THE UNINVITED GUEST

There is an excellent book out on creativity and innovation entitled "The Grace of Great Things". In this book, Robert Grudin describes the process of discovery and how discovery actually occurs. He describes discovery by ANALOGY and discovery by ANOMALY. In discovery by analogy, the discovery comes through the unexpected perception of order and organization as in the discovery of the connection between yellow fever, malaria, and varieties of mosquito.

In discovery by anomaly, discovery is provoked by a disorganization of experience, not so profound as to throw us into total confusion, but significant enough to challenge our current view of things. Having noticed the anomaly, we normally cannot rest until we have explained it in terms of our current view, or altered our view to accommodate it. This is the very stuff of scientific progress.

Discoveries by anomaly fall into three major categories: the anomaly of rearrangement, the anomaly of the empty chair, and the anomaly of the uninvited guest. In the anomaly of rearrangement, the predicted factors are present but anomalously organized - successful entrepreneurs are alert to anomalies in commerce and technology. Our dreams are another example.

In the anomaly of the empty chair, the discoverer notices that in trying to account for or explain a phenomenon, a necessary factor is missing. The factor must then be supplied theoretically. Paracelsus, for example, predicted the existence of bacteria and much of modern theoretical physics is based on these kinds of predictions.

But, it is to the anomaly of the uninvited guest to which I would like to turn your attention for a moment. During the course of some sort of serious exploration or experience, the discoverer notices the presence of an unexpected factor, something unnoticed or not apparent before.

I would like to share with you my own personal experience with "the uninvited guest" and how that has led to a treatment philosophy that we call "The Sanctuary Model of Inpatient Care".

I have been working on inpatient units since I was a teenager and had summer jobs as a mental health tech. Twelve years ago
a team of us created a new inpatient program and have been running it ever since. I considered myself an eclectic psychiatrist, well-versed in psychodynamics and biological psychiatry, and had put together in my mind a theoretical base for my treatment approach that seemed to cover all the bases.

My confidence, however, was shaken about 1985 when a young woman who I had worked with in psychotherapy for several years, decompensated and required hospitalization after what I had considered a successful resolution of her problems. Her mother drove her down from Boston to be hospitalized with us and when I entered the room to admit her I was greeted by my "uninvited guest". Sitting before me was not the twenty-three year old woman I thought I knew so well, but a seven-year old child self.

In 1985 I had never seen anything like this, certainly not in anyone I knew well. Over the next two weeks of hospitalization, the child-self proceeded to reveal the history of incest and physical abuse and terror that had necessitated the split in the first place. The release of these memories and the attendant affect rapidly led to a reintegration of the selves and there have been no further emotional problems since.

The presence of this "uninvited guest" led to a reorganization of experience that, for me, challenged many of the underlying assumptions upon which treatment is based, and on a larger scale, upon which our social values are embedded. We are, in fact, in the beginning of what I hope will be a major "paradigm shift" a shift in the underlying assumptions upon which all knowledge is based.

On a personal level the questions that this "uninvited guest" presented me with were: how could I, an experienced psychiatrist, know this person so well and yet not know for five years that this other "self" existed? How could traumatic experience of this magnitude be completely missed by me despite the fact that I knew that her father had been an abusive, disturbed man? How could I have missed what in retrospect was clear evidence for flagrant dissociative experiences that had been going on for years?

In the history of psychiatry it is usually our patients who force us to make leaps ahead. So too in this case, this patient's courage, tenacity, and drive to survive, all of which had been present since childhood, and the positive
outcome of her reintegration in the face of a near suicide, led me to ask more general, professional questions as well.

How many other patients were hiding overwhelming traumatic experience? If a history of physical and sexual abuse is more common than previously assumed, how did our treatment need to change to reflect the impact of actual events as well as the resolution of intrapsychic conflict? And most critical for those of us practicing in the inpatient setting, how could we create environments that would not be retraumatizing and that would promote recovery, growth, and healing, particularly given the ongoing devaluation of the necessity and utility of inpatient treatment?

In the course of this odyssey I began listening to colleagues like Bessel Van der Kolk, author of *Psychological Trauma*, Judith Herman, author of *Father-Daughter Incest*, Christine Courtois, author of *Healing the Incest Wound*, Alice Miller, author of *Drama of the Gifted Child* - all of whom were asking and in the process of answering the same questions. I discovered a burgeoning literature on psychological trauma, particularly as it related to combat veterans, Holocaust survivors, and disaster victims.

