THE SANCTUARY MODEL:  
A SHORT-TERM HOSPITAL APPROACH TO THE  
TREATMENT OF CHRONIC PTSD  

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INTRODUCTION  

Alienation as our present destiny is achieved  
only by outrageous violence perpetrated by human  
beings on human beings. No man can begin to think, feel, or act now except from  
the starting point  
of his or her own alienation.  

R.D. Laing,  
The Politics of Experience  

Trauma inflicted on human beings by human beings does not just injure the  
body or even the psyche. Trauma has biopsychosocial and moral consequences that  
are cross-generational. Trauma experienced at the hands of members of one’s social  
group results in a wounding of the social self so profound that the victim becomes  
the Outcast, the Scapegoat, doomed to wander in an inner - and often an outer -  
wilderness, alone, abandoned, and uncomforted.  

Social wounds require social healing. The healing that is achieved through  
the establishment of healthier individual attachment bonds is necessary but not  
sufficient to restore a sense of wholeness to the social self that has been profoundly  
wounded.  

The purpose of this paper is to describe a treatment philosophy and program  
that attempts to begin the process of social recovery for adult victims of childhood  
abuse. Over the last several hundred years there have been many attempts to create  
similar environments that promote healing utilizing the therapeutic effects of an  
entire treatment milieu.  

The inherent difficulty in these more social therapeutic settings is that to be  
effective, they inevitably must challenge the implicit social and moral alienation  
that characterizes the entire social group. Julian Beck has said, "We are a feelingless  
people. If we could REALLY feel, the pain would be so great that we would stop all the
PTSD (Figley, 1986) in which he described "sanctuary trauma" in which people who are expecting a protective environment find only more trauma. Psychiatric patients have been traumatized for centuries by institutions supposedly designed to provide asylum. We began to try to define and operationalize what has come to be called "The Sanctuary".

At present the program is comprised of twenty-two beds situated in a discrete unit within a private psychiatric hospital in the suburbs of Philadelphia, Pennsylvania. We specialize in treating adults who have been - or are suspected of having been - abused as children. The staff is made up of a Medical Director, an Assistant Medical Director, both of whom are psychiatrists, attending psychiatrists, a Program Director who is a licensed social worker, a Clinical Nurse Specialist, two Psychologists, two Clinical Social Workers, three Creative therapists, and a complete nursing staff.

Patients receive individual psychotherapy sessions daily after having been given complete psychiatric, psychological, social service, and medical evaluations. Family therapy evaluations and the beginning of family therapy sessions are routinely provided. There are two Community Meetings a day led by a Community President.

In addition to individual sessions, the patients attend three to four groups per day. The unit provides about thirty-two to thirty-six group experiences per week. Psychoeducational groups are designed to provide didactic information about trauma and its effects on the individual and on the society. This cognitive information reframes the symptoms, places them into a more comprehensible intellectual structure which can assist the patient in learning how to use intellect to modulate affect.

Stress management groups help the patients learn new coping skills to replace compulsive, self-destructive habits. Traumatic reenactment groups focus on the ways in which patients reenact their own traumatic scenarios in the context of the community. Discharge planning groups prepare the individual to utilize the insights they have gained during their admission to anticipate and prepare for problems after discharge.

Psychodrama, art therapy, occupational, and movement therapy all use the creative arts to help the patient express affect nonverbally, translate nonverbal into verbal expression that can be shared, and rehearse new behaviors. The creative therapy groups are often the most evocative of emotional, rather than cognitive, expression.

Each patient is assigned a "contact person" from every nursing shift so that individual problems can be addressed. The regular supervision and management of the nursing staff is coordinated by a Nurse Manager. Patients who have particularly destructive symptoms can be placed on special protocols to help manage these problems. Protocols that have already been established address eating disorders, self-mutilation, and traumatic reenactments. More individualized protocols are
psychoeducational curriculum (Van der Kolk, 1987; Herman, 1981, 1992.)

