From Traditional Inpatient to Trauma-Informed Treatment: Transferring Control From Staff to Patient

Genevieve Chandler

Mental health professionals worldwide realize the imperative for reducing inpatient restraints and seclusion. The high incidence of posttraumatic stress disorder for inpatients and the resulting symptoms support the creation of a trauma-informed approach. The objective of the current article is to describe the experience of staff in a 20-bed unit transitioning from traditional inpatient care to a trauma-informed approach. The study comprised a qualitative design using content analysis (n = 10). The patterns clustered into the following categories: changing perspective, developing collaborative relationships, implementing safety measures, and prescribing educational resources. Staff underwent a deep cultural change that subsequently won state recognition for the reduction of seclusion and restraints. **J Am Psychiatr Nurses Assoc, 2008; 14(5), 363-371. DOI: 10.1177/1078390308326625**

At least 85% of public mental health consumers have been exposed to trauma (Mueser, Rosenberg, Goodman & Trumbetta, 2003). The lifelong effects of trauma can result in vulnerable hospitalized patients' exhibiting negative approaches to coping. Owing to internal stimuli or external pressures, vulnerable individuals may turn to self-destructive behaviors or lash out at others. This emotional lability and aggression toward self and others has been described by staff as "manipulative," "narcissistic," and the well-known pejorative "so borderline." To manage patient symptoms, staff have been trained to "take control." The cycle of trauma for psychiatrically hospitalized consumers has been inadvertently perpetuated by mental health professionals who respond to escalating threatening behavior by using restraints, isolation, and coercive practices that often retraumatize individuals (National Association of State Mental Health Program Directors, 2005, 2007).

The foundation of trauma-informed care principles lies in the recognition that violence and victimization play a central role in the lives of hospitalized consumers (Huckshorn, 2004). Thus, in trauma-informed treatment, a person's symptoms are understood as attempts to cope within the context of one's life experiences, history, and culture. This article describes the experience of staff in a 20-bed unit that was transitioning from traditional treatment to a trauma-informed program. The introduction of such principles resulted in a consistent trend to use fewer restraints: In 2003, 26 restraints were used; in 2004, 24 restraints; in 2005, 10 restraints (but with the same patient); in 2006, 13 restraints (same patient); in 2007, 10 restraints (same patient); and as of October 2008, 3 restraints have been used.

In 2008, the unit subsequently won state recognition for reducing restraints. In the trauma-informed program, education and skills training are the building blocks for change. Staff start with the skills that the patients have and so build on their strengths. Cognitive–behavioral therapy and dialectical–behavioral skill training are offered daily. A resource room is available, with literature on diagnosis and coping skills, as well as written exercises, and with videos and audiotapes to assist patients in managing symptoms.

Persons who are diagnosed with a psychiatric illness may be hospitalized in inpatient mental health

Genevieve Chandler, RN, PhD, associate professor, School of Nursing, University of Massachusetts, Amherst; gec@nursing.umass.edu.

units for symptom management. Indeed, psychiatric patients perceive "the essential meaning of the hospital . . . [as] a refuge from self-destructiveness" (Thomas, Shattell, & Martin, 2002, p. 101). With the majority of public mental health consumers having been exposed to trauma (Mueser et al., 2003), creating a trauma-informed program is essential to helping patients feel less vulnerable and more in control. The national imperative for reducing restraints and seclusion (Jennings, 2004) further supports the need for a trauma-informed program to decrease coercive responses and increase safety. Thus, to develop and support trauma-informed systems of care, mental health directors from 12 states formed a network, the National Association of State Mental Health Program Directors (Jennings, 2004).

Trauma-informed systems of care emphasize individual choices through empowerment models that are collaborative, strength based, culturally sensitive and that minimize retraumatization by recognizing the extent of posttraumatic stress disorder (PTSD) experienced by clients. Developing a trauma-informed treatment approach begins by educating staff on the chronic and debilitating adverse effects of PTSD on familial, social, and occupational functioning.

