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TRYING OUT SANCTUARY THE HARD WAY

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Abstract

The authors of this paper describe the first author's personal experience of introducing a Sanctuary Model of treatment into a regressed and violent state hospital ward. When this experiment began, the ward averaged one hundred reported violent incidents per month. By a year later, the number of violent incidents had been dramatically decreased using trauma-based therapeutic milieu principles. Within two years, seventy-five percent of the patients had been re-diagnosed and only two of the original patients remained hospitalized.

Historical Background

Until the nineteenth century, people who were considered insane in the United States were kept in their communities unless they were a threat to public safety. As a result of broad social and economic changes of the nineteenth century, especially urbanisation, asylums were created to house the mentally ill, thus assuming what had previously been a family function. The philosophy of "moral treatment" was brought to the United States from the York Retreat in England in the early nineteenth century and small facilities for the treatment of the mentally ill were established in many states. Asylums based on moral treatment were based on the principle that providing a well-ordered regimen, opportunities to work and to pray, beautiful surroundings, fresh air, and healthy food would persuade the disturbed person to internalise the behaviour and values of normal society and promote recovery.

In the early days of asylum development, the facilities were designed to be small, personal, and focused on active treatment and recovery. There was an expectation that patients could recover if provided with the correct healing environment. These expectations were often fulfilled and in the early days, the recovery rates were far higher than might have been expected, given modern standards. But by the 1820's it became clear that these small, privately funded, and relatively exclusive facilities were not able

to serve all the needs of an increasingly fragmented, urbanised community and the stage was set for the development of public mental hospitals (Grob, 1994).

Within decades, every state had opened large mental institutions that rapidly took over the functions that had previously been maintained by families and communities. The state hospitals, as they came to be called because they were funded by the individual states, were flooded with the poor, the disabled, the senile, the syphilitic, and the mentally retarded, as well as those considered insane. The consequence was a decreased proportion in the rate of actual recoveries, a greatly increased financial burden on the local and state governments, and a spreading bureaucratic structure designed to administer to the needs of these institutions (Dwyer, 1987; McGovern, 1985; Rothman, 1980). The result was the growth of institutions that were the stuff of which nightmares are made. Grob, describing one Lunatic Asylum in New York City noted that, “*by 1870 . . . convicts from the prison served as attendants; the diet was substandard, epidemics were common; and treatment was nonexistent*” (Grob, 1994, p. 114-115).

Despite these and many other criticisms and reform movements over the next century, the state hospital system remained largely intact until the 1970's. The state hospitals were the only places available for the care of the chronically mentally ill except for a few private facilities, and treatment remained at a minimum. After World War II, the growth of general hospital inpatient units provided some opportunity for acutely ill patients to receive short-term care, but the state hospitals remained the end point for many severely disturbed patients. But, due again to large social and economic forces, deinstitutionalization began in the late 1960's and picked up momentum throughout the 1970's. Thousands of chronically mentally ill patients were discharged from the state hospitals and placed in the communities without the simultaneous creation of adequate housing or treatment facilities that had been the plan of those who favoured the abolition of the state hospital system. The result has been a dramatic increase in the number of homeless mentally ill and incarcerated mentally ill. The state hospital systems have been downsized and now, only the most recalcitrant, dangerous, or self-destructive patients end up staying within the walls of the greatly reduced state hospital system. This paper describes the introduction of “The Sanctuary Model” into a ward of chronically violent women institutionalised on what was considered a “back ward” of a state hospital, located in a rural area of a northeastern state in the United States.

American Bedlam

In 1993, I (Dr. Bills) was appointed Medical Director of an inpatient, all female unit. The institution was located in a small rural town, whose main employer was the hospital. Like many other mental health facilities, the state hospital had experienced significant downsizing with accompanying layoffs that had placed considerable strain on many families in the community, some of whom could cite four generations of members who had worked at the hospital. The building itself was run down and in a state of rapid deterioration. The patients resided on huge wards that afforded little privacy. The high ceilings, large and echoing rooms, barred windows, locked doors, and barren walls served as an architectural metaphor for the miserable lives of the twenty-four women who inhabited the place. A quarter of them had been in the hospital for six months to four years and another quarter had been there for more than ten years, all confined there against their will. The care they received was limited to servicing only their most basic needs and most of the attention they received was from nurses and aids.

