



Trauma-Informed Care in Psychiatric Settings

Prepared by:

Faten Ahmed Abd Elrahman

Supervised by:

Prof. Dr/ Nelly Ahmed Mahgob

Prof. Dr/ Zeinab Abdel-Halim

**Faculty of Nursing
Cairo University
2025 / 2026**

Outlines

- Definition of Trauma
- Types of Trauma
- How trauma affect on Mental Health Conditions
- Definition of Trauma-Informed Care and Its Importance of in Psychiatric Settings
- Core Principles of Trauma-Informed Care
- Trauma-Informed vs Trauma-Specific Care
- Trauma-Informed Therapy definition
- Trauma Therapy Techniques
- Role of Mental Health Nurses in TIC
- Implementation Strategies for PMHNPs

Introduction

Trauma is increasingly recognized as a critical public health issue with profound and long-lasting effects on mental health. A significant proportion of individuals receiving psychiatric care have experienced some form of trauma, whether acute, chronic, or complex. These experiences may alter neurobiological functioning, disrupt emotional regulation, and shape maladaptive coping patterns that persist into adulthood.

Traumatic events are common and can have lasting effects on a person's life and health and a community's well-being. The effects of trauma go far beyond its immediate psychological and physical effects. Experiencing trauma can alter individual biology and behavior over the life course; these changes have an impact on interpersonal and intergenerational relationships.

Ultimately, traumatic events alter the well-being of not only individuals but also our communities and society. How a person responds to trauma is complex and dependent on many factors, including the resources of the individual and their supporting community

Definition of Trauma

The word trauma is often used to refer to both injurious events themselves and to their outcomes. Certainly, the outcomes of traumatic experiences vary greatly from person to person based on a wide spectrum of circumstances including genetic, epigenetic, biological, psychological, environmental, family, community, societal, historical, and other factors. How a person responds to a harmful event, or series of events, is now thought of as a process resulting from the interaction between the events themselves and the person.

Trauma may occur because of a harmful incident or series of events that are emotionally disturbing or life-threatening, such as violence, neglect, abuse, disaster, serious illness, or historical injustice.(Berring et al., 2024)

Trauma should not be understood only as a painful event that happened in the past. It is better understood as an experience that can continue to influence the person's body, brain, emotions, behavior, and relationships long after the event has ended.

In psychiatric settings, trauma is especially important because many patients present with symptoms such as aggression, withdrawal, dissociation, anxiety, depression, or self-harm. These symptoms may look like isolated psychiatric problems, but in many cases they are connected to previous traumatic experiences.

For example, a patient who refuses treatment or becomes angry when approached by staff may not simply be “difficult” or “non-compliant.” The patient may be responding from a trauma-based survival system, especially if previous experiences involved abuse, control, humiliation, or loss of safety.

Therefore, understanding trauma helps mental health professionals shift their thinking from asking, **“What is wrong with this patient?”** to asking, **“What happened to this patient?”**

This shift is the foundation of trauma-informed care.

Before discussing the different types of trauma, it is important to understand that **trauma is not simply the event itself.**

Many people mistakenly believe that trauma is the accident, abuse, or disaster. However, in mental health, trauma refers to **the individual's response to that experience and its long-term consequences.**

In other words, **the event alone does not determine whether trauma develops.** Instead, trauma occurs when the event overwhelms a person's ability to cope and leaves lasting psychological, emotional, biological, or social effects.

One of the most important concepts in trauma-informed care is that **the same event can affect different people in completely different ways.**

For example, imagine two children involved in the same car accident.

One child receives emotional support from family members, talks openly about the experience, gradually recovers, and returns to normal functioning.

The other child has no emotional support, develops nightmares, avoids riding in cars, becomes anxious whenever hearing loud sounds, and later develops PTSD.

Both children experienced exactly the same accident.

The difference lies **not in the event itself but in how the brain processed the experience and the protective factors available after the trauma.**

Therefore, clinicians should never assume that the severity of trauma depends only on the severity of the event. Instead, trauma depends on the interaction between:

- The traumatic event itself
- The individual's perception of the event
- Biological vulnerability
- Previous life experiences
- Family support
- Social environment
- Personal coping skills

This explains why trauma-informed care always focuses on understanding **the person's experience**, not simply identifying the even

Types of Trauma

Trauma can be classified according to its **duration, cause, developmental timing, and context** into:

1. Acute Trauma
2. Chronic Trauma
3. Complex Trauma
4. Developmental Trauma
5. Secondary (Vicarious) Trauma
6. Medical Trauma

Trauma is not a single condition. Mental health professionals classify trauma into different types because **each type affects individuals differently and may require different interventions.**

The classification depends on **how the trauma occurred, how long it lasted, and when it happened during the person's life.** Will discuss each type separately

1. Acute Trauma

Acute trauma results from **a single overwhelming event** that threatens a person's life, safety, or emotional stability. The event occurs once but may leave long-lasting psychological effects.

Examples include:

- Road traffic accidents
- Physical assault
- Natural disasters
- Sudden death of a loved one
- Terrorist attacks

Clinical Example

A 24-year-old man survives a serious car accident. Although he physically recovers, he later develops:

- nightmares
- fear of driving
- intrusive memories
- panic attacks whenever he hears car brakes.

This is an example of **acute trauma** because one traumatic event triggered persistent symptoms.

Not every acute trauma develops into PTSD.

Recovery depends on:

- resilience
- social support
- previous mental health
- early intervention

2. Chronic Trauma

Chronic trauma occurs when a person is exposed to **repeated or prolonged traumatic experiences** over months or years. Unlike acute trauma, the threat never completely disappears. Examples include:

- Domestic violence

- Child abuse
- Ongoing bullying
- War
- Human trafficking
- Long-term emotional abuse

Clinical Example

A woman lives with an abusive husband for ten years. Every day she experiences:

- fear
- humiliation
- physical violence
- emotional abuse

Because the trauma is repeated over time, it becomes **chronic trauma**.

3. Complex Trauma

Complex trauma refers to **multiple interpersonal traumatic experiences**, usually beginning in childhood and involving caregivers or trusted individuals. This type affects not only mental health but also:

- identity
- attachment
- emotional regulation
- personality development

Clinical Example

A child experiences:

- physical abuse by the father
- emotional neglect by the mother
- sexual abuse by a relative

over several years.

This child develops:

- difficulty trusting others
- unstable relationships
- dissociation
- emotional instability

This represents **complex trauma**.

Complex trauma is often associated with:

- Borderline Personality Disorder
- Complex PTSD
- severe attachment problems

4. Developmental Trauma

Developmental trauma occurs **during critical stages of childhood brain development**.

Because the brain is still developing, trauma interferes with normal emotional, cognitive, and social development. Examples include:

- early neglect
- institutional care
- caregiver inconsistency
- emotional deprivation

Clinical Example

A two-year-old child grows up in an orphanage without consistent caregivers. Although no physical abuse occurs, the child later shows:

- attachment difficulties
- poor emotional regulation
- delayed language
- behavioral problems

This is developmental trauma.