Trauma that results in mental health problems is usually caused not by a single event but by prolonged, persistent, intentional abuse that originates in childhood and may extend over the life span (Giller, 1999). The effects of trauma have been shown to outlive the trauma itself, with the meaning of trauma interpreted by individuals well after the trauma has ended (van der Kolk, McFarlane, & Weisaeth, 2007). Such trauma can result in fear, mistrust, depression, limited relational capacity, and negative coping behaviors, such as self-harm, dissociative behavior, and aggression (Saakvitne, Gamble, Pearlman, & Lev, 2000). Trauma can precipitate neurobiologic changes such that the act of entering new and familiar situations can be interpreted as being threatening and fearful as a result of the tyranny of the past (van der Kolk et al., 2007). Using coercive methods on inpatient units exacerbates patients' symptoms of PTSD (Borckardt et al., 2007). For staff to change their perspective on negative coping behaviors, they need to recognize that patients who have developed harmful behavior patterns because of trauma histories may be unaware of their stress responses or sensory needs, which can lead to inadequate self-soothing (Champagne & Stromberg, 2004). Huckshorn (2004) recommends a comprehensive approach to the reduction of seclusion and restraints, including assessment tools, trauma history, safety plans, creative changes to

the physical environment, and meaningful treatment activities. The inpatient unit milieu is an ideal environment for identifying and offering alternatives to behaviors that compromise health. The practices used by expert psychiatric staff to keep inpatient units safe, as described in a growing body of nursing literature (Johnson & Delaney, 2006, 2007; Johnson & Hauser, 2001), describes new behavior for staff. Implementing trauma-informed treatment offers inpatient staff an additional approach to increase patient safety and decrease the use of restraints.

STUDY PURPOSE

The purpose of this qualitative study was to provide an in-depth description of the experience of staff who had successfully transitioned from traditional care within an inpatient unit to trauma-informed treatment. The aims were to (a) describe and compare the experiences of staff in reducing patient symptoms in a traditional inpatient model and a trauma-informed treatment model and (b) to describe how the staff created a trauma-informed culture of safety.

METHOD

Design

A qualitative descriptive study design was used to document the experience of staff in creating a trauma-informed treatment model. The staff described their experience via narratives, reflecting on the traditional approach and the transition to the trauma-informed program of care. Personal narratives are a means through which one's experience is organized and made coherent. The stories that the staff told illuminate the comprehensive change required to create a culture of safety.

Sample and Setting

The participants were purposively recruited from the staff of a 20-bed inpatient psychiatric unit at a community hospital in the Northeastern United States. This unit, which had instituted trauma-informed guidelines, won statewide recognition in 2005 and 2006 for decreasing patient restraints. The staff members—including nurses, physicians, social workers, and mental health counselors—were educated on adopting and implementing the trauma-informed philosophy. Of the 20 nurses and 14 mental health counselors on staff, those who had worked on the unit for more than 12 years were invited to participate because they had

spanned the transition from a traditional program to a trauma-informed program. Of the 34 eligible nurse and counselor providers, 8 volunteered to participate in the study. In addition, 2 administrators volunteered, to participate. Participants were primarily from the day shift ($n = 8$), with 2 representatives from the evening shift ($n = 1$) and night shift ($n = 1$).

Data Collection

The study was approved by the institutional review board of the investigator's university and the study site's vice president. After participants gave written informed consent, individuals were interviewed. Interviews ranged from 60 to 90 min. Narratives were tape-recorded or handwritten, depending on the interviewees preference. Participants were first asked to describe the symptoms that brought patients into the unit. Participants were then invited to tell their story about changes in patient care over the previous 12 years. Specifically, they were asked, "What was your experience in reducing symptoms under the traditional inpatient model and the trauma-informed treatment model?" Participants' tape-recorded responses were transcribed verbatim.

Data Analysis

Verbatim transcripts were analyzed by inductive content analysis (Hsieh & Shannon, 2005). This approach was chosen to classify large amounts of text into categories representing similar meaning (Weber, 1990). For this study, inductive content analysis consisted of nine steps:

1. reading the entire text to obtain a sense of the whole;
2. making memos of initial impressions;
3. conducting more careful word-by-word readings;
4. performing line-by-line coding of significant statements that appeared to capture key concepts;
5. analyzing statements for labels that captured more than one thought;
6. transforming labels to themes;
7. grouping themes into descriptive categories;
8. developing definitions for each category; and
9. identifying exemplars of stories, themes, and categories from the data.