For the entire hospital of two hundred and fifty patients, there were only two psychiatrists. The medical care was supplemented by several other physicians who had no psychiatric training, although they were expected to fill psychiatric roles. Many of the patients on the unit had not seen a physician for years.

There were no social workers, psychologists, or occupational therapists assigned to this unit, due in part to its reputation for uncontrolled violence. The hospital had some therapeutic programming available for other patients, but the patients on this unit were considered too dangerous to be allowed to participate. The nursing staff had been urged not to talk to the patients in any but the most minimal way, since therapy was considered to be beyond their expertise. They were instead to observe, record, and report their findings, usually to each other. The result was that although the patients had little if any active therapy, they did have voluminous charts. Two shopping carts were required to haul one patient's chart into my office for review. There were twenty-four women on the unit. The average age of the patients was thirty-eight. Fifty percent of them had graduated from high school, and two had obtained Master's degrees. Seventy-five percent carried a diagnosis of schizophrenia, ten percent of mood disorders, ten percent with personality disorders, and five percent with dissociative disorders.

My first day at work served as a realistic prologue for what lay ahead. I had taken the job, considered the least desirable post in the hospital, because I suspected that the unresolved legacy of trauma was playing a role in the evolution – or devolution – of the women's mental and social function. I had completed a fellowship in the study of psychological trauma as a part of my residency and had come to recognize that many of the patients most resistant to psychiatric intervention were those who had a past history of child abuse and neglect. When I interviewed at the hospital, I had been impressed by the sense of cohesion and good humour of the staff who were functioning under such adverse conditions and had come to believe that this was a place where I could make a difference. But I was not truly prepared for what I found.

I heard the sound of women's screams, even before I set foot on the unit, but it was the vision of what I saw when I opened the ward door that has never really left me. As I looked down the long, dimly lit and drab corridor, a chair flew across the hallway, crashed to the floor, and a large woman in a hospital gown ran up behind the nurse that was dealing with the situation, and began to pound the nurse on the head. Several other staff members stepped into the fray, apparently unconcerned about their own well being, grabbed the patient's arms, and began talking to her, responding to the routine nature of this behaviour. Looking down the hall, there were staff members sitting outside the rooms of four different patients, all of whom were on twenty-four hour a day, one-to-one supervision and had been for many months. One patient, who I later rediagnosed as suffering from dissociative identity disorder, was on two-to-one supervision because her self-mutilative acts were so unpredictable, frequent, and imaginative. But despite all this contact, the patients were only getting custodial interventions – no attempt was made to understand their problems or what had brought them to this impasse.

During my initial few weeks, I spent most of my time listening to the staff and patients and learning about the way the unit functioned. There was no structured programming available for the patients at all, although various forms of treatment were offered to patients on other units. But these patients were considered far too disorganised and regressed to be able to benefit from therapy. The most basic needs and desires of the patients, such as eating and smoking, largely imposed what structure there was on the unit. There were no established or set expectations for the patients whatsoever. Nor was there any sense of a community or established community norms. Most importantly, however, violence was normative behaviour. Few real efforts were made to understand the factors that may have provoked each violent episode. The patients routinely lashed out violently at each other, sometimes provoked by an insult or a despised behaviour, 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 defence against serious harm. Even in those early days it was apparent to me that the patients were engaged in some

kind of bizarre reenactment behaviour that was satisfied only by the use of straitjackets and solitary confinement.