Children do not need to be physically abused to experience trauma.

Neglect alone can seriously affect brain development.

5. Secondary (Vicarious) Trauma

Secondary trauma occurs when professionals become emotionally affected through repeated exposure to other people's traumatic experiences. It is common among:

- psychiatric nurses
- psychologists
- social workers
- emergency physicians
- first responders

Clinical Example

A psychiatric nurse spends years caring for victims of sexual abuse. Gradually she develops:

- emotional exhaustion
- nightmares
- avoidance
- intrusive thoughts

Although she never experienced the trauma herself, she develops **secondary trauma**.

Secondary trauma increases the risk of:

- compassion fatigue
- burnout
- reduced job satisfaction

6. Medical Trauma

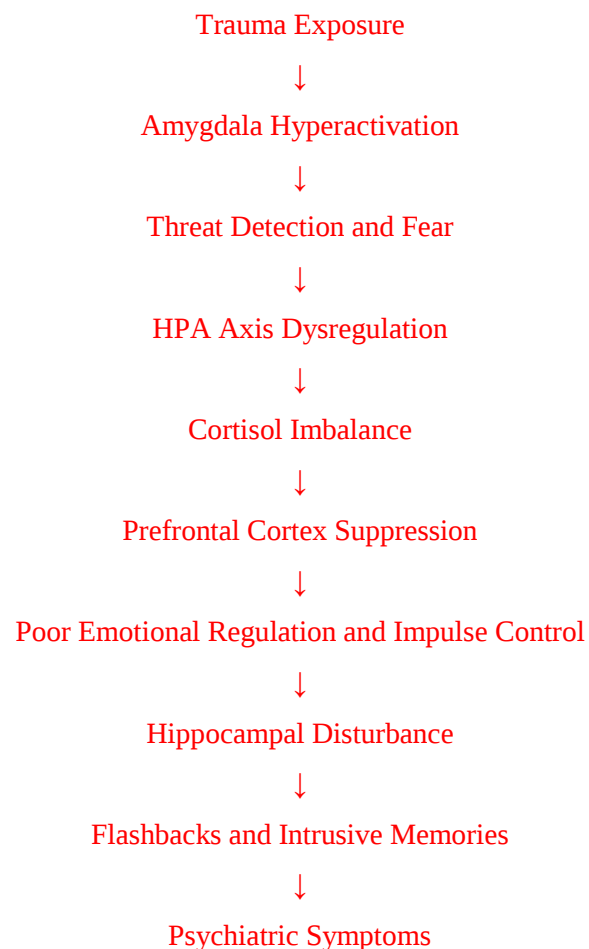
Medical trauma develops after frightening or life-threatening medical experiences. Examples include:

- ICU admission
- invasive surgery
- prolonged hospitalization
- cancer treatment
- mechanical ventilation

Neurobiological Impact of Trauma

Trauma produces measurable changes in the brain and stress-response systems, especially in:

1. **HPA Axis Dysregulation**
2. **Amygdala Hyperactivation**
3. **Prefrontal Cortex Suppression**
4. **Hippocampal Changes**
5. **Autonomic Nervous System Dysregulation**



Trauma does not only affect emotions or behavior. It also affects the way the brain and body respond to danger.

Normally, when a person faces danger, the brain activates a short-term survival response. The body becomes alert, the heart rate increases, breathing becomes faster, and stress hormones are released. After the danger ends, the body should return to a calm state.

However, after severe or repeated trauma, the brain may fail to return to normal. Instead, it remains in a state of continuous alertness. This means the person may feel unsafe even when there is no real danger.

In simple words: **The traumatized brain becomes trained to expect danger.**

This explains why trauma survivors may show:

- hypervigilance
- exaggerated fear responses
- irritability
- sleep disturbance
- emotional dysregulation
- impulsive reactions
- dissociation

These reactions are not weakness or intentional behavior. They are survival responses produced by changes in the brain and nervous system.

1. HPA Axis Dysregulation

The HPA axis is the body's main stress-response system. It includes:

- **Hypothalamus**
- **Pituitary gland**
- **Adrenal glands**

During stress:

Hypothalamus releases CRH
↓
Pituitary gland releases ACTH
↓
Adrenal glands release cortisol

The HPA axis is responsible for helping the body respond to stress.

When the brain detects danger, the hypothalamus sends a chemical signal called CRH. This stimulates the pituitary gland to release ACTH. ACTH then stimulates the adrenal glands to release cortisol, which is known as the stress hormone.

Cortisol is useful in short-term danger because it helps the body survive. It increases energy, raises blood pressure, sharpens attention, and prepares the person for fight or flight.

But in trauma, especially chronic trauma, this system becomes overactivated.

The body keeps producing stress responses even when the danger is no longer present.

This leads to cortisol imbalance. In some people, cortisol remains high for long periods. In others, after prolonged stress, cortisol regulation becomes abnormal and may even become too low.

Both patterns can disturb:

- sleep
- immunity
- memory
- mood
- emotional regulation
- physical health

2. Amygdala Hyperactivation

The amygdala is the brain's danger detection system.

After trauma, the amygdala may become overactive, leading to:

- increased threat detection
- hypervigilance
- exaggerated startle response
- intense fear reactions

The amygdala is a small structure in the brain that detects threat and processes fear.

Its role is to answer one question: **“Am I safe or am I in danger?”**

After trauma, the amygdala becomes highly sensitive. It starts detecting danger too quickly and too strongly.

This means that neutral or harmless situations may be interpreted as threatening.

For example, a loud sound, a sudden movement, a strict tone of voice, or a locked door may activate a trauma survivor's fear response.

The person may suddenly become frightened, angry, defensive, or withdrawn.

This does not mean the person is overreacting deliberately. Their amygdala is reacting as if the old trauma is happening again.

3. Prefrontal Cortex Suppression

The prefrontal cortex is responsible for:

- reasoning
- decision-making
- impulse control
- emotional regulation
- problem-solving

During trauma or chronic stress, prefrontal cortex activity may be reduced.

The prefrontal cortex is the rational part of the brain. It helps the person think clearly, make decisions, control impulses, and regulate emotions.

When the person is calm, the prefrontal cortex helps control emotional reactions from the amygdala.

But during trauma or severe stress, the prefrontal cortex becomes less active.

This means the person may lose the ability to think logically or control reactions at that moment.

This explains why trauma survivors may:

- shout suddenly
- run away
- refuse treatment
- act impulsively
- have difficulty concentrating
- struggle to make decisions
- become emotionally overwhelmed

In simple words: **When the fear center becomes overactive, the thinking center becomes underactive.**

4. Hippocampal Changes

The hippocampus is important for:

- memory processing
- placing memories in time and context
- distinguishing past from present

Trauma may disturb hippocampal functioning.

The hippocampus helps organize memories and tells the brain: **“This happened in the past, not now.”**

In trauma, hippocampal functioning may be disturbed. This makes traumatic memories poorly organized and strongly emotional.

