

# THE SANCTUARY MODEL: INTRODUCTION

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In the United States, the therapeutic milieu/therapeutic community model of psychiatric treatment is now rarely mentioned. The excesses of biological reductionism and "managed care" leave little room for the maintenance or development of psychosocial forms of treatment. In the managed care system, an insurance company hires another company to "manage" the benefits offered by the insurance company. In practice, this means that physicians and hospitals must get permission from the managed care company to admit patients and once admission is agreed to, the clinician must repeatedly receive permission to continue treatment – sometimes requiring daily, time-consuming phone calls with company representatives who have never met or spoken to the patient and who may have relatively little clinical expertise. The managed care company has a strong economic incentive to refuse hospitalisation or, if admission is granted, to seek discharge as soon as possible, since their payment is based on how much money they save the insurance companies who hire them. There is also an incentive to reduce costs by the preferential use of biological forms of intervention – electroshock and medications – rather than the more prolonged forms of intensive individual and group therapies. In such a climate, short-term solutions like the use of drugs to calm anxiety, are frequently preferred over more intense, complex and time-consuming methods of anxiety resolution.

Mental health treatment in general and inpatient treatment in particular has been massively altered as a result of decrease in funding. According to a report commissioned by the National Association of Psychiatric Health Systems, between 1988 and 1997, behavioral health benefits costs were slashed 670% more than general health care benefit costs (Hay Group, 1998). Spending on general healthcare benefits declined 7% while spending on mental health care

benefits declined 54%, plummeting the behavioural health percentage of the total healthcare benefit by 50% (Zwillich, 1998).

This economic phenomenon has profoundly influenced hospital-based treatment programs in the past decade and is likely to continue to do so for the foreseeable future. Lengths of stay in inpatient settings have been dramatically driven down by this profit-dominated medical industry. Hardest hit have been inpatient days which dropped by 69% while the average length of stay has decreased by 50% (Hay Group, 1998). In some states, the average lengths of psychiatric stays are down to three days, providing opportunity for little but stabilisation of medication and emergency management of crisis situations.

These changes have little to do with the actual benefit that the therapeutic milieu offers to people suffering from various forms of emotional problems, or the very real demand for these services. Nonetheless, when financial cutbacks occur, the requirements of the therapeutic milieu for adequate staff, for time spent in case discussion, for creative therapies, and for the bridging between disciplines are often the first to go - the first functions that are considered dispensable.

While the health care industry in the U.S. has been undergoing these dramatic changes, another important development has occurred in health care – the recognition that a substantial proportion of patients seeking psychiatric care have a history of serious traumatic experiences that are playing a vital – and often unrecognised – role in the evolution of their mental health problems.

There are a number of disorders known to be related to traumatic experience. Post-traumatic stress disorder (PTSD) is only the most obvious and well-recognised. But as Davidson (1993) has pointed out, the DSM-III-R lists at least ten other diagnoses that have been connected to trauma – brief reactive psychosis, dissociative identity disorder, dissociative fugue, dissociative amnesia, conversion disorder, borderline personality disorder, depersonalisation disorder, somatization disorder, dream anxiety disorder, antisocial personality disorder (Davidson, 1993). We also know that there is a high level of comorbidity between post-traumatic stress disorder and depression, anxiety, panic disorder, phobic disorder, substance abuse, and many physical disorders. As the reader will recognise from this list – these are the patients who populate therapeutic milieu environments.

It is to be expected, therefore, that as our understanding of traumatic experiences has grown, so has the demand for safe and therapeutic environments within which victims can gain the skills necessary to set out on the road to recovery. One of the challenges posed in the United States by the managed care system is how to create these kinds of safe environments while keeping down costs and, over time, adjusting to diminishing resources.

This special edition of the *Journal of Therapeutic Communities* is dedicated to the description of three therapeutic milieu programs, two in the United States and one in Canada, designed to specialise in the treatment of adults who were traumatised and/or abused as children and therefore suffer from syndromes that are complex and intertwined with development.

The first and second papers describe *The Sanctuary®*, a short-term treatment program for adults who have been traumatized, usually beginning in childhood. The average length of stay is less than two weeks. *The Sanctuary* is physically located at two sites – one at Horsham Clinic in Ambler, Pennsylvania and another at the Hampton Behavioral Health Center in Rancocas, New Jersey. The first paper describes how the fundamental philosophical basis of the programs is trauma-based, modified therapeutic milieus that sustain constant change due to the rapid turnover of patients and therefore a constantly shifting population. The second paper addresses the SAGE Model of treatment that provides the staff and patients of Sanctuary with a coherent “map of recovery”. Some data are presented in this paper about the incidents of violence in The Sanctuary during a specific time period.

The third paper provides an interesting contrast to the first two papers as it describes a treatment program in Guelph, Canada located at Homewood Hospital, the only private psychiatric hospital in Canada. The average length of stay in the Canadian facility is six weeks, providing for the establishment of a more traditional therapeutic milieu. Their paper describes preliminary data on outcome measures. When the unit was originally established, I consulted with the program founders and shared with them our experience in the development of The Sanctuary and did some training with the nursing staff. The program then went on its own developmental course which is described in this paper, although as friends and colleagues, we have stayed in touch with each other over the years. Our development of the SAGE Model (Foderaro and Ryan, this volume) occurred years after this consultation and reflects our adaptation to the U.S. health care system, while the Wright and Woo paper reflects the Canadian health care system. The terminology differences, as in our different terminology for the stages of treatment and the concept of safety, represent this early divergence in experience. Our theoretical orientation however, remains very similar, integrating new knowledge about the effects of traumatic experience with the long established tenets of the therapeutic community.

The fourth paper describes a program that briefly existed in a state hospital system when a young psychiatrist introduced The Sanctuary Model into an extremely violent and regressed, all-female unit. This paper is published here as an illustration of what can be done, even in the most backward and recalcitrant of systems, using the combination of a trauma-based approach and therapeutic community principles. The question of addressing violence has become a major

issue of concern in the United States' inpatient psychiatric system as decreases in funding and staffing and therefore the breakdown of a community model have produced an escalation of violence and an increased use of seclusion and restraint. Some data about the decreases in violence after instituting The Sanctuary Model are presented.

We hope the experiences that clinicians and their patients have had in all these programs will be of benefit to the survival and continued evolution of the therapeutic community ideals and ideas. Now that we understand that a majority of psychiatric illness is related to the effect of unresolved traumatic experience and that trauma causes biopsychosocial and existential difficulties for people, traumatic stress studies may be able to provide more of the evidence-based data that the therapeutic community model has needed to lend it more credibility in the eyes of funding officers (Lees, 1999). In study after study, social support turns out to be critical to the recovery of victims, and the lack of that support, damaging (Andrykowski and Cordova, 1998; Feiring et al, 1998; Holtz, 1998; King et al, 1998; Kliewer et al., 1998; Schutzwahl, 1999; Taft et al., 1999) . Given the experience of the therapeutic milieu as an "experimental laboratory" this is particularly important. Since exposure to trauma is endemic in the population, then the therapeutic milieu becomes one of the rare examples of a laboratory for social, not just personal change.

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# CREATING SANCTUARY:

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## *HEALING FROM SYSTEMATIC ABUSES OF POWER*

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### ABSTRACT

This paper describes a short-term modified therapeutic milieu program called *The Sanctuary*, designed specifically for the treatment of trauma-related disorders in adults. The relationship between a trauma-based model and the therapeutic milieu model are explored. The fundamental assumptions that inform the treatment model are outlined as well as the goals of treatment.

### INTRODUCTION

If one reviews the general psychiatric literature of the past decade, it would be relatively easy to conclude that the therapeutic community model of treatment has died what many of us would consider an “untimely death” – at least in the United States. In a search of U.S. literature databases for the last five years for the therapeutic community and the therapeutic milieu, less than twenty-five articles focus on the inpatient psychiatric aspects of these topics. However our growing awareness of the long-term consequences of unresolved traumatic experience combined with the disintegration of communities of meaning, encourages a new look at the established practice and principles of the therapeutic milieu model.

Our program is called *The Sanctuary* and is now located at two sites, one in suburban Philadelphia and another in New Jersey. It is a program designed to meet the needs of adults who have been traumatised, usually as children. We treat men and women over the age of eighteen. Given the constraints of the current health care environment in the United States, the lengths of stay for our patients is very short – down to around nine days (See Bloom, Introduction, this volume). Frequently however, patients are hospitalised several times over

the course of a year, an outcome we do not see as an increase in “recidivism”, since they rarely have the time necessary to accomplish appropriate goals during their initial admission. In between admissions, patients are followed by their outpatient therapist who has usually become familiar with the treatment regimen, goals, and practices of the inpatient setting and is thereby able to utilise the hospital as a part of an overall treatment continuum when necessary.

In this paper, I will outline how our practice has changed as a result of the demand to shorten lengths of stay while functioning with fewer staff to help patients who are suffering from higher acuity conditions. We have responded to these challenges in a number of ways, while still maintaining a sense of community. Given the short lengths of stay, it would be a mistake to think of our program as a traditional therapeutic community (TC). We tend to use the term “therapeutic milieu” in the sense of a carefully arranged environment for the treatment of our patients, a milieu designed to begin reversing the effects of growing up in situations characterized by interpersonal violence (Bloom, 1997; Leeman, 1986). However, we adhere as best we can to the tenets of the TC, including an emphasis on an informal and communal atmosphere, the central place of group meetings in the program, a belief in the therapeutic role of everyone in the environment, and a sharing of authority, responsibility, and the tasks of maintaining the community (Kennard, 1998). We also share a system of values and beliefs that will be discussed in this paper. It is more accurate to call *The Sanctuary* a trauma-based, nonviolent, therapeutic culture that emphasizes what Haigh has described as the five ingredients of a such an environment: 1) attachment: a culture of belonging; 2) containment: a culture of safety; 3) communication: a culture of openness; 4) involvement: a culture of participation and citizenship; 5) agency: a culture of empowerment (Haigh, 1999).

## BACKGROUND

In 1980, we – a psychiatrist, clinical nurse specialist, and social worker - founded a psychiatric unit in a general hospital using a therapeutic milieu approach in an open, voluntary setting. Our patients suffered from a variety of different problem and usually stayed in the hospital for about three weeks. Around 1985, consistent with the observation of other clinicians (Jacobson and Herald, 1990; Jacobson and Richardson, 1987; Jacobson et al, 1987), we began to recognise that a majority of our patients had been exposed to severely traumatising environments as children. They had learned to survive and to cope with overwhelming stress, but the price of their survival had been paid with their mental health. Our patients were victims of torture, usually suffered at the hands of those upon whom they were supposed to be able to depend. In order to survive under such abnormal conditions they had been forced to adopt extremely twisted norms for self-in-relation-to-other.

We were compelled to rethink our conceptualisations of treatment and to re-evaluate our basic assumptions, goals, and practice. Out of this process emerged our conceptualisation of a “sanctuary” which I have described in several articles and a book (Bloom 1994a, 1994b, 1997). The name itself derived from the concept of “sanctuary trauma”, defined as that which occurs when an individual who has suffered a severe stressor next encounters what was expected to be a supportive and protective environment and discovers only more trauma (Silver, 1986).

In 1991, we moved our program to a private psychiatric facility in suburban Philadelphia and named it *The Sanctuary*, in order to specialise in the treatment of adult survivors of trauma and abuse. We continued to develop our treatment philosophy and practice from 1991-1996, but then were forced to move again because of the deteriorating economic position of the institution. From 1996-1999 we located our program at an urban not-for-profit institution, encountering an even more severely impaired and diverse population. Meanwhile, the health care environment had become increasingly hostile to intensive, psychotherapeutically-driven care and in the Summer of 1999, we simultaneously moved our program to yet another private suburban hospital and opened a sister unit in the neighbouring state of New Jersey. These moves have been disruptive but have also compelled us to think about and plan for program replication.

Our patients enter the hospital for a number of different reasons and carry many different psychiatric diagnoses. Most of them are engaged in some form of self-destructive behaviour such as self-mutilation, addictions, eating disorders, suicidality, risk-taking behaviours, and involvement in violent relationships. They are labelled as suffering from major depressive disorders, anxiety disorders, dissociative disorders, and personality disorders. Some of them claim to have been involved in satanic cults, some have been involved in religious organisations that could be considered cults. Many of them come from families in which terrible deeds have been perpetrated under the veil of secrecy, tied by the bonds of loyalty and obedience that an abusive family system demands. Virtually all of them share in common deep and pervasive experiences with abuses of power.

We call our shared value base the “trauma model”. In order to talk about, and write about these shared values, we were compelled to take a retrospective look at the ways that our growing recognition of the impact of traumatic experience had altered us as clinicians. In brief, we had come to have more respect for the critical impact of development on the evolution of emotional disorders, especially when that development is skewed by exposure to overwhelming stress. The recognition that our patients were injured compelled us to make dramatic shifts in what we believed about mental illness, in our

stance towards our patients, and in the way we understand communication between our patients and each other.

We came to call these our “shared assumptions”, the underlying constitutional basis for doing the work we do together. These assumptions derive directly from an understanding of what trauma does to individuals and therefore of what the treatment environment needs to reflect if it is to correct these biopsychosocial disruptions. But the assumptions also derive from our understanding of how groups work together, particularly in light of the fact that trauma always occurs within a social context and social wounds require social healing. We recognised that all that we had previously learned about group influence and community milieu treatment was more important than ever. In fact, the evidence-based knowledge about the effects of trauma gave us a scientific underpinning for the principles of good milieu management that we had routinely applied in the past and also gave support for actively confronting the abusive use of power, that is such an inherent part of both dysfunctional families and dysfunctional institutions.

We also realised that we had become far more definitive about what we expected from our patients and about the goals of treatment. In retrospect, we saw that we had previously been very unclear about what we expected from ourselves and from them. Because our goals were unclear, we had often given inconsistent messages, sometimes excusing irresponsible behaviour because of “mental illness” and at other times becoming irritated at our patient’s failure to make more progress. By necessity, and as an outcome of our theory development, our goal setting became clearer, more specific, more focused, and more quantifiable.

In a similar way, it became easier to talk about our practice, the natural outgrowth of our shared assumptions and our shared goals. It also became simpler to understand, discuss, and manage the inevitable conflicts that emerge when what we do is not consistent with what we believe and what we are trying to accomplish. In the remainder of this paper I will summarise these shared assumptions, goals, and practice as they have emerged in the course of our endeavours thus far.

## SHARED ASSUMPTIONS

The growing body of knowledge about the impact of overwhelming and repeated stress, known as traumatic stress studies, provides a way of understanding the complicated biopsychosocial and existential syndromes that characterise so many of the patients who challenge the mental health system in any country. The long-lasting effects of trauma and abuse also lead to some practical implications for any treatment environment hoping to address these effects successfully.