Assessing the Violence

The hospital had little therapeutic programming for the patients, but it did keep incident reports that provided me with a way of assessing the level of violence and ultimately, changes in that level (Bills and Bloom, 1998). On the average there were one hundred reported violent episodes per month, including violence to self, others and accidents. But as can be expected in virtually any institution, the reported events represented only a fraction of the violence that occurred but was not reported. Only the most serious incidents were worth the bother of filling out the required paperwork. When violence occurred it was not processed within the community, but was simply dealt with as aberrant individual behaviour that needed to be managed and subdued. Informally, the nurses would chat about their own negative experiences, but even they had become blunted to the routine violence to which they were exposed.

The types of violence were variable and some of the routine episodes of self-mutilation were particularly repellent. One woman, sexually and physically abused first by her family and then later in foster care, would repeatedly smash pieces of glass to put into her eyes. Another would repetitively and compulsively insert dangerous objects into her vaginal canal and demand that the physician remove them. Not surprisingly she was a known victim of incest. A woman who had been horrifically physically abused by her father, would engage in situations with staff that would escalate to violence necessitating an emergency call to male staff members in the hospital who would rush to assist the staff, wrestle the patient into submission and tie her in restraints. In this scenario she managed to use the staff to recreate a scenario of her own childhood over and over again.

As I observed the day-to-day functioning of the unit, I began to look for aspects of the environment that were supporting and reinforcing the resort to violence on the part of the patients. Clearly the lack of structure and an expectation of more normal social behaviour were significant. It also became clear that violence was the one way that these isolated and bored patients could get noticed by the staff. If a patient cut her arms severely enough to require stitches, she was rewarded by an ambulance trip to the local hospital where her wounds would be bathed and bound. For those hours she was accompanied by a staff member who could give her undivided attention. For some patients, this kind of wound care was the only time they experienced the touch of another human being. Being labelled as manipulative, needy, crazy, or borderline was a small price to pay to satisfy this normal need for attention and human contact.

➤ **Creating a Milieu Environment**

At first, I made no changes on the unit, choosing instead to allow the staff to become familiar with me and allowing me to become familiar with them and their routines. I spent hours pouring over each patient's chart at the nursing station, in the presence of the nurses. I witnessed and participated in many emergency situations with them. I came back to the hospital at night and in the early morning hours to familiarize myself with the evening and night shift staff. I spent twelve hours a day and one weekend day a week, working on the unit, motivating the staff, using the force of my own personality to bring about change. The hospital had live-in on-call, so at least once a week I slept at the hospital. As the nurses witnessed my willingness to actively participate in care, to be available to teach them, and my

commitment to patient care, they became more at ease with me. I was the first physician in many years who was willing to spend a great deal of time on the unit, with the patients, and with them.

And they were ready for change. I saw how frustrated they were by the repetitive violence and seized a window of opportunity with them, convincing them through my own behaviour that there were alternatives, that violence could be stopped, that patients could benefit from a more dynamic structure and could change and make progress. They needed a leader to organize their energy and shift their anger in the direction of positive change. I saw this response on the part of the staff and on the part of the patients.

Having established my “credentials” in this way, I began to talk about the structure of change. I had become well acquainted with The Sanctuary Model through contact with Dr. Bloom and her writing during my residency. She had agreed to become my consultant when I decided to take this job and was available to me by phone throughout the start-up period. I began bringing in reading material for the staff and held regular education sessions about trauma, therapeutic community principles, and The Sanctuary Model. I shared my own reactions to the violence on the unit with the staff and encouraged them to talk to each other about their reactions, discussing with them the importance of this sharing for their own well-being and that of the unit (Flannery, 1991, 1994). Gradually I prepared them for the changes that I intended to initiate and recruited them to help make these changes. I instructed the nursing staff in how to hold community meetings and daily meetings commenced, using violence prevention as a focus of the meetings with the patients.

My next step was to meet with the patients. I called them all together – a significant event in and of itself – and asked them to talk about the violence that had become so much a part of their lives. Not surprisingly in retrospect, all of the patients who were willing to talk agreed that the violence was an overwhelmingly noxious influence in their lives. But they felt helpless to do anything about each other’s aggression. Patients who had been withdrawn and isolated, began to respond more positively when opportunities arose to try to make some sense out of what was happening on the unit as an introduction to making some positive changes. Lorna is a dramatic example of this change.