1. People start out life with normal potential for growth and development given certain constitutional and genetic predispositions and then become traumatized. Post-traumatic stress reactions are the reactions of normal people to abnormal stress.

2. If people are traumatized in early life, the effects of trauma interfere with normal physical, psychological, intellectual, and moral development.

3. Trauma has psychological, biological, social, and moral effects and these effects are spread horizontally and vertically, across and through generations.

4. Much of what we call symptoms and syndromes are manifestations of adaptations that were originally useful coping skills, but that have now become maladaptive or less adaptive than originally intended.

5. Many victims of trauma suffer post-traumatic stress disorder on a chronic basis and may manifest any combination of the symptoms of post-traumatic stress disorder.

6. Victims of trauma become trapped in time, with fragments of their self - their ego or personality - caught in the repetitive re-experiencing of the trauma, dissociated and unintegrated into their overall function.

7. Dissociation occurs when a people distance themselves from overwhelming feelings by shoving their thoughts, or feelings or memories out of their consciousness. All people who are traumatized dissociate to some extent in order to protect themselves at the time of the trauma from being overwhelmed by feelings and even from dying. However, when feelings, thoughts, or memories stay dissociated many problems can occur because the mind needs to function in an integrated way that the dissociation prevents.

8. Although the human capacity for fantasy elaboration and imaginative creation are well established, the memories of traumatic experience must be assumed to have at least a core of basis in reality.

9. Human beings hate the feeling of helplessness more than anything else, even pain and grief and shame. Stressful events are more seriously traumatic when there is an accompanying helplessness and lack of control.

10. The more severe the stressor, the more prolonged the stressor, the earlier the age, the more impaired the social support system, the greater the degree of previous trauma, -the greater will be the resultant post-traumatic pathology.

11. Attachment is a basic human need. The more that people feel their life is endangered, the more strongly they will feel compelled to attach to other human beings. Unfortunately, people, and especially young people, are unable to
focus of inpatient treatment.

**Biological Safety**

Biological safety means providing for basic biological survival needs. Medical evaluation assesses the current physical status of the person. Medications may be indicated in the treatment of physical illnesses that are often stress-related and psychopharmacological agents may be utilized if it is clear that they may do more good than harm. Antidepressants often are of significant benefit.

The achievement of biological safety also necessitates the substitution of healthier coping skills for compulsive, self-destructive behaviors. Issues of self-harm, including self-starvation, bulimia, self-mutilation, destructive dissociation, and addictions must be addressed. In order to be admitted to our unit, patients must be willing to make a commitment to transforming their self-destructive habits into self-creative ones. We then construct specific protocols to achieve this goal.

If the patient discovers that they are not yet willing to give up these behaviors, we will respect their decision and prerogative to pace their own treatment, but we will not permit them to victimize the entire community with their self-destructiveness. When such a case arises, the patient will be returned to outpatient treatment or referred to a more restrictive and controlled setting depending on the degree of potential lethality of the symptoms.

Self-destructive behaviors have been necessary coping skills in service of preventing even worse destruction. If patients are to give up these behaviors, something else must be substituted. The entire program is geared to helping the patient develop more creative and constructive strategies for coping with stress. However, this is all set within a meta-context within which the social milieu must substitute for the rewards of the harmful behavior.

Victims of trauma have become attached to their own self-destructive habits as the only forms of self-comfort in easing the awesome sense of helplessness and pain. It is the responsibility of the social environment to provide an opportunity for the patient to develop more meaningful and constructive attachments to other people and to the community. The comforting of other people must be substituted for the comfort of the knife.

**Psychological Safety**

Psychological safety is a product of the therapeutic alliances that are formed with the individual therapists and key staff members, as well as relationships that develop with other patients, often their roommate.

The maintenance of a sense of psychological safety is dependent on the establishment of healthy boundaries. Trauma by its very nature, is a boundary
must be room in the environment to imagine the ideal, room for hope, and love, and forgiveness, and atonement. It must also be a safe place for patients and staff alike to recognize the hypocrisy that is an implicit part of all of our lives and of the society within which we are all embedded.