Instead of being stored as normal memories, traumatic memories may return as:

- flashbacks
- nightmares
- intrusive images
- body sensations
- emotional reactions

This is why trauma survivors may feel as if the traumatic event is happening again.

The person may know logically that they are safe, but emotionally and physically they feel they are back in the traumatic situation.

5. Autonomic Nervous System Dysregulation

Trauma affects the autonomic nervous system, especially:

- sympathetic nervous system
- parasympathetic nervous system

Trauma survivors may shift between:

- hyperarousal
- hypoarousal
- shutdown
- dissociation

The autonomic nervous system controls automatic body functions such as heart rate, breathing, digestion, sweating, and muscle tension.

<https://youtu.be/R-ZQPDglhDg?si=x0h5Z68Lht1MDM-D>

After trauma, this system may become dysregulated.

Some patients remain in a state of hyperarousal. This means their body is constantly activated and ready for danger.

They may show:

- rapid heartbeat
- tense muscles
- sweating
- irritability
- panic
- insomnia
- exaggerated startle response

Other patients may enter hypoarousal or shutdown. This happens when the body feels that fight or flight is impossible.

They may show:

- emotional numbness
- dissociation
- low energy
- flat affect
- feeling detached
- reduced responsiveness

So trauma does not always look like panic or aggression.

Sometimes trauma looks like silence, withdrawal, or emotional numbness.

II. Psychological and Emotional Consequences of trauma

Trauma significantly increases vulnerability to multiple psychiatric conditions.

1-Post-Traumatic Stress Disorder (PTSD)

2-Depressive Disorders

3-Anxiety Disorders

4-Dissociation

III. Behavioral Impact

1-Substance Use Disorders

2-Self-Harm and Suicidality

3-Aggression and Externalizing Behaviors

IV. Social and Functional Impairment

Trauma affects multiple domains of life functioning:

- Relationship instability
- Trust difficulties
- Social withdrawal
- Occupational dysfunction
- Academic impairment
-

Trauma-informed care

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and setting.(SAMHSA,2012).

Trauma-informed care is an approach that recognizes the prevalence of trauma, understands its impact, and seeks to avoid re-traumatization by embedding principles of safety, trust, collaboration, empowerment, and cultural sensitivity within services.(Sweeney et al. ,2018)

Importance of Trauma-Informed Care in Psychiatric Settings

Before discussing the importance of Trauma-Informed Care (TIC), we need to ask an important question:

Why should psychiatric professionals care about trauma?

Trauma is extremely common among individuals receiving psychiatric services. Many psychiatric patients have experienced childhood abuse, neglect, domestic violence, sexual assault, war, medical trauma, or other adverse life events.

Unfortunately, trauma is often hidden. Patients may not disclose it, may not remember it clearly, or may not realize that their current symptoms are related to past traumatic experiences.

As a result, if healthcare professionals focus only on psychiatric symptoms without considering trauma history, they may misunderstand patients, provide inappropriate treatment, and unintentionally retraumatize them.

Trauma-Informed Care changes the philosophy of care.

Instead of asking: "**What is wrong with this patient?**" we ask: "**What happened to this patient?**"

This shift improves assessment, communication, treatment planning, and recovery.

1. High Prevalence of Trauma in Psychiatric Populations

- Trauma exposure is extremely common among psychiatric patients.
- Approximately **75–98%** of psychiatric inpatients report lifetime trauma exposure.
- Up to **50%** of individuals with Severe Mental Illness (SMI) also meet criteria for PTSD.
- Trauma histories are frequently under-recognized and under-diagnosed.

One of the strongest reasons for implementing Trauma-Informed Care is the very high prevalence of trauma among psychiatric patients.

Research consistently shows that most individuals receiving psychiatric care have experienced at least one significant traumatic event during their lifetime.

These traumatic experiences may include:

- Childhood abuse
- Domestic violence
- Sexual assault
- War
- Neglect
- Medical trauma
- Emotional abuse

Many patients never tell healthcare professionals about these experiences.

- Sometimes they feel ashamed.
- Sometimes they are afraid.
- Sometimes they do not realize that their current symptoms are connected to earlier trauma.

As a result, trauma often remains undetected.

When trauma is not recognized, clinicians may diagnose only depression, anxiety, psychosis, or personality disorders without understanding the underlying cause.

Clinical Example

A patient is admitted with depression and repeated suicide attempts.

The healthcare team treats only the depression.

Months later, the patient does not improve.

Later, during psychotherapy, clinicians discover that the patient experienced severe childhood sexual abuse.

The depression was only part of the picture.

The unresolved trauma was driving many of the patient's symptoms.

Not every psychiatric patient has trauma, but because trauma is so common, clinicians should approach every patient with trauma awareness.

This is known as **Universal Trauma Precautions**.

2. Prevention of Re-traumatization

Psychiatric environments may unintentionally recreate traumatic experiences through:

- Seclusion
- Physical restraint
- Forced medication
- Locked units
- Power-based interactions

Trauma-Informed Care aims not only to treat trauma but also to prevent patients from experiencing trauma again while receiving care.

Many psychiatric interventions are necessary for safety. However, these same interventions may remind patients of previous traumatic experiences.

For example:

Imagine a patient who was physically restrained during childhood abuse. Later, during hospitalization, staff physically restrain the patient because of aggressive behavior. Although the intervention is clinically necessary, the patient's brain may interpret the restraint as another assault. Instead of calming down, the patient becomes even more frightened and aggressive.

This is called **re-traumatization**.

The patient is not simply reacting to the current situation. They are reliving the emotional experience of the previous trauma.

Trauma-Informed Care asks: **How can we maintain safety without unnecessarily recreating previous traumatic experiences?**

3. Reducing Coercive Practices

Trauma-Informed Care encourages safer alternatives such as:

- Verbal de-escalation
- Sensory modulation
- Collaborative safety planning
- Comfort rooms

Traditional psychiatric care often relied on coercive practices to manage aggressive or distressed patients.

Although these interventions may sometimes be necessary, they should never be the first option.

Trauma-Informed Care encourages staff to understand why the patient is distressed before using restrictive measures.

Instead of immediately controlling behavior, staff first attempt to reduce emotional arousal.

Common trauma-informed alternatives include:

Verbal De-escalation

Using calm communication to reduce fear and anger.

Sensory Modulation

Helping patients regulate emotions using sensory tools such as:

- weighted blankets
- calming music
- stress balls
- quiet rooms

Collaborative Safety Planning

Developing individualized plans with the patient before a crisis occurs.

Comfort Rooms

Providing safe environments where patients can calm themselves voluntarily.

Research has shown that implementing these approaches significantly reduces the use of restraint and seclusion.

4. Improved Therapeutic Alliance

Trauma often disrupts:

- Trust
- Attachment
- Emotional regulation

TIC strengthens therapeutic relationships through:

- Safety
- Transparency
- Collaboration
- Predictability
- Shared decision-making

Many trauma survivors have learned that people cannot be trusted.