## SICKNESS VS. INJURY

The starting point of a trauma-based approach is that it serves to normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance. In such a model, dissociation, self-mutilation, abnormal eating behaviours, chronic suicidality and many other forms of compulsive, self- and other-destructive behaviours are seen as “normal responses to abnormal stress”, originally useful coping skills for a besieged child, struggling to survive. In this way, the philosophical emphasis shifts from a sickness to an injury model of human dysfunction.

In a sickness model, the cause of the illness is safely lodged within the individual, whether the attributed cause is faulty genes, biochemical dysregulation, or basic badness. In an injury model, the individual certainly brings basic constitutional features into the situation, but then something, or more usually somebody, else, injures the person thus connecting the personal and the sociopolitical environments. In a sickness model, the individual is largely passive, waiting for expert advice or help, expected to understand relatively little about the nature, causes, or cure of his own problems. In an injury model, the injured person is expected to learn about the nature of her injuries and how to promote her own recovery. A sickness model may imply a “magical” cure, or at least stabilisation of symptoms, while an injury model implies recovery and rehabilitation, even if the person needs to learn to function with certain limitations or disabilities. In a sickness model, the individual has relatively little personal responsibility for either the cause of his illness or its treatment, nor does the social environment have much responsibility for the cause or the treatment outcome. In an injury model, the individual and the social environment have a shared responsibility both for the causes of, protection from, and relief of the individual’s symptoms. Viewing our patients as adults who experienced primary injuries as children and then often secondary and tertiary injuries as adults shifted our understanding of how to view their problems and shifted our interactions with them.

## DEVELOPMENTAL INJURIES

There is a growing understanding of the profound developmental threats posed by a child’s exposure to repeated, overwhelming stress. We now know that traumatised children have disruptions in their basic biological regulatory systems and attachments systems (Ito et al, 1993; Perry, 1994; Perry and Pate, 1994; Trickett and Putnam, 1993). We came to recognize that we were attempting to treat these same children grown up, witnessing the transmutation of childhood stress response syndrome into adult pathology. Years, and sometimes decades later, our adult patients were continuing to behave as if the childhood abuse was ongoing, as if their perpetrators were still an ever-present threat. Their bodies were still reacting to even minor provocation with extreme symptoms of hyperarousal and cognitive distortions.

Most of them had internalised the perpetrator and were themselves engaged in destructive acts of violence towards their own bodies and toward others. Frequently, they did not even remember what had happened to them and only through their behaviour – and the symptoms of their bodies - were they able to tell the story of their pain. The past was haunting them through flashbacks, nightmares, and body memories that were unrelenting in their intensity, as were their own attempts to shut-off the overwhelming nature of these intrusive experiences with whatever substances or behaviours were available. Although carrying many different traditional diagnostic labels, we came to see our patients as suffering from the complex disorders related to exposure to overwhelming stress (Herman, 1992; van der Kolk et al., 1994). All of this meant that we had to simultaneously approach them as functional adults and injured children. Since we could not undo the past, we had to learn how to teach the adult how to “reparent” the child that lived within.

### UNDOING THE DAMAGE OF DYSFUNCTIONAL SYSTEMS

This kind of teaching and reorientation process cannot be successful if the treatment environment mimics the behaviours of the dysfunctional systems our patients experienced as children. Given this background, it was necessary to design a treatment program and treatment strategies that could potentially undo some of the damage of living in a dysfunctional system. A dysfunctional system is characterised by a number of traits (Courtois, 1988). These characteristics define many of the system attributes of an abusive family, an abusive religious group, an abusive therapy group, an abusive educational or occupational institution and an abusive government. Typically such systems are riddled by collective denial of problems and shared and shameful secrets. There is a lack of honesty between system members and a web of lies that is difficult to penetrate. The system tends to stay isolated from other systems so that information is not easily shared. The isolation helps maintain the atmosphere of secrecy and ignorance. Those who have power in the system control information and manipulate the information that is available to other members of the system. In doing so, they define reality for everyone. There are often very unclear and shifting roles between members of the system so boundaries are diffuse and confusing and personal boundaries are often violated. There is a poor tolerance for differences among members of the system and no good mechanism for conflict resolution. Instead of resolving conflicts they are kept submerged for as long as possible and if they finally rise to the surface they are dealt with in a highly moralistic, and usually hypocritical way. The open expression of emotion, most importantly the positive emotions that lead to joy, laughter, play, relaxation, friendship, affection, tolerance, forgiveness, and mutual self-regard, are discouraged or actively inhibited. Negative emotional experiences of anger, shaming, ridicule, cynicism, and humiliation are far better tolerated or even encouraged in such systems. Violence or the threat of violence is tolerated, encouraged, and used as an on-

going method of controlling the behaviour and experience of others. This violence can come in the form of humiliation and shaming, verbal threats, verbal abuse, sexual abuse or exploitation, physical violence, and threats to the integrity of attachment relationships.

In an attempt to provide a corrective systems experience, the community aspects of the program are primarily maintained by the staff through the explicit and implicit norms that have become a part of the Sanctuary program. During their stay, each patient partakes in this therapeutic milieu, and has the taste of what he or she can feel in an alternative environment. Intensive individual psychotherapy is constrained in such a setting due to time and staffing limitations. Despite these limitations, we have been surprised to discover just how much can actually be accomplished in a short period of time if the patient is a willing partner in the therapeutic exercise. Most importantly we can use the time to provide the patient with a completely different cognitive framework for understanding themselves, their symptoms, and the world around them. The consequent shift in meaning paradigm often has a dramatic and long-lasting impact.

Our sense of comfort and safety in any setting is largely determined by factors outside of our conscious, verbal awareness. The pressures to conform in any group setting are likely to be conveyed through nonverbal channels and not through information that is verbal, logical and therefore easily analysed or critically appraised by the individual. Human beings adapt to even very adverse conditions quite rapidly and once an abusive environment has become normalised for them, attempts to change these norms will be met with resistance. The more dangerous the environment is and the more normalisation of that environment has been mandatory to survival, the greater the resistance to change, as long as the individual has remained blind to the discrepancy between what is said and what is done within that environment. People who are exposed to lengthy periods of immersion in such dysfunctional systems internalise the norms of these systems in order to survive and remain safe. Within such systems the normative behaviour of denial, coercion, secrecy, and manipulation may be cloaked and given other words like “privacy”, “loyalty”, “self-sacrifice”, and “obedience” so that the individual who is subject to such norms becomes cognitively confused – accepting of the verbal interpretation while nonverbally sensing the more hostile aspects of the environment. Psychological or physical safety may require that the contradictory nonverbal information be denied. Additionally, a coercive system makes it clear that there is no tolerance for questioning this double and contradictory level of meaning and any attempt to do so is labelled as “disloyalty” or “disobedience” and is summarily punished.

This is what makes individual, one-to-one therapy so difficult for people who have been exposed, particularly for a prolonged period of time in childhood, to

such “sick” systems. Although the therapist may provide an entirely different normative experience of relationship for the patient, the therapy situation becomes the exception to the rule, while the rule – the normative internalised dysfunctional system – remains intact. People who have been exposed to such pervasive influences can benefit from an immersion in an entirely different environment so that the experience of a reversal of the dysfunctional norming behaviour can occur. Clinical research on such a “laboratory for experimental change” was first explored beginning in the 1940’s with the birth in England and the United States of the “therapeutic community”.

The therapeutic community norms were consciously designed to be different from those of dysfunctional systems. Safety with oneself and each other was considered paramount. The entire environment was designed to create “living-learning” opportunities for everyone involved – staff and patients alike. The role of the community was to educate its members through a process of conscious problem solving in the midst of critical interpersonal difficulties and conflicts. Decisions were to be made democratically and communally. Each individual was expected to control his or her impulses and to express a need for assistance if these impulses threatened to get out of control. Everyone in the community was expected to behave with dignity and respect toward every other individual, regardless of their status. Authority could safely be questioned and those in authority were expected to learn from experience along with the patients. The community was designed to provide multiple opportunities for all participants to have new experiences in learning how to trust self and others. The environment was to be as least restrictive as possible and every individual was expected to recognise that the community had a responsibility for providing the maximum freedom for the individual while simultaneously enforcing the sense of shared social responsibility that allowed such freedoms to safely flourish (Jones, 1953, 1968a, 1968b; Main, 1946).

### **SAFETY - THE FIRST PILLAR OF SANCTUARY**

The concept of “sanctuary” refers to the important emphasis we place on the active and conscious development of a sense of safety within the context of a therapeutic milieu (Bloom, 1997). Safety, however, is not a particularly easy subject to define. Haigh has described this fundamental necessary attribute of the therapeutic environment as “containment”, and in doing so focuses on the bimodal aspect of true safety: the “maternal” sense of support, tolerance of distress, and connection along with the “paternal” sense of limits, discipline and rules (Haigh, 1999). We found that to adequately talk about safety in the community context, we had to understand four levels of safety simultaneously and dynamically: physical safety, psychological safety, social safety, and moral safety.

Physical safety is the easiest aspect of containment to describe, largely because it relies on tangible and concrete factors. Physical safety is usually what people

think of when describing the sense of being safe, since without it, other forms of safety are difficult to achieve. Psychiatry has always recognised the importance of physical safety. Locked doors, bars on the windows, straitjackets, seclusion and restraints have all been used – and misused – in the service of physical safety. Unfortunately, however, an exclusive focus on the maintenance of physical safety tends to result in the creation of environments more like prisons than therapeutic spaces. As we discovered, our refusal to tolerate violence of any sort constituted our best defence against any breach in physical safety. Physical safety alone does not constitute a safe environment for growth. Likewise, breaches in physical safety generally do not occur until the other forms of safety have already been violated.

Psychological safety refers to the ability to be safe with oneself, to rely on one's own ability to self-protect against any destructive impulses coming from within oneself or deriving from other people and to keep oneself out of harm's way. This ability to self-protect is one of the most shattering losses that occur as a result of traumatic experience and it manifests as an inability to protect one's boundaries from the trespass of other people. Another loss is a sense of self-efficacy, the basic sense of experiencing oneself as having the ability to relate to the world on one's own terms without abusing power and without being abused by it. A sense of personal safety is achieved as the injured individual learns how to be effective in protecting themselves from violations of their personal and psychological space.

Social safety describes the sense of feeling safe with other people. Victims of trauma- particularly interpersonal trauma - have serious difficulties in their ability and willingness to trust other people. Experience has taught them that people are dangerous, betraying, and duplicitous. If they have been injured as children, then they have come to expect bad treatment and are often suspicious of kindness. They expect that other people will violate their boundaries and may have learned that the way to get along in the world is to violate the boundaries of others. They will exert pressure on the other to conform to their normative expectations of abuse. The miracle is not that so many are distrustful; it is, instead, that so many are willing to try trusting again, and again, and again, despite past experience. But for victims of trauma, interpersonal relationships continue to pose enormous challenges. Creating a safe social environment requires a shift in perspective away from viewing only the individual, towards viewing the individual-in-context. In so doing, the entire community serves as a model of "organisation as therapist" (Whitwell, 1998) so that all of the chaotic, impulsive, and painful feelings of the members can be safely contained and defused. A strict emphasis on the individual is exchanged for the work of creating and sustaining a well-bounded structure within which all the therapeutic interactions can safely take place (Campling, 1999). It is also the social milieu that provides our patients with the very necessary "reality confrontation". As our patients inevitably recreate the relational patterns they

have learned as children within a social context, they are afforded the opportunity to change those patterns in order to achieve a higher degree of psychological and social safety.

How many of us have ever felt truly safe in a social setting, a setting in which we felt secure, cared for, trusted, free to express our deepest thoughts and feelings without censure, unafraid of being abandoned or misjudged, unfettered by the constant pressure of interpersonal competition and yet stimulated to be thoughtful, solve problems, be creative, and be spontaneous? Yet this is the kind of setting that human beings need to maximise their emotional and intellectual functioning in an integrated way. Our social system is created to produce human beings who will fit into a highly industrialised, competitive, often cutthroat capitalist environment that still prepares at least half of us for mortal combat. Our social system is not designed to maximise the human potential for growth, self-exploration, mutual co-operation, nurturing of the young, artistic endeavour, or creative expression and exploration.

Moral safety is a subject that is even more difficult to describe. It is a search and a process. It is an attempt to reduce the hypocrisy that is present, both explicitly and implicitly, in our social systems. It is a fundamentally important quest for patients who are victims of abusive power because their internal systems of meaning have become confused and contradictory (Janoff-Bulman, 1992). A morally safe environment engages in an on-going struggle with the issues of honesty and integrity.

Our attempt to create a morally safe environment began with a self-evaluative look at our therapeutic presumptions, our training, our rationalisations, and our fixed beliefs, as well as our practice. We had to look at our own issues with authority and become willing to participate in, not just manage, the relational web that forms the structure of the program. We were forced to ask ourselves, “What do we really believe in?” “What is it that we are actually doing, and what are we trying to achieve?” “Will the means get us to the desired ends?” “Do the means *justify* the ends?” “Do the activities we are prescribing lead to autonomy, connectness, and empowerment or dependence, alienation and helplessness?” These were tough and embarrassing questions with answers that were, at times, noxious. In an era of managed – some would say, mangled – care a morally safe environment demands that we be honest with our patients about our limitations, about our increasing inability to provide them with what we know they need, while continuing to offer them hope for the future and encouragement to keep on with the struggle towards recovery, even when they cannot get the support they deserve.

Similarly, our patients must confront the breaches in moral integrity that characterise the specific systems within which their normative behaviour developed, be it their family, a religious organisation, another form of a cult, or an institution. This breach in moral integrity also relates to the fundamental

reasons for hospital admission – a clear and present danger to oneself or others. Victims internalise the role of perpetrator and a fantasy of rescuer. In hurting themselves, they act out the role of the perpetrator, thus re-enacting the past. Self-destructive behaviour creates a moral climate that is as degrading as violence against others. While it is essential to express understanding and compassion towards the self-mutilating or suicidal patient, requirements for physical, psychological and social safety demands that this fundamental moral discrepancy be confronted.

Additionally, we are all forced to look at the ways in which our culture reinforces the messages conveyed by the institutions within which we all are socialised. This entails looking at the way our society is organised around unresolved traumatic experience – what I have called the “Nine A’s of Trauma” - and manifests this dysfunction through disrupted attachments, unmodulated affect, poorly managed aggression, abusive authority, diminished awareness, multiple addictions including an addiction to trauma, automatic repetition of destructive behaviours, avoidance of feelings and accountability, and alienation from self and others (Bloom, 1997; Bloom and Reichert, 1998).