Through "discovery by analogy" we began to recognize that most of our psychiatric inpatients had a history of severe, often prolonged psychological trauma in childhood and that symptoms of delayed post-traumatic stress were intertwined with the impact of developmental disturbance.

It became apparent that treatment had to focus on the reality of the events that had interrupted the normal growth and development of these adults, events that had subsequently caused biological, psychological, social, and moral damage to our patients. It was this subsequent damage that we were seeing as the psychiatric symptoms and attributing to biological, genetic, or characterological weakness.

We stopped asking the question "What is wrong with you?" with its inherent quality of distancing and blaming and judging and reframed the question as "What has happened to you?", a question which allows room for understanding and compassion and respect.

To our surprise, the shift in emphasis in our questions produced a corollary shift in expression in our patients. As we consistently refused to locate the BLAME for the patients' problems in their inherent nature, they felt
increasingly validated, less hopeless, and more empowered. As they began to understand the impact on their development of the harm inflicted by OTHER people, they became more willing to accept responsibility for their OWN recovery.

To our pleasure, many patients, who were formerly the cause of great frustration and resentment, became active participants in the therapeutic process and began assuming power and control over their own lives and symptoms. Rather suddenly, the borderlines, the cutters, the manipulators, the addicts, the eating disorders, the chronic depressives all became comprehensible and treatable within a trauma-based approach.

It became apparent that virtually all of our patients had serious impairments in their capacity to trust other human beings and to establish safe, predictable, and useful boundaries between the various ego states within themselves and between themselves and other people. As a result of the traumatic experiences of childhood, their self had been fragmented as a complex and tactical strategy to retain some level of functioning, but this fragmentation was seriously compromising their adult functioning.

This splitting had served the purpose of protecting the child from overwhelming affect but now the inability to integrate that affect was preventing the adult from relating and performing as an adult.

The tasks set before us became clearer. We needed to provide a treatment environment that could provide the patient with an experience of safely trusting another human being; an environment within which healthy boundaries could be established and maintained; an environment perceived as safe and nurturing enough to encourage the patient to at least begin the process of learning how to tolerate and reintegrate painful affect, without becoming or remaining self-destructive; an environment in which enough psychoeducation could be offered to support and encourage the use of higher ego function to manage more primitive ego states.

It became evident that treatment could be divided roughly into three stages as articulated by Judith Herman: the establishment of safety, reconstruction of the trauma, reconnection with the interpersonal sphere. Often, on an inpatient basis, most of the initial work would focus on the establishment of safety - safety from self-harm, safety in the environment, safety with other people. Only when safety
could be assured was it advisable to encourage reconstructive work in which the actual memories could be recalled, affectively re-experienced and processed, and integrated into the overall ego functioning. Rapidly it became clear that this kind of work demanded a level of team functioning and countertransference processing that we had never reached before.

We quickly discovered why the mental health profession had veered away from the study of the impact of real life events on patients. As we agreed to believe and validate our patients' reports of their childhood abuse, we suffered secondary traumatization. It continues to be quite tempting to re-enter a comfortable state of denial. The alternative is FEELING WITH the patient, and those feelings are NOT nice.

In reading the literature which was rather sparse at that time, I came across one of the few articles on the inpatient treatment of victims of trauma. In it, Stephen Silver described a concept he called "sanctuary trauma", referring to the traumatic experience that the Vietnam veterans endured when they returned from the chaos of the jungle, seeking refuge in the institutions which were supposed to support them, only to find that even these institutions rejected and abandoned them.

As I mentioned earlier, another way that discoveries occur is through the anomaly of rearrangement. Silver's rearranging of the concepts of "sanctuary" and "trauma" led me to reassess our own therapeutic environment and ask the potentially guilt-evoking question - just how much of a sanctuary do psychiatric inpatient units generally provide?

I didn't always like the answers to that question. I saw that our definition of what comprises a SAFE therapeutic environment were very limited, often extending only to physical notions of safety as mandated by state licensing boards. Practices such as mixing voluntary and involuntary patients and decentralized admitting procedures without regard for the overall milieu were still quite acceptable.