This step-by-step analysis, an iterative process, occurred following each interview.

Trustworthiness

Trustworthiness, or rigor, ensures that the data accurately represent the participants' perceptions of their experience. Confirmability, as a measure of scientific rigor, was determined by auditability, credibility, and fittingness (Lincoln & Guba, 1985). Auditability, the ability for outside investigators to follow the process of decision making, occurred by bracketing (before data collection) and by using a memo log (throughout interviewing and analysis). Credibility was developed by having participants review their transcribed response, the typed data results, and the final discussion. Fittingness, or how categories represent data, was established by using direct quotes from the narratives to explicate categories and by having an external expert reader review a sample of text, categories, and conclusions.

Findings

The experience of staff, and their working with patients to reduce symptoms in a traditional inpatient model and a trauma-informed treatment model, was described in terms of creating a culture of safety. Content analysis of narratives describing symptom management revealed an overarching theme of transferring control from staff to patient. Within this theme, the experiences of staff nurses were captured via four categories: changed perspectives, collaborative patient–staff relationships, the implementation of safety protocols (including staffing ratios), and the prescription of individualized evidence-based educational resources. For each category, participants first described their experience in the traditional model, then that in the trauma-informed model.

Transferring control from staff to patient. At the beginning of every interview, participants emphasized that their experience in transitioning from traditional to trauma-informed treatment was not a simple case of going from a bad approach to patient care to a good approach but more of moving from a traditional inpatient program to a patient-center approach with a milieu-based focus on safety. As one participant said, "There was always a culture that supported the staff. Communicating with each other and the patients has always been really respected, but now we have shifted control from the staff to the patient."

Participants suggested that control was historically maintained by different means—for example, through physical plant design, rigid protocols, information control, and physical/chemical interventions. One participant said, "Then people fit into the protocol rather than adjusting the protocol to meet patients' needs. There were clear lines drawn between who was ill and

who was in control." Today, the philosophy of collaboration between the staff and patients is the basis for symptom management. Participants described their experience of changing perspectives, developing collaborative staff–patient relationships, implementing safety protocols, and using educational resources.

Changing perspectives. Staff members who had worked on the inpatient unit for more than 12 years had been trained in managing patient symptoms by supervising the milieu, monitoring medications, and controlling information. The participants reported a gradual change of perspective regarding patient behavior owing to consultation with a trauma expert and to required education on the effects of trauma on inpatient behaviors. The shift in perspective initiated by staff development was reinforced by role modeling of the nurse manager who deeply believed in trauma-informed treatment. One participant said, "She was there to teach us about new approaches and on the unit demonstrating how to interact with patients when things were quiet and when there was a crisis. We could count on her." Creating a structure of active administrative involvement, staff development, skills training, and staffing ratios was critical so that staff had the tools to try new approaches to patient care.

Collaborative patient–staff relationships. Participants voiced that patient–staff relationships had always been central to the treatment milieu but that under the traditional model

> there was a pronounced hierarchy that went from the physician to the social worker to the nurse to the mental heath counselor and finally to the patient, with everyone on the staff understanding that the therapy was conducted by the psychiatrist, with the expectation that all symptoms would be resolved before discharge.

The milieu had "insight-oriented groups, and patients were absolutely required to attend." Group attendance was a struggle for some patients, which had to potential to escalate into a staff–patient control issue. Minimal information was offered to patients; information flowed down the hierarchy, with the physician as primary source of information. A participant commented that the staff gave "much less information to patients; people weren't even given their diagnosis. There was a stigma about diagnosis, it was too shameful." Family, friends, or sponsors were not involved in therapy. Patients were warned against sharing information. A participant recalled, "The rule was [that] patients could not exchange any personal information related to their

life outside of the hospital. Patients were also forbidden to contact each other after discharge." Separating and silencing patients was another approach to keeping control in the hands of the staff, which in turn increased patient dependence.

With trauma-informed care, the relationship hierarchy shifted. Participants described a trauma-informed philosophy as one that recognizes that information is the key to empowering patients to have control over their lives. Thus, sharing information with patients begins on admission:

> Within 24 hours of admission, a specific, individualized plan is developed with each patient to specify a written agreement of responsibility for the patient, physician, nurse, social worker, art therapist, and occupational therapist. The staff functions as a team, with each member contributing information that is respected and recognized as a critical piece of the patient's life puzzle.