None of us lives in an ideal world, the therapeutic milieu will never be ideal. Were we able to provide a perfect environment it would probably be a disservice to our patients since it would bear so little resemblance to the world within which they actually must learn how to survive. Our most fundamental obligation is not to pretend that it is ideal, but to honestly admit when it is not, change what we can, and accept what we cannot change.

The creation of an atmosphere of relative moral safety leads directly to the sense of "survivor mission" (Herman, 1992). Often as part of recovery, perhaps a vital part of recovery, the patient develops a recognition that their suffering is part of a general pattern of traumatization that is an outcome of human evolution and expresses itself through all of the problems of mankind. As their own healing progresses it quite naturally leads to the possibility of healing on a social scale that is the only key to prevention of further trauma. In this way, the transformation of the victim into socially active citizen provides a useful model for larger social change.

Reconstructive Work

Once safety is in the process of being established, reconstructive work can begin. This involves the powerful experience of giving the traumatic images words, putting those words into a cohesive narrative, integrating the narrative with the associated affect, and experiencing the full impact of the traumatic experience, only this time with the social support that was missing during the initial trauma.

This work can often be accomplished much more easily and safely in an inpatient setting because of the high degree of support and control that is available and is tremendously reassuring for the patient. This is particularly true for the first stages of reconstructive work or in those cases where the deeper memories are the most horrific.

The reconstruction of traumatic memories must proceed at the pace the patient sets, not a pace determined by the staff. Correct pacing can be assessed by an evaluation of level of function. If a patient is stabilized in terms of safety, begins reconstructive work, and deteriorates to the point where safety is once again jeopardized, then reconstructive work should be halted until safety is reestablished. When a patient demands intrusive techniques to "bring out the memories", this is a form of self-abuse and should be discouraged. Integration will proceed at the pace that the person can tolerate and this internal knowledge about self-protection should be respected by staff and patient alike.
As a consequence, anger is expressed either passively at the self, passively-aggressively towards others, or aggressively towards self or others. Using various Gestalt and psychodramatic techniques they are taught ways of expressing physical rage without inflicting harm. When they discover that they can vent rage in a nonharmful way, without doing any damage to themselves or others, and without "going crazy", they discover that they can still feel angry, without rage and that then their anger can serve a useful and constructive purpose.

**Traumatic Reenactment**

The most lethal aspect of trauma is its profound tendency to be repeated throughout a lifetime. Traumatic reenactment is unconscious, often heavily disguised, and at the center of most pathology, both individual and social. It is to be expected, therefore, that when twenty-two traumatized people are put together under one roof, they will unwittingly and symbolically recreate their individual traumatic scenarios with the inpatient unit as the stage, utilizing each other and the staff as players in their own personal drama.

No one emerges from our society unscathed, so the traumatic scenarios of the staff interact with the scripts of the patients. The result can be chaos. Our job is to wrest order from this chaos and utilize the opportunity to engender constructive change.

This requires active management, constant vigilance, and an absolute commitment to TRUE team treatment - no one is immune to the effects of traumatic reenactment. Our only counterforces to the tremendous push to compulsively repeat the past are knowledge, a sense of humor, compassion, a love of creative change, and a willingness to lean on and learn from each other.

Patients who have used hostility as a means of coping with the helplessness of previous trauma will unconsciously provoke rejection in the therapeutic environment. For them, the intimacy of the milieu will be so simultaneously threatening and enticing that as they get closer to the affect they will increase their rejectable behavior.

It takes enormous forbearance on the part of the staff not to be coerced into the automatic repetition that is being sought by the patient by rejecting the patient. There are times, however, when the patient's conduct becomes so destructive to the overall milieu that rejection of some sort is unavoidable. When this occurs, it is necessary to at least make this behavior conscious to enable the patient to pursue the opportunity of altering the outcome the next time.