Lorna

The oldest woman on the unit, Lorna was a toothpick of a person. She never approached the staff or me, preferring to stay in the background. There were only a few things that the staff knew about her. She had been a sergeant in the armed services during World War II and supposedly came from a wealthy family in New England. She had the physical bearing of a military person and conducted herself with the propriety befitting a New England matron. She was chronically paranoid and based on prior experience, everyone agreed that it was inadvisable to bring up any mention of the war. When I reviewed her chart, I found little information about her. I did discover that even though she had been in the hospital for over ten years, she had never had a medical examination. At the time of admission, in her paranoid state, she had refused an exam and had refused to allow any blood studies to be done.

Other than being a picky eater, she never caused problems for the staff. She simply kept to herself, usually in her room, and therefore was largely ignored. But this all changed when the staff and I began helping the patients form a real community. Once community meetings began, Lorna started to attend. She was the first patient to actively articulate the horror attendant on living with the constant threat and reality

of violence. She ably described the destructive impact of the self-mutilation that she witnessed around her, and explained that she stayed in her room because coming out of it was simply too frightening.

As Lorna began to talk and engage with others, the staff began seeing her differently and she began interacting more with both staff and patients. But her medical condition remained a problem. She was of the opinion that women had no business being doctors and so refused to talk to me. She was finally convinced to take a little medication – an antipsychotic – to help with sleep and then agreed to see a family practice physician in the town – a man. This probably saved her life. The medical examination showed colon cancer, which was the origin of her “picky eating”. She had successful removal of the colon, healed well from surgery, became less paranoid, and was released from the hospital.

Introducing the Sanctuary Model

Converting a violent environment to nonviolence does not happen overnight, but gradually, change began to occur. I educated the staff and patients about the Sanctuary Model. I established a set of unit rules that insisted on the active practice of nonviolence. Once the new norms were established, every episode of violence became an opportunity to reiterate the new normative pattern. I insisted that both staff and patients review what had led up to the violence, how the pattern of violence could be altered, what alternative coping skills were available to manage the emotion that had led to violence. The use of restraint and seclusion illustrated how violence leads to violence in a vicious and escalating cycle. As this review process became institutionalised and understood, the reenactment patterns became clearer. Patients became able to talk about their present violence in terms of understanding their past experiences with violence that usually dated back to childhood. And the staff began putting the violence into perspective, began making sense of what caused each violent episode and what they could potentially do to prevent further eruptions. The patients benefited from hearing the staff's comments about how much they abhorred the violence but were compelled to respond violently in order to prevent the patients from doing more harm. Gradually, instead of being some autonomous and unknowable force in the environment, the violence became meaningful and relational in context. It began to make sense.

I instituted a review process for every episode of violence, seclusion and restraint and as a result, both the patients and the staff began to recognise the events in the environment that 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. Trudy was one person who presented a challenge to this developing therapeutic system.

Trudy

Trudy was thirty-eight years old when I first met her. There was a long trauma history of multigenerational incest in her family – and that was only one of many problems. Trudy was diagnosed as being developmentally delayed. Her characteristic behaviour was extremely violent, impulsive, and unpredictable, and she

was considered to have an impulse control disorder. She came to the unit from a group home as a new admission, although she had already had multiple hospitalisations and could no longer be contained in the group home. At admission she was taking a number of medications, suffered from a seizure disorder, was a binge eater, and needed help with even the simplest tasks, like getting dressed. Worst of all, she was a large woman and given to episodes of unprovoked aggression towards staff and patients if she did not get immediate gratification of her demands. As the community began to be more cohesive, the patients became increasingly frustrated with Trudy. Behavioural plans had not worked because the level of violence made it very difficult for the staff to be consistent. The nursing staff was afraid of her and as a result would often fail to follow-through with necessary consequences for her negative behaviour. The staff increasingly resorted to medications that were not very effective but did carry side effects that posed problems. As time passed, the staff and the patients became increasingly frustrated with Trudy and would lash out at her provocations.