One participant reported, "We tell patients that there's a recipe for managing symptoms: 'What ingredients work for you?'"

During the treatment-planning meeting within the first day on the unit, patients are informed of educational resources, with specific tools being prescribed and implemented with their assigned staff nurse or counselor. The milieu is structured with art therapy groups, dialectical–behavioral therapy groups, recovery meetings, wellness exercises, and a community meeting. Every community meeting, which has "a human rights officer" to protect patient rights, begins with a mindfulness meditation exercise and ends with an inspirational quote. Patients can choose whether to attend group meetings, but the staff encourage them to actively participate in their treatment.

Patients are perceived by other patients as a resource, helping one another manage symptoms and develop coping skills. Patients share the community services that work well, and they refer others to successful outpatient programs. The policy of no contact between patients after discharge has evolved into one that recognizes that patient networks are a key component to recovery. Patients decide whether they will continue the relationships formed in the unit. One participant said, "It used to be patients just talking to their therapist. They were missing their whole support base. Now we have friends and sponsors come on the unit, to meetings, and they become part of the discharge plan." A support network of friends and family is one component of creating a culture of safety.

Implementing safety measures. Under the traditional treatment model and the philosophy of mental health treatment at the time, the approach to maintaining safety was to physically separate patients according to disability, age, and threat. For example, psychiatric patients and those with substance abuse issues were hospitalized in separate units. Medically compromised patients were transferred to a medical unit; violent patients were referred to the state hospital; and adolescents were on a separate unit. "It was a different unit then," one participant said. "We did not take the elderly or wheelchair bound." Back then, the physical structure of the unit would not have supported such diverse patient groups. Participants suggested that the old, inadequate physical plant created opportunities for patients to inflict self-harm. For example, the unit had a full kitchen where patients could find the means to cut and burn themselves.

The strict interpretation of protocols was presumed necessary to maintain control. "Rigid, our practice then seemed very rigid. We followed protocols to the letter in response to symptomatic behavior." For example, staff members attempted to control self-mutilation by instituting protocols that were designed to help patients gain self-control. Given that knowledge about the effects of trauma was limited at the time, the protocols were not designed to account for the trauma history suffered by the majority of patients. One participant explained that when patients harmed themselves, no distinction was made between self-mutilation and suicide attempts. Mutilation was understood as manipulation symptomatic of the patient's diagnosis. As one participant admitted, self-mutilation "often resulted in using restraints as punishment." If patients' self-harm was the problem, strict protocols were set in place to minimize patient manipulation of staff and to prevent splitting between staff. One participant reported,

> The cutters were secluded away from the rest of the unit; they did not have contact with staff or patients for 24 hours. They were asked to consider what they had done and what it meant and, the next morning, report to the community meeting to see how their action affected the community as a whole.

Another participant observed,

> Once a patient was in restraints, it took a long time to come out, one limb at a time. This could take 4 hours; then there was a very gradual reentry to the unit. Looking back at it does feel like the shame-and-blame approach.

Under the traditional model, the staff exerted control with the best intention of keeping everyone safe in the face of limited alternate resources. The resources offered to patients were primarily diversionary and not based on the evidence currently available on the therapeutic use of diversion, as one participant explained: "To keep the patient occupied, there were group outings to bowling or the movies. There were group walks, smoke breaks, and coffee klatches with patients and staff gathering around the dining tables."

Under traditional psychiatric care, different medications were used. The older psychotropic medications were described by a participant as such: "using a mallet for a symptom when one just needed a tap from a delicate jeweler's hammer." Another participant commented, "Back then the older medications were less refined and so were the security men that came up to help seclude or restrain. They were older men and less refined, with no education for managing psychiatric emergencies."

Today, in keeping with the philosophy of patient-centered treatment, planning meetings, and medication education, patients and staff have more opportunities to collaborate on medication decisions. Participants reported that before the trauma-informed treatment philosophy, patients were not asked about their trauma history. "We were not aware of warning signs of escalation back then," and retraumatization was an unknown concept. A participant noted that "both patients and staff often felt unsafe." One nurse observed, "We did not talk about safety and violence directly; we just tiptoed around and hoped."

