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FROM CHAOS TO SANCTUARY: Trauma-Based Treatment for Women in a State Hospital System

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Introduction

In 1993, I (LJB) was appointed Medical Director of a chronic, extremely violent, women's unit in a State-Hospital in a rural, mid-Atlantic region. I accepted the position because of the challenge it presented. I had been trained as a resident and fellow in the relatively new field of psychotraumatology (Tinnin, 1992), the study of how psychological trauma, particularly early childhood trauma, affects adult functioning. The level of reported violence, particularly self-harming behavior, that was an endemic part of this environment, convinced me that there must be a high level of previously unrecognized and unresolved traumatic experience in the backgrounds of these patients, a finding that has been recognized in previous research (Saxe, et.al.1993). If this was the case, then perhaps the level of chronicity and violence could be decreased. To bring about such a change, it would be necessary to introduce two separate but mutually compatible theoretical systems to the inpatient unit: a trauma-based approach combined with the systematized use of a therapeutic milieu, previously articulated as "The Sanctuary Model of Inpatient Treatment" (Bloom, 1994; in press). This chapter summarizes the process of converting a deteriorated, chaotic, violent, and alienated culture into a community milieu with established nonviolent norms and the resultant changes in patient behavior and outcome.

Background

As I entered the system, the hospital had been and was continuing to undergo significant change. The State Hospital was the major employer for a very small town. Some of the local families could claim four generations working at the hospital. Like so many other mental health facilities in these times of economic decline for the mental health system, the hospital was in the midst of rapid downsizing with attendant staff layoffs and a dramatic switch from public to private management. Most of the patient care was provided by nursing staff members and other ancillary staff. There were only

two psychiatrists for two hundred and fifty patients. The medical care was supplemented by several other physicians who had no formal psychiatric training, although they were expected to function in that role to the best of their ability.

Several years prior to my employment there had been several patient deaths that were, at least in part, attributed to deficiencies in patient care. State officials had responded by instituting a patient advocacy system which answered directly to the State and not to the local hospital authorities. Intended as a solution to problems of deficient patient care, the advocacy system had somehow gone astray and the potential for abuse of patients by staff had made a pendulum swing in the direction of increased potential for abuse of staff by patients. The patient advocates were perceived as wielding an unusual amount of power and staff members had reportedly been fired, without a chance for appeal, in the face of confronting a patient about violence. Allegedly, one of the advocates had himself been accused of violence towards patients in the past and was rumored to have a personal problem with domestic violence. I had no opportunity to search out the veracity of these incidents, but I did observe that the staff were extremely hesitant to establish any rules for the unit that could serve to curb the violence and they attributed their reluctance to fear of the consequences for their jobs at the hands of the patient advocates were they to set any limits on patient behavior.

Evaluation Phase

My first day on the unit will always stand out vividly in my memory. I was freshly out of my residency and eager to start my new job. I had chosen this particular unit, noted to be the most difficult and least desirable post in the hospital, because I believed that there was a potential to make a significant difference and because I had been impressed with the cohesion and humor of the staff already present on the unit.

But the first few moments of that first day prepared me to re-evaluate my decision. As I opened the door, I looked down a long, dimly lit, drab hallway. The sound of women's screams filled the air and as I stared, halted in my progress for a moment, a chair flew across the hallway and crashed to the floor, and then a large woman, presumably a patient, came up behind a staff member and began to pound the nurse on the head. Several other staff members rushed up, grabbed the patient's arms and began to talk to her. Only later did I learn that this was routine behavior for that patient. During the brief period of calm that ensued, I discovered that there were four rooms with staff posted on chairs outside because those four patients required one-to-one supervision for twenty-four hours a day and one room with two staff posted outside because their patient required two-to-one supervision for twenty-four hours per day. Even with this close contact, however, the staff would rarely talk

to the patients to whom they were assigned, but each fifteen minutes they would carefully note the status of the patient on the clipboard that accompanied them throughout their long and tedious shifts. When they were not assigned to this kind of supervisory duty, the staff members would gratefully retreat behind a raised plexiglass wall at the nursing station which separated the staff from the patients. The nurses were clear that the job they had been instructed to do was to observe, record, and report. Talking to the patients, engaging in a therapeutic dialogue, was considered beyond their abilities. The nursing staff did not necessarily always follow this dictate, but it was clear that if they wished to do so, such a policy would be backed up by the normative expectations of the institution.

