., 2017). These findings have encouraged policymakers, accreditation bodies, and professional organisations to increasingly recommend trauma-informed practice as a standard component of mental health service delivery.

Despite encouraging evidence, widespread implementation remains challenging. Organisational resistance, limited resources, inadequate staff training, inconsistent leadership support, workforce shortages, and

variations in institutional culture continue to hinder successful adoption across many psychiatric facilities. Furthermore, considerable heterogeneity exists regarding intervention models, outcome measurements, implementation strategies, and evaluation methodologies, making direct comparisons across studies difficult (Wilson et al., 2017).

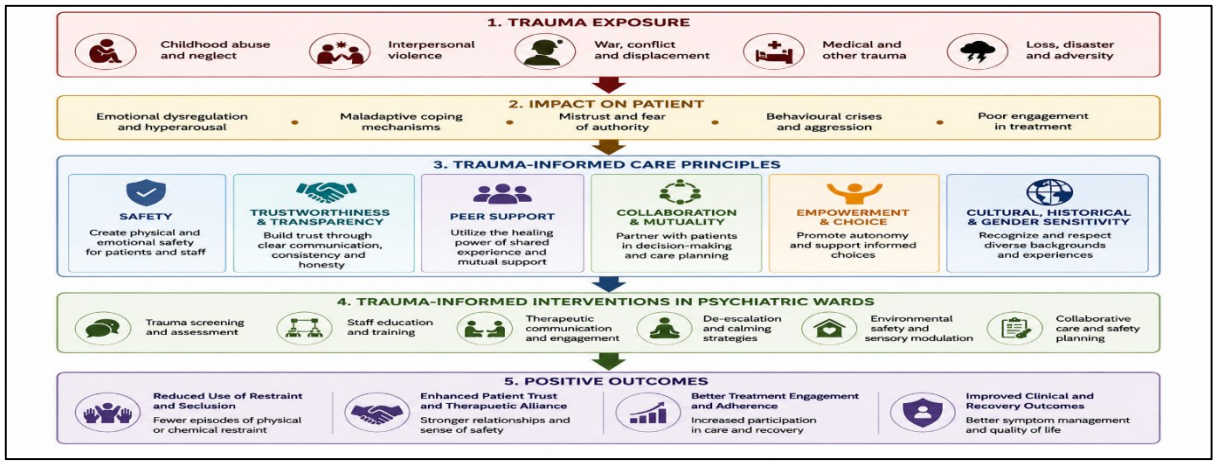

Figure. 1: Conceptual Framework of Trauma-Informed Care in Psychiatric Wards Burden of Trauma among Psychiatric Patients

1.1. Understanding trauma in mental health care:

Trauma is defined as an emotional, psychological, or physical response to an event or series of events that overwhelms an individual's ability to cope effectively. While many people experience potentially traumatic events during their lifetime, not everyone develops persistent psychological consequences. However, among individuals requiring psychiatric inpatient care, traumatic experiences are disproportionately common and frequently contribute to the onset, progression, and recurrence of mental illnesses. Trauma may arise from childhood maltreatment, domestic violence, sexual assault, emotional neglect, military combat, forced migration, natural disasters, severe accidents, medical procedures, discrimination, bullying, or repeated exposure to interpersonal violence (Substance Abuse and Mental Health Services Administration et al., 2014).
Research conducted over the past two decades consistently demonstrates that psychiatric inpatients report significantly higher rates of trauma exposure than the general population. Many patients experience multiple forms of trauma throughout their lives, resulting in cumulative psychological effects that influence emotional regulation, cognitive processing, interpersonal relationships, and behavioural responses. Rather than representing isolated life events, trauma often becomes a chronic determinant of mental health that shapes an individual's perception of safety, trust, control, and social interaction (Sweeney et al., 2018).
The relationship between trauma and psychiatric illness is bidirectional. Trauma increases the likelihood of developing psychiatric disorders, while psychiatric illness itself may increase vulnerability to further victimisation, social exclusion, homelessness, exploitation, and repeated traumatic experiences. Consequently, many psychiatric inpatients enter hospital with complex trauma histories that remain unidentified during routine clinical assessment, leading to interventions that may unintentionally exacerbate distress.

1.2. Epidemiology of trauma in psychiatric populations:

Numerous international studies indicate that between **70% and 90%** of psychiatric inpatients have experienced at least one significant traumatic event during their lifetime, with many reporting repeated exposure beginning in childhood (Read et al., 2005). Childhood abuse, particularly emotional abuse, physical abuse, and sexual abuse, has been strongly associated with schizophrenia spectrum disorders, bipolar disorder, major depressive disorder, substance use disorders, personality disorders, and post-traumatic stress disorder (PTSD) (Bendall et al., 2012).
Women admitted to psychiatric facilities are more likely to report histories of sexual violence and intimate partner abuse, whereas men more frequently report community violence, physical assault, or combat-related trauma. Nevertheless, both genders experience high levels of cumulative adversity that influence psychiatric presentation and recovery trajectories (Isobel et al., 2021).
Trauma prevalence is particularly elevated among patients diagnosed with:

- Post-traumatic stress disorder (PTSD)
- Borderline personality disorder

- Dissociative disorders
- Severe depressive disorders
- Psychotic disorders
- Substance use disorders
- Bipolar affective disorder
- Complex trauma syndromes

Individuals with co-occurring psychiatric disorders frequently demonstrate more severe symptoms, longer hospital admissions, poorer treatment adherence, and increased use of emergency psychiatric services than patients without significant trauma histories (Bryson et al., 2017).