Owing to fiscal constraints in mental health care and a focus on community care, emphasis on a less confined environment for all patients has led to a closing and combining of units. Currently, patients diagnosed with substance abuse, mental health, and PTSD issues are housed in the same unit with the elderly, the medically compromised, and the potentially violent. Patients are no longer segregated by diagnosis, because one individual could fall into all six categories. Within a restricted budget and confined physical space, staff have worked to create an environment that promotes relational connections. One participant explained, "We have created more common areas and quiet spaces." For example, the staff recently converted a bedroom into a quiet room that is minimally decorated to retain the simplicity of a calm, soothing space. This space was named by vote as the *kiva*, which is a chamber built by Pueblo Indians for religious rites or a meditative space. On a busy unit with double bedrooms, the *kiva* is frequently used.

To ensure safety, the kitchen has been renovated without a stove but with basic dietary supplies, healthy snacks, and limited caffeinated drinks. The staff ideology, as articulated by one participant, is that "recovery is a process and hospitalization is just a tool, so let's use the tool to the best of our ability." Several plans are in place to assist patients in maintaining control. For example, on admission each patient is interviewed about how to create a safe environment, by using the Safety Tool, an interview protocol developed by the Massachusetts Department of Mental Health (1996). Patients are also asked, "Identify how [the staff] can support your safety and the safety of others on the unit." Furthmore, they are told, "[The staff] review a list of triggers with the patient that may provoke loss of control, and [they] identify strategies for safety with each patient" (see Table 1).

A participant described the process as such: "The Safety-First Plan helps staff think about how to work with patients differently. [To facilitate safety] takes someone else's presence. [Safety] is more than just tasks; it takes presence, being aware, and intervening as [patients] are getting upset." Another participant explained,

> We have an increased awareness of trauma behavior. We used to think that emotional lability was manipulative. Now we recognize [that this behavior] is a response to trauma. Cutting was seen as manipulative; now we know it can be a way to release emotions, a coping skill, so the staff response is more individualized. Now we include the patient in the plan. Through planned written exercises, we look at what are triggers, what are responses, and what are alternatives. We teach more skills for distractions. The Safety-First Plan takes the power struggle out and brings the patient in to collaborate.

Participants described using a self-soothing cart to promote healthy coping in response to symptomatic behavior. This cart was designed by the staff on the basis of evidence suggesting that individuals who are anxious or depressed may use self-destructive coping behaviors. The self-soothing cart is somewhat like the code cart in medical emergencies. It has five drawers with objects that address the five senses to encourage a positive sensory experience, thus providing alternate supports for coping. For example, music is located in the auditory sense drawer. Nurses and counselors offer the cart to patients, along with an opportunity to talk or sit with them. One participant clarified that the cart does not take the place of a relationship but that it offers patients an opportunity to use new coping mechanisms to help them to stay in control. Psychopharmaceutical agents are also offered to help patients feel safe.

Under the trauma-informed model, safety is central to the unit's function, with an appropriate staffing ratio as a key component. All staff are involved in professional development programs that complement the development of a safe milieu. The trauma philosophy is a strongly held belief, frequently stated within the unit as such: "Everyone has the right to feel safe." The assurance of safety begins on admission, well before any potential escalation.

Implementing individualized evidence-based educational resources. In response to the question "What educational resources were available 12 or so years ago?" one nurse said, "There were none." Few patient educational resources were available in the traditional model. One participant explained, "Before there was a lack of written information. Now we have books for each diagnosis, a template for procedures, written assignments for here and to take home." Skill-building resources are prescribed through the multidisciplinary treatment plan or offered on an as-needed basis, with the results documented in the chart. Staff members review patients' homework assignments and assist them in reflecting on their responses. Table 2 describes three examples of regularly prescribed educational exercises.

"Before, we'd come up with therapy plans," a participant commented, "but they were not the patient's idea; it was more of a therapy plan for staff." Now a central component of treatment planning is designing an educational plan that includes developing the patient's knowledge about symptom management and skills training for healthy coping. Based on the belief that acting out (from cutting to violence) is a default behavior for healthy coping, trauma-informed treatment weaves coping skills training throughout the day in teachable moments around medications to more formal group meetings. One participant said, "We have a lot more groups with a specific structure for each, like anger management or anxiety management. These are much more useful groups where patients get nurturing and where they can give nurturing." Another participant reflected, "[Patients] come in because they feel they have no choice. We give them choices. 'What skills would you like to have? You tell us.'" A third participant added, "Now there is a whole team on the patients' side to help them help themselves."