In my first days and weeks on the unit I spent a great deal of time watching, listening, and learning. I attended many shift change reports, nurses unit meetings, and paid close attention to the everyday functioning and underlying norms of the unit milieu. There were two nurses and four to six psychiatric aids on every shift. There were no social workers, no psychologists, or other unit-based support. Although the hospital had some strong therapeutic programming including art therapy, recreational therapy, work programs, and psychoeducational programming, our patients were not considered to be safe enough to participate in these activities. What structure there was on the unit was imposed by the most basic needs or desires of the patients - the desire to eat, to smoke or to have a pass. Usually, the patient was able to attain these privileges by simply nagging a staff member until she gave in to the request, as long as there were no immediate safety concerns. Patients were neither expected nor required to attend programming or to engage in treatment in any way. The barriers to any kind of therapeutic progress were immense.

My impressions of the first day were reinforced with every passing day. Violence was normative behavior. On the average there were 100 reported violent episodes per month, which included violence to self, others, and accidents. But this did not take into account the hundreds of other violent incidents and threats that did not get reported, since only the most severe incidents were worth the trouble of filling out the inevitable and time-consuming paperwork. Susan was thirty-two years old and had been physically and sexually abused as a child, first by her family and then in numerous foster homes. Her expression of distress was through self-harm. In one day alone she stole staples off the nursing station and put them in her eye and then crushed tiny pieces of glass and put them in the other eye. She managed to extract the light bulb in her room out of its socket, smashed it and with the pieces of glass, sliced up her arms. Geraldine was twenty-two and mildly retarded. She was an incest victim and had a child at age 12, by her father. She was put into foster care at the time, but placed back in the home with her abuser at age 18

and was sent to the State Hospital at age nineteen after her self-harming behavior had escalated to an unmanageable degree. At one point the State had put her in a placement with eight staff members assigned to her to try to prevent self-harm, costing about \$125,000 per year. Even with that regimen her self-harming behavior could not be stopped. She repeatedly cut herself so severely that the wounds required plastic surgery. She also had frequent gynecological problems. Five times in one day she placed objects into her vagina - the top of an aluminum soda can, a large square earring, broken glass, a pencil, and batteries. Neither she nor any of the staff appreciated this behavior as a symbolic reenactment of her incest.

Everyone abhorred the violence but felt helpless to do anything to stop it, nor were any real efforts made to understand the factors that may have provoked it. It was as if Violence was an active entity that ran the unit. The patients routinely lashed out violently at each other, sometimes provoked by an insult or a despised behavior, other times provoked by nothing. The patients were frequently and unremittingly violent towards staff who resorted to the use of seclusion and restraint as their only defense against serious harm. Even in those early days it was apparent to me that the patients were engaged in some kind of bizarre reenactment behavior that was satisfied only by the use of strait jackets and solitary confinement.

One of the most accurate demonstrations of this was Michelle, twenty-five years old, very tall and obese, who had a serious substance abuse problem and was hospitalized after an overdose and repeated episodes of self-mutilation. Her father was an alcoholic and unhappily married to Michelle's mother and Michelle became a pawn in their routine marital battles. He would kill her pets in front of her as a way of exerting control and was physically violent towards her. On the unit, as Michelle's behavior would escalate the staff would begin to threaten consequences for her behavior which led to a further escalation. The staff would call an emergency code, men would flock to the unit and roughly haul her into the seclusion room and tie her down with restraints. She had become close to one of the nursing staff who was involved one such code and she felt betrayed by her. Subsequently she cut off all interaction with the staff, reported the incident to the patient advocates, who then confronted the staff. Until we all sat down together to debrief, no one had any insight into the fact that Michelle and the staff had become involved in a dramatic reenactment of her childhood experiences with her father. This resolved the problem and ended Michelle's use of restraint. A less successful example was Ruth. Everyone in the town knew Ruth, who had been a beautiful young woman from a not so beautiful family. It was rumored that she had been sexually abused but Ruth would not provide me with any family history. She was known to have been raped, then known to have supported herself as a prostitute in the town, but at some point she had turned to violence and ended up hospitalized. She had been put on many drugs, but nothing controlled the