Not only were there occasionally glaring deficiencies in physical safety, but patients' psychological and social safety was also frequently compromised. The use of inpatient units as holding facilities while waiting for medications to exert some magical curative power cannot satisfy the patients' needs to reestablish the capacity for trust and tolerance for negative affect.
This analysis of our notions of inpatient treatment - an
analysis which continues today - led us to reformulate our
concept of how and why we treat patients on an inpatient
basis and we have called that "The Sanctuary Model". It can
best be seen as an on-going experiment in pursuit of the
definition and creation of a "functional system".

In studying the history of inpatient psychiatry it became
apparent that despite the work of such people as Jones and
Gunderson and Laing and all those involved in the therapeutic
community model, increasingly little attention was being paid
to inpatient psychiatry so that by 1982, Kirshner and Johnson
were warning that "as in prior periods, the pendulum has
again swung towards 'doing something to the patient', towards
medication management, away from psychotherapy and milieu"
and as Thomas Gutheil cautioned in 1985, this was ".... much
to the detriment of good patient care."

Despite the now vast literature on systems theory and
practice, little has been discussed about the interaction
between staff and patients since the 1960's. Although the
power of a social system such as an inpatient unit staff, to
do harm has been more readily noted, i.e. note the literature
critical of the state hospital system, the positive, healing
qualities of social systems has been minimized and virtually
ignored.

As a result, the state hospital system has been intentionally
destroyed, replaced usually by systems less organized and
less gargantuan, but arguably no less destructive. The growth
of private psychiatric hospitals has offset some of the loss,
but only for a proportion of the population that can afford
it, and only within a climate that makes the provision of
quality inpatient care increasingly difficult, if not
impossible. General hospital units, with their inherent
structure based on the medical model, have usually only
succeeded in medicalizing the problems without solving the
underlying psychological or social difficulties.

In addition, our field as a whole stands in theoretical
embarrassment and disarray. We are a house divided against
itself. We persist in wasting time and energy defending false
dichotomies, like nature vs. nurture, the bottom on line on
whether psychiatrist should be trained in psychotherapy OR
biological psychiatry. Or inpatient vs outpatient treatment.
Or this diagnosis vs. that diagnosis.
While we are engaged in these meaningless and futile debates, the public perception is often that we are money-grubbing charlatans who speak in jargon to guarantee our ongoing superiority. Meanwhile, the people who control the pursestrings and who know the LEAST about treatment are dictating treatment and because money is involved, care the least about what is effective if it also happens to be expensive.

Which leads me to yet another discovery, the anomaly of the empty chair. What is the necessary factor that is missing in this picture I have just described? Who is the "uninvited guest" that sits in the empty chair, forcing us to reassemble our previous notions into a new pattern, drawing us from the practice of psychiatry into an analog relationship with the world at large, with society as a whole?

The uninvited guest is the CHILD, the whole potential person that each of us and each of our patients was born to be, before we met the world. Child abuse and neglect has been denied and ignored because historically parents have refused to take responsibility for their duty to nurture and safeguard that potential by protecting a child's boundaries and securing their trust and attachment through compassion.

Without healthy boundaries and the ability to form sustaining relationships, children are unable to become functioning adults and regardless of chronological age, will stay dysfunctional children forever.

Whether we like it or not, patients come to us in the child-position requiring parental functions from us. If we assume that position of power, than we must also assume the position of responsibility. Within that context we must protect our patients from harm - harm from others, including those who would deny their needs for care. But also harm from themselves and harm from us. We must nurture their growth, providing a holding environment within which they can undergo the painful process of integration and transformation.

But, we must never forget that the point of parenting is to become obsolete. The job of parents is to produce healthy and functioning adults. Our job as mental health providers is to guide our patients, most of whom employ behaviors that are self-destructive and immature, towards integrated and creative adult functioning.

To do this WE have to function as adults. WE must create systems that are healthy, not dysfunctional, for our patients.
AND for ourselves. WE must be more invested in problem-solving than scapegoating. WE must learn to settle our squabbles without engaging in fanaticism or the lure of false dichotomies. WE must stop "blaming the victim" and ally ourselves with our patients in their efforts to grow up. WE must stop permitting ourselves to be victimized by lawyers, so-called managed care, government, our institutions, our colleagues, and even our patients. To do this we must know ourselves how to establish adequate boundaries and we must begin talking about VALUES.