In such situations it can be helpful to get the perspective of an outside consultant, someone not immediately involved in or responsible for the problem. After a phone consultation with Dr. Bloom, I decided to try an approach in which the staff and the other patients would “kill her with kindness” as a way of breaking free from the set patterns of interaction that Trudy had established for herself and others. With the support of the staff, I convinced everyone to start being extra nice to Trudy, giving her little presents, attention, and comfort when she wasn’t hitting. So the patients, relieved at least to have something new to do, began treating Trudy like the little child she really was. They gave her stuffed animal toys, held her hand to walk her around, offered to go with her when she wanted to go out for a smoke. They cooperated with each other in sharing the burden for caring for Trudy. The strategy met with success. Trudy’s violent episodes ceased and she became a part of the community.

Broadly Defining – and Changing - Violence

Episodes of self-mutilation were so common that the staff often failed to even make much comment about them. At first, the problem seemed insurmountable. But I realised that there was no way to create a nonviolent environment without tackling the issue of self-harm. In this trauma-based approach, self-mutilation is understood as perpetration against the self, an internalised form of identification with the aggressor. Patients often begin self-mutilating in an attempt to cope with the overwhelming affect generated by exposure to trauma. The self-harming behaviour can be employed as a method of self-soothing, a distraction from intrusive flashbacks, a way to relieve guilt, a device for terminating dissociative states of consciousness. But over time the behaviour itself can become addictive and compulsive. Within a community setting self-harming behaviour can come to dominate the milieu. When it is the behaviour that attracts the attention of the staff, patients are then compelled to compete with each other for the meagre amount of attention they so desperately need. This was the situation that I set about remedying. I began making it abundantly clear that harming oneself was not consistent with the goal of nonviolence – that violence is violence, whether you do it to yourself or someone else.

As I began helping the community to redefine the boundaries of acceptable behaviour, I began to assert a norm that required the patients to be responsible for helping each other reduce the level of violence and protecting the safety and integrity of the unit. I also required the patients to be more responsible

about their own self-care, including applying their own bandages and antibiotic ointment and in filling out their own incident reports. In doing so they had to think about the circumstances that had led them to self-mutilate and alternative behaviours that could achieve a more acceptable response.

As incidents of violence began to decrease, hospital staff outside of the unit became more willing to participate in treatment. At the same time, the interactions between regular staff and patients multiplied and the patients discovered that they could get the attention they longed for by engaging in healthier behaviours. As less staff time was consumed in one-to-one and two-to-one supervision, more time was available for positive patient contact. As the violence diminished, active therapy could begin. Individual and group therapies were initiated and changes in the patients began to be noted.

➤ Quantifying Results

The changes that occurred on the unit over the next year were dramatic and measurable. For the first three months of my leadership, the average number of violent episodes was about one hundred per month and after that the levels of violence began to decrease. Six months into the measured period, the hospital moved into new quarters and the previously all-female unit became a mixed-gender unit. The addition of men appeared to effect the unit positively. The average rate of incidents decreased from 63 to 24 incidents per month. Increases in levels of violence occurred when I went on vacation, clarifying the continuing need for a strong leadership presence, and again after I took another position and left the unit. Before leaving however, there was one month during which there were no incidents of the use of seclusion or restraint – a first in the history of the institution. Another benefit to the institution was the decrease in lost time from work on the part of the employees. When the violence level was high, employees were injured as a result of being bitten, hit, scalded with hot coffee, and kicked. On average this was costing the hospital about twenty hours per month and in one month alone there were over 74 lost hours of employee time secondary to violence.