violence. By the time I met her she had already been in the hospital for more than ten years and of those years had spent four continuous years in seclusion because of her repeated violence. She was hugely obese and only her history spoke of her former beauty. She engaged in a great deal of inappropriate sexual behavior with humans and even with animals. The best that the changed milieu could offer her was a less provocative environment and for her, no use of seclusion and restraint.

The level of self-mutilation was astonishing and terrifying. One of the environmental reasons for this behavior rapidly became obvious. Being taken to the emergency room for suturing of self-inflicted wounds was one of the only times that a patient could count on the undivided attention of another human being. Throughout the drive to the local emergency room and the visit to the hospital, a patient would have a staff member entirely to herself, in close proximity and surrounded by strangers. This provided an increased likelihood that the staff member and the patient would actually carry on a conversation. Even though the emergency room staff would often disparage the patient with comments about her “manipulative”, “needy” or “problem” behavior, the attention and change from the extreme monotony of everyday life was well-worth the effort.

I was certainly not immune to the effects violent climate. I was hit in the head, thrown down steps, and repeatedly threatened. The patient who was on constant two-to-one supervision was a young woman diagnosed with dissociative identity disorder who was so volatile that she only was allowed to get air outside while cloaked in a strait jacket behind an enclosed and walled courtyard. On one occasion she had managed to climb her way up the bars of a window, had punched out the window through the heavy mesh screen and was preparing to slice her wrist with a long shard of glass when I climbed up behind her, grabbed her around the waist and yanked until we both fell about six feet to the ground, at which point I sat on top of her, held both her hands out, and tried to control my own impulse towards violence until help finally came. That night, and for many nights afterwards, my own sleep was plagued by nightmares and, like other victims of violence, I became hypervigilant and on edge.

It took many days to go through every patient chart in order to perform a careful review of each case. There were twenty-four women on the unit, all involuntarily committed. One-quarter of them had been hospitalized for six months to four years and another one-quarter had been in the hospital for more than ten years. The charts were so voluminous that one patient’s chart alone required two shopping carts to haul the paperwork onto the unit for my review. Their average age was thirty-eight. Fifty percent of the patients had a high school degree or equivalency and two had Master’s degrees. Three-quarters were diagnosed with schizophrenia, ten percent with mood disorders,

ten percent with personality disorders and five percent with dissociative disorders. Many of them had not seen a psychiatrist or been re-evaluated in many years. I rediagnosed sixty percent of those carrying a schizophrenic diagnosis and of these, fifty percent met criteria for post-traumatic stress disorder or a dissociative disorder.

Planning Phase: The Sanctuary Model

After carefully evaluating the milieu from a cognitive and experiential point of view I was ready to make some serious changes. But I needed some guidelines and some teaching materials to assist me in the process of transformation. I knew that I would need some support for this task. I began talking to two of my mentors, Sandra Bloom MD and Louis Tinnin MD. I spoke with them on the phone as often as I needed to help provide an objective viewpoint and a perspective outside of the system. Bloom and her colleagues had created a specialized treatment program for adult survivors of childhood trauma and abuse in a general hospital setting. She had discovered, consistent with other research data (Jacobson & Herald,1990; Jacobson & Richardson,1987; Saxe et al., 1993), that a substantial proportion of her general psychiatric population had a childhood history of extreme and traumatic experiences that had been neglected as contributory causes to their adult symptomatic picture. Once her treatment team revised their protocols to reflect an understanding of how childhood trauma and unresolved post-traumatic stress symptoms impact on adult pathology, formerly resistant patients became treatable. The changes that this team made did not require fancy techniques or expensive equipment, but rather a change at the level of system norms, a change in the way the treatment team approached the patient, understood and explained the problems, and altered their expectations of behavior for themselves and their patients.