Their traumatic experiences often involved caregivers, family members, partners, or authority figures.

As a result, psychiatric staff may initially be viewed as another source of danger.

Patients may appear:

- suspicious
- hostile
- withdrawn
- resistant

These behaviors are often protective survival strategies.

- Trauma-Informed Care helps rebuild trust.
- Healthcare professionals explain procedures before performing them.
- They ask permission whenever possible.
- They involve patients in treatment decisions.
- They maintain consistency.

Gradually, patients begin feeling safe enough to participate in treatment.

5. Improved Clinical Outcomes

Research shows that Trauma-Informed Care is associated with:

- Reduced PTSD symptoms
- Reduced anxiety
- Reduced depression
- Less self-harm
- Better treatment adherence
- Shorter hospitalization
- Lower staff injury rates

Trauma-Informed Care is not only compassionate.

- It is also evidence-based.
- Research demonstrates that psychiatric services using Trauma-Informed Care achieve better outcomes than services relying only on symptom management.
- Patients feel safer.
- They engage more actively in treatment.
- They trust staff.
- Aggression decreases.
- Self-harm decreases.
- Recovery improves.

An important point to emphasize is that:

Trauma-Informed Care does NOT replace trauma-specific therapies like EMDR or TF-CBT.

Instead, it creates the safe environment necessary for those therapies to be effective.

6. Reduction of Staff Burnout and Secondary Trauma

TIC also benefits healthcare professionals by reducing:

- Secondary traumatic stress
- Compassion fatigue
- Burnout

Trauma does not affect only patients. Mental health professionals repeatedly listen to stories of abuse, violence, suicide, and loss. Over time, this emotional exposure can affect nurses, psychologists, psychiatrists, and social workers.

Trauma-Informed organizations support staff by providing:

- education
- supervision
- reflective practice
- peer support
- debriefing after critical incidents

Healthy staff provide better patient care.

Core Principles of Trauma-Informed Care

After understanding why Trauma-Informed Care is important, the next question is:

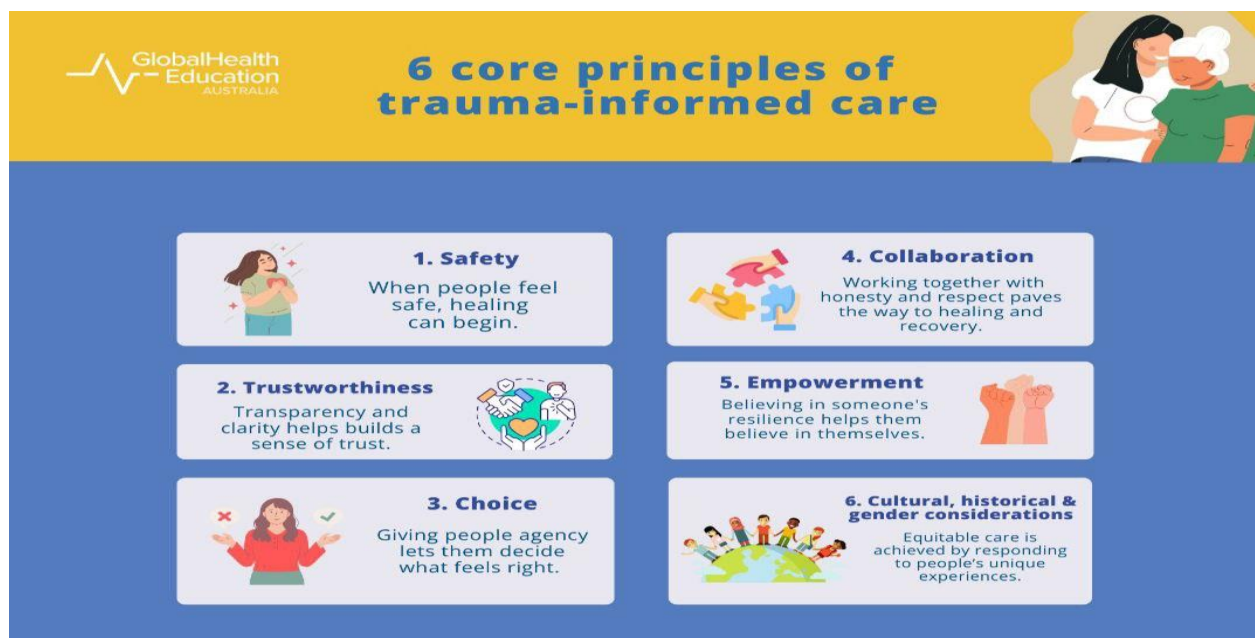
How do we actually practice Trauma-Informed Care?

Trauma-Informed Care is not a specific therapy or treatment technique. Instead, it is a philosophy or framework that guides every interaction between healthcare professionals and patients.

SAMHSA identified **six core principles** that should guide all trauma-informed services.

These principles help create an environment where patients feel safe, respected, empowered, and supported throughout their recovery.

will discuss each principle individually.



1. Safety

Safety refers to ensuring both:

- Physical safety
- Emotional (psychological) safety

for patients, families, and healthcare professionals.

Safety is the foundation of Trauma-Informed Care.

A person who has experienced trauma often lives in a constant state of fear or hypervigilance.

Even when no real danger exists, the brain continues searching for threats.

Therefore, before treatment can begin, patients must first feel safe.

Safety includes much more than preventing physical injury. It also means creating an environment where patients feel emotionally secure. Healthcare professionals should ask themselves:

- Does the patient feel respected?
- Does the patient feel heard?
- Does the patient feel protected?
- Does the patient believe that no one will harm them?

Only when patients feel safe can they begin to trust healthcare providers and actively participate in treatment.

Example

A psychiatric nurse enters the patient's room, knocks on the door, introduces herself, explains why she is there, and asks permission before beginning the assessment.

Although these actions appear simple, they increase the patient's sense of safety and control.

2. Trustworthiness and Transparency

Healthcare professionals should communicate openly, honestly, and consistently.

Patients should always understand:

- what will happen
- why it will happen
- who is involved
- what choices they have

Many trauma survivors have experienced betrayal, deception, manipulation, or broken trust.

As a result, they may expect authority figures to hide information or misuse power.

Trauma-Informed Care restores trust through transparency.

- Professionals should explain procedures before performing them.
- Avoid surprises whenever possible.
- Provide consistent information.
- Keep promises.
- Admit mistakes honestly.

Transparency reduces uncertainty, and reducing uncertainty decreases anxiety.

Example

Instead of saying: "Come with me."

The nurse says: "I would like to take you to the treatment room to check your blood pressure. It will only take a few minutes. After that, we'll return here."

The patient knows:

- what will happen
- why
- how long it will take

This increases trust.

3. Peer Support

Peer support involves people with lived experience helping others during recovery.

Examples:

- Peer support groups
- Recovery mentors
- Former patients sharing recovery experiences

Trauma survivors often believe that no one understands what they have experienced.

