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Trauma-Informed Care and the Reformation of Restrictive Interventions: An Advanced Nursing Perspective

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ABSTRACT
Despite growing knowledge of their detrimental consequences, restrictive measures including physical restraint, isolation, and pharmaceutical restriction are still widely used in nursing practice in psychiatric, emergency, pediatric, and critical care settings. While these measures are frequently justified as necessary to ensure the immediate safety of patients and healthcare workers, mounting evidence suggests that they can exacerbate psychological trauma, jeopardize therapeutic relationships, and violate professional nursing values such as dignity, autonomy, and advocacy. Trauma-Informed Care (TIC), as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a transformative framework that questions traditional approaches to behavioral management by framing challenging behaviors as adaptive responses to trauma rather than willful defiance. Despite growing knowledge of their detrimental consequences, restrictive measures such as physical restraint, isolation, and pharmaceutical restraint are still widely used in nursing practice in psychiatric, emergency, pediatric, and critical care units. While these measures are frequently justified as necessary to ensure the immediate safety of patients and healthcare workers, growing evidence suggests that they can exacerbate psychological trauma, jeopardize therapeutic relationships, and contradict professional nursing values such as dignity, autonomy, and advocacy. Trauma-Informed Care (TIC), as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a transformative framework that challenges traditional approaches to behavioral management by viewing challenging behaviors as adaptive responses to trauma rather than willful defiance. Reforming restrictive therapies based on trauma-informed principles is more than just a clinical adjustment; it is an ethical and professional necessity. Nurses may move beyond coercion to a style of care that actually supports recovery, fosters trust, and preserves human dignity by incorporating safety, compassion, and respect for autonomy into their daily practices.

KEYWORDS: *Trauma-Informed Care, Restrictive Interventions, Nursing Practice, Restraint Minimization, Advanced Practice Nursing, Patient Safety, Ethical Care*

INTRODUCTION

Restrictive measures including physical restraint, isolation, and pharmacological restriction are still heavily debated in contemporary nursing practice. While they are frequently explained as required for patient or staff safety, research suggests that their use can perpetuate trauma cycles, undermine therapeutic trust, and contradict nursing ideals of dignity and autonomy. Patients commonly perceive being restrained as a very upsetting and traumatic event, reactivating previous trauma experiences and resulting in long-term psychological repercussions such as intrusive memories and nightmares (1). Restrictive methods also harm therapeutic relationships, as patients report distancing from staff after restraint events, with trust only partially restored when staff engage in open conversation and emotional processing (2). Nurses, on the other hand, describe emotions of moral discomfort, dread, and blame while using restraints, and many are concerned about their capacity to maintain safety without these measures, especially in high-risk clinical contexts (3).

Trauma-Informed Care (TIC) provides an alternative framework that recognizes trauma's extensive impact, actively seeks to prevent re-traumatization, and promotes safe, trusting, and collaborative

workplaces. Training in TIC has been proven to provide nurses with a better grasp of the psychological and physiological aspects of trauma, boost their confidence in de-escalation tactics, and contribute to a reduction in the use of restrictive policies in psychiatric and emergency settings (4). Thorough assessments show that successful TIC implementation involves more than just education; it also relies on organizational preparation, leadership commitment, and cultural change to assure sustainability (5). In this environment, advanced nursing roles, including education, policy advocacy, and clinical leadership, are crucial in changing procedures to provide safer and more compassionate care.

UNDERSTANDING RESTRICTIVE INTERVENTIONS IN NURSING

Restrictive techniques have long been used in nursing practice to control behavior and ensure safety in clinical settings. These practices include physical restraint, which involves holding or mechanically immobilizing patients; seclusion, which involves the involuntary confinement of a patient in a designated space; and chemical restraint, which is defined as the administration of psychotropic medications with the primary goal of controlling behavior rather than treating underlying medical or psychiatric conditions (6).

While such treatments are generally characterized as essential responses to an urgent risk of harm to patients or others, their usage is hotly debated since they violate key ethical concepts such as autonomy, beneficence, and nonmaleficence. Despite continuous global attempts to limit their use, restrictive practices are nevertheless common in mental health, emergency, pediatric, and critical care settings. International surveys show wide variation in prevalence, with some mental institutions reporting rates as high as 20-50% of inpatients suffering restraint or isolation during admission (7). Mechanically ventilated patients are commonly confined in critical care to prevent unplanned extubating, whereas clinicians in pediatric and emergency departments frequently use restraint to control acute agitation or violent behavior (8,9). Multiple contextual variables contribute to the longevity of such practices, including organizational culture, risk perceptions among employees, a lack of training in de-escalation strategies, and insufficient staffing levels, which limit alternatives to restrictive measures (10). This fact highlights the conflict between policy directives aiming for restraint minimization and the clinical realities that justify their usage.