They based these changes on a series of shared assumptions rooted in a relatively new knowledge base about the effects of profound trauma and a shared practice rooted in the decades-old methodology of the therapeutic community. The trauma-based assumptions became the normative basis for understanding psychopathology and developing treatment strategies and the community practice became the platform for promulgating those norms and organizing interventions.

Tinnin had been my fellowship supervisor and a proponent of a very different treatment model. From him I had learned the importance of finishing the trauma story or narrative using special techniques like trauma art, video dialogue, and recursive videotherapy. The combination of the Sanctuary model and knowledge of traumatic memory processing procedures seemed to be the best approach to this violence dilemma.

TRAUMA-BASED ASSUMPTIONS VS TRADITIONAL/MEDICAL MODELS

Trauma-Based

1. Patients begin life with normal potentials for growth and development, given certain constitutional and genetic predispositions, and then become traumatized. *"Post-traumatic stress reactions are essentially the reactions of normal people to abnormal stress"*.
2. When people are traumatized in early life, the effects of trauma interfere with normal physical, psychological, social, and moral development.
3. Trauma has biological, psychological, social, and moral effects which spread horizontally and vertically, across and down through the generations.
4. Many symptoms and syndromes are manifestations of adaptations, originally useful as coping skills, that have now become maladaptive or less adaptive than originally intended.
5. Many victims of trauma suffer chronic post-traumatic stress disorder and may manifest any combination of the symptoms of PTSD.
6. Victims of trauma become trapped in time, their inner experience fragmented. They are caught in the repetitive re-experiencing of the trauma which has been dissociated and remains unintegrated into their overall functioning.
7. Dissociation and repression are core defenses against overwhelming affect and are present, to a varying extent, in all survivors of trauma.
8. Although the human capacity for fantasy elaboration and imaginative creation are well established, memories of traumatic experiences must be assumed to have at least a core of basis in reality.
9. Stressful events are more seriously traumatic when there is an accompanying helplessness and lack of control.
10. Traumatic experience and disrupted attachments combine to produce defects in the regulation and modulation of affect, of emotional experience. Human beings require other human beings to resonate with their emotions and to help contain feelings that are overwhelming.
11. People who are repeatedly traumatized develop "learned helplessness" a condition which has serious biochemical implications.
12. Trauma survivors often discover that various addictive behaviors restore at least a temporary sense of control over intrusive phenomena.
13. Survivors may also become addicted to their own stress responses and as a result, compulsively expose themselves to high levels of stress and further traumatization.
14. Many trauma survivors develop secondary psychiatric symptomatology and do not connect their symptoms with previous trauma. They become

guilt-ridden, depressed, and exhibit low self-esteem and feelings of hopelessness and helplessness.

15. Trauma victims have difficulty with the appropriate management of aggression. Many survivors identify with the aggressor and become victimizers themselves. A vicious cycle of transgenerational victimization often ensues.

16. The more severe the stressor, the more prolonged the exposure to the stressor, the earlier the age, the more impaired the social support system, the greater the degree of exposure to or involvement in previous trauma, the greater the likelihood of post-traumatic pathology.

17. Attachment is a basic human need from cradle to grave. Enhanced attachment to abusing objects is seen in all studied species, including man.

18. Childhood abuse leads to disrupted attachment behavior, inability to modulate arousal and aggression toward self and others, impaired cognitive functioning, and impaired capacity to form stable relationships.

19. Although it may require lifelong processing, recovery from traumatic experience is possible. Over the course of recovery, survivors may temporarily need safe retreats within which important therapeutic goals can be formulated and treatment can be organized.