Meeting someone who has faced similar challenges provides hope.

Peer supporters are individuals who have experienced mental illness or trauma themselves and have progressed in recovery.

Because of their lived experience, they can connect with patients in a unique way.

Peer support:

- reduces isolation
- increases hope
- improves engagement
- encourages recovery

Example

A patient newly diagnosed with PTSD joins a support group.

Another member shares how therapy and coping strategies helped them regain control of their life.

The patient begins believing: "If they recovered, maybe I can recover too."

Sometimes patients believe another survivor before they believe a healthcare professional.

4. Collaboration and Mutuality

Patients and healthcare professionals work together as equal partners. Shared decision-making replaces authoritarian care. Trauma often involves losing control. Many survivors experienced situations where decisions were made for them.

Examples include:

- abuse
- neglect
- violence
- forced hospitalization

Trauma-Informed Care restores control through collaboration.

Instead of telling patients what they must do, professionals involve them in planning treatment.

This creates partnership rather than hierarchy.

Patients become active participants rather than passive recipients of care.

Example

Instead of saying: "This is your treatment plan." The nurse says: "Let's discuss your goals and decide together which treatment options fit your needs."

Collaboration increases motivation because patients are more likely to follow plans they helped create.

5. Empowerment, Voice, and Choice

Trauma-informed services encourage patients to:

- express their opinions
- make choices
- recognize strengths
- build confidence
- participate in recovery

Trauma often leaves survivors feeling powerless.

They may believe:

- "I have no control."
- "My opinions do not matter."
- "I cannot protect myself."

Trauma-Informed Care aims to reverse these beliefs. Healthcare professionals focus on strengths instead of deficits. Patients are encouraged to make decisions whenever possible. Even small choices matter.

For example:

- choosing appointment times
- choosing seating
- choosing coping strategies
- deciding who participates in meetings

These choices gradually rebuild autonomy and self-confidence. Empowerment does not mean giving patients unlimited control. It means maximizing choice whenever it is safe and appropriate.

6. Cultural, Historical, and Gender Sensitivity

Trauma should always be understood within the person's:

- culture
- gender
- religion
- ethnicity
- historical experiences
- social background

Trauma does not occur in isolation. People interpret traumatic experiences differently depending on their cultural background. The same event may carry different meanings in different cultures. Healthcare professionals must avoid assumptions. Instead, they should ask respectful questions and remain culturally humble.

Patients should never feel judged because of:

- religion
- ethnicity
- language
- gender identity
- socioeconomic status

Trauma-informed care recognizes that discrimination, racism, poverty, and social inequality may themselves be sources of trauma.

Example

A refugee patient refuses eye contact during assessment.

Rather than interpreting this as resistance or poor communication, the nurse considers possible cultural norms and previous traumatic experiences before making conclusions.

Cultural competence means learning about different cultures.

Cultural humility means recognizing that every patient is the expert on their own experience.

Trauma-Informed Care vs Trauma-Specific Care

Aspect	Trauma-Informed Care (TIC)	Trauma-Specific Care (TSC)
Definition	An organizational and clinical framework that recognizes the widespread impact of trauma and integrates this awareness into all aspects of service delivery	Evidence-based clinical treatments specifically designed to address trauma-related symptoms or PTSD
Primary Focus	Preventing re-traumatization and creating safe environments	Direct treatment of trauma symptoms

Scope	System-wide (policies, culture, environment, staff training)	Individual therapeutic intervention
Target Population	All service users (universal precautions approach)	Individuals diagnosed with trauma-related disorders
Goal	Safety, empowerment, collaboration, trust	Symptom reduction and trauma processing

Trauma-informed therapy

Trauma-informed therapy is a therapeutic approach that recognizes and understands the pervasive nature and impact of trauma (Evans & Coccoma, 2014). It emphasizes the physical, psychological, and emotional safety of the client and helps survivors rebuild a sense of control and empowerment.

The main goal is not only to reduce trauma symptoms but also to help individuals **regain control, develop resilience, and rebuild trust in relationships**. (Black et al., 2012).

Now that we understand Trauma-Informed Care as an organizational approach, let's move to Trauma-Informed Therapy. Although the names sound similar, they are not identical.

Trauma-Informed Therapy is a **clinical therapeutic approach** used during psychotherapy.

Its purpose is to help trauma survivors heal in a safe and supportive therapeutic relationship.

Unlike traditional therapy, Trauma-Informed Therapy begins with one important assumption:

Many emotional and behavioral problems may be rooted in trauma.

Therefore, therapists do not immediately focus on symptoms. Instead, they first try to understand how traumatic experiences have shaped the person's current thoughts, emotions, behaviors, and relationships.

Philosophy of Trauma-Informed Therapy

One of the biggest changes introduced by Trauma-Informed Therapy is changing the clinician's perspective. Traditional thinking often asks: "**What is wrong with you?**" This question assumes the patient is the problem. Trauma-Informed Therapy asks instead: "**What happened to you?**" This question

encourages understanding rather than judgment. Instead of labeling behaviors as abnormal, therapists explore how those behaviors may have developed as survival strategies.

Goals of Trauma-Informed Therapy

The major goals include:

- Establishing safety
- Building trust
- Emotional regulation
- Developing healthy coping skills
- Processing traumatic experiences safely
- Promoting resilience
- Restoring empowerment

Major Trauma Therapy Techniques

1. Internal Family Systems (IFS)

Internal Family Systems (IFS) is a psychotherapy approach developed by **Richard Schwartz**. It views the human mind as consisting of different internal "parts," each with its own emotions, beliefs, and roles. Instead of seeing these parts as pathological, IFS considers them protective adaptations that developed in response to life experiences, including trauma.

IFS suggests that we all have multiple internal parts. These parts are not separate personalities. Instead, they are different aspects of ourselves.

For example, after trauma, one part may become fearful to protect us from danger. Another part may become angry to defend us. Another part may avoid relationships to prevent future pain.

The goal of therapy is not to eliminate these parts but to understand their protective roles and restore balance among them.

At the center of every person is the **Self**, which represents calmness, compassion, confidence, curiosity, and wisdom.

Healing occurs when the Self learns to lead these different parts rather than allowing fearful or protective parts to dominate.

2. Polyvagal-Based Techniques

Polyvagal Theory was developed by **Dr. Stephen Porges**. It explains how trauma affects the autonomic nervous system. Polyvagal-based therapy focuses on helping individuals regulate their nervous system rather than only changing thoughts. Trauma is not stored only in memories. It is also stored in the nervous system. Many trauma survivors remain in one of three physiological states:

Safe State (Ventral Vagal)

The person feels calm, connected, and socially engaged.

Fight or Flight (Sympathetic Activation)

The person experiences:

- anxiety
- panic
- hypervigilance
- anger
- rapid heartbeat

Shutdown (Dorsal Vagal)

The person experiences:

- emotional numbness
- dissociation
- exhaustion
- withdrawal

Polyvagal therapy teaches patients how to move back toward the safe state.