Out of this process of self and systems examination, we developed an understanding about the underpinnings of our practice, as that practice is informed by three key foundation concepts: trauma theory, the practice of therapeutic community principles, and the active creation of non-violent environments. These key concepts have practice implications in any setting that chooses to be a “living learning” environment for human healing and growth (Jones, 1968b).

## TRAUMA-BASED ASSUMPTIONS AND MILIEU IMPLICATIONS

**Normal Reactions to Abnormal Stress.** Research has demonstrated that the majority of patients who require intensive psychiatric treatment are victims of previous trauma, usually originating in childhood. We have come to understand that many of their symptoms are the reactions of normal people to abnormal stress. This means that they need experiences within environments that can normalize their experience, while educating them about the long-term liabilities involved in continuing to believe that these protective responses are still necessary. While being blamed and labelled for their behaviour in other settings, much controllable and socially irresponsible behaviour has been condoned or supported. We neither blame nor condone, but expect our patients to conduct themselves as socially responsible and capable adults who have been injured and need help recovering from their injuries as well as education about the enormous impact that trauma has had on every aspect of their lives.

**Multilevel effects.** We assume that a past history of psychological trauma has physical, psychological, social and moral effects and treatment interventions must therefore address and integrate all these levels of injury. This requires the achievement of safety and safety must address not just physical, but psychological, social and moral safety as well.

**Helplessness.** Since traumatic experiences by definition are experiences of utter helplessness, the environment must consistently promote mastery experiences that result in personal and social empowerment while resisting inducing further experiences of helplessness. If a human being has enough experiences of helplessness, they will rapidly learn that nothing they can do will affect the outcome of events. As a result, even when put in situations where they could bring about successful change, they fail to do so having “learned helplessness” (Seligman, 1992). This counsels us in the need for therapeutic patience and repetition.

**Hyperarousal and the Loss of Words.** The hallmark signs of traumatic experience are hyperarousal and intrusive symptoms. When the body is exposed to extreme states of emotional arousal leading to a potentially life-threatening level of physiological hyperarousal, the brain rapidly employs strategies of self-protection. It appears that normal, verbally-based information processing is shutdown, replaced by a nonverbal form of data input characterized by images, strong emotions, and all kinds of sensory and kinaesthetic information. These fragments of experience then serve as the “fuel” for the nightmares, body memories and flashbacks that make up the intrusive symptoms. There is a timeless quality to nonverbal experience, so an intrusive memory or flashback is experienced as happening in the present, not the past. In this way, the terror of the original experience can be repeatedly evoked by stimuli that the mind connects to the original trauma, even though in the present, there is nothing to fear (van der Kolk and Fislser, 1995; van der Kolk et al., 1997).

**Soothing and Self-soothing.** As a result we must create an environment that is soothing and that responds to high levels of stimulation with calming, rather than escalating, responses. Staff members must learn to recognize the “flashbacks” that accompany the re-experiencing of traumatic events and be able to differentiate such intrusive phenomena from psychosis. Medical personnel must avoid the overuse of medication, while recognizing that the physiological hyperarousal that accompanies post-traumatic states often “reset” the nervous system so dramatically, that only medication can bring even partial relief. Additionally, patients need to be taught techniques for managing their own affect and soothing themselves safely when an intrusive experience occurs, without resorting to self-destructive behaviours.

**Self-destructive behaviours.** Many of the behaviours that serve as criteria for treatment originate in the person’s attempts to cope with the overwhelming

nature of the intrusions and states of unacceptably high levels of arousal. Substance abuse is frequently an overt attempt to self-medicate and to alter overwhelming anxiety states. Self-mutilation, bingeing, purging, risk-taking, stealing, gambling and violent acting-out, are all ways that a traumatised person may attempt to cope with overwhelming states when both internal and external resources fail.

**Addiction to Trauma.** People who are repeatedly traumatised may become “addicted to trauma”, unable to function properly unless they are constantly exposed to highly stressful situations and occupations. Like other compulsive behaviours like self-mutilation, the addictive aspect of behaviours may be related to problems in the body’s opiate system since the body’s natural opiates, the endorphins, are a fundamental part of the normal stress response. Under conditions of repetitive hyperarousal and fear states, it has been hypothesized that the individual may become accustomed to an abnormally elevated level of endorphins and then experience any decrease in the level of stress as a physiological state of withdrawal (van der Kolk et al., 1985, 1989). Hence, they must elevate the environmental stress in order to achieve a state more like their abnormal “normal”.

**Dissociation and Integration.** Dissociation – the loss of normally integrated mental functions – is another common characteristic of traumatic experience. When dissociative defences originate in childhood, the adult may only be able to cope with stress – even relatively minor stressors – by utilizing this splitting (Herman, 1992). Our patients must learn how to identify their own dissociative coping skills, learn what environmental and internal stimuli “trigger” dissociation, and then learn ways they can “ground” themselves as they gradually learn to control their own practiced tendencies to dissociate from feelings, memories, or consciousness itself. Usually they have been using avoidance as a tool for protecting themselves against overstimulation, but the habitual use of avoidant techniques can rob them of normal and health-promoting experiences. Essentially, our patients must learn how to substitute self-soothing coping skills and healthy relationships for dissociation, self-mutilation, risk-taking, avoidance, substance abuse, and other compulsive and self-destructive behaviours. Since exposure to overwhelming stress has a profound impact on the brain’s capacity to take in and process verbal information, the therapeutic environment must promote the integration of memory and affect, making essential the availability of nonverbal and creative forms of therapy.

**Aggression.** All of our patients have been exposed to interpersonal violence of some variety – physical, sexual, verbal or psychological. This exposure to unhealthy forms of aggression leaves them without the ability to adequately cope with their own aggression or the aggressive feelings and behaviours of others. As a result, the treatment milieu must be prepared to cope with

aggressive feelings before they escalate to violence and thus be able to contain, deflect and metabolise the rage before it erupts. Patients need assistance in learning how to manage their own anger without turning to violence and how to express anger in a healthy way that protects their own boundaries without violating the boundaries of others.

**Attachment, Loss and Trauma Bonding.** Traumatization results in loss – sometimes of loved human beings, other times of bodily parts, relationships, opportunities, idealized fantasies, wishes, hopes and dreams. This means that victims must find ways to grieve for losses that are often decades old. Unresolved bereavement can present as chronic and unresponsive depressive and anxiety symptoms that must be worked through rather than avoided for therapeutic resolution to occur (Herman, 1992). Since healthy grieving is related to the ability to form attachments in the first place, working through the stages of grief can be particularly difficult because of the universal disruption in attachment that accompanies interpersonal violence. Grieving is a social process, a ritual passage supported by one's community. This presents particularly difficult problems for our patients because it is difficult to grieve for events, relationships, or losses for which there is no social understanding or acceptance, particularly when one's capacity to make and sustain healthy attachments and to work through the loss of meaningful attachments, is severely compromised. The ability to create, maintain, and work through the loss of attachment relationships is complicated by another aspect of the profound alterations produced by exposure to trauma. Victims of prolonged torment – hostages, political prisoners, domestic violence and child abuse victims – often form strange, rigid, pervasive, and destructive relationships with their captor – a phenomenon known as “trauma bonding” (Dutton and Painter, 1981; Herman, 1992; James, 1994; van der Kolk, 1989).

**Traumatic Reenactment.** One of the most important challenges to the therapeutic environment is the successful management of traumatic reenactment (van der Kolk, 1989). Trauma demands repetition. Patients come into treatment exhausted after a lifetime based on repeating an overwhelming and humiliating past. Trauma produces a fragmentation that results in the accentuation of a nonverbal and a verbal split in memory, affect, perception, and identity. The language of the nonverbal self is behaviour and in the presentation of their symptoms, our patients tell the story of their most terrible experiences (van der Kolk, 1994). The role of the treatment environment is to engage enough with the story to understand the script but then to change the automatic roles that are being cued for by the patient so that the story changes instead of being repeated. Traumatic reenactment can be seen in the shifting roles that patients assume on the “rescuer-victim-perpetrator” triangle. In our model, perpetration is broadly defined so that in a socially responsible community, violence to the self is also considered to be an act of perpetration against the community and is not acceptable behaviour.

**Comorbidity.** Complicating all this is the astonishingly high rate of comorbidity associated with trauma-related disorders. Comorbid conditions can be expected and treatment for both psychological and physical comorbid problems must be offered and integrated with any treatment directed at the treatment of post-traumatic stress. Men with post-traumatic stress disorder are 6-10 times more likely to have an affective disorder, while women are 4-5 times more likely (Kessler et al., 1995). Anxiety disorders in men with PTSD are 3-7 times more likely, in women 2-4 times more likely. Of those seeking treatment for substance abuse, 25-58% also have PTSD. In a study by Breslau and colleagues (1991), those with PTSD were more than six times as likely to have some other psychiatric disorder. Even in the most conservative study, those with PTSD were two to four times more likely than those without PTSD to have virtually any other psychiatric disorder, particularly somatization (Solomon and Davidson, 1997). The large epidemiological study of Kessler and colleagues (1995) showed that those with PTSD are almost eight times as likely to have three or more disorders and 88% of men and 79% of women with PTSD had a history of at least one other disorder.

**Somatisation.** According to one study, somatisation was found to be 90 times more likely to occur in those with PTSD than in those without PTSD (Davidson et al., 1991). Hypertension, fibromyalgia, irritable bowel syndrome, chronic pain syndromes, skin diseases, migraines, chronic pelvic pain have all been associated with post-traumatic stress (Bloom, in press). Felitti et al.(1998) have recently demonstrated a strong correlation between various categories of adverse childhood experience and adult diseases including heart disease, cancer, liver disease, chronic lung disease and skeletal fractures.

## GROUP-BASED ASSUMPTIONS AS THE KEY TO NONVIOLENCE

“Creating Sanctuary” refers to the shared experience of creating and maintaining safety within a social environment - any social environment. This means that the standards of care – of how human beings should behave towards each other to create safety - will be similar in any environment within which people gather to live, to work, to learn, or to play and should apply to all members of the community, without exception. From the very beginning of the therapeutic community movement, the idea that there is no fixed boundary between “normal” people and the mentally ill has been a fundamental concept (Spielman, 1998). In a healthy human setting, all members of the community share two kinds of equality: *human equality*, which is the belief that we should treat others as we would like to be treated, that we should not exploit others or unduly restrict rights or freedom and *psychological equality*, describing the recognition that all members of the community share many of the same psychological processes and no one is completely “well” or completely “sick” (Kennard, 1998).

The foundation question that the mental health community addresses to the patient, and that the general community addresses to anyone in distress is *“What’s wrong with you?”* regardless of whether that question is explicit and spoken or implicit and simply implied. The Sanctuary Model changes that fundamental question to *“What’s happened to you?”* a position of connectedness and compassion rather than distance and judgment. This is essentially a deep philosophical movement from an illness or badness model of human deviance to an injury model. Instead of viewing people as sick or bad, we view disturbed behaviour as being a response to a previous injury that can be understood if we recognize the total context and experience of the person’s existence.

All human systems are open and complex, interacting within themselves and externally with other systems and parts of systems, producing a whole that is greater than the sum of the parts. This whole emerges from the elements of the system and cannot be predicted by just looking at or even understanding, the system elements (Gray, 1969). As a result, focusing therapeutic attention only on the individual will not resolve the complex problems that emerge when any individual interacts with a system. Instead we have to understand and work with the individuals, the context they exist within, and the interactions between the elements of this context and the individual. This means that every member of the staff and patient community plays a role in creating or failing to create a non-violent, health-promoting atmosphere.

All human development occurs within a social context and therefore providing people with a corrective emotional and relational experience should also occur within a group context. This “social learning” describes the process of change that may result from the interpersonal interaction when some crisis or conflict is understood as emerging from and having potential solutions discovered within a group context (Jones, 1968b). Social influence is a powerful force that can be used both negatively and positively. Victims of family violence have been subjected to the most insidious, persistent, and devastating forms of negative social influence originating in their home environments. A healthy environment will maximize the positive and minimize the negative, providing injured people with corrective relational experiences. The negative affects associated with exposure to violence are so noxious that the individual cannot contain them without resorting to protective defenses that are often destructive. As a result, the entire group needs to serve as the container for unmetabolized affect and help the individual find constructive ways of channelling, sublimating and transforming the negative affect.

The social influence of leaders is a particularly potent force in mobilizing social change (Jones, 1953, 1968b). In any group situation, leaders emerge and in general follow two courses – creating hierarchical power structures with centralized authority or creating structures that encourage a more democratic

and consensus-based form of group functioning. Hierarchical power structures are more able to rapidly respond in emergency situations, but if left unchecked lead to the abuse of power and a “dumbing down” of individuals lower in the hierarchy. This is a particularly critical issue for victims of violence, all of whom have been exposed to the abusive use of power. A healthy environment can respond to emergencies by instituting a centralized authority structure, but rapidly shifts back to a non-hierarchical, network model of democratic functioning when the crisis has passed in order to promote creative and complex problem-solving. The relationship between those who lead and those who are led is a dynamic, dialectical one. In our existing institutions, conflict tends to originate near the top and interpersonal conflict can be followed down through the staff and into the patient community (Stanton and Schwartz, 1954). Those in positions of authority are often threatened by the openness and dispersed accountability of group process, while those who are subject to authority are often intimidated and fearful about assuming the shared responsibility that democratic functioning requires.

Open communication is vital in order to avoid the build-up of tension around conflictual issues in any community setting. If communication is blocked, failure to deal with a source of collective tension will result in a mutual withdrawal of staff and patients and ultimately, this will manifest as a collective disturbance of some sort (Stanton and Schwartz, 1954). Victims of violence have grown up in families who inhibit direct communication and channel unresolved tension and conflict onto destructive pathways that lead to violence. These patterns will be repeated in the inpatient setting. Therefore the therapeutic milieu must be prepared to counteract the forces of secrecy, while protecting the right to privacy. Episodes of collective disturbance can be predicted if the signs are recognized, and therefore can be prevented from escalating to violent acting-out. But to do this, violence must be viewed as a symptom of a breakdown in the social order, not just a problem of the individual. Every act of violence must be analysed as a problem of and for the entire community, including the use of seclusion, restraint, or any other form of coercive control.

Since order and law is the basis of all civilization, every community must create its own constitution comprised of shared assumptions, shared goals and a shared practice. A basic tenet of such a constitutional process must be that of non-violence. In using this term, we are moving away from a context within which violence is expected, even while techniques are used or policies developed to prevent it. We mean the creation of environments that see non-violence as the norm and that practice non-violence regularly through practices of de-escalation, conflict resolution, mediation, and consensus driven problem-solving, all behaviours that are expected to occur between patients, staff members, and administration. In a true therapeutic community, patients can share extensively in the development, implementation and maintenance of such a constitutional government. In our short-term milieu, the patients are

usually only involved in the maintenance of a body of rules that constitute the values structure of the program. As they learn how we have adopted these principles in response to an understanding of the traumatizing nature of their native environments, they rapidly embrace these values as their own and carry the culture into all of the group settings, holding even the staff accountable for upholding these tenets.