TABLE 1. Safety Checklist Used for Each Admission

Check the Triggers for Trauma-Based Symptoms	Check the Patient-Identified Response to Symptoms
Being touched	Time in one's room / quiet room
Bedroom door open	Sitting by nurse's station
Particular time of the day	Talking with staff/patient
Loud noise/yelling	Writing in a journal
Not having control/input	Healthy self-talk/affirmations
Overcrowding	Deep breathing exercises
Specific person	Visual imagery
Being isolated	Wrapping up in a blanket
People in uniform	Exercise
Time of year	Reading
Being around men or women	Watching TV
Weather	Pacing halls
Observing others out of control	Calling a friend
	Putting hands in cold water, ice on wrists
	Lying down with a cold face cloth
	A walk with staff
	PRN medication
	Use of DBT skills
	Mindfulness exercises
	Self-soothing cart

TABLE 2. A Sample of Safety Educational Interventions

Assignment	Description
Early warning signs	"When things fall apart, we can usually look back and identify unseen clues which signified trouble." From a list of 44, such clues include not answering the phone to overeating to increased negativitying, warning signs are identified and responses are designed.
Crisis planning	"When all efforts at feeling better are lacking success, you are reaching a crisis and may need to ask for strong help. You may find it hard to ask for help because of feeling oversensitive or fragile. You may notice that you are unable to slow down or you are sleeping all the time or not sleeping at all. Who are the people you can call? Include phone numbers of friends, MDs, hospitals, and sponsors."
Dialectical–behavioral	This analysis includes a list of possible events that lead to symptoms, considering action, body, cognition, therapy chain analysis events, feelings, skilled behavior, and attentive breathing exercises.

DISCUSSION

The mental health staff in this study described their successful transition from a traditional model of inpatient care to the trauma-informed model. They portrayed the trauma-informed inpatient milieu as that designed to reflect the high incidence of PTSD among patients. Their attention to "ingrained attitudes of the past and their influence on new approaches to care [were] essential to understanding not only changes in ways of doing nursing tasks, but also ways of relating" (Pejlert, Asplund, Gilje, & Norberg, 1998, p. 264). In the past, limited evidence was available regarding the lifelong effects of PTSD, but staff now know that PTSD leaves in its wake a vulnerability to fear and mistrust that can result in anxiety, depression, harmful coping behaviors, and a fragile capacity for building relationships.

The findings suggest that being aware of the preponderance of trauma histories is key to creating a safe environment for healing. Such healing grows in the fertile ground of a collaborative staff–patient relationship. Active administrative involvement, safety protocols, reasonable staff–patient ratios, and evidence-based educational material are resources required by both staff and patients. The findings indicate that sharing information with patients to build their awareness and knowledge is critical to helping them cope with symptoms, manage their relationships, and attend to their environment. The decreasing trend in restraint and seclusion incidents may be one indication of the benefits of trauma-informed treatment.

Implications

Moving from the traditional model of care within many mental health inpatient units to

trauma-informed treatment will involve incremental change. This process is reflected in Mahatma Ghandi's life, as he was giving up his British business suit to adopt the Indian way of weaving clothes from cotton grown in his homeland. Weaving on the steps of his humble cabin, Ghandi reflected that change is incremental; it does not come about by sweeping reforms. In the case of trauma-informed treatment, incremental change in practice is made by each individual. Leadership to staff—needs to be involved in educational initiatives and practice behaviors. To establish a deep cultural change, all policies and procedures need to be reviewed through a trauma-informed lens. Staff–patient interactions need to be reconsidered in groups, in one-to-one interactions, and in the hallways. Cultural change takes both individual commitment and structural supports.

In terms of research, nurse scholars need to investigate the extent to which staff in inpatient units collaborate with patients, implement safety protocols, and employ educational resources. Future studies should describe the transition as it occurs, to capture shifts in staff perceptions and staff/patient responses to implementing safety protocols and educational resources, while tracking incidents of seclusion and restraint.