Techniques

- Grounding
- Breathing exercises
- Mindfulness
- Body awareness
- Gentle movement
- Relaxation

3. Attachment-Based Therapy

Attachment-Based Therapy focuses on how early caregiver-child relationships influence emotional development, attachment patterns, and later relationships.

Attachment theory was developed by **John Bowlby** and later expanded by **Mary Ainsworth**.

According to Attachment Theory, the relationship between an infant and the primary caregiver forms the foundation for emotional development. When caregivers consistently respond to the child's needs, the child develops a sense of safety and trust.

This is called **Secure Attachment**.

However, when caregivers are neglectful, inconsistent, or abusive, children may develop insecure attachment styles. These attachment patterns often continue into adulthood and influence romantic relationships, friendships, and therapeutic relationships.

Attachment Styles

Secure Attachment

The person trusts others, Comfortable with intimacy, Healthy emotional regulation.

Avoidant Attachment

Avoids closeness, Values independence, Suppresses emotions.

Ambivalent (Resistant) Attachment

Fear of abandonment, Needs constant reassurance, Emotionally dependent.

Disorganized Attachment

Common after severe childhood trauma, Mixed approach-avoidance behaviors, Difficulty trusting anyone, Often associated with complex trauma.

4. EMDR (Eye Movement Desensitization and Reprocessing)

EMDR is an evidence-based psychotherapy developed by **Francine Shapiro**. It helps patients process traumatic memories using bilateral stimulation.

Normally, the brain stores memories in an organized way. Traumatic memories often remain "stuck." They continue triggering fear as though the event is still happening.

During EMDR, the patient recalls traumatic memories while simultaneously following bilateral stimulation, usually through eye movements.

Other forms include:

- alternating taps
- alternating sounds

This process helps the brain reprocess the traumatic memory, reducing its emotional intensity.

Importantly, EMDR does **not erase memories**. The patient still remembers the event, but it no longer produces overwhelming emotional distress.

5. Dialectical Behavior Therapy (DBT)

DBT was developed by **Marsha Linehan**. Originally for Borderline Personality Disorder, it is now widely used for trauma survivors with emotional dysregulation.

Four Main Skills

Emotional Regulation: Learning to understand and manage emotions.

Distress Tolerance: Learning healthy ways to survive emotional crises without harmful behaviors.

Mindfulness: Remaining aware of the present moment.

Interpersonal Effectiveness: Building healthy relationships while maintaining self-respect.

6. Somatic Experiencing

Somatic Experiencing was developed by **Peter Levine**. It focuses on the body's role in trauma recovery.

Trauma affects not only the mind, but also the body. Many trauma survivors carry chronic muscle tension, rapid breathing, and nervous system dysregulation. Somatic Experiencing helps patients notice body sensations, release physical tension, and restore nervous system balance.

7. Trauma-Focused CBT (TF-CBT)

TF-CBT is a specialized form of Cognitive Behavioral Therapy designed specifically for trauma.

It is particularly effective for children and adolescents.

TF-CBT combines:

- psychoeducation
- cognitive restructuring
- gradual exposure
- coping skills
- parent involvement

The therapist helps patients identify distorted beliefs caused by trauma.

8. Accelerated Experiential Dynamic Psychotherapy (AEDP)

AEDP emphasizes emotional processing and the healing power of the therapeutic relationship.

AEDP believes that trauma often blocks healthy emotional processing.

The therapist creates a highly supportive relationship where patients safely experience,

process, and transform painful emotions. Rather than avoiding emotions, patients learn that emotions can be experienced safely.

9. Psychedelic-Assisted Therapy

Psychedelic-Assisted Therapy is an emerging area of trauma treatment currently being studied.

Under carefully controlled medical supervision,

substances such as:

- MDMA
- Psilocybin

are combined with psychotherapy.

Current research suggests these substances may reduce fear,increase emotional openness,

and help patients process traumatic memories. However,this treatment remains highly regulated,

is not considered routine clinical practice,and should only be performed within approved medical and research settings.

Summary Table

Therapy	Main Focus	Best Used For
IFS	Internal parts and self-leadership	Complex trauma
Polyvagal Therapy	Nervous system regulation	Hyperarousal, anxiety, dissociation
Attachment-Based Therapy	Early relationships	Childhood trauma, attachment disorders
EMDR	Reprocessing traumatic memories	PTSD
DBT	Emotional regulation and coping skills	Emotional dysregulation, self-harm
Somatic Experiencing	Body awareness and tension release	Stored physical trauma responses
TF-CBT	Thoughts, emotions, and behaviors	Children, adolescents, PTSD
AEDP	Emotional processing	Relational trauma and emotional healing

Psychedelic-Assisted Therapy	Assisted trauma processing	Experimental treatment for complex trauma
------------------------------	----------------------------	---

The Role of Mental Health Nurses in Trauma-Informed Care

1. Screening and Assessment

- Sensitive inquiry about trauma history.
- Recognize trauma-related symptoms.
- Avoid re-traumatization during assessment.

Assessment is usually the first contact between the nurse and the patient. This first interaction determines whether the patient feels safe enough to trust the healthcare team. Many trauma survivors are reluctant to disclose traumatic experiences. Some feel ashamed, Some fear being judged, Others have never told anyone about their trauma, Therefore, nurses should never force disclosure. Instead, they should create an atmosphere where patients feel safe enough to share their experiences if they choose.

Questions should be asked gently, respectfully, and only when clinically appropriate.

The goal is **not to collect traumatic stories** and to understand how trauma may influence the patient's current health.

The nurse should never pressure the patient to discuss traumatic memories before trust has been established.

2. Creating a Safe Environment

- Physical safety
- Psychological safety
- Minimize triggers
- Maintain privacy
- Calm, respectful communication

Trauma survivors constantly monitor their surroundings for danger. Even ordinary hospital routines may remind them of previous traumatic experiences. Therefore, nurses should create an environment that promotes safety rather than fear.

Safety includes:

Physical safety

- clean environment
- adequate lighting
- secure surroundings

Psychological safety

- respect
- confidentiality
- predictability
- emotional support

Nurses should identify possible trauma triggers.

Triggers may include:

- loud voices
- sudden touch
- locked doors
- uniforms
- male authority figures
- certain smells

Reducing unnecessary triggers helps prevent emotional distress.

3. Supporting Emotional Regulation

Teach patients:

- Grounding techniques
- Distress tolerance
- Breathing exercises
- Mindfulness
- Healthy coping strategies

Many trauma survivors struggle to regulate emotions, Small stressors may trigger overwhelming fear, anger, or panic. Mental health nurses help patients learn practical strategies to regain emotional control. These techniques do not eliminate trauma. They reduce physiological arousal so the patient can think more clearly.

Common interventions include:

Grounding: Helping patients reconnect with the present moment.

Example: The 5-4-3-2-1 grounding exercise.