## GOALS OF TREATMENT

We also attempt to be quite clear about the goals of our work together. In the short period of time we have available to us to hospitalise people, we must focus on achievable goals for the short time of their inpatient stay, while providing them with a map of recovery that will continue throughout outpatient treatment. If people seek admission to our program then they must be committed with us to the achievement of these goals. Mary Harvey (1996) has articulated seven of the major goals of treatment: gaining authority over the remembering process; the integration of memory and affect, development of affect tolerance, symptom mastery, attainment of a sense of self-esteem and self-cohesion, the ability to form safe attachments, a willingness to engage in the process of meaning-making, of placing the past into some sort of perspective that makes a viable contribution to the present sense of purpose and place in the world. These represent the goals for the individual victim of unresolved traumatic experience.

There are also goals we share as an entire community. First, we must all share in a belief that recovery is possible by mutually creating an environment of hope. This goal can only be accomplished by substituting healthy relationships and different normative environments for abuse. Healing requires that the injured people construct a coherent and meaningful narrative of their experiences and be willing to place their individual pain into a broader social context and in service of this goal we regularly relate the microcosm of the individual's family pathology to the macrocosm of the larger socio-political and historical environment. Since conflict resolution is so vital to the healthy operation of any community, we seek to resolve conflicts together in non-violent ways through the development of "group mind", recognizing that decisions and problem solutions that arise out of a consensus process are usually far better than those that originate in typical authoritarian structures.

Institutions function properly only if they meet the needs of all of the people who are a part of them. Therefore another goal of the program is to meet the needs of the patients and the staff as well as the institution in which the program is located. To the extent that the needs of these various parties conflict, the institution will find it difficult to maintain a health promoting environment for any of its members. Given the present health care system in the United States, achieving this goal of system integrity is the most difficult

challenge we face. There are deep and unresolved conflicts between the basic needs of patients/staff and the larger health care institution that remained unresolved.

Ultimately, our shared goal is to end violent perpetration. We share a belief that the therapeutic milieu does offer a true “experimental laboratory” for conscious social change were the learning to be transferred to all of our institutions instead of applying only rarely, and then only to those labelled “mentally ill” (Tucker and Maxmen, 1973). We have come to believe that retraumatizing people by placing them in environments that reinforce helplessness, scapegoating, isolation, alienation and violence must be viewed as antitherapeutic, dangerous, immoral and a violation of basic human rights.

## THE SHARED PRACTICE OF SANCTUARY

In service of these goals, we engage in a shared practice that is routinely informed by our four-stage recovery model, SAGE© (See Foderaro and Ryan, this volume). To achieve the goals for each individual, treatment focuses on individual and group kinds of psychotherapy of all kinds, ranging from psychodynamic, explorative therapy to art therapy, movement therapy and psychodrama. We have also begun using techniques like “trauma art” and “video dialogue” to help address the specific dissociative breaks that are so problematic in this population (Tinnin and Bills, 1994).

At the same time, the entire community is constantly engaged in the process of establishing and maintaining alternative norms. We call this activity “creating Sanctuary” to indicate that “Sanctuary is not just a place” but a process. The sense of safety that we are creating for each other is something that we are doing – or not doing – all the time, every moment of every day. It is a choice, an active constructive behaviour that we all must participate in if it is to remain viable. All violence is perceived as an effort to destroy sanctuary, and violence is broadly defined as anything that hurts the self or the community, including self-mutilation and other forms of self-destructive behavior. Given the short-term nature of the program, and the decreases in staffing secondary to managed care cut-backs, we have shifted a great deal of the burden for maintaining safety onto the patients. This is an expectation and a responsibility that is articulated from the moment the person is accepted for admission when they agree to a contract for safety and is reinforced throughout the hospital stay. This expectation counters the regression that is typical of hospitalisation and is a community norm that is carried and enforced by the entire community.

We also share the active and ongoing process of resolving both conscious and unconscious conflicts. Deliberate conflict resolution measures are extremely important and for the most part are learned behaviours, quite different from the skills developed within the context of dysfunctional systems. Patients are

encouraged to verbally engage other patients, staff, and physicians in problem resolution through verbal negotiation and staff are expected to participate actively in this process without resorting to abusive authority.

Unconscious conflicts are harder to address simply because they are so hidden. Unconscious conflicts within the individual manifest as reenactment behavior in which the patient nonverbally cues the environment to provide experiences that repeat the past. Although this can lead to a simple reenactment of the past in which the patient is retraumatized, with careful direction, such a traumatic scenario can provide the opportunity for an entirely different, redirected experience in which the unconscious pain can be surfaced, verbalized, and resolved. The management of traumatic reenactment requires skill and cohesive teamwork. A reenactment is in process when a team becomes split, when a staff member begins to behave atypically, when the patient fails to respond to individual interventions and begins to escalate negative behaviour – all the behaviors described by Main in his seminal paper about the “special patient” (Main, 1957). When this occurs, the first breakthrough for the staff and the patient is to recognize that it is, in fact occurring. This recognition is often in itself a therapeutic triumph. When recognition is slow in coming, bringing together the involved parties to look at the presumed conflict, its roots in the past, and to plan for how to shift the action in another direction can be a profound revelation for the patient in learning how to manage and control affects and experiences that have been considered previously impermeable to change.

There are also unconscious conflicts within a group that manifest through the acting-out behaviour of the patients, individual staff members, or the entire group. When the group can recognise that something uncomfortable needs to be surfaced instead of suppressed, rather than attempting to scapegoat an individual for the problem, significant movement ahead can occur, collective disturbance can be uncovered before it spirals out of control, and violent acting-out can thus be avoided. This practice of viewing the group-as-a-whole as something different from the individuals who comprise the group is a challenging practice that needs to be continually reinforced. Coming from a culture of extreme individualism as we do, functioning within the context of the group is not something that seems to come naturally for most of us and requires constant vigilance and repeated reminders.

At all times we are seeking integration. In order to gain authority over the remembering process, victims often need to dig into the past and surface forgotten and split-off memories and feelings that are a by-product of the “speechless terror” of traumatic experience (van der Kolk, 1994). The objective of this expedition is the integration of memory, affect, and behaviour in the context of safe attachment. Memory recovery without such a contained context can do more harm than good. This kind of intensive work often

requires the use of adjunctive forms of nonverbal therapies such as art therapy, video therapy, movement therapy, psychodrama, poetry, writing and any form of intervention that serves to bridge the gap between the nonverbal affective experience and the verbal, cognitive, conscious mind.

There is an ongoing agreement that we are all vulnerable to emotional contagion and that a significant element of healing is learning how to modulate and manage overwhelming emotions within oneself and within a group. This requires the analysis and negotiation of what defines a healthy boundary between people. We share a willingness to participate in an empathic exchange between people that can be a healing experience, while refusing to become emotional toilets for other people's unacceptable and hostile impulses. This requires the development of a special consciousness of what it means to be a victim and what it means to be a perpetrator. All forms of violence, including self-mutilation, self-starvation, and suicidal behaviour are considered a violation of the self and a violation of the community. Special contracts and protocols are utilised to help patients gain control over these kinds of self-destructive behaviours. Sometimes we must protect ourselves and the community against a patient who is locked into an identification with the perpetrator, trapped in a repetitive cycle of re-enacting the perpetrator role thus forcing the staff, the other patients and the entire community into shifting roles of victim and rescuer. In such cases our admonitions are not enough and we are compelled to behaviourally demonstrate our ability to self-protect. Our own capacity to protect ourselves and the people who need our protection mirrors and models the kind of protection that the re-enacting individual should have had as a child and needs to discover for himself or herself now. This may mean that the reenactor is administratively transferred or discharged if that is the only way of protecting the integrity of the therapeutic environment. Although this rarely happens, it is critical that the community has the power to adequately protect itself from abuse, even if that abuse is coming from one of its own members.

### **S.A.G.E.**

SAGE is an acronym for the four important aspects of recovery that we believe are the most important if people are to recover from trauma. SAGE stands for safety, affect management, grief, and emancipation. People who have been traumatized have lost the sense of safety in their lives. The first step in recovery is to re-establish the feeling of being safe. This is always where treatment begins and recovery cannot progress until safety has been established. We use "affect" to refer to the biological equivalents of emotional experience. Affect management deals with the stage of recovery in which people must learn how to manage their emotional arousal in a less destructive way. Grieving refers to the inevitable sense of profound loss, sadness, and

despair that accompanies a traumatic experience and that must be experienced and worked through if normal life is to be restored. Emancipation encompasses all that goes into full recover from trauma - social reconnection, finding meaning, establishing a survivor mission.

This model is meant to provide a structure and framework for the evaluation and treatment of people who have been traumatized as children and/or adults. SAGE represents aspects of recovery, and although Safety is always the first step, and Emancipation usually the last, in actual life, these aspects tend to intertwine, interconnect, and present on going challenges at each life stage. Future episodes of danger or grief are likely to reawaken old wounds. Therefore, the goal of recovery is to provide the tools necessary to guarantee that a person will be equipped to deal with future experiences without turning to behaviour that is destructive to self or others.

The needs and problems of people who have been traumatized can vary greatly. Using the SAGE model provides an approach that is flexible and useful to the patient and clinician. It is designed to change with the needs of the patient. An important component of this model is the belief that people who have been traumatized can help themselves throughout the process of recovery and that in helping themselves, they are promoting their own recovery. There is also an assumption that an important part of recovery - and an important part of finding meaning - is to be found in helping others. Trauma occurs in a social context and social wounds require social healing. The most important part of the therapy experience may be in helping a traumatized person recover a sense of trust in other people, but this is only effective if that sense of trust can be generalized to other people outside of the therapy context. Therapy is a tool, an educational experience, not an end point. Therapy can only be proven useful if the result of the treatment is a healthier, better-educated, socially proactive and constructive human being.

When things are not going well in a person's life and/or therapy, the treatment should be re-evaluated. Part of the SAGE model includes thorough evaluation and reassessment when indicated. Progress in therapy can become stalled for a number of reasons including the inherent difficulties in exchanging comfortable, albeit dysfunctional behaviours, for behaviours that are more frightening, challenging, but ultimately health promoting. Ultimately, healthy behaviour is the personal choice of the person who is seeking help. The issue of choice will come into play for all steps of the SAGE model. A person must be willing to engage and consider the steps of SAGE and change behaviour or he/she will be unable to benefit from this model. This question should be addressed early in treatment and may need to be looked at periodically throughout the course of treatment, particularly when progress appears to be halted or regression to previous forms of destructive thinking and behaviour has occurred.

## CONCLUSION

Ultimately, the purpose of our shared assumptions, shared goals, shared practice and shared vision is to create what Maxwell Jones described as a living-learning environment within which healing, growth, and creative expression can occur (Jones, 1968b). This is as urgent a calling today as it was half a century ago. Over thirty years ago Jules Henry asked a question that is as relevant today as it was then. "Cruelty has an institutional structure that sustains, teaches, and may even glorify it. But where are the institutions - the organisations - that sustain and teach tenderness?" (Henry, 1965, p.367). Our patients who have suffered extraordinary violence at the hands of others, have much to teach us about both individual and social healing, about how to change our institutions to reflect actual human needs rather than the distortion of unresolved trauma.

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# SAGE: MAPPING THE COURSE OF RECOVERY

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## ABSTRACT

This paper describes the inpatient utilization of a staged model for recovery from trauma-related disorders called SAGE, an acronym for *Safety, Affect Management, Grieving, and Emancipation*. The authors particularly emphasize the importance of the achievement of a sense of safety if treatment progress is to be made.

## BACKGROUND

Modern medical research now corroborates the long-held "hunch" that abuse, deprivation, neglect and exposure to any form of interpersonal violence can have a most debilitating impact upon the normal development of a children – their physical, physiological, psychological, social and moral development (Herman, 1992; Van der Kolk, McFarlane and Weisaeth, 1996). We are now beginning to understand how the negative effects of such childhood exposure to violence and neglect is transmuted over time into adult psychopathology (Van der Kolk et al, 1994).

*The Sanctuary Programs* address the specific clinical needs of adults who have been profoundly injured in childhood through some form of physical, sexual or psychological trauma/or abuse. Trauma can have a long-term devastating impact upon survivors, and much of this impact is disruptive to the continued social functioning of the individual (Bloom, this volume, 1997). Survivors of abuse have experienced disruptions in basic attachment resulting in difficulties in trusting others and in establishing healthy social relationships. The therapeutic milieu must set a different example, providing lessons of daily living in a social context that are not identified with traumatic experiences of

the past. Sanctuary represents a social experiment for people who have been severely developmentally damaged psychologically, socially and existentially. Sanctuary offers, in addition to psychiatric and medical care, an opportunity for all participants to engage in a social exercise in which new ways of accessing and containing affect are practised. The program employs group and individual clinical modalities in ways that are designed to teach, encourage, entice and protect people who are engaged in personal journeys of recovery.

Paradoxically, as the awareness and interest in psychological trauma and human response to it has rapidly developed, the resources available to address the issues seem to have diminished at a similarly accelerated pace in the United States. The demand to stretch the health care dollar has created an environment in which a consumer-based need for treatment collides with the realities of "managed care" (See Bloom, Introduction, this volume).

Over the last ten years, The Sanctuary program has been repeatedly challenged with the task of doing more with less. The financial constraints of a managed care environment have resulted in decreased staff, shorten lengths of stay, a much faster patient turnover, and therefore a higher volume of work. We constantly attempt to meet the mandate to assist in the recovery of traumatised people while trying to survive in institutional environments that make this mandate more difficult to fulfil. The management and staff of the program initially balked at what felt like untenable ethical dilemmas. How could the program continue to be effective, how could we maintain a sane environment and refrain from losing the basic values of the program that had enabled us to preserve our humanity and the dignity of our clients, when we were given so little time and diminished resources? What reconfiguration of the program could adequately address the range of presenting problems our patients brought to the Sanctuary when an already short length of stay of two to three weeks was to be reduced to less than one week? A 42-year-old rape victim is transferred to us five days post-surgery for a self-inflicted gunshot wound. A 27-year-old incest survivor, whose limbs and breasts are covered with scars as a result of nineteen years of mutilating herself, is sent to us because the cutting behaviour has escalated. A man, whose masochistic sexual behaviours mimic the abuses he endured as a boy at the hands of camp counsellors, signs himself into the hospital because his behaviour now threatens his marriage and career. A young wife urges her husband into the hospital when he becomes suicidally depressed and talks about his shame at the terrifying flashbacks he has when he attempts to bathe their child. A woman, mother of three young children, enters the program after her second abusive spouse has battered her and threatened to take the children away. How could we help these people in the brief one to two-week stay that "managed care" permits us?