1.3. Adverse childhood experiences (aces) and psychiatric illness:

The landmark Adverse Childhood Experiences (ACE) studies transformed understanding of how childhood adversity influences lifelong health outcomes. ACEs include physical abuse, emotional abuse, sexual abuse, household violence, parental substance misuse, parental incarceration, neglect, divorce, and chronic family dysfunction. Higher ACE scores are strongly associated with increased risks of depression, anxiety disorders, suicidal behaviour, psychosis, substance misuse, chronic physical illnesses, and premature mortality (Felitti et al., 1998).

Repeated childhood trauma alters brain development during critical developmental periods. These neurodevelopmental changes impair emotional regulation, stress tolerance, executive functioning, and interpersonal trust. Consequently, many adults admitted to psychiatric wards display behavioural responses that are adaptive survival strategies developed during earlier traumatic experiences rather than intentional non-compliance or aggression (Anda et al., 2006).

Understanding ACEs enables psychiatric nurses and multidisciplinary teams to interpret patient behaviours through a trauma-informed lens, thereby reducing blame, stigma, and punitive responses.

1.4. Trauma and behavioural dysregulation:

Patients with unresolved trauma frequently exhibit behavioural manifestations that can be misunderstood during psychiatric admission. Hypervigilance, emotional outbursts, avoidance, withdrawal, dissociation, agitation, impulsivity, aggression, self-harm, and refusal of treatment often represent protective responses developed following previous traumatic experiences (Harris et al., 2001).

Traditional psychiatric care may interpret these behaviours solely as symptoms requiring behavioural control. Trauma-informed care, however, recognises that many behavioural crises occur when patients perceive threats to their autonomy, dignity, or personal safety. Loud environments, unexpected physical contact, coercive communication, locked doors, invasive procedures, or restraint may trigger traumatic memories and provoke defensive reactions.

For example, a survivor of childhood abuse may experience routine physical restraint as a re-enactment of previous victimisation. Similarly, patients with histories of sexual violence may become extremely distressed during physical examinations or involuntary procedures. Recognising these associations allows healthcare professionals to intervene earlier through de-escalation, collaborative communication, and environmental modifications rather than coercive measures (Isobel et al., 2021).

1.5. Trauma and the therapeutic relationship:

Trust forms the cornerstone of effective psychiatric treatment. However, trauma frequently disrupts an individual's capacity to trust authority figures, healthcare professionals, and institutions. Previous experiences of betrayal, neglect, coercion, or abuse may cause patients to approach psychiatric admission with fear, suspicion, or emotional withdrawal (Sweeney et al., 2018).

Trauma-informed communication seeks to restore trust by promoting transparency, respect, collaboration, and predictability. Nurses explain procedures before initiating care, seek informed consent whenever possible, encourage patient participation in treatment planning, and acknowledge emotional responses without judgement. Such approaches reduce anxiety while strengthening therapeutic alliances that improve treatment adherence and long-term recovery.

Table.1: Common Types of Trauma Experienced by Psychiatric Inpatients and Their Clinical Impact

Type of Trauma	Examples	Common Psychiatric Consequences
Childhood abuse	Physical, emotional, sexual abuse	PTSD, depression, personality disorders, self-harm
Neglect	Emotional or physical neglect	Attachment difficulties, anxiety, impaired trust
Domestic violence	Intimate partner violence	Depression, PTSD, substance misuse
Sexual violence	Assault, exploitation	Dissociation, anxiety, suicidal ideation
Community violence	Assault, robbery, gang violence	Hypervigilance, aggression, PTSD
Combat exposure	Military conflict	PTSD, depression, substance misuse
Medical trauma	ICU admission, painful procedures	Healthcare avoidance, anxiety
Disaster-related trauma	Earthquakes, floods, pandemics	Adjustment disorders, depression, PTSD
Forced migration	Refugees, displacement	Chronic stress, anxiety, cultural isolation

2. Neurobiology of trauma:

2.1. Biological response to trauma:

Trauma produces profound neurobiological changes affecting brain structure, neuroendocrine regulation, autonomic nervous system activity, and cognitive processing. These alterations influence how psychiatric patients perceive threats, regulate emotions, process memories, and respond to interpersonal interactions. Understanding these biological mechanisms helps clinicians recognise why trauma-informed care is more effective than coercive behavioural management.

Acute traumatic events activate the **hypothalamic-pituitary-adrenal (HPA) axis**, triggering release of cortisol and catecholamines that prepare the body for survival through fight, flight, freeze, or submission responses (van der Kolk et al., 2014). Although adaptive during immediate danger, repeated activation produces chronic physiological dysregulation that contributes to psychiatric illness.

2.2. Brain regions affected by trauma:

Several brain regions undergo structural and functional alterations following repeated trauma:

- **Amygdala:**
  The amygdala becomes hyper-responsive, increasing fear perception and emotional reactivity. Patients may interpret neutral situations as threatening, contributing to aggression or panic.
- **Hippocampus:**
  Chronic stress may reduce hippocampal volume, impairing memory consolidation and contextual processing. Traumatic memories often remain fragmented and easily triggered.
- **Prefrontal Cortex:**
- Reduced activity within the prefrontal cortex impairs executive functioning, emotional regulation, planning, impulse control, and decision-making. Consequently, patients may struggle to regulate emotional responses during psychiatric crises.
- **Anterior Cingulate Cortex:**
- Altered functioning affects attention, emotional awareness, and conflict resolution, reducing patients' ability to cope with stressful interpersonal situations.

Collectively, these neurobiological alterations explain why seemingly minor environmental triggers may provoke disproportionate behavioural responses among trauma survivors.