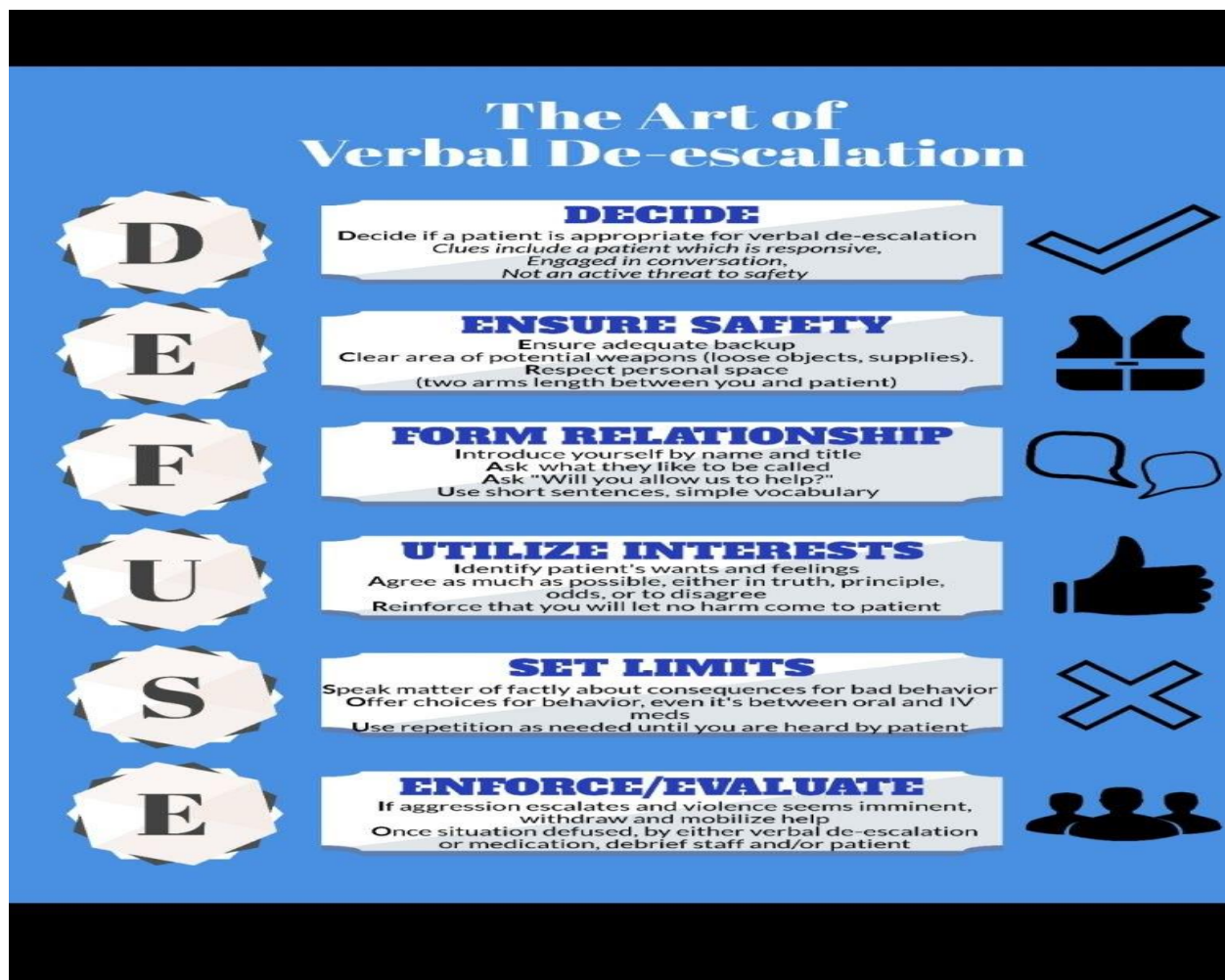
Breathing exercises: Slow diaphragmatic breathing activates the parasympathetic nervous system.

Mindfulness: Helping patients observe thoughts without reacting automatically.

Healthy coping: Replacing harmful coping behaviors such as self-harm or substance use with healthier alternatives.

4. De-escalation and Crisis Intervention

- View aggression as a trauma response.
- Use verbal de-escalation.
- Therapeutic communication.
- Use medication only when necessary.



Aggression is not always intentional. Sometimes aggression is a survival response. The patient's brain may perceive danger where none exists. Therefore, before responding with force, the nurse should first ask: **What is making this patient feel unsafe?**

Verbal de-escalation includes:

- speaking slowly
- maintaining calm body language
- allowing personal space
- listening actively
- validating emotions

Medication and restraint should be reserved for situations where less restrictive interventions have failed.

5. Advocacy and Collaboration

- Promote empowerment.
- Protect patient rights.
- Involve families.
- Collaborate with the multidisciplinary team.

Trauma often leaves survivors feeling powerless. Mental health nurses help restore autonomy by advocating for patient rights.

Advocacy includes:

- respecting patient preferences
- involving patients in decisions
- ensuring informed consent
- supporting dignity
- encouraging independence

Whenever appropriate, families should also be involved. Family education improves understanding and supports recovery. Nurses also collaborate with psychiatrists, psychologists, social workers, occupational therapists, and peer supporters. Trauma recovery is a team effort.

Implementation Strategies for PMHNPs

Psychiatric Mental Health Nurse Practitioners (PMHNPs) have a broader role than bedside nurses. In addition to direct patient care, they lead trauma-informed practice, educate staff, develop policies, and improve healthcare systems.

A. Implementing Trauma-Informed Practice

Screening and Assessment

PMHNPs should routinely assess trauma history using validated tools.

Examples include:

- ACE Questionnaire
- Trauma Screening Questionnaire (TSQ)

However, screening should always be conducted respectfully and with patient consent.

Environment Adaptation

PMHNPs help create environments that reduce stress.

Examples include:

- private interview rooms
- reduced noise
- comfortable seating
- calming colors
- sensory rooms

Patient Engagement

PMHNPs establish therapeutic alliance through:

- empathy
- active listening
- collaboration
- shared decision-making

B. Avoiding Re-traumatization

One of the PMHNP's greatest responsibilities is preventing unnecessary trauma during treatment.

Simple actions make a huge difference.

Avoid:

- touching patients without permission
- sudden movements
- shouting
- unnecessary restraint
- power struggles

Instead, always explain procedures, ask permission, and respect personal boundaries.

Trauma-Informed Language

Instead of saying: "**Why are you behaving like this?**" say: "**What happened to you?**" or "**Can you help me understand what you're feeling right now?**" This shift encourages empathy rather than judgment.

C. Cultural Humility and Intersectional Trauma

Trauma does not affect everyone in the same way. Race, culture, religion, gender, sexual identity, poverty, and discrimination all influence trauma experiences. PMHNPs should never assume that they fully understand another person's experience. Instead, they practice cultural humility by remaining curious, respectful, and open to learning from each patient.