20. We are all interconnected and interdependent, for good or for ill. Safety must be constantly created and maintained by everyone in the community as a shared responsibility.

21. The whole is greater than the sum of the parts (Bloom, in press; Herman, 1992; Van der Kolk, 1987; Van der Kolk et al. 1996).

TRADITIONAL/MEDICAL

1. Patients are perceived to be too weak, impaired, or dysfunctional in comparison to normal people. They may have “nervous breakdowns” because of an inability to handle stress. The “nervous breakdown” is the basic failure of the patient as a person.
2. The focus of evaluation and treatment revolves around symptom description. In other words, there is little consideration for why someone is having the particular problem or symptoms.
3. The organization is hierarchical and revolves around the physician. There is less involvement with a team approach, and less acceptance for non-physician involvement to patient treatment.
4. The patient is kept as a “child” in treatment i.e. helpless, powerless, and weak as compared to the physician-parent.
5. The treatment environment is viewed as a “holding tank” for severe and/or chronic disorders.
6. The focus is on the individual with little attention to the group or community as a whole. There is minimal regard for emotional safety

- because the problems are viewed as being more “biological” in nature.
7. The treatment is primarily short-term and behavioral with little input from the patient. Even when emotional expression would be therapeutic, it would not be encouraged by the staff in hopes that the patient would more quickly return to premorbid level of function.
 8. The primary mode of treatment is biological, with an emphasis on very brief medication management visits. There is very little individual therapy with less skilled clinicians providing this form of treatment.
 9. Medication is a primary treatment modality, but is used often as a restraint. There is little emphasis or understanding of the interactions and relationships between medication and psychotherapy.
 10. Physicians are more and more isolated, often struggling with difficult transference and counter-transference issues alone. There is little consideration for the overall well-being of staff. Physicians often get pulled in the direction of utilizing their resources to do emergency coverage, consultation, etc. thus less involved in collaborative patient treatment.
 11. The view of the family is more likely to support the patient as the “problem”. There is little focus on family therapy or a systems view of the patients presentation.
 12. There is little linking between the treatment modalities and locations of treatment i.e. inpatient, outpatient, etc.. There is often no communication between the inpatient clinicians and the outpatient providers.
 13. Returns to the hospital are considered the patients’ failure. The patient is reminded of what he/she did that was “bad” leading up to the hospitalization.
 14. Patients are not expected to get better or get beyond their “illness” or problem. They are reminded of the chronicity of mental illness, and that their role should be one of acceptance. There is no room for a combination of serious mental illness and the potential for going beyond or overcoming tragedy.
 15. The traditional model does not accept trauma/childhood abuse as a reasonable explanation for any type of problem.

Intervention Phase: Creating a Community

Armed with a cognitive framework for beginning to organize change, I began my intervention by freely vocalizing the way I felt about the violence on the unit. I directed the staff to begin daily community meetings that would engage all of the patients in face-to-face encounters with each other, the staff, and myself. At these meetings I spoke about the devastating effect that the unit violence was having on all of us. I shared my own experience and feelings about the conditions and urged other staff members to do the same (Flannery

et al., 1991; 1994). Using violence as the central focus, I gradually trained the staff and the patients in the basic rules of the therapeutic milieu.

All therapeutic milieu environments rest on several assumptions: the patient should be responsible for much of their own treatment; the running of the unit should be more democratic than authoritarian; patients are capable of helping each other; treatment is to be voluntary whenever possible and restraint kept to a minimum; psychological methods of treatment are seen as preferable to physical methods of control. The most striking characteristic of the therapeutic milieu is that the community itself - and all the individuals who constitute it - are expected to be the most powerful influence on treatment (Bloom, in press). These concepts were largely new to the staff and certainly new to the patients. There were many questions about how any of these ideas could be instituted with such a violent and unpredictable population. But I remained convinced that much could be done if we were jointly able to change the existing norms of the institution. In my analysis of the situation, I had come to recognize that violence was not only condoned but encouraged by the normative structure of the unit and by the lack of an alternative model (Katz & Kirkland, 1991). And I was going to guarantee that there was, in fact, an alternative option. I met with the medical director and actively participated in the medical staff administration. I verbalized the enormity of the violence problem and the barriers to change, namely the advocacy system. I also met fairly regularly with my department chair to express how overwhelming my situation was to me. He regularly stated that I was the perfect person for this job, and verbally patted me on the head.