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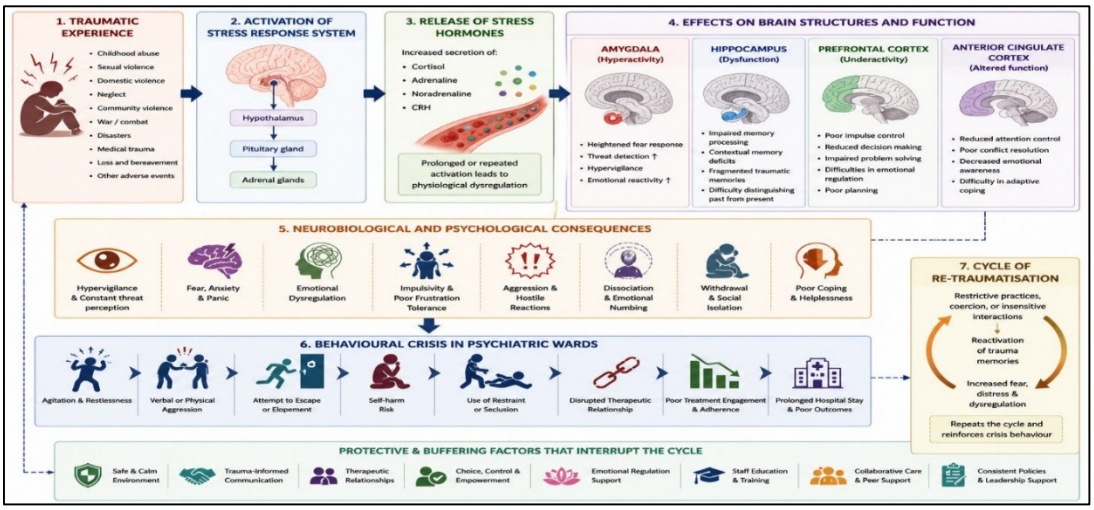

Figure. 2: Neurobiological Effects of Trauma Leading to Behavioural Crisis

2.3. Implications for psychiatric nursing:

Knowledge of trauma neurobiology reinforces the importance of calm communication, predictable routines, sensory modulation, emotional validation, and collaborative decision-making within psychiatric wards. These interventions reduce activation of stress pathways, promote emotional regulation, and decrease the likelihood of behavioural escalation requiring restrictive interventions (Azeem et al., 2015).

Rather than viewing aggression as deliberate misconduct, trauma-informed nurses recognise behavioural crises as manifestations of dysregulated neurobiology shaped by previous traumatic experiences. This perspective encourages compassionate, evidence-based interventions that improve both patient safety and therapeutic relationships.

3. Theoretical foundations of trauma-informed care:

3.1. Evolution of trauma-informed care:

Trauma-informed care (TIC) has evolved from growing recognition that traumatic experiences are not isolated psychological events but fundamental determinants of physical health, mental health, behaviour, interpersonal relationships, and recovery outcomes. Prior to the 1990s, psychiatric services primarily focused on symptom reduction, behavioural management, pharmacotherapy, and risk containment. Although these approaches improved acute psychiatric stabilisation, they often overlooked the influence of previous traumatic experiences on patients' responses to treatment. Consequently, many routine psychiatric practices—including coercive interventions, involuntary admissions, seclusion, and physical restraint—unintentionally re-traumatised vulnerable individuals (Harris et al., 2001).

The concept of trauma-informed care emerged through collaborative efforts involving mental health professionals, trauma researchers, survivors of psychiatric services, nursing leaders, and public health organisations. Rather than viewing challenging behaviours as deliberate non-compliance or manifestations of psychiatric illness alone, trauma-informed care proposes that many behavioural responses represent adaptive survival mechanisms developed following exposure to overwhelming adversity. This conceptual shift transformed psychiatric practice from asking "What is wrong with this patient?" to "What has happened to this patient?", thereby encouraging compassionate, collaborative, and recovery-oriented care (Substance Abuse and Mental Health Services Administration et al., 2014).

Today, trauma-informed care represents an organisational philosophy rather than a single clinical intervention. It influences leadership, workforce education, clinical assessment, communication strategies, environmental design, policy development, quality improvement, and multidisciplinary teamwork throughout psychiatric services.

3.2. Definition of trauma-informed care:

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma-informed care as an organisational approach that recognises the widespread impact of trauma, understands potential pathways for recovery, recognises the signs and symptoms of trauma among patients and staff, integrates trauma knowledge into policies and clinical practices, and actively seeks to prevent re-traumatisation (Substance Abuse and Mental Health Services Administration et al., 2014).

Trauma-informed care does not require every healthcare professional to provide specialised trauma therapy. Instead, it ensures that all interactions within healthcare environments acknowledge the possibility of trauma and minimise practices that may unintentionally trigger distress.

This distinction is particularly important in psychiatric wards where nurses, psychiatrists, psychologists, occupational therapists, social workers, and support staff interact continuously with patients experiencing heightened emotional vulnerability.

3.3. The four assumptions of trauma-informed care (the "4 RS"):

SAMHSA introduced four fundamental assumptions underpinning trauma-informed organisations.

- **Realise:**
- Healthcare organisations recognise that trauma is common across all populations and significantly influences physical health, emotional wellbeing, interpersonal functioning, and healthcare engagement.
- **Recognise:**
- Professionals identify signs and symptoms of trauma among patients, families, caregivers, and healthcare workers themselves.
- **Respond::**
- Healthcare systems integrate trauma knowledge into clinical practice, organisational policies, workforce education, and quality improvement initiatives.
- **Resist Re-traumatisation:**
- Every aspect of care seeks to minimise practices that recreate feelings of helplessness, fear, humiliation, coercion, or abuse.
- Together, these assumptions create the conceptual foundation for trauma-informed psychiatric services.
- **Core Principles of Trauma-Informed Care:**
- Although implementation strategies vary internationally, most trauma-informed frameworks are based upon six core principles proposed by SAMHSA.