A central question that deserves further attention is, what are the most critical factors that facilitate successful adoption of trauma-informed treatment across units that vary in location, size, and patient populations? The essential recommendation is that all units must consider the effects of trauma on past, present and future behavior.

Conclusion

A trauma-informed approach to inpatient care provides an alternate lens for viewing patient behavior. By understanding the negative effects of a trauma history on patient symptoms and coping behaviors, staff can develop a milieu that anticipates and responds to patients who feel out of control. To develop a culture of safety, staff perceptions need to change through education, training, and role modeling. The importance of collaboration between staff and patients needs to be recognized. Safety protocols need to be implemented from admission to discharge, and written educational resources need to be available for staff and patients. Staff development on all shifts is required to assist staff in implementing trauma-informed principles. The cultural change that staff need to undergo is deep; they have to transition

not only to new approaches to patient care but also to approaches that differ dramatically from their original training. This change necessitates a paradigm shift for both unit leadership and staff, from control to collaboration, which results in patients' learning healthy coping responses and in staff's decreasing their use of restraints. This unit is one exemplar of a work in progress that challenges staff to continue making incremental changes that will support a culture of safety.

REFERENCES

Borckardt, J. J., Grubaugh, A. L., Pelic, C. G., Danielson, C. K., Hardesty, S. J., & Frueh, B. C. (2007). Enhancing patient safety in psychiatric settings. *Journal of Psychiatric Practice, 13*(6), 355-361.

Champagne, T., & Stromberg, N. (2004). Sensory approaches in inpatient settings. *Journal of Psychosocial Nursing and Mental Health Services*, *42*(9), 35-44.

Giller, E. (1999). *What is psychological trauma?* Lutherville, MD: Sidran Press.

Hsieh, H.-F., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288.

Huckshorn, K. (2004). Reducing seclusion and restraint use in mental health settings. *Journal of Psychosocial Nursing, 42*(9), 22-33.

Jennings, A. (2004). *The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioral health system*. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

Johnson, M., & Delaney, K. (2006). Keeping the unit safe: A grounded theory study. *Journal of American Psychiatric Nurses Association, 12*(1), 13-21.

Johnson, M., & Delaney, K. (2007). Keeping the unit safe. *Journal of American Psychiatric Nurses Association, 13*(1), 42-52.

Johnson, M., & Hauser, P. (2001). The practices of expert psychiatric nurses: Accompanying a patient to a calmer personal space. *Issues in Mental Health Nursing, 22*, 651-658.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Massachusetts Department of Mental Health. (1996). *Safety tool*. Retrieved May 31, 2008, from http://www.mass.gov/Eeohhs2/docs/dmh/rsri/safety_tool.pdf

Mueser, K., Rosenberg, S., Goodman, L., & Trumbetta, S. (2003). Trauma, PTSD, and the course of severe mental illness: An interactive model. *Schizophrenia Research, 53*(1/2), 123-143.

National Association of State Mental Health Program Directors. (2005). *NASMHPD position statement on services and supports to trauma survivors*. Retrieved September 11, 2008, from http://www.nasmhpd.org/position_statement.cfm

National Association of State Mental Health Program Directors. (2007). *NASMHPD position statement on seclusion and restraint*. Retrieved September 11, 2008, from http://www.nasmhpd.org/position_statement.cfm

Pejlert, A., Asplund, K., Gilje, F., & Norberg, A. (1998). The meaning of caring for patients on a long-term psychiatric ward as narrated by formal care providers. *Journal of Psychiatric and Mental Health Nursing, 5*(4), 255-264.

Saakvitne, K., Gamble, S., Pearlman, L. A., & Lev, B. (2000). *Risking connection*. Lutherville, MD: Sidran Press.

Thomas, S. P., Shattell, M., & Martin, T. (2002). What's therapeutic about the therapeutic milieu? *Archives of Psychiatric Nursing, 16*(3), 99-107.

van der Kolk, B., McFarlane, C., & Weisaeth, L. (2007). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York : Guilford Press.

Weber, R. P. (1990). *Basic content analysis*. Beverly Hills, CA: Sage.