In the Sanctuary Model, progress in treatment can only be expected if safety has been established. Creating a safe environment free from physical and verbal violence is absolutely necessary before any other kind of progress can be made and this nonviolent environment can only be created and maintained through the joint effort of the entire community. I educated the staff about the Sanctuary Model, and wrote a beginning set of unit rules which were extremely definitive about the insistence on nonviolence (see figure 1). I repeatedly iterated my goals for the community to the staff and to the patients. Every episode of violence presented a renewed opportunity for the simple restatement of this changed norm. Instead of ignoring the episode, I would respond to it, usually by doing what was always done - using whatever method it took to get the violence under control - but then altering the established pattern by insisting on reviewing what led up to the violence, how the pattern could have been altered, alternative forms of coping with the same emotion.

The use of mechanical restraint and seclusion provided frequent illustrations of the violence-begets-violence cycle (see figure 2). As I helped the staff and patients develop a methodology for reviewing episodes of violence (Bloom, 1994; Flannery et al, 1991; 1994), it became increasingly easy to

establish the patterns of reenactment that were involved in the use of restraints. The patients were able to articulate how helpless, trapped, and revictimized they felt when the staff response to their violence began. They would often regress, dissociate, and begin experiencing flashbacks and increased autonomic arousal, often followed later by terrifying nightmares. They would perceive the staff as abusive. Likewise, the staff felt uncomfortable about having to resort to violence to curb violence but had never before expressed their feelings and perceptions to the patients. Gradually, with repeated debriefings after every episode of seclusion and restraint, both the patients and the staff began to recognize what events in the environment tended to trigger these episodes and how these triggers related to unresolved traumatic experiences from the past. As the violent episodes began to be contextualized and understood, it became possible for the staff and patient community to begin to experiment with other kinds of interventions that preceded and often prevented the violent outburst. There was an obvious decrease in the level of violence felt on the unit within about ten months, and certainly noticeable within a year.

I dealt with the issue of self-harm by addressing it head-on. In the trauma-based approach, self-mutilation is understood as an addictive and compulsive behavior that originates in attempts to self-soothe and then often takes on secondary meanings. Once it is understood as perpetration against the self, an internalized form of identification with the aggressor, the behavior becomes more accessible to treatment. I portrayed self-harm as no different from any other form of violence and an abuse of the entire community. I made the patients responsible for helping each other reduce the level of violence by helping to protect the safety of the unit and each other rather than by encouraging or trying to ignore the violence. Since repeated self-mutilative behavior was one other way the patients had of seeking out extra staff attention, I decided that we needed to take away the secondary reinforcement for the behavior, even at the same time as we were understanding and explaining it using a trauma-based approach. In service of this, I insisted that the patients were to apply bandages and antibiotics to their own self-inflicted wounds and they had to fill out their own incident reports. As the unit became calmer, more hospital staff were willing to provide treatment, one psychologist (Bell, personal communication), trained in Marsha Linehan's approach (Linehan, 1993) and a good behaviorist, helped me to develop some self-harm protocols (see figure 3) that were put into place. As the staff to patient interactions multiplied, patients were able to get attention from staff members through healthy behavior, rather than having to depend on getting a meager amount of attention through self-harming behavior. As less staff time was consumed in one-to-one and two-to-one supervision, more time was available for positive patient contact.