3.4. Safety:

Safety encompasses both physical and psychological security. Patients admitted to psychiatric wards frequently experience heightened vigilance due to previous traumatic experiences. Creating calm environments, predictable routines, respectful communication, and emotionally supportive interactions reduces anxiety while promoting therapeutic engagement.

Environmental safety includes adequate lighting, reduced noise, private consultation areas, comfortable sensory environments, and respectful nursing interactions. Psychological safety requires patients to feel listened to, valued, respected, and free from humiliation or unnecessary coercion (Sweeney et al., 2018).

3.5. Trustworthiness and transparency:

Patients with trauma histories often experience profound mistrust towards authority figures because previous relationships involved betrayal, abuse, neglect, or exploitation.

Trauma-informed psychiatric care therefore emphasises:

- Honest communication
- Clear explanations before procedures
- Consistency between words and actions
- Shared expectations
- Reliable routines
- Transparent decision-making

These practices gradually strengthen therapeutic alliances and reduce anxiety during hospitalisation.

3.5. Peer support:

Individuals who have personally experienced mental illness and recovery possess valuable lived expertise that complements professional knowledge. Peer support workers provide empathy, hope, practical guidance, and emotional validation that promote recovery while reducing feelings of isolation.

Evidence indicates that peer involvement improves patient engagement, satisfaction, self-efficacy, and trust in mental health services (Bryson et al., 2017).

3.6. Collaboration and mutuality:

Traditional psychiatric care often positions healthcare professionals as decision-makers while patients remain passive recipients of treatment.

Trauma-informed care promotes collaborative partnerships whereby patients actively participate in:

- Goal setting
- Crisis planning
- Medication discussions
- Discharge planning
- Safety planning
- Recovery planning

Collaboration restores autonomy that trauma survivors frequently lost during previous abusive experiences.

3.7. Empowerment, voice, and choice:

Traumatic experiences commonly involve loss of personal control. Consequently, restoring autonomy forms a central objective of trauma-informed psychiatric nursing.

Whenever clinically appropriate, patients are encouraged to make decisions regarding:

- Daily activities
- Preferred coping strategies
- Sensory modulation techniques
- Family involvement
- Treatment preferences
- Personal recovery goals

Even small opportunities for choice reduce helplessness while strengthening resilience and self-confidence (Isobel et al., 2021).

3.8. Cultural, historical, and gender sensitivity:

Trauma occurs within broader social contexts shaped by discrimination, racism, colonisation, gender inequality, poverty, migration, and historical oppression.

Trauma-informed organisations therefore provide culturally responsive services that respect patients' beliefs, identities, languages, traditions, and lived experiences. Staff receive education regarding implicit bias, cultural competence, and inclusive communication to ensure equitable psychiatric care.

Table. 2: Comparison Between Traditional Psychiatric Care and Trauma-Informed Care

Aspect	Traditional Psychiatric Care	Trauma-Informed Care
Primary Question	What is wrong with you?	What happened to you?
Behaviour	Symptom requiring control	Adaptive survival response
Decision-making	Clinician-directed	Collaborative
Communication	Directive	Respectful and transparent
Patient Role	Passive recipient	Active partner
Safety	Physical safety	Physical and psychological safety
Restraint	Behaviour management	Last resort after de-escalation
Recovery	Symptom reduction	Holistic recovery and empowerment
Trust	Secondary outcome	Primary therapeutic objective
Organisational Focus	Risk management	Healing environment

4. Trauma-informed nursing models:

Several nursing theories complement trauma-informed psychiatric care.

4.1. Recovery model:

The Recovery Model emphasises hope, autonomy, dignity, community participation, and meaningful life goals despite ongoing mental illness. Trauma-informed care aligns closely with recovery-oriented nursing by promoting patient empowerment and shared decision-making (Anthony et al., 1993).

4.2. Person-centred care:

Person-centred nursing views patients as experts regarding their own experiences. Nurses collaborate with

individuals to develop personalised treatment plans that respect preferences, values, and lived experiences.

4.3. Strengths-based nursing:

Strengths-based nursing shifts focus from illness and deficits toward resilience, coping abilities, family support, cultural resources, and personal strengths that facilitate recovery.

4.4. Sanctuary model:

The Sanctuary Model provides an organisational framework promoting safety, emotional intelligence, shared governance, open communication, and trauma-sensitive workplace culture. Hospitals adopting Sanctuary principles frequently report reductions in restraint use and improvements in staff wellbeing.

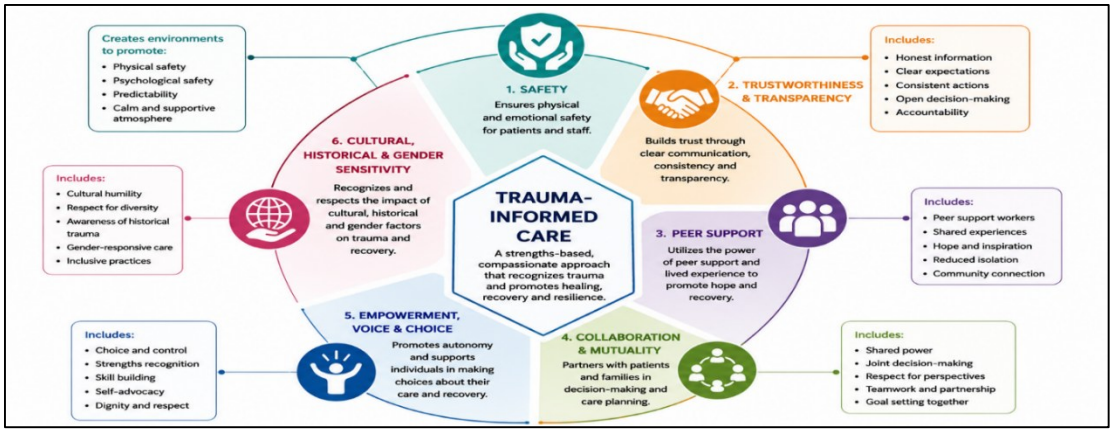

Figure. 3: Core Principles of Trauma-Informed Care (SAMHSA Framework)