Human beings are hurt by other human beings. Human beings can only heal through the intervention of other human beings. We are social creatures and our need to attach to others accompanies us from cradle to grave. It has become fashionable to substitute description for explanation. It is much easier to distance oneself from raw pain by labeling it with a diagnosis and therefore maintaining the illusion of control than it is to see and share in the experience of raw, horrible pain.

It is also much easier to insist that mental illness is attributable to biologic causes and can be treated with a drug than to have to follow the more difficult course of balancing biologically-based distress with human love and compassion.

The Sanctuary Model is not anything brand new. The concept is solidly founded on insights from the "moral treatment" of the 19th century and the therapeutic community of the 20th. We still have psychiatrists treating patients with psychotherapy and medication. We still have social workers seeing families and organizing discharge plans, and group therapists doing various kinds of special groups. What has changed is our values orientation and our willingness to look at the real life experience of our patients without defending against the pain of it as much. It has been a humbling and painful experience.

As a treatment team we have become more nurturing and supportive of our patients and each other and less prone to fault-finding, judging, and blaming. This increase in maternal function however, has been matched by an increase in our acceptance of limited responsibility and the need for clear and stable boundaries. We cannot determine the pace of recovery - only the patient can do that. And we cannot make the choice for a patient about whether or not they give up self-destructive behavior and face the affect they are
avoiding.

It is the patient's responsibility to make those life choices and all we can do is provide an alternative choice and an environment within which they can safely make that choice. It is a fundamental treatment issue that we should never work harder than the patient at their recovery. It is, however, our responsibility to protect ourselves, other patients, and our society, as best we can, from the perpetration of abuse by anyone, including our patients and including those in authority over us.

We have allowed ourselves to be open to the experience of victimization so that we can be effective guides on the path from victim to survivor. This shift in perception has allowed us to perceive victimization at other levels of reality.

From this perspective, it is truly amazing that as an entire profession we sit silently and helplessly by while our institutions, both public and private, are systematically dismantled, replaced by nothing proven more effective. We listen to the histrionic cries for "decreased health care costs" and do not even challenge whether the mental health cost IS inequitable.

This can only be happening because, like our patients, we suffer from impaired self-esteem and a sense of hopelessness and fault. We doubt whether our methods DO, in fact work, whether our patients can recover and become functioning adults. As a profession, we HAVE made mistakes and there have been abuses perpetrated. We have at times abused our patients - explicitly, and by not being willing to listen to them. Our body of knowledge has NOT been complete and yet we have often behaved as if we DID know all the answers. We HAVE been guilty of stupidity and arrogance. We have found comfort in identifying with the aggressor, rather than with the victim. In doing so, we have, as a profession, dissociated ourselves from our own compassion and creativity.

The goal of the Sanctuary is to welcome the "uninvited guest". We must listen to the CHILD within our patients, learn from their experience and intrinsic wisdom, and guide them safely into adult functioning. We can only do this if our own CHILD feels safe and secure within our institutions and within the society. There is a basic law that has been grossly ignored - if you hurt a child, whether it is physically, emotionally, or spiritually, that child will hurt
him or herself and/or somebody else. Psychiatric patients in our society at least, are on the bottom rung in the hierarchy of worth and power. Yet it is from psychiatric patients that we have the most to learn about the causes and solutions to our problems as a species.

Traditionally psychiatric units have been seen as snakepits, holding tanks, storage facilities. If we are ready to evaluate our progress so far, engage in problem-solving rather than scape-goating, and take responsibility for our shortcomings AND our strengths, than the inpatient unit can and should be seen as a laboratory within which the most injured but persistent survivors are able to experiment with more adaptive and creative methods of living.

If the child who suffers the betrayal of incest, the child subjected to pornographic and sadistic abuse, the child whose body is repeatedly broken and maimed can recover from trauma, then certainly there is hope for our abused environment, hope that the cycle of vicimization and perpetration that underlies all our major social problems can also be healed. There is much yet to learn if we will just welcome the uninvited guest who occupies the formerly empty chair.