Another benefit was a change in the discharge rate. Many of the patients, previously considered untreatable and hopelessly chronic, responded to a more intensive, trauma-based therapeutic milieu. Before leaving my position, I had rediagnosed 75% of the patients on the unit. Five years after my departure, one of the original patients has died, but only one other remains in the hospital. All the rest have been discharged and in that five year period have not been readmitted. The dissociative identity disorder patient who had consumed so many months of two-to-one supervision was released from the hospital thirty months after her admission and at least two years after discharge had not self-harmed, been suicidal, or been rehospitalized.

Figure 1. Number of Self-Harm Episodes per month from September 1993-March 1995.

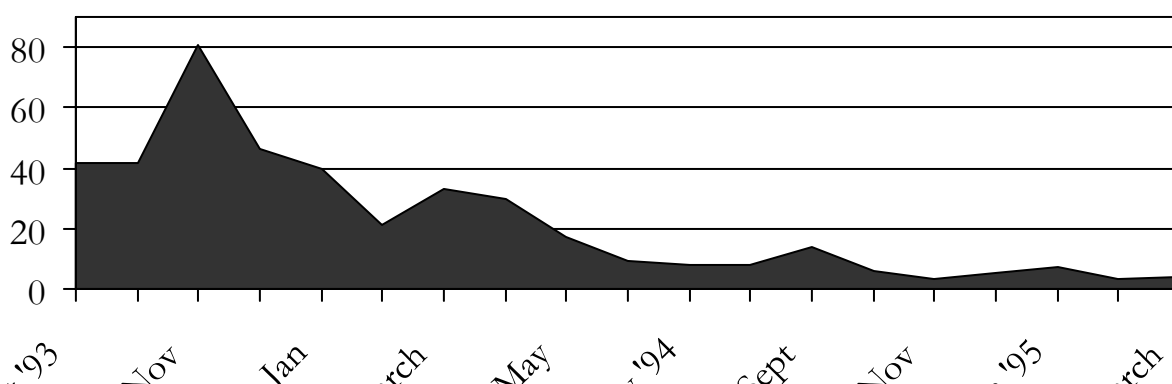
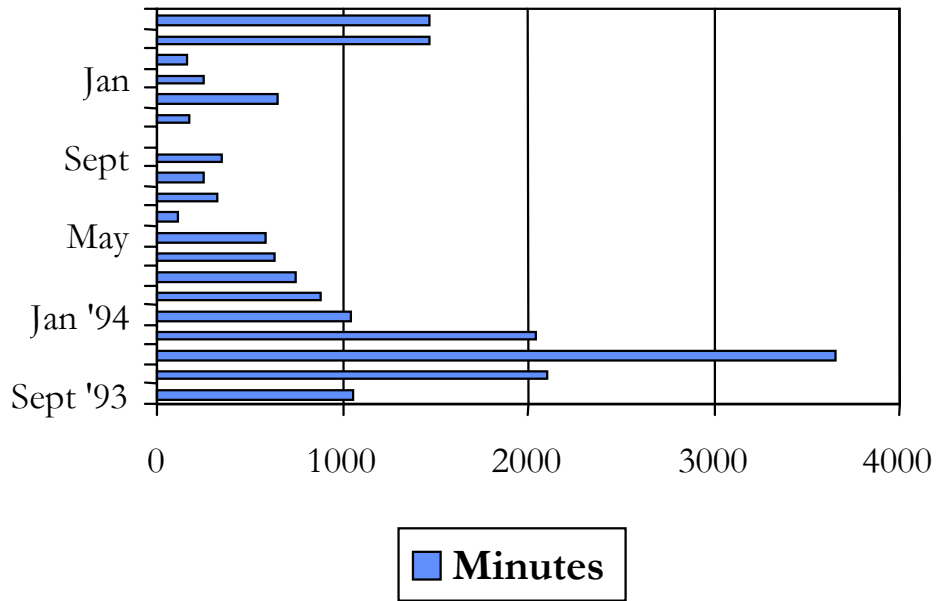


Figure 2. Number of minutes used for seclusion/restraint per month from September 1993-March 1994