4.5. Clinical significance:

The six principles collectively create environments where patients feel respected, safe, empowered, and understood. Rather than controlling behaviour through coercion, trauma-informed nursing seeks to understand behavioural responses within the context of previous traumatic experiences. Such approaches contribute to reductions in restraint use, improved patient satisfaction, stronger therapeutic relationships, enhanced staff confidence, and improved recovery outcomes.

5. Trauma-informed interventions in psychiatric wards:

5.1. Introduction:

The successful implementation of trauma-informed care (TIC) in psychiatric wards requires more than recognising trauma histories; it necessitates systematic changes in clinical practice, communication, environmental design, workforce education, and organisational culture. Trauma-informed interventions seek to prevent re-traumatisation while promoting patient safety, dignity, autonomy, and therapeutic engagement. These interventions are implemented throughout the patient's journey, from admission and assessment to discharge planning and follow-up care. (Thakur et al., 2019, Rathore et al., 2018, Verma et al., 2023)

Unlike traditional psychiatric management, which often prioritises symptom control through restrictive measures, trauma-informed interventions aim to understand the reasons behind behavioural distress and intervene proactively before behavioural crises escalate. Psychiatric nurses play a central role because they maintain continuous therapeutic contact with patients and are frequently the first professionals to identify early signs of emotional dysregulation (Isobel et al., 2021, Rathore et al., 2021)

5.2. Trauma-informed assessment:

Trauma-informed assessment begins with establishing a therapeutic relationship based on trust, empathy, confidentiality, and respect. Rather than conducting rigid interviews immediately after admission, healthcare professionals create opportunities for patients to disclose traumatic experiences voluntarily when they feel emotionally safe.

Assessment focuses on understanding:

- Previous traumatic experiences
- Current emotional triggers
- Preferred coping mechanisms

- Existing support systems
- Previous psychiatric admissions
- Experiences with restraint or seclusion
- Cultural beliefs and spiritual needs
- Personal strengths and recovery goals

Importantly, trauma-informed assessment does not require detailed exploration of traumatic memories during acute psychiatric admission. Instead, clinicians identify how trauma influences current care needs while avoiding unnecessary emotional distress (SAMHSA et al., 2014).

Healthcare professionals also assess environmental triggers such as loud noises, crowded spaces, unexpected physical contact, authoritative communication, and loss of privacy, all of which may precipitate behavioural escalation among trauma survivors. (Chawla et al., 2012)

5.3. Trauma screening:

Routine trauma screening has become an important component of modern psychiatric care because many patients never voluntarily disclose traumatic experiences unless specifically and sensitively asked. Screening enables clinicians to identify individuals who may benefit from trauma-informed interventions without requiring extensive psychological assessment.

Validated screening instruments commonly used include:

- Adverse Childhood Experiences (ACE) Questionnaire
- Primary Care PTSD Screen (PC-PTSD)
- Trauma History Questionnaire (THQ)
- Life Events Checklist (LEC)
- Brief Trauma Questionnaire (BTQ)

Trauma screening should always be accompanied by informed consent, emotional support, privacy, and appropriate referral pathways if patients become distressed during assessment.

Studies indicate that systematic trauma screening increases recognition of trauma histories while improving individualised care planning and reducing inappropriate behavioural management strategies (Sweeney et al., 2018, Chawla et al., 2008)

5.4. Therapeutic communication:

Communication represents one of the most powerful trauma-informed interventions available to psychiatric nurses.

Effective communication involves:

- Introducing oneself before care
- Explaining all procedures beforehand
- Asking permission before physical contact
- Speaking calmly and respectfully
- Avoiding confrontational language
- Providing reassurance during distress
- Offering realistic choices whenever possible
- Validating emotional experiences

Patients frequently report that respectful communication is more effective than medication alone in reducing fear and anxiety during psychiatric admission. (Thakur et al., 2018)

Examples include replacing statements such as:

"You need to calm down immediately."

with

"I can see that you're distressed. Let's work together to understand what is happening."

Such language reduces perceived threats while promoting collaboration.

5.5. De-escalation strategies:

Behavioural crises rarely occur suddenly. Most episodes develop gradually through identifiable stages of emotional escalation. Trauma-informed psychiatric nursing therefore prioritises early recognition of behavioural warning signs and implementation of non-coercive de-escalation techniques. (Singh et al., 2021)

Common early warning signs include:

- Increased pacing

- Raised voice
- Restlessness
- Rapid breathing
- Tearfulness
- Social withdrawal
- Refusal of communication
- Increased irritability

Trauma-informed de-escalation strategies include:

- Calm verbal reassurance
- Active listening
- Offering quiet spaces
- Allowing personal space
- Encouraging deep breathing
- Sensory modulation
- Collaborative problem solving
- Involving trusted family members or peer supporters
- Respecting patient autonomy whenever clinically safe

Numerous hospitals implementing structured de-escalation programmes report significant reductions in restraint episodes and aggressive incidents (Azeem et al., 2015, Thakur et al., 2021)

5.6. Sensory modulation:

Sensory modulation has become an increasingly important component of trauma-informed psychiatric nursing. Trauma survivors frequently experience heightened sensitivity to environmental stimuli. Bright lights, loud sounds, overcrowding, unpleasant odours, or excessive physical contact may activate traumatic memories and emotional dysregulation.