These changes were noted, of course, by the larger hospital environment. I educated the administration and medical staff about the trauma-based approach and my intention to reduce violence on the unit. The patient advocates initially posed some problems because they objected to any restriction of patients and my policies required that there be consequences for violent behavior, including the loss of privileges. I regularly accompanied my nursing staff to meetings with the patient advocates. The routine established by the advocates involved a sort of threatening interrogation of nursing staff about the ways they had “wrongly” or “badly” managed patients. To me, this was the same problem at a different level. The staff were not safe. I tried not to be partisan in my approach. I also asked for advocacy help to improve services and the quality of patient care. I expressed to them my conviction that their role had been diffused and was no longer focused on the betterment of patient care. So they eventually knew I would communicate with them as well. I had to become increasingly firm in my insistence that these changes were necessary and unnegotiable, but there were still occasions on which I found it necessary to accompany unit nurses when they were summoned by the advocates about my approach and policies. My presence clearly tended to have a muting effect on the proceedings.

When the violence had been reduced, therapy could really begin. Individual and group therapies were initiated and changes in the patients began to be noted. I could not overstate the importance of continuous and active leadership.

Results

The unit violence began to decrease as can be noticed in figures 4-7. For the first three months the average number of violent episodes was about one hundred per month. After that, the levels of violence began to decrease. In May, 1994 a hospital move occurred and one result was that the unit was changed from an all-female unit to a mixed unit. The addition of men to the unit appeared to effect the environment positively with a decrease in the average rate from 63 to 24 incidents per month. In August, 1994, I went on vacation and I left in November of 1994 and increases in violence can be seen at these points as well, probably representing the effects of loss of leadership in a milieu that is still reconstituting itself and continues to require the strong norming function that leaders must provide. A striking salute to the effectiveness of the trauma-based approach was the month of October, 1994 in which no seclusion and restraint was used. This was a first in the history of the institution (see figure 2).

The cost of violence is quite high. Employee time was lost as a result of being bitten, hit, splashed with hot coffee, and kicked. The average was about twenty hours per month at the peak of the violence, but in one month alone

there was 74.5 hours of employee time lost from work.

As expected, many of the patients who had been considered untreatable and chronically mentally ill, responded to a more intensive, trauma-based therapeutic milieu. By 1996, two years after I had left, one of the original patients had died, but only two others remained in the hospital. All the rest had been discharged. The dissociative identity disorder patient who had consumed so many months of two-to-one supervision was released from the hospital shortly after I left, thirty months after her admission and has not self-harmed, been suicidal, or been rehospitalized since that time.

Implications for Mental Health Services Delivery

Unfortunately, the constraints of the environment prevented me from engaging in any formal research on the unit, so my account must remain largely anecdotal. However, the dramatic alteration in violence patterns over such a comparatively short period certainly speaks to the possibility for change that does not require large reservoirs of capital or increases in personnel. It did require leadership, commitment, vision, and desire. Drawing upon the time-proven tenets of the therapeutic milieu and the newer insights of the trauma field, we were able to accomplish a striking change in a setting that ostensibly was resistant to any improvement. As resources diminish and victims of interpersonal violence multiply, the mental health system must be prepared to use innovative, community-based approaches in an effort to help victims heal.

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Figure 1: Unit Rules

- 1) Violence in general will not be tolerated on our unit. This includes verbal and physical violence, aggression and abuse of other patients, staff, or property.
- 2) Treatment is an opportunity for you to work on your problems. Your program schedule is the most important thing you will be doing, and is a requirement for all patients. We have a “No Class - No Pass” policy.
- 3) All patients should go to all meals unless specifically ordered not to by the physician.
- 4) Community meetings are an opportunity for patients to express concerns to each other and staff. It is also an opportunity to learn more about how to communicate and how to interact with each other.
- 5) All patients should observe quiet time after 11:00pm (Staff may confiscate items like radios if the quiet time is not respected).
- 6) The use of the phone is a privilege for everyone. Phone use is limited to 10 minutes per call. If you are unable to use the phone properly, then staff may ask you to get off of the phone.
- 7) Patients are not allowed to come into staff offices unless requested by staff.
- 8) Patients who are on a level 3 or above will have pass time off the unit depending on their level of function.
- 9) During the weekdays, especially, treatment is top priority; therefore, no visitors are allowed before supper without treatment team approval.