Conclusion

Changing a system was a powerful learning experience for me and in the last five years I have had the opportunity to reflect on the lessons I learned. I personally witnessed just how powerful the Sanctuary Model is in stopping violence, in creating sane working and living environments, and in promoting health. I became convinced of the power of the therapeutic milieu in bringing about change and learned that if you are using milieu therapy, the intensity of individual treatment can be diminished. The milieu is a continuous, rather than an intermittent, modality that is multidimensional, naturalistic, less regressive, less encouraging of dependency, and more responsive to the complex needs of patients who have been raised in highly dysfunctional homes. Patients respond in a more empowering ways to the peer interventions than they do to those that derive from authority figures and these peer contacts are a routine part of the therapeutic environment.

I also learned the vital importance of having a conceptual framework within which we are able to understand our patients' symptoms and can convey that understanding to the patients. Until I introduced trauma theory, no one had understood the trauma-based nature of the patients' symptoms and had consistently labelled that behaviour "crazy" or "bad" – and therefore not really subject to change. The trauma model allowed the staff to see the patients as having the potential to change, not needing to be hospitalised for the rest of their lives. They came to believe that if we were able to address the reasons they were there, they could heal enough to live more functional lives outside of the hospital. This sense of hope was contagious, spreading from me to the staff and on to the entire patient community.

But there were also some harder lessons to learn that are still impacting me today. I learned that it was an advantage to be naïve, to know nothing about power structure, bureaucracy and to maintain a certain irreverence for the established "rules" of institutionalisation. In my case, "ignorance was bliss", in that I was unafraid to enter this system and start making changes when I saw there was a window of opportunity for such change. As a result, the decisions I made were not motivated by politics and were not decisions of compromise. Consequently, changes in the staff and in the patients were dramatic and significant.

However, this same advantage turned out to be a disadvantage in terms of creating the circumstances for lasting change. When I left, there was no leader ready to continue the changes I had made and no changes had occurred in the hierarchy of the hospital. I vividly recall presenting the remarkable statistics for our unit to the medical staff and administrators. The numbers clearly showed significant changes in the level of violence. I knew that everyone at the meeting was fully aware that my unit had been the most violent unit in the hospital and had become the least violent unit in a relatively short time. Naively assuming they would want to bring about changes in their programs as well, I asked them if they would like to do what we had done, telling them briefly how with simple changes, the entire hospital could become a non-violent institution. The members of this leadership group, comprised largely of other physicians, just smiled at me and declined to comment. Nothing of what we had accomplished spread to the rest of the hospital.

It was finally this resistance that compelled me to leave. I knew I had to find a safer setting within which I could continue this work. The fixed hierarchy of the institution was clearly not about to change easily and as a solo change agent, I came to doubt my ability to impact on it before it took an irremediable toll on me. The staff were totally behind me, but they did not have sufficient power within the institution to lead change throughout the institution. This was another hard-earned lesson. Bringing about change required an enormous amount of time, energy, and commitment from me and essentially

prevented me from having any life outside the hospital. This in itself is unhealthy and helps to explain, perhaps, why it has been so difficult to see the ideas inherent in the therapeutic community movement achieve the status that they should, given how effective milieu therapy can be.

Since I have joined the Sanctuary team, I have witnessed the toll that this constant demand to challenge the existing bureaucracy takes, and how little real political power is derived from doing good work. There is clearly a pressure in the larger system to resist change, to keep institutions violent, to prevent the creation of systems that improve the physical and mental well being of those who work and live within these systems. I am still wrestling with these issues and challenges on a daily basis and the struggle has convinced me, more than ever, that the key to individual and social health lies in group process, in enough people becoming sufficiently sick of the violence that they join together to stop it. And if that time comes, they will need the record we leave behind of our individual and group struggles in this experimental laboratory we call "the therapeutic community movement" to demonstrate how it is possible to go beyond individualism toward a sense of "groupmind" and group functioning that does not sacrifice, but indeed promotes individual rights while protecting the welfare of the entire community.

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