Sensory modulation interventions include:

- Weighted blankets
- Soft lighting
- Comfortable seating
- Music therapy
- Aromatherapy (where appropriate)
- Breathing exercises
- Stress balls
- Fidget devices
- Quiet sensory rooms
- Guided relaxation

These interventions reduce physiological arousal while improving emotional regulation and decreasing behavioural crises.

Research suggests sensory rooms significantly reduce patient anxiety and lower the frequency of restrictive interventions in psychiatric inpatient settings (Champagne et al., 2010, Sharma et al., 2023)

5.7. Environmental modifications:

The physical environment strongly influences emotional wellbeing during psychiatric admission.

Trauma-informed wards attempt to create healing environments characterised by:

- Reduced noise levels
- Natural lighting
- Comfortable furniture
- Privacy during consultations
- Clear signage
- Safe communal areas
- Personal storage facilities
- Comfortable waiting spaces
- Access to outdoor environments where feasible

Environmental predictability reduces uncertainty, thereby decreasing anxiety among trauma survivors.

Many hospitals also redesign nursing stations to appear more welcoming rather than creating physical barriers

between staff and patients.

5.8. Collaborative safety planning:

Instead of relying exclusively upon restrictive interventions during crises, trauma-informed psychiatric services encourage collaborative safety planning.

Safety plans typically include:

- Individual triggers
- Early warning signs
- Preferred coping strategies
- Helpful staff interventions
- Individuals to contact during distress
- Cultural or spiritual supports
- Emergency management preferences
- Recovery goals

Because patients participate actively in developing safety plans, they experience greater autonomy and trust throughout hospitalisation.

Table. 3: Major Trauma-Informed Nursing Interventions in Psychiatric Wards

Intervention	Purpose	Expected Outcome
Trauma-informed assessment	Identify trauma history and triggers	Individualised care planning
Trauma screening	Early recognition of trauma	Appropriate interventions
Therapeutic communication	Build trust and reduce fear	Improved therapeutic alliance
De-escalation	Prevent behavioural crisis	Reduced aggression
Sensory modulation	Reduce physiological arousal	Emotional regulation
Environmental modification	Increase physical and psychological safety	Reduced anxiety
Collaborative safety planning	Promote patient participation	Reduced restraint use
Family involvement	Enhance emotional support	Improved recovery
Peer support	Increase hope and engagement	Better treatment adherence
Staff education	Improve trauma-informed practice	Consistent patient-centred care

6. Trauma-informed nursing care across the patient journey:

Trauma-informed care should be integrated throughout every phase of psychiatric hospitalisation.

- **Admission**
- Respectful welcome
- Privacy during assessment
- Explanation of ward routines
- Identification of trauma triggers
- **Early Hospitalisation:**
- Establish therapeutic relationship
- Trauma screening
- Collaborative goal setting
- Family involvement
- **Crisis Management:**
- Early de-escalation
- Sensory interventions
- Emotional validation
- Collaborative decision-making
- **Recovery Phase:**
- Psychoeducation
- Coping skill development
- Occupational therapy
- Peer support
- Recovery planning
- **Discharge:**

- Community referrals
- Relapse prevention
- Safety planning
- Follow-up appointments
- Family education

This continuum ensures trauma-informed principles remain central throughout the patient's recovery process.

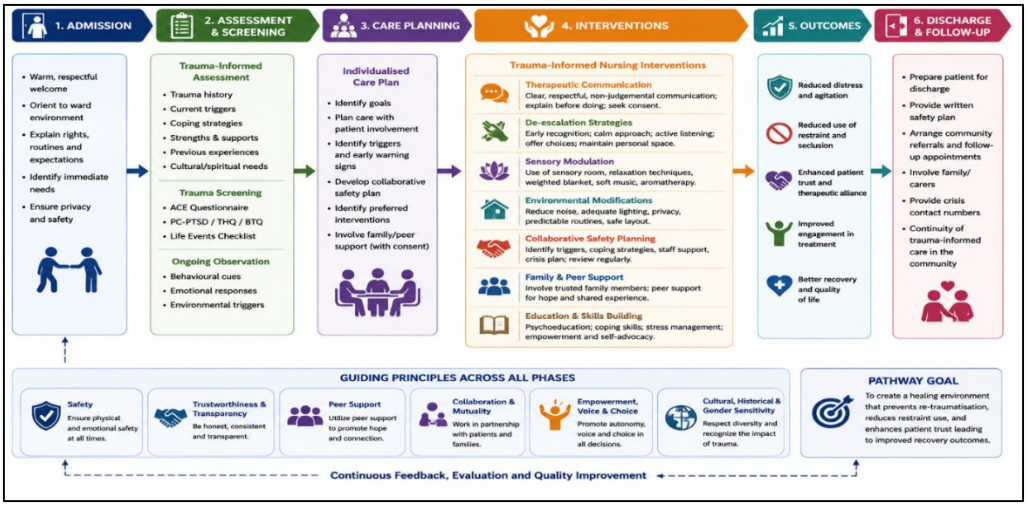

Figure. 4: Trauma-Informed Intervention Pathway in Psychiatric Wards

7. Restraint and seclusion in psychiatric care:

7.1. Introduction:

Restrictive interventions, particularly physical restraint, mechanical restraint, chemical restraint, and seclusion, have historically been used within psychiatric inpatient settings to manage aggressive behaviour, prevent self-harm, or protect patients and healthcare professionals from immediate danger. Although these measures may occasionally be clinically necessary during life-threatening emergencies, their routine or prolonged use has become increasingly controversial because of the associated physical, psychological, ethical, and legal consequences. Contemporary psychiatric practice therefore advocates that restraint should be considered only after all reasonable trauma-informed and least restrictive alternatives have been attempted (World Health Organization et al., 2021).