A group of senior clinicians on the Sanctuary set out to design a framework for use by clinicians and clients alike that would enable us to bring into focus the critical elements which needed to be addressed to effect recovery from trauma. Our goal was to design a program that would assist those engaged in trauma recovery work, to stop repeating old and destructive patterns of behaviour and to aim toward the goal of a life of choice and empowerment. We needed to create a model that could be easily understood, rapidly taught, and simply replicated. This model needed to provide a flexible map of recovery that patients could use during their inpatient stay and continue to utilize in whatever outpatient setting(s) they pursued. This led to the development of the SAGE Model of Recovery.

## **S.A.G.E. SAFETY, AFFECT MANAGEMENT, GRIEVING, EMANCIPATION**

The SAGE model of recovery has been in use in Sanctuary programs for several years. SAGE is an acronym for Safety, Affect Modulation, Grieving and Emancipation. These reflect the recurrent themes that our patients need to confront in order for healing to occur and are consistent with other staged models of trauma treatment (Herman, 1992; Janet, 1976). Given the complicated and multi-tiered nature of the effects of trauma, we needed to find a clear, concise, and easily applied model that could be understood and utilised by clinicians and clients alike. SAGE is designed to be used in both inpatient and outpatient settings to distil complex theoretical tenets of trauma and recovery into a practical road map that patients can follow with their outpatient therapist. This map begins with the establishment of safety and ends with the individual feeling the empowerment that comes with being emancipated from the tyranny of the past.

The process of SAGE is not so much linear as it is spiral. Patients achieve one level of safety, move on to become better at managing affect, confront the grief that remains unresolved about those particular issues, and then experience an increase in personal freedom and empowerment, only to come to the next safety issue on their recovery map. When they come onto the unit, the safety issues focus on physical safety. Over time, and usually in outpatient treatment, issues of psychological, social, and moral safety become more dominant, but the same recovery cycle is followed throughout every new turn on the spiral.

The patients are taught the SAGE Model from the time they begin treatment through direct one-to-one education and through formal psychoeducational groups. The initial assessment and treatment planning process use SAGE as a way of looking at the patient's immediate problems and strategizing how to

best help them make progress. Every progress note reflects this SAGE evaluation, reviewing how the patient is making progress through each one of the stages.

## SAFETY

Safety has always been a fundamental construct upon which all other clinical goals must be based. Our ideas of safety reflect the four kinds of safety that we recognize: physical, psychological, social and moral safety. Without some reasonable assurance that one's physical safety can be protected, higher-order psychological gains are easily disrupted or quickly lost.

This first step is the most important and fundamental of all of the SAGE steps. A person must be carefully assessed regarding his/her safety. The issue of safety is broadly defined. It includes not only interpersonal but intrapersonal safety and safety within the entire social community. Behaviours such as self-mutilation are obviously unsafe for the individual and negatively impact the entire community, while sexually addictive behaviours are unsafe both for the individual and the other members of the community. Suicidal and homicidal behaviours are carefully evaluated and specific protocols for self-mutilation, suicidality, and homicidality have been established. The safety of every patient that enters the unit has become compromised in some way. For many patients, the achievement of safety dominates the entire hospital stay. For others, the structure of the inpatient setting rapidly restores them to a level of safety that allows them to more effectively deal with issues of affect management or grieving.

When people first enter the hospital, safety issues are the greatest concerns. A level system has been developed that reflects these concerns. Patients earn privileges based on this level system that is tied to the SAGE Model. When they first enter the hospital, they are placed on the "S" level, indicating a need for supervision, safety and relative restriction until they are properly evaluated and integrated into the community. Very concrete questions must be addressed by both patient and staff - Has a "No Harm Contract" been signed? Is the patient able to take care of his/her activities of daily living? Is the patient communicating with other members of the community? Has the patient created a "5-Step Safety Plan"? The No Harm Contract is an agreement that our patients must make if they are to stay on the unit, that commits them to guaranteeing their own safety while they are with us and the 5-Step Safety Plan describes a series of behaviours the patient will engage in when he or she is not feeling safe in order to get the help they need control the self-destructive behaviour. As patients become socialized to the culture and demonstrate their willingness to participate in the community, their level is changed to Group level representing an understanding that they are actively working on their therapeutic goals and conveying an increase in privileges. Before leaving, they

can earn an Individual level, indicating their imminent “emancipation” from the hospital environment.

This concrete cognitive-behavioural strategy, set within a much broader and more abstract theoretical system of meaning and values related to the therapeutic community (See Bloom, this volume) has been enormously helpful in reducing the level of harmful behaviours in the therapeutic setting. Statistics were kept during the period July 1, 1996 to June 31, 1998 representing over 1000 admissions, all of whom were admitted because they presented a clear and present danger to themselves and/or others. A majority of the patients had a history of self-mutilation. Despite the relative freedom that an open unit permits, only one incident of self-harm was serious enough to warrant sutures.

*Ariel is a 35 year old single Caucasian woman, mother of one child, college educated, from a working class, alcoholic family. Both parents have severe substance abuse problems that have lasted throughout Ariel's life. Her father began an incestuous relationship with her when she was six and her child, now aged twenty-two, and raised by Ariel' is a product of that relationship. She also experienced severe physical violence as both victim and witness in her family of origin. She has been psychiatrically hospitalised on numerous occasions starting in adolescence and has been diagnosed as suffering from schizoaffective disorder as well as post-traumatic stress disorder.*

*When she was first admitted to The Sanctuary, Ariel was very symptomatic. She frequently self-mutilated, binged and purged, and was actively suicidal. She was admitted to the unit and a SAGE Assessment was performed. She was suffering from a thought disorder, characterized largely by paranoid ideation, as well as experiencing the intrusive symptoms of PTSD. It was clear that major safety issues were current in her clinical picture. She agreed to contract with us for safety and was given the Self-Harm protocol to help her learn to manage the impulse to self-mutilate, and instructed to begin work on a Five-Step Safety Plan. She was rapidly integrated into the community and began the process of re-education by beginning to participate in community meetings, creative therapies groups, and psychoeducational activities. It also was clear that medication would be a critical adjunct to her care and her medications were adjusted to reflect the increased level of regression. Specific behaviours were targeted: self-mutilation, binge eating, purging and the suicidal thoughts. As with other patients, Ariel was assigned a privilege level – Supervised – that reflects the S stage of SAGE and requires a higher level of monitoring and attention from staff and other patients. Ariel's behaviour shifted rapidly under this regimen. She was particularly affected by the notion that the violence she perpetrated against herself was a moral equivalent to the perpetration that she had experienced at the hands of others. This gave her a strong incentive for finding other options to handle her unmanageable feelings.*

## AFFECT MANAGEMENT

In the world of managed care, the story of recovery would most likely end here. The goals of hospitalisation in the present health care system are to stabilize a crisis and get the person out of the hospital, the most costly aspect of mental health treatment. The problem with this view of hospital treatment, however, is that the focus only on establishing physical safety leads to highly restrictive environment within which safety is maintained through coercion and control rather through learning self-control. This does not help the person learn how to cope once they leave the restrictive setting of the hospital. Achieving a sense of safety from destructive impulses within oneself and developing an ability to maintain a relatively safe external environment requires new learning, the establishment of self-discipline and self-control, and hope that there is life beyond trauma and mental illness. This can only happen if someone has learned how to manage the overwhelming affect that is associated with repetitive trauma.

Affect management represents some of the most difficult work for anyone recovering from trauma (Nathanson, 1992). The powerful biochemical effects of chronic post-traumatic symptoms are most obvious in the alternating hyperarousal and numbing typically associated with PTSD and are often accompanied by flashbacks, nightmares, and dissociative episodes. Patients commonly present with difficulties managing aggression, feeling “out of control”, overwhelming anxiety and panic, inability to tolerate any kind of emotional arousal, episodes of loss of memory, and dramatic mood swings (van der Kolk et al, 1996). These underlying difficulties with affect modulation result in behaviours that result in hospitalization: outbursts of rage and violence, revictimization experiences, self-mutilation, suicidal acts, substance abuse and addiction, sexual addictions, risk-taking behaviours, eating disorders. Such behaviours lead to serious relational and occupational difficulties that serve to create a downward spiral of dysfunction (Bloom, 1997).

The feelings that initially accompanied traumatic events - the fear, and anger, and the sadness - are often repressed or dissociated from conscious awareness. The affects remain hidden while the individual repeatedly but unconsciously constructs complicated patterns of reenactment that keep therapy focused on basic issues of safety. Compulsive behaviour patterns emerge as efforts to manage the affect but safety requires that these behaviours be sacrificed in service of recovery. If safety can be reasonably assured, then the affect becomes available for reconstructive therapeutic work. With this increased availability often comes a sense of overwhelming intensity that accompanies any energy or force that has been too long repressed or denied.

For the sake of simplicity we call the major affects: “Mad, Glad, Sad, Scared – and Ashamed”. Until the individual can effectively utilise cognitive and language skills to more clearly articulate their internal emotional state, they are

trapped in patterns of behavioural and emotionally-driven storms that are either perceived to be all-encompassing and overwhelming, or conversely, so threatening as to require emotional numbing and disconnection. As a result, clinicians are usually faced with extremes of affect, too much, or too little, but rarely appropriate to the context of the perceived threat.

In the SAGE Model of recovery, Affect Management is the stage following Safety in which people learn the skills required to more effectively modulate their emotional responses. The identification of the feeling is the first step when learning how to modulate affect. One of the common accompaniments of chronic trauma is the development of alexythymia – the inability to put feelings into words (Krystal, 1988). Survivors are taught how to describe their feelings and how to assign values that range from 0 (feeling no anger, sadness, fear, etc.) through 10 (feeling overwhelmed by the emotion). Learning how to recalibrate the “volume control” of affect is an essential part of learning how to apply an emotionally variable response to different types of problems.

There is often a tendency for a survivor of trauma to confuse the emotions, thoughts, and behaviours demanded by current events with the responses demanded in the past, during and after the traumatic events. This over-responsiveness to or disconnection from emotionally charged current events then tends to lead the individual into making familiar, but unproductive decisions in response to such events. This is the essence of the patterns of reenactment in which survivors become trapped. These patterns of utilising familiar responses to new events that are mistakenly interpreted as being exactly similar to the original traumatising events, is what perpetuates a sense of being trapped in time. This emotional and cognitive entrapment deprives the individual of many of the cognitive and intrapsychic skills that could be available to the adult survivor.

After a lifetime of being emotionally depleted, disconnected, or overwhelmed, the concomitant use of appropriate medication is often necessary to achieve biological stability. The complex nature of the trauma-related disorders often necessitates the use of unusual combinations of medication requiring careful monitoring and excellent psychopharmacological management. Physiological stability is crucial if the person is to do the necessary reconstructive work in both internal and social/interpersonal spheres. The ability to self-soothe during an emotional storm, and the ability to arouse affect during times of emotional disconnection are both critical elements in the ongoing efforts of the individual to learn how to constructively and creatively use the emotional energy that accompanies the therapeutic process. Victims of trauma must also be taught how to manage the dissociative experiences that so often accompany a history of trauma and are a result of the earliest attempts to manage overwhelming affect. They gradually must assume responsibility for their dissociative experiences and learn how to integrate memory and affect so

that they can remain conscious and utilize all their resources, even when under stress.

Many different therapeutic modalities are used on the unit to help manage affect. The milieu is designed to be a container for all of the overwhelming affects that surface once a group of trauma victims begin to work through their traumatic stress. Direct psychoeducational groups deal with affective education and provide cognitive-behavioural interventions. One-to-one therapy and group therapies provide opportunities for the development of insight and the rehearsal of new behaviours and cognitive strategies. Individualized problem identification and goal setting helps each patient to focus on the area of affect management most problematic for them. Learning anger management is particularly important for our patients since their experience of anger tends to be overwhelming and uncontrollable, a mirror of the uncontrolled rages that they witnessed as children. As a result, they tend to over control and deny their anger, while taking it out via self-destructive behaviour, or they act out aggressively in a more direct manner. Some people alternate between the two styles. The therapeutic challenge is to help them find constructive and healthy ways of both expressing and containing anger. Creative therapies such as movement therapy, art therapy, and psychodrama offer opportunities to integrate dissociated affect, rehearse new patterns, and rework the past. Community meetings and informal community interactions offer numerous opportunities for trying out new behaviours and developing a deeper understanding of how the present relates to the past and how past relationships are being relived in the present.

*As Ariel became able to inhibit her self-destructive behaviour and therefore manage her safety issues more adequately, her affect began to increase. The symptoms of PTSD actually increased, a quite common occurrence once the compulsive behaviours are arrested. She became more hyperaroused and began to have increasingly florid flashbacks that became almost continuous. She was flooded with memories of the previous traumatic events and experienced an increase in both depression and paranoia. But, at the same time, she was able to share the relief she felt in having some way of understanding these symptoms, now that she was learning about the effects of trauma. She and her physician worked closely around regulating her medication more effectively so she could get some relief. With the help of the staff and other members of the community, Ariel began rehearsing some new ways of coping with the flashbacks including using a journal, talking to other people, participating actively in the groups, drawing her memories in art therapy, and acting out ways of venting her anger at those who had hurt her through the psychodrama groups. She was placed on Group Level, representing the shift to the A-G aspects of SAGE and encouraging her utilization of the social milieu. This activity level required that she accompany another patient in activities that would take her off the unit, while increasing her own personal responsibility. As*

*she used these therapeutic modalities she learned that she could gain control over feelings, thoughts, and behaviours that had previously held her in a helpless grip. She began to talk about a future that did not require staying in a hospital.*

## GRIEVING

As safety issues become less predominant, and a degree of affective stability is achieved, the individual is more adequately prepared to address the issues of loss that invariably accompany a life beset by traumatic events. The impact of such loss is enormous. Unresolved grief accompanies unresolved trauma and is an underlying source of many chronic psychiatric symptoms. Many patients with years of therapy and hospitalisation are arrested at this stage of treatment and unable to move further without a more structured and coherent approach to care. Instead, they stay stuck, fluctuating between failures in maintaining safety and an inability to modulate affect (Herman, 1992; Jacobs, 1999).