Figure 2. Number of minutes used for seclusion/restraint per month from September 1993-March 1994.

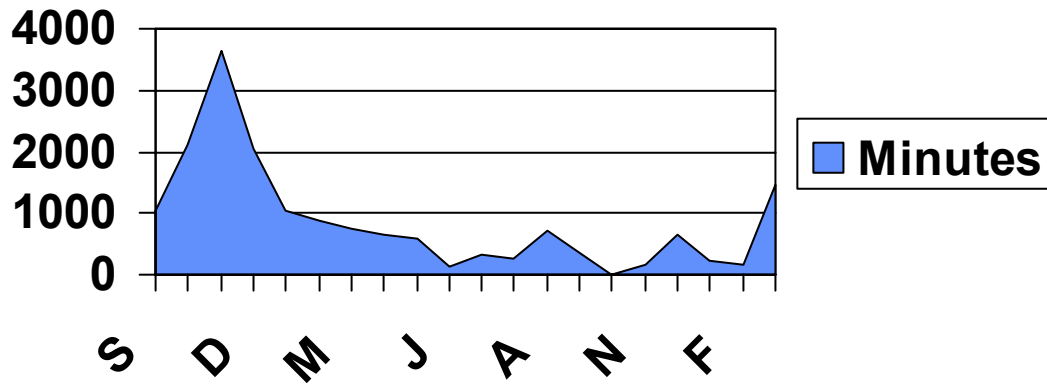


Figure 3: Self-Harm Behavior Policy

It shall be the policy of this unit to quickly establish a safe, constructive treatment plan with those individuals who, by history or current behavior, are self-mutilating or otherwise a danger to their own or to others physical or emotional well-being and comfort. Furthermore, efforts to re-establish control over such behavior will be constructive, utilizing the least amount of physical restraint necessary to insure the individual's and the community's continued safety.

Procedure:

- 1) All admitted patients and/or transferred patients with a known history or self-harm or self-mutilative behavior will be advised of the unit policy regarding such behavior at the time of admission. The patient will be asked to make a written contract regarding his/her understanding of the policy (noted below).
 - a) It is the responsibility of the admitting nurse to insure that the the patient reads and/or understands the self-harm behavior policy.
 - b) The self-harm behavior policy will be an intervention for self-harm in the patients' treatment plan and the policy/ contract will be placed in the permanent medical chart.
- 2) All patients with a history of self-mutilation will be involved in the following treatment:
 - a) Referral and evaluation to Dialectic Behavior Therapy.
 - b) Referral and evaluation for a post-traumatic disorder or dissociative disorder.
 - c) Patients will be given a Trauma Profile upon admission or at any time self-mutilation is identified as a problem.
 - d) Referral and evaluation for Anger Management.
- 3) If, despite the efforts to prevent such activity, there is evidence of self-mutilative behavior occurring or having occurred, efforts will be taken to insure that there is adequate opportunity for treatment and observation.

Self-Destructive Protocol

- a) There will be an immediate drop of at least one level for 24 hours.
- b) All sharps and items with potential for self-harm will be prohibited for 24 hours.
- c) There will be no group attendance or work program attendance for 24 hours, exclusive of community meeting, individual therapy, and Dialectic Behavior Therapy.
- d) Written assignments will be given and supervised by the patient's primary contact and/or nursing staff.

These include the following:

- 1)Self-Abuse Scale
- 2)Refocusing Assignment
- 3)Incident Report
- 4)Self-Check Timesheet (interval determined by patient and staff)
- e) Free time will be spent in the day room or at the nursing station.
- f) Visitation will be restricted to the immediate family for a period of 24 hours following the self-mutilative behavior.
- g) Meals will be eaten on the unit for 24 hours.

Patient Signature

Staff Signature

Date