Trauma-informed care has fundamentally changed professional perspectives regarding restraint. Rather than viewing restrictive practices solely as behavioural management tools, trauma-informed approaches recognise that restraint may reactivate traumatic memories, undermine therapeutic relationships, increase fear, and delay psychological recovery. Consequently, modern psychiatric services increasingly prioritise prevention, de-escalation, collaborative care planning, and early intervention strategies that minimise the need for coercive measures (Huckshorn et al., 2005).

8. Definitions of restrictive interventions:

Restrictive interventions encompass several practices designed to limit a patient's movement or decision-making during situations perceived to involve imminent risk.

8.1. Physical restraint:

Physical restraint involves direct bodily force applied by healthcare professionals to restrict patient movement temporarily.

Examples include:

- Holding the patient's arms
- Restricting body movement
- Manual immobilisation during emergencies

8.2. Mechanical restraint:

Mechanical restraint involves devices that physically restrict movement.

Examples include:

- Wrist restraints
- Ankle restraints
- Waist belts
- Special restraint chairs

Because mechanical restraint substantially limits autonomy, many countries regulate or prohibit its routine use.

8.3. Chemical restraint:

Chemical restraint refers to administering medication primarily to control behaviour rather than treating the underlying psychiatric condition.

Common medications include:

- Benzodiazepines
- Antipsychotics
- Sedatives

Trauma-informed care recommends that medication should always be clinically justified and not used solely for staff convenience.

8.4. Seclusion:

Seclusion involves placing a patient alone in a locked or supervised room to prevent immediate harm.

Although seclusion may temporarily reduce behavioural risk, prolonged isolation frequently increases emotional distress, anxiety, fear, anger, and feelings of punishment.

8.5. Indications for restrictive interventions:

International guidelines generally agree that restrictive interventions should only be considered when:

- Immediate risk of serious harm exists
- Less restrictive alternatives have failed
- Behaviour cannot be safely managed through de-escalation
- Clinical assessment supports emergency intervention
- Continuous monitoring is maintained
- Restriction is terminated as soon as safely possible

Every episode should undergo formal review to identify opportunities for prevention during future admissions.

8.6. Physical consequences of restraint:

Restrictive interventions may produce serious physical complications affecting both patients and healthcare professionals.

Reported complications include:

- Fractures
- Soft tissue injuries
- Pressure injuries
- Respiratory compromise
- Deep vein thrombosis
- Aspiration
- Cardiac arrhythmias
- Sudden cardiac arrest
- Death (rare but documented)

Healthcare workers are also at increased risk of musculoskeletal injuries, bites, scratches, fractures, and occupational stress during restraint procedures.

These risks have strengthened international efforts to minimise restraint utilisation whenever clinically feasible (Stewart et al., 2010).

8.7. Psychological consequences of restraint:

Psychological consequences often persist long after hospital discharge.

Patients frequently report:

- Fear
- Humiliation

- Loss of dignity
- Anger
- Helplessness
- Anxiety
- Flashbacks
- Re-traumatisation
- Sleep disturbance
- Reduced trust in healthcare professionals

Individuals with previous histories of childhood abuse, sexual assault, torture, domestic violence, or interpersonal violence appear particularly vulnerable because restraint may closely resemble previous traumatic experiences (Sweeney et al., 2018).

These psychological consequences may contribute to future avoidance of mental healthcare services and poorer treatment adherence.

8.8. Ethical considerations:

Restrictive interventions raise significant ethical concerns because they directly affect patient autonomy, dignity, and human rights.

Four fundamental ethical principles guide decision-making.

- **Autonomy:**
- Patients possess the right to participate in decisions affecting their care whenever clinically possible.
- **Beneficence:**
- Healthcare professionals must act in the patient's best interests while promoting recovery and wellbeing.
- **Non-maleficence:**
- Clinicians should minimise physical and psychological harm associated with restrictive interventions.
- **Justice:**
- All patients should receive equitable, evidence-based care regardless of diagnosis, ethnicity, age, gender, or socioeconomic background.

Trauma-informed care supports ethical psychiatric practice by reducing unnecessary coercion while promoting compassionate care.

8.9. Trauma-informed alternatives to restraint:

Trauma-informed psychiatric services implement multiple preventive interventions before considering restrictive practices.

Common alternatives include:

- **Early Risk Assessment**
- Identifying behavioural warning signs allows intervention before escalation occurs.
- **Verbal De-escalation**
- Respectful communication frequently resolves behavioural crises without physical intervention.
- **Sensory Modulation**
- Calming sensory environments reduce physiological arousal.
- **Collaborative Safety Planning**
- Patients identify preferred coping strategies before crises develop.
- **Comfort Rooms**
- Dedicated calming environments provide alternatives to seclusion.
- **Family and Peer Support**
- Trusted support persons often reduce emotional distress during hospitalisation.
- **Staff Education**
- Trauma-informed education improves confidence in managing behavioural crises without coercion.
- Hospitals implementing these interventions consistently report reductions in restraint frequency while maintaining patient and staff safety (Azeem et al., 2015).

9. Evidence supporting restraint reduction:

Over the past two decades, multiple hospitals internationally have successfully reduced restraint utilisation

through comprehensive trauma-informed organisational change.