Grieving, in the case of a trauma victim, is made difficult by the fact that the loss is often not as tangible as the death of a beloved person. Loss of innocence, of childhood, of a sense of meaning, of hope, of a part of the self, of God, of a potential alternative life or career or love or family, all cause symptoms of unresolved grief without ever achieving the social acceptance of mourning that is so vital for human beings. In its most extreme forms, survivors of early and chronic trauma can lose an entire childhood. Compared to the agonising reliving of this type of loss, loss of life can be seen as a blessing. This helps to explain why so many survivors of trauma gravitate towards chronic suicidality as a reasonable alternative to dealing with the profound sadness and pain that accompanies realisation of the long-term consequences of their particular personal tragedy.

Most world cultures have ritualised standards and customs that facilitate the act of mourning. Some even have a set period during which mourning and social paralysis is expected. However, when addressing issues of physical, sexual, and emotional abuse in childhood, especially in westernised cultures, there is an attitude that supports premature closure without processing grief and loss. This attitude is oftentimes promoted through such platitudes as "let bygones be bygones", or "it happened a long time ago, just get over it", "let sleeping dogs lie", or, most dramatically, "that can't possibly be true!" With such social prohibitions against processing loss, it is little wonder that many survivors of traumatic events as well as the clinicians who treat them, often fail to appreciate the profound impact that loss engenders. Sadness, rage, and fear are all very real and very appropriate reactions to traumatic losses. Such losses can be losses of parts of the self (e.g. physical traumas), losses to one's social support system (e.g. family or even community structures), or losses to one's psychological integrity, such as loss of one's sense of safety and trust of others.

The sadness, rage and fear that accompanies such loss, if not given appropriate structure and context for processing, often leads one to feel affectively aroused. This level of arousal can lead to a familiar feeling of having a lack of safety, thus perpetuating a cycle of circular therapeutic motions between therapist and client that never seems to be adequately resolved. When therapy is “stuck” it is often because of this arrested grief. The role of the therapist must be to help provide a context within which grief work can be done and to assist in the construction of appropriate ritual passages for the achievement of a completed grieving process. A commitment to the process of mourning and to addressing issues of loss while practising the management of all the affect that accompanies such loss, is all preparation for the survivor to do that which is absolutely necessary for "full" recovery. To free oneself from the tyranny of the past means not forgetting the past, but moving on from the past. It means not continuing to live in the past by way of perpetuating past traumas through patterns of reenactments, but learning how to use affect, rituals, and social and interpersonal resources to facilitate new and creative responses to loss that allow for real transformation to proceed.

*Ariel was released from the hospital after two weeks with a fairly clear map of recovery. She had some idea of what lay ahead for her and knew that therapy was a vital part of promoting her continuing progress. She worked for several months in outpatient therapy and then appeared to regress as the holidays approached, during which time she was going to have to see her family again. She came into the hospital again with suicidal ideation and an increase in depression, though she had been able to forestall the inclination to harm herself. As we began to work with her around this regression in the face of significant therapeutic gains, it became clear that she had indeed been making more sense out of her life, but as a result, she had been hit hard by the reality of her present and past existence. The horrors of her childhood were not something she could no longer avoid by covering up her pain with drugs, by cutting herself or fantasizing about suicide. By beginning to wrestle with the stages of grieving, she started to come to terms with all that she had lost in her life, the terrible price she had paid – and was still paying – for being a member of such a dysfunctional family. As she did grief work in individual and group therapy and through creative therapies, she began to be able to envision life after trauma.*

## EMANCIPATION.

Such transformative processes can lead to real Emancipation. It is important to note that emancipation is not an idealised end point. Rather, in the course or journey through the recovery process, emancipation is, instead, the very beginning of a life that allows for real choices to be made. Such choices can

now be made with a developing sense of personal empowerment as opposed to a prior assumption that outcomes were dictated by one's traumatic past. The successful management of safety fosters this growing sense of empowerment, affect and loss accomplished in the preceding stages of SAGE. The individual's recognition of personal empowerment is both liberating and challenging for they are then facing an unfamiliar opportunity to manage freedom and create a present and a healthier future. This stage of recovery is characterised by an ongoing process of self-discovery and self-definition accompanied by an evolving sense of mastery. Some patients have adopted the identity of "thrivers" instead of survivors, people who have learned to transform their personal tragedies into experiences of benefit to themselves and to their society. Emancipation, while providing an opportunity to manage freedom, also presents one with the challenge to engage in responsible choice. Survivors are intimately familiar with the irresponsible and tyrannical exercise of power with its concomitant destructive outcomes. Their lives were often rendered meaningless by those who victimised them via abuses of power. Perhaps the most critical challenge faced in this stage of recovery is that of restoring meaning to one's life through the responsible utilisation of power.

*Before leaving the hospital, it was clear that Ariel's grieving process was alternating with a vision of what life could be like without trauma. While still in the hospital, she began to make plans for taking more responsibility for her life, not allowing her family to continue to control her behaviour through their criticism and finding ways to more adequately support herself. She recognized that she needed more support to be able to make more progress and therefore she took steps to get herself admitted to a residential setting for emotionally disturbed patients who are trying to live in their own apartments. After discharge, while continuing her outpatient therapy and responsibly using her medication, she began working at a part-time job, sought out new and healthier relationships with people, became more able to reach out for help and to accept feedback and even criticism.*

## CONCLUSION

This is where the journey through SAGE both ends and begins. It began when there was a critical need to identify central therapeutic themes in recovery, and then formulate them in a way that was both understandable and applicable. SAGE provides a framework for the therapeutic process that not only applies to those who have been abused or otherwise traumatised by horrific events, but to those who need to work through other, perhaps less destructive, life events. Who among us has not experienced the increased sense of vulnerability, sadness tinged with anger, and sense of profound loss that accompanied the loss of a significant relationship? Those who suffer from other forms of mental illnesses also can benefit from the application of SAGE principles to the general therapeutic agenda. SAGE is a model that has been applied to inpatient,

outpatient and other clinical environments, including domestic violence shelters and residential settings for children and adolescents.

SAGE. Webster's Third International Dictionary describes sage as "eminent in wisdom: wise through reflection and experiences"; whole healthy; from its use as a medicinal herb". Little wonder then that in eighteen years of providing inpatient and outpatient psychiatric services, Sanctuary has found SAGE to be, more than any other intervention, both effective and resilient in its applicability to diverse populations with diverse problems.

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# TREATING POST-TRAUMATIC STRESS DISORDER IN A THERAPEUTIC COMMUNITY: THE EXPERIENCE OF A CANADIAN PSYCHIATRIC HOSPITAL

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## ABSTRACT

This paper will discuss The Program for Traumatic Stress Recovery. A program description follows a discussion of both the trauma model and the therapeutic community. Information about treatment outcomes will be presented, along with a discussion about the role of the therapeutic community in achieving positive treatment gains.

## BACKGROUND

The Program for Traumatic Stress Recovery (PTSR), situated in a psychiatric hospital in Guelph, Ontario, Canada, is a specialized, inpatient treatment program for adults suffering from post-traumatic stress disorder (PTSD). This program has been in existence since October 1993, and was initially designed for the treatment of adult survivors of childhood abuse. With time, the mandate of the PTSR has grown to encompass all types of trauma (e.g. work place, military, motor vehicle accident) at any life stage.

Drawing upon the work of Herman (1992) and van der Kolk et al. (1996), a new way was developed to treat adults suffering from the presumptive negative impact of childhood abuse on their current adult life. The resulting so called "trauma model" was then applied within the context of a therapeutic community milieu, adapted from Bloom's Sanctuary Model (1994). The PTSR was developed to treat the under recognized symptoms of chronic PTSD. While during the first years of operation, more than 95% of the participants met diagnostic criteria for PTSD, as determined by the Clinician Administered PTSD Scale (Blake et al., 1985), only 33% had been given that diagnosis

prior to admission. Instead they were being diagnosed with depression, anxiety, and personality disorders.

Since the program's onset, outcome studies have been employed in an attempt to measure treatment effects. Hypotheses have been developed regarding the roles that specific program elements have on treatment outcome. The impact of the therapeutic milieu as a potential treatment factor will be postulated in this article.

## TRAUMA MODEL

Following the Vietnam War and the inclusion of PTSD in the American Psychiatric Association DSM-III (APA, 1980), many people's symptoms have been re-examined through the constructs of the trauma model. In the past, some of these people may have been diagnosed with bipolar, borderline, schizoaffective, or other anxiety or depressive disorders without an appreciation of the impact that trauma may have on their current presentation. According to the American Psychiatric Association DSM IV (APA, 1994), a diagnosis of PTSD requires exposure to a traumatic event (Criterion A), and symptoms in three other categories to meet diagnostic criteria. These categories are intrusive recollections of the event (criterion B), avoidance (criterion C), and hyperarousal (criterion D). With the onset of DSM-IV, criterion A has been expanded to include a wider range of traumatic events. Symptoms may be acute or chronic, and the onset of symptoms may be delayed.

Much of our initial knowledge regarding the aetiology and treatment of PTSD was derived from the study of Vietnam veterans. Over the years, other populations including civilians, survivors of natural disasters, and victims of violence began to be studied. One of the earlier concepts behind the trauma model was that PTSD is a normal response to an abnormal event. This is now the focus of a debate in the literature with some suggesting that PTSD is an abnormal response to an abnormal event (Yehuda and McFarlane, 1995). Others, who continue to support its being a normal response, are suggesting that the severity of the trauma is the defining factor (Engdahl et al, 1997). Examining differences between the after effects of a single incident trauma versus prolonged and repeated episodes of trauma have led some such as Terr (1991) to label these Type I (single incident) and Type II (prolonged, repeated) traumas. There is also considerable debate regarding the impact of trauma experienced during the earlier developmental stages upon later adult life. It is not yet clear whether early traumatic experiences can be responsible for Axis II pathology, particularly borderline personality disorder (Gunderson et al., 1993). This has led others to suggest a construct of complex PTSD.

Herman (1992) proposed the term "Complex PTSD" to refer to PTSD following prolonged extreme stress. Examples of situations that may lead to the development of complex PTSD include being a prisoner of war, domestic battering, childhood abuse, and hostage conditions. Herman identifies a set of six alterations that occur for the individual suffering from complex PTSD. These alterations are in the areas of affect regulation, consciousness, self-perception, perception of the perpetrator, relations with

others, and systems of meaning. The distinction between simple and complex PTSD has also been proposed by van der Kolk (1995). Complex PTSD was field tested for DSM-IV as Disorder of Extreme Stress Not Otherwise Specified (DESNOS). While DESNOS was not included as a specific entity in the DSM-IV, it is included as a description within the associated features of PTSD (1994). Further research may lead to further differentiation of this category.

Along with these developments in diagnoses, corresponding new treatment models have been created. Under the rubric of the trauma model, a stage model of treatment has been suggested (Herman, 1992; Chu, 1992). The first stage is 1) Creation of Safety. People suffering from PTSD, either acutely or chronically, report recurrent intrusive symptoms, which lead to re-experiencing the fear associated with the traumatic event, and re-experiencing the world as an unsafe place. The other two stages, as labelled by Herman are 2) Remembrance and Mourning, and 3) Reconnection. The later two stages cannot be effectively worked through if the individual has not discovered ways of first remaining safe during the process. In addition, the trauma model places an emphasis on the question "What's happened to you?" rather than "What's wrong with you?" (Foderaro cited in Bloom 1997, and in this volume). It is believed that this approach decreases shame and allows the individual to observe and take responsibility for their behaviour in new ways.

An additional issue of concern arising out of earlier applications of the trauma model is the role of memory (Paris, 1996a; Paris, 1996b). The "false memory syndrome" and the ensuing debate regarding the reliability of memory is acknowledged within the PTSR. The therapeutic stance taken in our program toward alleged histories of trauma is that the history of trauma represents the individual's belief, but may not accurately represent what truly occurred. It is however the impact of those beliefs on the present, rather than a search for accuracy that is the therapeutic work. This position has increasingly found support in the literature (Gutheil & Simon, 1997).

## THERAPEUTIC COMMUNITY:

The therapeutic community model of treatment gained momentum starting with the writings of Main (1946) and Jones (1956). This model of therapy was applied to both in-patient and out-patient settings, as well as both specialized and general psychiatric populations. While the structure and specific program elements varied depending on the population being treated, these therapeutic communities held the common philosophy that the milieu of the therapeutic environment in and of itself is an instrumental part of healing. Key principles of the therapeutic community included self-responsibility, joint decision-making, and open communication as well as a belief that all community members, staff and patients alike, are active agents in healing.

The therapeutic community model was adopted in Canada, and served as the framework for the creation of North America's first day hospital, established at the Allan Memorial Institute in Montreal, Canada (Cameron, 1947). This movement later spread

throughout the country (Azim, 1993). In addition, the concept of treating difficult patients through the use of specialized multidisciplinary teams also has a well-established history in Canada (Geben, 1983).

Therapeutic communities and milieus have been difficult to describe due to poor operational definitions of their therapeutic variables. Gunderson (1978) attempted to characterize classes of therapeutic communities by defining five functional variables: Containment, support, structure, involvement, and validation. He suggested that these variables are somewhat hierarchical in that each depends upon the successful incorporation of those preceding. Flexibility and a tolerance of uncertainty on the part of staff were also acknowledged as important attributes in the successful operation of a milieu.

The PTSR offers a structure that provides predictability through mandatory program elements. However, it is also flexible by being responsive to specific individual needs when appropriate. Involvement in all aspects of the community is strongly encouraged, and validation (affirmation of individuality) is an important aspect of the PTSR experience. The PTSR is on an unlocked unit. If an individual declines in functioning or experiences an acute crisis, the program addresses the crisis through lowering the level of stimulation, focusing on safety, and providing support. If these measures are not effective in containing the crisis, a transfer occurs from the PTSR to other programs in the hospital with greater containment. Sometimes these crises can extend beyond the individual to the entire therapeutic community. Such a crisis may arise because one or more members have violated community rules (e.g. stealing, sexual relationships, violence) that may require discharge from the community. This can lead to a division within the community and needs to be addressed at a community level. During such times, there is a great emphasis placed upon communication and sharing of information. Sometimes, members of the community become too involved in each other's issues, producing excessive rescuing behaviours that interfere with the functioning of the community and distract people from focusing on their own therapeutic work.

In the literature about therapeutic communities, much attention is paid to the expanded roles which staff members of all disciplines must perform and the potential difficulties they may experience. In the trauma literature, discussion and concern regarding vicarious traumatization or compassion fatigue is addressed (Pearlman & Saakvitne, 1995). These factors are acknowledged within the PTSR, and the staff continually examine these concerns through ongoing supervision, team building exercises, and program staff retreats.