D. Training, Supervision, and System-Level Support

Staff Training

PMHNPs educate staff on:

- trauma awareness
- grounding
- de-escalation
- crisis intervention

Education should be continuous, not a one-time event.

Supervision

Regular supervision allows staff to:

- discuss difficult cases
- process emotional reactions
- prevent burnout
- reduce secondary trauma

System-Level Support

Trauma-informed care succeeds only when the entire organization supports it.

PMHNPs help develop:

- trauma-informed policies
- least restrictive interventions
- staff wellness programs
- patient-centered environments

Summary

Trauma is increasingly recognized as one of the most significant public health challenges because of its profound and long-lasting effects on mental health, physical health, interpersonal relationships, and overall quality of life. Rather than being defined solely by a distressing event, trauma refers to the lasting psychological, biological, emotional, social, and spiritual consequences that occur when an individual experiences events that overwhelm their ability to cope.

Traumatic experiences may occur as **acute, chronic, complex, developmental, secondary (vicarious), or medical trauma**, each differing in duration, developmental timing, and mechanism of exposure. Importantly, exposure to the same traumatic event does not produce identical outcomes in every individual. Biological vulnerability, previous life experiences, resilience, family support, coping skills, and environmental factors all influence how trauma is experienced and processed.

One of the most important concepts presented in this lecture is that trauma produces measurable neurobiological changes. Chronic trauma dysregulates the **Hypothalamic–Pituitary–Adrenal (HPA) axis**, resulting in abnormal cortisol regulation and persistent activation of the body's stress-response system. At the same time, the **amygdala becomes hyperactive**, increasing fear responses and hypervigilance, while the **prefrontal cortex becomes less active**, reducing emotional regulation, decision-making, and impulse control. Trauma also affects the **hippocampus**, impairing memory processing and making traumatic memories feel as though they are occurring in the present rather than the past. These neurobiological alterations explain why trauma survivors frequently experience PTSD, depression, anxiety disorders, dissociation, substance use disorders, emotional dysregulation, and maladaptive behavioral responses.

The lecture emphasizes that psychiatric symptoms should not always be interpreted as manifestations of mental illness alone. Many behaviors observed in psychiatric settings—including aggression, withdrawal, emotional dysregulation, avoidance, and treatment refusal—may represent adaptive survival responses developed following traumatic experiences. This understanding forms the foundation of **Trauma-Informed Care (TIC)**.

Trauma-Informed Care is not a specific psychotherapy but an organizational and clinical framework that recognizes the widespread prevalence of trauma, understands its impact on health and behavior, and seeks to prevent re-traumatization throughout all aspects of healthcare delivery. Rather than asking "**What is wrong with you?**", trauma-informed practice encourages clinicians to ask "**What happened to you?**", thereby shifting the focus from pathology to understanding, compassion, and recovery.

The implementation of Trauma-Informed Care is especially important in psychiatric settings because trauma exposure is extremely common among individuals receiving mental health services. Failure to recognize trauma histories may result in misdiagnosis, inappropriate treatment, coercive interventions, poor therapeutic relationships, and re-traumatization. Research demonstrates that trauma-informed psychiatric services improve patient engagement, reduce the use of restraint and seclusion, decrease PTSD and depressive symptoms, reduce self-harm, improve treatment adherence, shorten hospital stays, and simultaneously reduce burnout and secondary traumatic stress among healthcare professionals.

The practical application of Trauma-Informed Care is guided by six core principles established by SAMHSA: **Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment with Voice and Choice, and Cultural, Historical, and Gender Sensitivity**. These principles create therapeutic environments in which patients feel respected, emotionally secure, actively involved in decision-making, and empowered throughout their recovery journey.

Although Trauma-Informed Care establishes the therapeutic environment, recovery from trauma frequently requires evidence-based psychotherapeutic interventions. The lecture reviewed several major trauma therapies, including **Internal Family Systems (IFS), Polyvagal-Based Therapy, Attachment-Based Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy (DBT), Somatic Experiencing, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Accelerated Experiential Dynamic Psychotherapy (AEDP), and Psychedelic-Assisted Therapy**. Each therapy addresses trauma from a different perspective, focusing on cognitive restructuring, emotional regulation, nervous system stabilization, attachment repair, body awareness, or trauma processing.

Mental health nurses play a central role in translating trauma-informed principles into everyday psychiatric practice. Their responsibilities include conducting trauma-sensitive assessments, recognizing trauma-related symptoms, creating physically and psychologically safe environments, teaching grounding and emotional regulation techniques, implementing verbal de-escalation strategies, advocating for patient autonomy, collaborating with multidisciplinary teams, and involving families in recovery whenever appropriate. Psychiatric Mental Health Nurse Practitioners (PMHNPs) extend these responsibilities through advanced assessment, medication management using a trauma-informed perspective, implementation of evidence-based trauma interventions, leadership in organizational policy development, staff education, supervision, and the promotion of trauma-informed healthcare systems.

Ultimately, Trauma-Informed Care represents a fundamental paradigm shift in psychiatric practice. Rather than viewing patients through the lens of pathology, it recognizes that many psychiatric symptoms are understandable adaptations to overwhelming experiences. By integrating trauma awareness into assessment, communication, treatment planning, organizational culture, and professional education, Trauma-Informed Care promotes safer, more compassionate, and more effective psychiatric services while supporting both patient recovery and healthcare professional well-being.

References

- Ashcraft, L., & Anthony, W. A. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services*, 59(10), 1198–1202.
<https://doi.org/10.1176/ps.2008.59.10.1198>
- Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. (2011). Effectiveness of six core strategies based on trauma-informed care in reducing seclusion and restraint at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, 24(1), 11–15. <https://doi.org/10.1111/j.1744-6171.2010.00262.x>

- Berring, L. L., Holm, T., Hansen, J. P., Delcomyn, C. L., Søndergaard, R., & Hvidhjelm, J. (2024). Implementing trauma-informed care—Settings, definitions, interventions, measures, and implementation across settings: A scoping review. *Healthcare*, 12(9), 908. <https://doi.org/10.3390/healthcare12090908>
- Harris, M., & Fallot, R. D. (2001). *Using trauma theory to design service systems*. Jossey-Bass.
- Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80–100.
- Khalifeh, H., Oram, S., Trevillion, K., Johnson, S., & Howard, L. M. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological Medicine*, 45(4), 875–886. <https://doi.org/10.1017/S0033291714001962>
- Mauritz, M. W., Goossens, P. J., Draijer, N., & van Achterberg, T. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, 4, 19985. <https://doi.org/10.3402/eipt.v4i0.19985>
- Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 23(1), 51–59. <https://doi.org/10.1111/inm.12012>
- Nikopaschos, F., Gibbons, O., Bailey, E., Foxall, A., Giachero, C., & Burrell, G. (2025). Trauma-informed care on mental health wards: Staff and service user perspectives. *Frontiers in Psychology*, 16, 1578821. <https://doi.org/10.3389/fpsyg.2025.1578821>