One of the earliest large-scale initiatives was the **Six Core Strategies©** developed by Huckshorn, which combines leadership commitment, workforce development, patient involvement, data monitoring, prevention tools, and post-incident debriefing. Numerous psychiatric hospitals implementing this model reported substantial reductions in restraint and seclusion while improving staff satisfaction and patient outcomes (Huckshorn et al., 2005).

Similarly, trauma-informed organisational programmes implemented across child and adolescent psychiatric services demonstrated reductions exceeding 50% in restraint episodes alongside improved workplace culture (Azeem et al., 2015).

International reviews conclude that restraint reduction programmes are most successful when interventions occur simultaneously at organisational, clinical, educational, and policy levels rather than relying upon isolated staff training sessions (Wilson et al., 2017).

Table. 4: Benefits and Risks of Restrictive Interventions

Aspect	Potential Benefits	Potential Risks
Immediate safety	Prevents imminent harm	Physical injury
Aggression control	Temporary behavioural containment	Psychological trauma
Crisis management	Short-term behavioural stabilisation	Re-traumatisation
Staff protection	Reduces immediate violence	Staff injuries during restraint
Patient protection	Prevents severe self-harm	Loss of dignity
Clinical care	Allows emergency treatment	Reduced patient trust
Ward safety	Temporary environmental control	Increased future aggression
Legal protection	Supports emergency intervention	Ethical and human rights concerns

10. Organisational strategies for restraint reduction:

Successful trauma-informed hospitals typically implement several interconnected organisational strategies.

- **Leadership Commitment**
- Hospital leaders establish restraint reduction as a strategic organisational priority.
- **Continuous Staff Education**
- Regular simulation training improves confidence in de-escalation.
- **Data Monitoring**
- Hospitals analyse restraint episodes to identify preventable patterns.
- **Patient Participation**
- Patients contribute to policy development and safety planning.
- **Post-Incident Debriefing**
- Patients and staff review restraint episodes to identify learning opportunities.
- **Quality Improvement**
- Continuous evaluation ensures sustained organisational change.
- Collectively, these interventions transform psychiatric wards into safer therapeutic environments where restrictive practices become increasingly uncommon.

11. Challenges and barriers to implementing trauma-informed care:

Despite growing evidence supporting trauma-informed care (TIC), implementation within psychiatric inpatient settings remains inconsistent. Organisational barriers include inadequate leadership commitment, limited financial resources, insufficient staffing, high patient-to-nurse ratios, lack of standardised protocols, and inadequate infrastructure. Individual barriers include limited staff knowledge, resistance to organisational change, fear of increased workplace violence without restraint, and compassion fatigue (Wilson et al., 2017).

Many psychiatric facilities continue to prioritise risk management over recovery-oriented care because of legal concerns and workforce shortages. Furthermore, variations in national legislation, healthcare funding, and mental health policies influence the adoption of trauma-informed practices. Continuous professional education, leadership support, interdisciplinary collaboration, and routine quality improvement are therefore essential to ensure sustainable implementation (Sweeney et al., 2018).

12. Future directions:

Future psychiatric services should move beyond isolated trauma-informed interventions towards fully trauma-

responsive healthcare systems. Priority areas include:

- Standardised trauma-informed nursing education.
- Routine trauma screening during psychiatric admission.
- Increased involvement of peer-support workers.
- Expansion of sensory modulation programmes.
- Development of culturally responsive trauma-informed care models.
- Digital tools for personalised safety planning.
- Large multicentre longitudinal studies evaluating long-term patient outcomes.
- International consensus regarding trauma-informed quality indicators.

Emerging evidence also supports integrating trauma-informed principles into undergraduate nursing curricula and continuing professional development programmes to improve workforce competence before clinical practice begins.

13. Clinical implications for psychiatric nursing:

Psychiatric nurses remain central to the successful implementation of trauma-informed care because they provide continuous bedside care and maintain the closest therapeutic relationships with patients. Through compassionate communication, early identification of behavioural triggers, collaborative safety planning, emotional validation, and least restrictive interventions, nurses substantially reduce the likelihood of behavioural escalation requiring restraint.

Trauma-informed nursing also improves workplace culture by reducing occupational stress, increasing professional confidence, strengthening multidisciplinary teamwork, and enhancing patient satisfaction. Consequently, trauma-informed practice should be regarded as a core competency for psychiatric nurses rather than an optional clinical approach.

14. Conclusion:

Trauma-informed care has emerged as one of the most significant developments in contemporary psychiatric nursing. Growing evidence demonstrates that traumatic experiences are highly prevalent among psychiatric inpatients and substantially influence emotional regulation, behavioural responses, therapeutic engagement, and recovery outcomes. Conventional restrictive interventions, including physical restraint and seclusion, may inadvertently recreate traumatic experiences, resulting in psychological harm, reduced patient trust, and delayed recovery.

This review demonstrates that trauma-informed psychiatric care provides an evidence-based alternative centred on safety, trust, collaboration, empowerment, cultural sensitivity, and recovery-oriented practice. Organisational transformation supported by workforce education, leadership commitment, trauma screening, therapeutic communication, sensory modulation, collaborative safety planning, and continuous quality improvement has consistently been associated with reductions in restraint use while simultaneously strengthening therapeutic relationships and patient trust.

Although implementation challenges remain, current literature strongly supports integrating trauma-informed principles into routine psychiatric nursing practice. Future research should focus on multicentre implementation studies, long-term patient outcomes, economic evaluations, and culturally adaptable trauma-informed models. Ultimately, trauma-informed care represents not only a clinical framework but also a commitment to delivering compassionate, respectful, and person-centred psychiatric services that promote dignity, safety, and sustained recovery.

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