The repercussions of restricted therapies are becoming recognized as clinical and ethical issues. Restraint and seclusion have been shown in studies to cause severe psychological harm, especially in individuals with prior trauma histories, by reactivating memories of violence, loss of control, or abuse. Such experiences frequently cause anxiety, anger, embarrassment, and a breakdown in therapeutic trust, which can lead to disengagement from care or avoidance of future health services (11,12). Physical hazards are also well-documented, ranging from small injuries like bruises to serious results like respiratory failure, aspiration, and, in rare cases, death from positional asphyxia (13). Restrictive therapies create serious ethical concerns because they undermine patient autonomy and dignity, and their continuous use has been criticized as incompatible with human rights frameworks that prioritize least-restrictive care and patient-centered methods (14).

When considered collectively, the use of restrictive treatments in nursing provides a difficult clinical, ethical, and organizational dilemma. While designed to maintain safety, their negative implications for both patients and practitioners necessitate critical thought and reform. This conflict serves as the cornerstone for trauma-informed care, which aims to reduce coercion while prioritizing healing connections.

PRINCIPLES FRAMEWORK OF TRAUMA-INFORMED CARE

The Substance Abuse and Mental Health Services Administration (SAMHSA) has helped shape today's knowledge of Trauma-Informed Care (TIC). In its key guideline report, SAMHSA (2014) defined TIC as an organizational framework that incorporates trauma awareness into all elements of service delivery, including policies, clinical procedures, and interpersonal connections (15). This approach symbolizes a paradigm change in healthcare, moving away from the traditional question "What is wrong with you?" and toward the more compassionate and context-sensitive inquiry "What has happened to you?" (16). The framework is based on two essential components: the "Four Rs" and the "Six Key Principles." These factors work together to create a philosophical framework as well as an operational blueprint for incorporating trauma sensitivity into nursing and broader health systems.

The "Four Rs" define the fundamental concepts underlying a trauma-informed approach. First, healthcare providers must recognize the pervasive impact of trauma and grasp the various paths to recovery. Second, they must detect the signs and symptoms of trauma, not just in patients but also in their families, workers,

and communities, as trauma can emerge in numerous domains of health and behavior. Third, clinicians are expected to respond by systematically incorporating trauma knowledge into policies, processes, and practices, ensuring that awareness permeates all levels of care delivery. Finally, organizations work to prevent re-traumatization by intentionally avoiding activities that may cause distress or recreate components of previous traumatic experiences, such as coercion or restraint (15,17). These principles promote a shift in professional attitudes and institutional cultures toward prevention, compassion, and resilience.

The "Six Key Principles" that serve as operational guides for trauma-informed systems of care supplement these assumptions. The first principle is safety, which focuses on establishing surroundings that are both physically and emotionally safe for patients and workers. The second pillar is trustworthiness and transparency, which necessitates constant, clear, and open communication in order to promote reliability and predictability in care relationships. Peer support is the third principle, emphasizing the importance of lived experiences in facilitating recovery and creating trust. The fourth concept, collaboration and mutuality, aims to flatten hierarchical systems by enabling shared decision-making among clinicians and patients. The fifth principle emphasizes empowerment, voice, and choice, which entails acknowledging patients' strengths, restoring autonomy, and encouraging self-direction. Finally, the idea of cultural, historical, and gender sensitivity emphasizes the need of recognizing systematic disparities and adapting care to individuals and communities' different needs (15,18).

In nursing practice, SAMHSA's concept is directly applicable to efforts to reduce coercion and promote alternatives to restrictive measures. Nurses who employ the Four Rs and Six Principles are better able to perceive problematic behaviors as adaptive reactions to trauma rather than purposeful noncompliance. This viewpoint encourages the use of de-escalation tactics, therapeutic communication, and tailored care planning instead of restrictive measures. Furthermore, trauma-informed nursing environments promote respect, empowerment, and recovery-oriented care, which is consistent with the profession's ethical values of dignity, autonomy, and advocacy. Evidence from implementation studies shows that implementing trauma-informed concepts in psychiatric and acute care facilities not only reduces the need for restraints and isolation, but also improves staff satisfaction, therapeutic interactions, and overall patient outcomes.

TRAUMA-INFORMED REFORMATION OF RESTRICTIVE PRACTICES

One of the most important contributions of trauma-informed care (TIC) to mental health and nursing practice is the rethinking of restrictive techniques like seclusion and physical restraints. Traditionally, these procedures have been rationalized as necessary to ensure patient safety in high-risk healthcare settings. However, TIC undermines this paradigm by focusing on collaboration rather than control. Within this perspective, actions that are commonly seen as disruptive or violent are reinterpreted as adaptive responses to earlier trauma rather than intentional acts of defiance (21). This shift in viewpoint encourages nurses to prioritize therapeutic conversation, negotiation, and de-escalation tactics over forceful measures, opening up opportunities for relational rather than combative care (22).

Instead of restrictive interventions, TIC advocates a wide range of evidence-based alternatives that prioritize rehabilitation, autonomy, and patient dignity. Advanced practice nurses, in particular, are well-suited to lead the implementation of such initiatives. Sensory modulation therapies, such as quiet rooms, weighted blankets, and soothing sensory inputs, have been demonstrated to reduce agitation and enhance self-regulation (23). Similarly, mindfulness training and therapeutic engagement strategies improve patients' coping skills, lowering the risk of escalation (24). Individualized crisis prevention and safety plans, designed in collaboration with patients, allow for more proactive distress treatment by identifying and addressing possible triggers before they progress into catastrophic episodes (25). These measures not only lessen the need for restraint, but they also match with nursing's ethical responsibility to maintaining dignity and autonomy.