Patients who have used compliance and appeasement behavior to deflect the abuse of their perpetrator, will often unconsciously engage in behavior that elicits boundary trespass on the part of other people. These are the patients who will become "special", for whom rules will be bent, special privileges assigned, special
that there would be a great reluctance to leave such an environment and return to
the often emotionally sparse homes in which these patients reside. By definition,
however, continued residence in the inpatient milieu requires a willingness to
sustain the patient role and therefore contradicts the goals of recovery.

The major resistance to giving up the patient role is the necessity for
grieving the lost and irretrievable state of an imagined childhood. Grief for such a
loss is normal,
and like any other loss, is lessened when the burden is shared with other
compassionate people.

It is important that the treatment staff be willing to share in the grief
without participating in the regression. Refusal to grieve and ultimately give up the
patient role must be sympathetically but firmly handled. Much of what has been
called patient dependency is in fact iatrogenic.

The mental health field has been guilty of offering ambivalent messages to
our patients and to the public. We have not been convinced, and therefore have not
been convincing, that our patients can recover. We have implied that therapy is a
very long and arduous process, that can take many years to be effective. It is
impossible to know how much this attitude has led to a self-fulfilling prophecy. If
we maintain the role of the expert, then the patient must always remain in the
novice, childlike position, forever trying to recapture a childhood forever lost.

The benefits of the patient role must give way to the benefits of health and
patients may have to be taught what these benefits are. But we must be convinced
that they CAN get well, and that we WANT them to get well. The patient has to
grieve for the loss of an idealized childhood. The therapist must grieve for the loss
of the child-patient. Just when the patient is becoming well enough to serve as an
interesting and enjoyable companion, the therapist must send the patient out into the
world, recovered and no longer in need of the therapist. As a result, the therapist
suffers through the bad times, but is deprived of the opportunity of sharing in the
good times. But that is what we get paid to do.

The Importance of Play

The saddest outcome of the loss of childhood is severe impairment in the
capacity to enjoy or even participate in play. Patients who have been abused as
children are made to feel ashamed or guilty about playfulness and the experience of
joy. In many dysfunctional families, play is a punishable offense.

The result is that the natural and spontaneous joy in living is curbed or
erased. This then becomes a significant part of the chronic depressive picture and
numbing of emotions. For these patients, playfulness, humor, creative expression,
even laughter all require active permission-giving and instruction. Constant work in
itself can be a traumatic reenactment, a reenactment not at all unusual among the
helping professionals who serve as role models for the patients.
of the software package that accompanies a healthy parenting experience. The greater the threat to survival and the more impaired the parenting, the more the world will be perceived as a dangerous place and the more attention will be paid to the programming that guarantees survival, not pleasure.

We are all programmed in the same way and have consequently paid little attention to imagining a better world, a world in which problems are resolved, suffering is relieved, joy and beauty have the highest value.

When the therapist makes the paradigm shift that is implicit in trauma theory, and sees for him or herself the inevitable dialectical relationship between victim and victimizer, the traditional Cartesian split becomes impossible to maintain on any level whether it be biological, psychological, social, or moral. Camus said "There is no suffering, no torture anywhere in the world which does not affect our everyday lives. Today, tragedy is collective."

The future for the patient beyond trauma, like the future for the world beyond trauma is yet to be imagined. We do not yet even have a methodology for exploring that new territory. It is safe to say, however, that a reality beyond trauma will look entirely different than the world we live in today, and to get there every aspect of our social network will have to undergo significant change.

The further development of social milieus within which change can be fostered and sustained should be seen as vital learning environments within which we are all offered the opportunity to make significant intrapsychic and interpersonal change. These then can serve as preliminary models for wider social change. We are limited only by our own imaginative capacity, a capacity which may conceivably be boundless. The greater part of the twentieth century has been spent living out unimaginable trauma and imagining only more. It is the task of the new millennium to imagine healing that goes beyond repetition, beyond trauma.