With Bloom's creation of the Sanctuary Model (Bloom, 1994; 1997; this volume), the trauma model and therapeutic community concepts were merged. The Sanctuary Model arose out of concern that traumatized individuals were coming for treatment (seeking sanctuary), and were instead being further hurt by a system that patients perceived did not understand or care about them. With a better understanding of the symptoms of PTSD, Bloom sought to combine a trauma framework with the established tenets of the therapeutic community. Since many individuals are traumatized as a result of interpersonal violence, they experience a social wound. The therapeutic community offers an environment where social wounds can have the necessary social healing.

The staff of the PTSR received the majority of their training in Canada. The principles of both the therapeutic community and the multidisciplinary team were embedded in much of our professional training. As such, the staff's familiarity with these principles made the adoption of Bloom's Sanctuary model easier. This awareness has also allowed the PTSR to adjust the Sanctuary Model to better accommodate to the Canadian culture.

While the Sanctuary and the PTSR share common treatment philosophies, several differences also exist. Bloom has taken the theory behind the Sanctuary model and incorporated it into a program appropriately entitled "The Sanctuary". The PTSR shares a similar theory base, however, it has evolved with time into a distinctly Canadian program. Differences can be seen in length of stay, predominance of group work in the PTSR, as well as different staff components giving rise to different therapeutic interventions, such as the use of different creative arts therapies.

The Canadian health care system is a socialized medicine model with the government being the single payer. This has protected programs of extended duration such as the PTSR from the onslaught of the American model of managed care. This economic and political reality has allowed the principles of the therapeutic community to be tested as to its clinical efficacy. Another difference that needs further exploration is the impact of the different cultures of the two countries on treatment, as well as exposure to violence and trauma. The American experience appears to have a higher level of background violence which may make it more difficult for the individual to achieve a sense of safety in their daily lives.

## PROGRAM FOR TRAUMATIC STRESS RECOVERY

### PROGRAM DESCRIPTION

The PTSR is a 28-bed, six week in-patient treatment program. In the initial phase of the treatment program, the length of stay was variable, up to three months in duration. With clinical experience, it became apparent that patients deteriorated after eight weeks in hospital, demonstrating more intense discharge anxiety with an exacerbation of suicidal thoughts and minor acting-out behaviours, an increase in dependency behaviours, and a weakening of connections to pre-existing external supports. In addition, there was reluctance on the part of third party payers to finance such

extended stays. Patients experienced any period shorter than one month as insufficient time to achieve change.

Individuals enter the program from all regions of Canada. Approximately 70% of participants are female, and the age range of individuals is 18 -70 years. The majority have co-morbid diagnoses of major depression. A significant portion have a history of previous addiction. The program is delivered by a multidisciplinary treatment team that includes psychiatry, psychology, nursing, occupational therapy, social work, recreation therapy, creative arts therapies, horticulture therapy and pastoral care. Delivering the program almost exclusively by means of a group modality enhances the experience of community. Shared group leadership allows for the development of a team and reduces the likelihood of splitting.

## ASSESSMENT PHASE

The individual's first week in the PTSR consists of a one-week assessment phase, during which participants are introduced to the program's core concepts such as those of safety, grounding and traumatic reenactment. During this period of time, individuals participate in small interactive psychoeducational and community based groups, and are evaluated regarding their ability to engage in group process, level of safety, tendency toward dissociation, and their capacity to tolerate interventions from others. This latter capacity is significant in becoming an active member of the therapeutic community and in being able to resolve the normal, inevitable conflicts that arise from living with others.

Individuals are excluded from participation in the program if they are markedly unstable with regards to an addiction, eating disorder, or psychotic condition. In addition, while the individual cannot be in a state of acute crisis while participating in the treatment program, chronic suicidality is not an exclusion criteria. This assessment process is facilitated with input from all disciplines, as well as the individual's self-assessment.

The PTSR has learned through clinical experience that speaking in generalities does not lead to positive outcome. A position of the PTSR is that insight is of little benefit unless it results in behavioural change. Adult survivors of childhood trauma often have a capacity to compartmentalize life experiences, which makes it difficult for them to generalize successful learning experiences to other situations or aspects of life. As such, the PTSR has taken a goal-focused approach to treatment. During the assessment week, participants are taught goal setting skills, and are asked to establish specific goals, along with corresponding action steps, that are achievable within the six-week program parameters. These goals are then ranked by the individual, regarding their current levels of ability and satisfaction with these self-established goals. The establishment of goals inform the treatment plan by helping with group selections and other program elements. For those individuals who have a limited capacity to pace, the goals also provide both the individual and the treatment team with a focus for their therapeutic activity.

## TREATMENT PHASE

It is during the treatment phase that the participant actively works on their established goals, receives feedback from other community members (co-patients and staff) regarding unhealthy behaviour patterns, and risks adopting new ways of thinking and being. Participants in this phase of the program attend daily psychoeducational groups that address topics such as flashback management and affect modulation. There is also a daily process group. Specialized groups with themes such as loss, sexuality and intimacy, spirituality, and body esteem, are also available. Community activities including community meetings, walks and parties are also a part of the treatment schedule. If a crisis occurs, emergency community meetings are called to address issues. The patients are encouraged to use all of these activities to work on their stated goals.

The PTSR's focus is almost exclusively on safety, the first stage of healing. The program has taken the stance that before exploratory or reconstructive work about the specific traumatic experiences can be undertaken, the individual must demonstrate an ability to establish and maintain safety in the here and now.

Within the PTSR, the issue of safety is addressed in a number of different spheres (environmental, somatic, interpersonal, spiritual, and emotional). The first is environmental safety, which refers to assuring that the therapeutic environment is physically safe for all members of the community. This is achieved by requiring all members of the community to sign a program agreement that clearly states that physical violence or sexual contact between community members will result in being asked to leave the community. Establishing this boundary allows all members of the community the opportunity to experience healthy, caring relationships in relative safety, without the threat of sexual coercion or physical intimidation.

Somatic safety refers to assuring a reasonable level of stability for the body. This includes the regulation of body functions such as eating and sleeping, as well as decreasing self-harming behaviours and providing individuals with tools to handle intrusive memories and physiological hyperarousal. The structure of the treatment program attempts to reflect a healthy, balanced lifestyle, with time for meals, rest, leisure, socialization and therapy scheduled into the program. Educational and skills groups are provided to develop skills to decrease self-harm and dissociation, and to manage intrusive memories and anxiety.

The use of medication, both for psychiatric and medical concerns, is seen as an appropriate tool to promote well-being. The majority of participants are on psychotropic medications prior to admission. These are reviewed and adjusted if agreed to by both the attending psychiatrist and the individual patient. If either a medical or psychiatric condition deteriorates so that it becomes the necessary focus of treatment, the individual is asked to take their leave of the PTSR and are invited to return when stable.

Many trauma survivors live their lives in isolation, or in environments where no guidelines or boundaries exist. As such, interpersonal safety within the therapeutic

community is created through the existence of guidelines for community living. These guidelines were developed by the client community and include several aspects of daily life from the care of community property, to the need to set time limits regarding telephone calls. Protocols for conflict resolution, emphasis on confidentiality as opposed to secrecy, learning about supportive relationships, and instruction in assertiveness training also adds to the development of interpersonal safety within the therapeutic community.

This experience of isolation frequently also exists within their current family situations. The PTSR has a focus on extending the work within the therapeutic community to the individual's outside relationships. A family dynamics group is offered weekly, during which time individuals can explore the impact of trauma on their family functions and the role they play in maintaining those dynamics. A family and friends program is available to offer support and information to the individuals in the participants social support network. In addition, brief couples or family therapy sessions are offered when appropriate.

Another realm of safety that the PTSR addresses is that of Spiritual safety. This involves developing a sense of hope, as well as a sense of belonging, having a place in the world, and participating in something larger than themselves. There are a number of aspects of the PTSR that facilitates the development of spiritual safety. There are psychoeducational groups that address topics such as developing and maintaining hope, as well as a spirituality group. Community meetings, leave taking rituals, and "Hope Books" where participants provide words of encouragement to one another all contribute to a sense of belonging and acceptance. The therapeutic community milieu however may be the greatest contributor to the development of spiritual safety. Patients live and work together with other trauma survivors and are exposed to the courageous ways that people deal with their past. This supports the development of hope and challenges their belief that they are alone.

For many survivors of trauma, safety is an experience that is difficult to access in the present. Because of intrusive memories and the process of traumatic reenactment, dangers from the past are displaced into the present. As such, achieving a sense of emotional safety needs to involve teaching the individual to be aware of the relative safety that exists in the present. A number of solution-focused strategies are used to help individuals develop a sense of comfort and security in the present, and cognitive-behavioural, as well as experiential exercises are used to help individuals challenge mistaken beliefs that negatively impact their sense of emotional safety in their day-to-day lives.

Many individuals arrive with the mistaken belief that telling their story is the therapeutic endeavour that needs to be undertaken. Instead, the program guides the individual to focus on how their past negative experiences and resulting mistaken beliefs about themselves and the world are impacting their current life. A theoretical construct that facilitates this process is called Traumatic Reenactment (van der Kolk, 1989). This is a

concept where maladaptive behaviours are seen as unsuccessful efforts to work through past traumatic events in the here and now.

A reframe of repetition compulsion, challenges the individual to look at repetitive unhealthy behaviour patterns that are employed in dealing with stress in the present. The unhealthy behaviours are linked with their past traumatic experiences and the individual is encouraged to give up the trauma based behaviour pattern in the present by risking healthier alternatives. An example of a traumatic reenactment may be the use of avoidance in the present. An acknowledgement is made that avoiding the traumatic stressor in the past may have been helpful, however, the individual is helped to realize that excessive avoidance in the present will often make attempts to fulfil adult needs harder to achieve. It is understood that concepts such as traumatic reenactment are rarely directly causally linked, but it has been found that individuals are more willing to look at and change their problematic behaviours in our program using this concept.

Panic disorder has been described as fear of fear. In contrast, the individuals that are treated in PTSD have a fear of feeling. A significant number are also alexithymic and have little specificity in their language to communicate their emotional experience. They experience their symptoms with extreme intensity and often describe themselves as being overwhelmed with those emotions. As such, a significant part of the program is aimed at helping participants achieve both an improved level of affect identification and modulation.

## DISCHARGE PHASE

All participants enter a discharge-planning phase before returning to their community of origin. Because of issues of rejection and abandonment, the leave-taking process is one that can result in reenactment, and crisis if not attended to appropriately. As such, opportunities to address their fears and feelings related to leaving the therapeutic community are provided, along with planning sessions that provide an opportunity to review new learning, and a chance to put into place resources that they will require once back home. At the conclusion of the program, the patients are asked to evaluate the goals that they established during the assessment phase with regards to attainment and satisfaction.

Attempts are made to communicate with and inform the outpatient resources that the individuals return to after discharge. The extent of involvement with out-patient resources varies from case to case, and ranges from sending reports accumulated during the individual's program stay, to meeting with the individual's entire out-patient team in a case conference. The available pre and post hospital therapeutic supports of the program participants range from nil to continued intensive outpatient work with multiple resources. In cases where the participant has no or little outpatient support, attempts to help them establish liaisons are made.

## THE COMMUNITY

From the moment a request for a referral is made, individuals are informed that the program is delivered within the context of a therapeutic community. On their day of

arrival, this is reintroduced through the admission process, where current community members welcome and orientate the new arrivals to the program.

The community is maintained through a number of experiences that are for the entire patient group and are identified as belonging to the community. These include community meetings, run by the participants three times a week, community walks and parties. A number of the program elements as previously described are delivered to the community as a whole. In addition, there is a weekly community session entitled "themes", which is an effort to address current issues within the therapeutic community. If there is a crisis or a rule violation occurring, the community is informed through "emergency community meetings", in an effort to promote open communication and achieve resolution.

This experience of community has often been stated by people at their discharge as the most important part of their treatment experience. Following discharge, individuals appear to keep in contact with one another, and significant numbers return to attend a yearly Christmas reunion. Christmas cards to the staff from former community members are not uncommon. Many also write from time to time to update us on their progress, and to inform us of significant life events e.g. the birth of a child.

## OUTCOMES

There had been a paucity of scientific data on the treatment efficacy of the first generation of programs using the trauma model. The PTSR has been involved with measuring treatment outcomes. There was a need to scientifically validate the anecdotal positive outcomes shared by the early participants of the PTSR.

The PTSR engaged in a repeated measures design to evaluate treatment outcome and maintenance (Wright & Woo, 1997). Data was collected at admission, discharge, three months post discharge, and one year post discharge. Measures administered during the course of the study included the Clinician Administered PTSD Scale, Trauma Symptom Inventory, and Symptom Checklist 90 Revised. Findings showed a significant improvement in symptoms of posttraumatic stress disorder, as well as associated symptoms such as depression, phobic anxiety, and anxiety at discharge, some decay at three months, and a return to the improved values seen upon discharge at the one year follow-up. While acknowledging some limitations of the study, these findings suggest that the PTSR is significantly effective in the treatment of adult survivors of childhood trauma.

Another study examined client ratings of goal performance and satisfaction using the Canadian Occupational performance Measure (COPM) at admission, discharge and four months post discharge (Isotupa & Templeton, 1998). Client goals were classified into the following six categories: self-care, productivity, leisure, feelings, relationships, and spirituality. Findings showed a statistically significant improvement in both goal performance and satisfaction scores from admission to discharge for goals in all six categories. While there was some decay in scores at four months post discharge, these

scores still showed statistically significant improvement as compared to admission scores.

Throughout the history of the therapeutic community, there has been more discussion of its theoretical application and speculation of its perceived benefits, rather than any direct measurement of the same. Within the PTSR, the therapeutic community has been positively commented upon frequently in patient satisfaction questionnaires, as well as participant self-reports. However, the design of the PTSR's initial outcome study did not identify the therapeutic community as a separate treatment variable. Nevertheless, some of the findings have led us to speculate as to the ways the therapeutic community may be impacting the treatment outcomes.

One of the ways in which the outcome data has been analysed is by comparing admission versus discharge outcomes against personality disorder clusters, as assigned by MMPI2 and MCMI-II profiles (Ross, 1997). According to the MMPI2, 53.1% of participants fit cluster A (paranoid, schizoid and schizotypal), 28.3% fit cluster B (antisocial, borderline, histrionic and narcissistic), 13.3% fit cluster C (avoidant, dependent and obsessive-compulsive), and 5.3% did not fit within a personality cluster. Analysis of MCMI-II profiles yielded a different distribution of personality types with 5.5% falling into cluster A, 15.7% falling into cluster B, 63.8% falling into cluster C, and 15.0% not fitting into a clear personality cluster. The fact that the majority of people, according to either measure, did not fall into cluster B (i.e. borderline personality disorder) was not anticipated.