Institutional reform is critical for sustaining trauma-informed approaches to restrictive behaviors. This involves incorporating TIC concepts into organizational rules, requiring staff training in de-escalation and trauma-sensitive care, and establishing uniform documentation processes to track both the use and reduction of restraint (26). Leadership commitment is especially important since corporate culture has a considerable impact on whether restriction minimization becomes a long-term norm or a one-time activity (27). Advanced nurse leaders play an important role in lobbying for policy reforms that limit forceful interventions and encourage system-wide adoption of trauma-informed principles, therefore cementing these values in the structural fabric of healthcare organizations.

Globally, there is growing support for restraint-free efforts that reflect both ethical imperatives and international human rights standards. Many countries are aligning their mental health policies with frameworks like the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which expressly prohibits the use of forceful interventions (28). Nursing voices are essential to this movement since nurses make up the majority of the mental health workforce and are frequently at the forefront of decisions about the use of restriction. Nurses who use trauma-informed techniques not only help to reduce restrictive practices, but they also fight for systemic changes that value human dignity, healing, and equity in mental health care (29).

BARRIERS AND CHALLENGES

Globally, there is an increasing push for restraint-free programs that respect both ethical imperatives and international human rights standards. Many countries are aligning their mental health care policies with frameworks like the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which clearly prohibits forceful interventions (28). Nursing voices are important in this movement since nurses make up the majority of the mental health workforce and are frequently at the forefront of decisions about the use of restraint. Nurses who embrace trauma-informed approaches not only help to reduce restrictive practices, but also fight for systemic changes that value human dignity, healing, and equity in mental health care (29).

Risk perceptions greatly influence nursing decisions. Many nurses, particularly in psychiatric and emergency settings, are concerned that eliminating restrictive measures will expose them and their coworkers to violence or legal consequences. This perceived vulnerability might lead to dependence on coercive techniques, particularly when organizational support for restraint minimization is limited (32).

Finally, legal and ethical tensions present persistent obstacles. Nurses must strike a delicate balance between patient autonomy and their responsibility of care and safety, which is frequently scrutinized by regulatory and judicial systems. When restrictive measures are used, personnel may feel morally distressed, especially if they believe they have violated trauma-informed care guidelines. This emphasizes the importance of clearer policies, supporting leadership, and shared accountability frameworks in successfully navigating these dilemmas (33).

IMPLICATIONS FOR ADVANCED NURSING PRACTICE

Advanced practice nurses (APNs) are especially qualified to bridge the gap between trauma-informed ideals and actual practice. Their clinical leadership allows them to model TIC concepts during crisis management, demonstrating in practice how communication, negotiation, and empathy can de-escalate many high-risk situations without using force. This not only protects patients from re-traumatization, but also allows colleagues to reinvent what safe treatment looks like (34).

Education and training are another important domain. APNs can help to increase workforce capacity by adding simulation-based learning, organized de-escalation training, and reflective practice into professional development programs. These techniques not only improve abilities, but also boost staff confidence in implementing restraint-free interventions (35).

Nurse researchers in advanced practice jobs play an important role in creating evidence. Evaluating the outcomes of TIC-driven reforms—such as reduced restraint episodes, increased patient satisfaction, and improved staff well-being—provides the evidence required to establish best-practice standards and justify organizational investment (36).

Finally, APNs are crucial advocates for policy reform. Their insights from both front-line practice and academic research enable them to impact regulations, accrediting standards, and institutional protocols. By advocating for restraint minimization at leadership tables, APNs guarantee that trauma-informed care becomes a standard of ethical and safe nursing practice not only at the bedside but throughout healthcare systems (37).

CONCLUSION

Reforming restrictive interventions through the perspective of Trauma-Informed Care is more than just a therapeutic adjustment; it is also an ethical and professional obligation. It signifies a transition from perceiving patients as problems to be solved to seeing them as individuals with distinct experiences, backgrounds, and vulnerabilities. Trauma-informed treatments focus on creating environments in which patients feel safe, respected, and valued, avoiding the need for forceful practices that can retraumatize or undermine trust. Nurses, particularly those in advanced practice areas, are driving this transition. Their

expertise enables them to apply trauma-informed approaches to both patient care and organizational decision-making. By demonstrating compassionate interactions, encouraging de-escalation tactics, and fighting for legislative reforms, they establish a standard of care that puts dignity over safety.

This change relies heavily on education and professional growth. Training nurses to recognize trauma responses, manage crises without resorting to restraint, and critically reflect on their practice fosters confidence and resilience in the workplace. Similarly, incorporating trauma-informed values into policies, procedures, and leadership practices promotes consistency and accountability throughout healthcare institutions. Finally, trauma-informed reformation is about more than just removing barriers; it is about creating a therapeutic environment in which healing relationships can develop. Nurses may lead a paradigm shift in healthcare environments by combining safety with empathy and clinical skill with ethical duty.

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