The most unexpected finding was that treatment gains were the same regardless of the personality cluster of either measure, to which the individual was assigned. This does not mean that every cluster started and ended at the same absolute values, but that the magnitude of improvement was not dependent upon personality cluster.

There has been a great deal of discussion about the degree of overlap between personality disorders. Evidence suggests that most individuals who have personality pathology meet criteria for more than one axis II personality disorder (Gabbard, 1994). This overlap of personality disorders does not in our opinion completely explain the equal efficacy of the PTSR across personality clusters. A potential explanation to explain these findings is to attribute them to the impact of the therapeutic community. The therapeutic community appears to serve as a holding container with a great capacity to tolerate differences. The qualities attributed to cluster A, such as idiosyncratic thinking and ways of relating appear to be handled by the community in a supportive, non-scapegoating fashion. This allows the treatment team to focus on intervening with cluster B impulsivity and emotional lability, and challenging the dependency and avoidance of individuals with prominent cluster C pathology. With the therapeutic community as a holding environment, it is noticed that with time, idiosyncratic behaviours decrease and more normative behaviours are adopted.

A research project using a program logic model is currently under development to measure more directly the role of the therapeutic community in treatment (Isotupa,

1998). This project is attempting to assign to each therapeutic activity during the patients stay a perceived value corresponding to the outcome.

## CONCLUSION:

The Program for Traumatic Stress Recovery has been described and its therapeutic underpinnings presented. Initial outcome studies suggest that the efficacy of the program appears to be substantial in both symptom reduction and goal attainment. Several interesting findings have pointed to the potential value of offering treatment in the context of a therapeutic community. Further research is underway to more directly quantify the community's impact on treatment gains. As scientific research into the sequelae of traumatic exposure continues, the theoretical supposition of a "social wound requiring social healing" may become more accepted. The PTSR is committed both to furthering its own development based on the growing science informing the treatment of PTSD and adding our clinical findings to the discussion of treatment in the literature.

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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 rediagnosed 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.

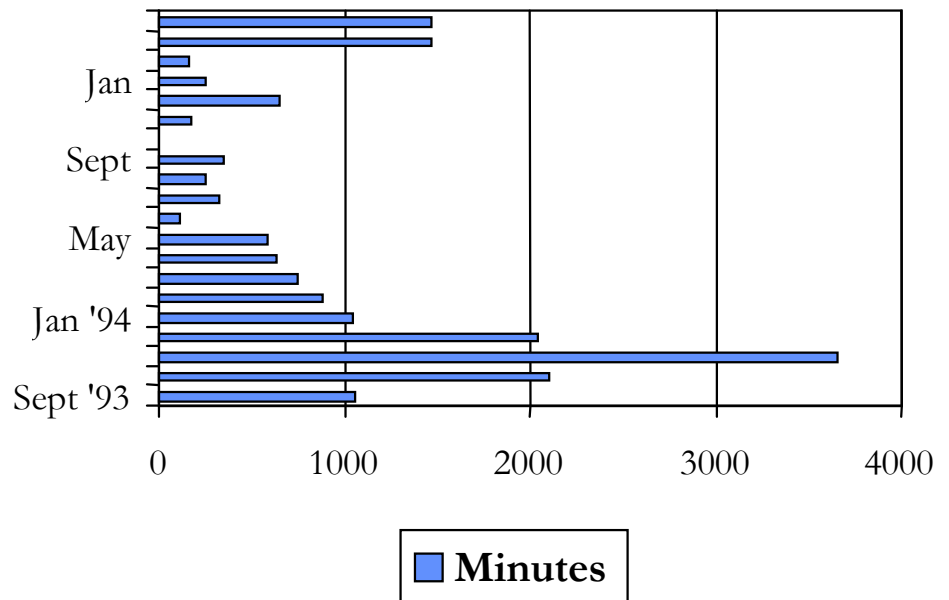
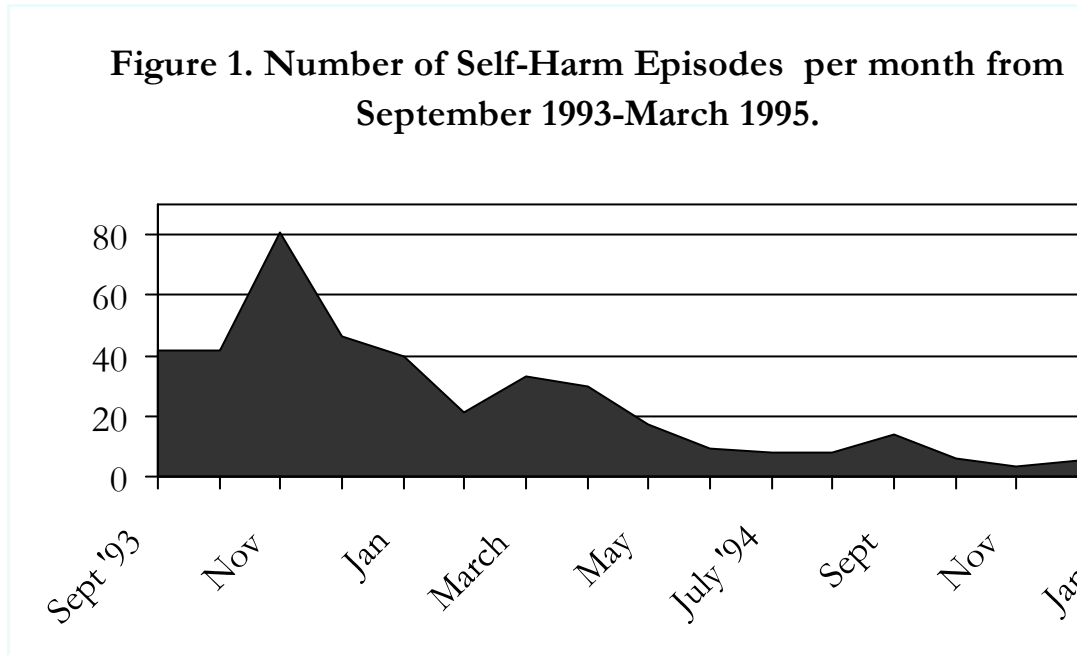
## QUANTIFYING RESULTS

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 re-diagnosed 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.**



## 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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# EPILOGUE

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THERAPEUTIC COMMUNITIES: THE INTERNATIONAL JOURNAL FOR  
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134, SUMMER 2000

SANDRA L. BLOOM, M.D.

## EDITOR

After four moves and twenty years of working together, the last ten specializing in the treatment of victims of trauma, those of us working on Sanctuary should take comfort in the fact that our program has survived and have influenced other programs like those described by Wright & Woo and Bills & Bloom in this volume. But it is disheartening to recognize how difficult this struggle for survival has been and how much we have been forced to compromise our highest goals and principles over the years in service of this survival. At the present moment, I cannot be assured that The Sanctuary will continue, since the health care environment in the U.S., so dominated by the demand for increasing profits, strangles anything but the most rudimentary of mental health services. As someone who would probably be considered a “charismatic leader”, I have read the therapeutic community literature about the problems surrounding this aspect of the movement. But is the problem really that the development and maintenance of a healthy human environment is dependent on the rare appearance of such a leader? Or is the real problem that the wisdom of the therapeutic environment goes so counter to the existing paradigm, that only a tremendous amount of energy can keep the flame of health alive?

As I have watched myself and my team repeatedly bang our heads against increasingly bureaucratic structures seemingly bent on resegregating the “mentally ill” and guaranteeing their continued “deviance”, I have felt an increasing sense of frustrated and even bitter resignation. In twenty years, our attempts to defend the rights of our patients, as fellow human beings, to live in the least restrictive, most health-promoting environments have if anything, become much harder, not easier. Just as our patients require a supportive social milieu if they are to recover, so too do we, in a parallel process, require a supportive social milieu to do the demanding work of promoting recovery.

On other fronts, however, we have received signals of support. The Jewish Board of Family and Children’s Services in New York City, the largest social service agency in the country, has been consulting with us for the past two years to introduce the Sanctuary Model into their 300-bed residential facility for children and adolescents. We have just begun three pilot programs, one for 7-11 year old boys, another for adolescent boys, and a third for adolescent

girls. Staff members from two of the pilot programs recently presented their “work in progress” at a large conference in Manhattan and the results are gratifying. Without the presence of a “charismatic leader”, they have begun to alter their settings in line with the Sanctuary model concepts and are already seeing the results in decreased violence and higher staff satisfaction. A pilot research project is already under way in these settings and a larger research initiative is waiting on proposed grant funding. We have also been training the staff members of three New York City domestic violence shelters in the Sanctuary model to study its application in yet another setting. And recently, I was welcomed in the Netherlands, where several psychiatric facilities are considering creating Sanctuary-type environments. We have also consulted with several state hospital systems that are attempting to respond to the escalating violence within their institutions.

Meanwhile, here at home, I feel a bit like a scholar must have felt upon entering the Dark Ages, as he (or she) busied himself with copying the old manuscripts and secreting them away to protect them from the infidels. I talk and write about the work to keep the knowledge alive in the hope that somewhere, someday, the ground will be more fertile for the development of institutions that truly are conducive to human health, creativity and well being.

# COMMENT: SANCTUARY, TRAUMA AND THE COMMUNITY

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THERAPEUTIC COMMUNITIES: THE INTERNATIONAL JOURNAL FOR  
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GWEN ADSHEAD

Sandy Bloom and her colleagues have provided us with a rich and thought provoking account of working with trauma and the traumatized, using a therapeutic community approach. I must own up to some degree of bias, since I visited the Sanctuary programme in Philadelphia when I was first working in a traumatic stress service and I have had the benefit (and pleasure) of spending time with Sandy Bloom, Joe Foderaro and Lyndra Bills in professional settings to discuss this important work. In this concluding piece, I want to think about what the strengths and weaknesses might be of the TC approach to trauma.

Perhaps one of the most immediate strengths of using the community approach is to address the feeling of isolation that is so often felt by victims of violence. One of the points that I thought perhaps needed to be emphasised more strongly is that there are many causes of traumatic stress and interpersonal violence is only one of them. However, interpersonal violence, both in adulthood and childhood is probably more common than the major transport disasters or other types of natural disasters that so often grab the headlines in relations to traumatic stress research. Of course the other are of research which generated perhaps more information about PTSD than other types of trauma was the study of war veterans. These are a group of people, mainly men, who were exposed to extremes of interpersonal violence both as victims and perpetrators. There is interesting evidence to suggest that the commission of violent victimization as well as the experience of being a victim, is psychologically distressing and can give rise to post traumatic stress disorders. PTSD is only one of a number of disorders that people can develop after exposure to trauma, but the risk of developing PTSD is higher after exposure to interpersonal violence.

When considering interpersonal victimization, it can also be important to consider whether the victimization took place in adulthood or childhood and whether it took the form of a comparatively brief discrete episode or whether

violence was a feature of an enduring relationship which continued over time. Violence victimization which happens as discrete episodes in adulthood does give rise to PTSD and other disorders, but people often make a good response to different types of treatment and continue with their lives. In his regard most research has focused on individual cognitive behavioural interventions or pharmacological interventions. What group based work there is relates more to voluntary groups or self help groups for survivors of violence.

Where interpersonal violence has continued over a long period of time and was an integral feature of a dependent relationship, then the psychological morbidity is more complicated. Judith Herman coined the term “complex post traumatic stress disorder” for the constellation of symptoms and experience that survivors of childhood violence demonstrated in adulthood. Several commentators have noted the similarity between the features of complex post traumatic stress disorder and many features of severe personality disorder, especially borderline personality disorder. Specifically, complex PTSD involved distortions of a sense of self, dysregulation of affect and arousal as well as unstable interpersonal relationships which are often formed in very intense ways. Dynamically we argue that these are individuals who have not been able to internalise a soothing or stable internal working model of themselves in relationship with others, which they could use when feeling needy or distressed. It is perhaps relevant here to quote the recent research which shows that therapeutic communities can be effective for people with mild to moderate personality disorder, many of whom might be better understood as suffering from complex PTSD. WE might argue that the living learning experience provided by the community provides an opportunity for people to develop or modify internal working models of relating, using the community as a secure base people are more able to develop a sense of self agency.

Using a therapeutic community approach therefore can be especially valuable for those who feel isolated and disconnected by their experience of trauma. Fear, helplessness and the sense of being out of control often leaves survivors feeling that their experience is both unthinkable and unspeakable and that there, no one else can really understand. Although perhaps less well researched, there is a long tradition of group analytic treatments for traumatic experiences. Specifically in relations to therapeutic communities, it could be argued that the TC approach was primarily treatment of war traumas; an approach which emphasized that the traumatic experience had happened to men as a group, as members of a military community. It was perhaps only by understanding their role in that community that they could make sense of what had happened to them and move on.

Elsewhere, Sandy Bloom has written about the provision of Sanctuary for victims of violence as a political issue (Bloom, 1997). She raises a question which may be disconcerting and uncomfortable for mental health care professionals. To

what extent could we, and should we, take up the question of violence as a political issue and refuse to engage with it as a question of individual morbidity and distress? In this sense, violence and interpersonal victimization is everybody's problem we experience it and respond to it as a community. In the forensic setting that I work in, we are conscious of the harm that had been done to the community as a whole when any of our patients harms another, both in the hospital and of course in relation to the offence that brought them to Broadmoor in the first place. The Special Hospital can sometimes come to represent a sub-community of people who have been excluded from the larger community because of their violence. When individual commit crimes, at least one of the many meanings for such complex behavior is the importance of breaking the rules that are set by the community or social group to which the offender belongs. This is a particularly relevant issue given that PTSD may increase the risk of acting violent. (McFall, et al, 1999).

What does it mean to be political? The 'Polis' or State is itself a community made up of individuals. To be political is to engage and activate a community of people into expressing their feelings and engaging their thoughts; to develop not only a culture of enquiry but also a capacity of community self reflection as an aid to growth. A therapeutic community approach to the treatment of psychological reactions to trauma might have to change. If one is victimized, the whole community victimized; therapeutic community work with victims of trauma cannot help but be political.

Most readers will be familiar with the assertion that "No man is an Island, entire of itself". Donne's famous sermon can be almost something of a cliché in TC terms. Donne is perhaps less well known for saying something that might be relevant to group work in the face of distress:

"God hath made all things in a roundness ... God has wrapped up all things in circles, and then a circle hath no angles; there are no corners in a circle"  
(Donne, 1938).

It seems to me that there is a crucial value to working 'in the round' when it comes to working with the sequelae of interpersonal violence, and this is true for both victims and perpetrators. We must not forget the past; we will however, have to acknowledge the effect of past traumas if we are to move into the future in a different way. The therapeutic community seems to offer a way to do that.

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