THE SANCTUARY MODEL:
BACKGROUND, PHILOSOPHY, PRACTICE

Sandra L. Bloom, M.D.
The Sanctuary at Northwestern
450 Bethlehem Pike
Fort Washington, PA 19034
# THE SANCTUARY MODEL:
## BACKGROUND, PHILOSOPHY, PRACTICE

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BACKGROUND

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. Trauma experienced at the hands of one's own caretakers produces an impairment in the capacity to trust other human beings so profound that healthy relational development is an impossibility.

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 chapter is to describe a treatment philosophy and program that attempts to assist 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 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 suffering".

In order to create and maintain environments that are truly healing sanctuaries for victims of trauma, the healers must begin the arduous process of healing their own social wounds as they tend to the damage done to their patients. In doing so, these environments must become essentially transformative to the status quo, revolutionary in their methodology and intent. It is upon these grounds that most attempts at social forms of treatment founder, either succumbing to internal stress or being crushed from without.

It is clear that history repeats itself, but never precisely. With the growing field of trauma research, there is now a new body of knowledge and a new language that provides the theoretical underpinning for a better understanding of human nature. This knowledge is not reductionistic but is instead a synthesis of findings, both old and new, from many different areas of study. Theoretical physics tells us that matter is not wave or particle, but both. Research tells us that the damage sustained as a result of traumatic experience is not physical, emotional, social or moral but all-encompassing. Therefore, our treatment approaches must be holistic if they are to be effective.

We have a fundamental assumption that aspects of milieu treatment can be more easily formulated using a trauma-based approach. This is work-in-progress and it is hoped that it will be perceived as a challenge for the development of other intensive treatment environments throughout the world. The importance of this development is not just relevant to psychiatric treatment. These milieus are social laboratories for what needs to be massive social change (Gunderson, 1978; Tucker and Maxmen, 1973). The knowledge that we are gaining must be moved out of the realm of the insulated world of psychiatry and into the realm of general knowledge and practice. Surely if patients who have been the most severely
damaged can become responsible and proactive citizens, it should be possible to learn something from them that can be applied to the rest of us.

CHILD ABUSE AND SOCIETY

Recognition of the abuse of children is such a recent development that only now are most Western countries willing to define as abusive, practices that for eons have been part of normal childrearing patterns (DeMause, 1982, 1991). The sexual use of children has a long history, a history that continues to be made today in the form of widespread child prostitution and child pornography (Simons, 1993). Corporal punishment is still far from being banned in most countries, although extremes in physical abuse are now condemned, at least in many Western countries. Emotional abuse and neglect are so pervasive that they have not yet even been adequately defined much less studied.

The 1960's marks a turning point in the United States in the recognition of child abuse. The pioneering work of Kempe and his associates, in identifying the "battered child syndrome" in 1962, brought the issue of the physical and sexual abuse of children to public attention (Helfer & Kempe, 1976; Kempe & Kempe, 1984). Although there has been continuing resistance to the implications of this work, the last thirty years has seen an increasing willingness on the part of the U.S. public to identify and protect child victims.

This century "megadeath" has claimed probably in excess of 175,000,000 lives as a result of deliberate, politically motivated carnage - more than the total killed in ALL previous wars, civil conflicts, and religious persecutions throughout history (Brzezinski, 1993). This haunting specter of potential species-wide destruction has given rise to a profound need for an explanatory system, a cognitive reframing system that will help us develop a conscious methodology for countering our obvious lethality.

For a problem of this magnitude we must search for factors related to primary causation. We must look everywhere. We must synthesize all available bodies of knowledge. We must have the courage to repeatedly ask the fundamental question, "Why?", even if it leads us to far-flung speculation and preliminary supposition. Since the violence that threatens to destroy all of humanity is quite obviously universal, not limited to time, place, or culture, we must look for other universal factors that bear on the problem. One of the most obvious factors that all humans share is a primary childhood experience of utter dependency and helplessness. At some time in their lives all people have experienced the abuse of power, for many, the perversion of power constricts and degrades the entirety of childhood experience.

CHILD ABUSE AND DEVELOPMENT

Children who are raised in homes that guarantee their safety and protection, homes which respect their individual prerogatives and potential and provide them with a framework of meaning and belief, grow up to become confident and caring adults (Bowlby, 1988). Children who grow up in homes in which they are either not protected from witnessing the violence done to others, are directly victimized by others' violence, or are compelled to participate in the perpetration of violence towards others, are developmentally damaged in a number of ways.

In the first place, aside from the actual physical damage that may be inflicted, abused children suffer severe deficits in the biological systems that normally regulate psychophysiological arousal, consistent with a diagnosis of post-traumatic stress disorder. This internal instability has many long-term consequences including difficulty with affect modulation, particularly the control of aggressive impulses and impairment in the capacity for learning new information (Van der Kolk, 1987). It may also be a significant contributor to many forms of psychosomatic and psychoimmune disorders that do not manifest for years after the initial insult (Van der Kolk & Saporta, 1993)
Secondly, children who suffer abuse experience severe impairments in their affective systems. In order for children to develop healthy affect modulation they require a stable internal physiological environment, which is missing as discussed above. Just as importantly, children need reliable adults who can provide the empathic resonance and containment necessary to prevent them from being overwhelmed by so much dysphoric affect that dissociation becomes a necessary way of coping. Caretakers who are unable to protect children, or who are themselves the source of the arousal of overwhelming affect produce an empathic failure that overwhelms the child and results in a severe impairment in the capacity to form healthy and sustaining relationships (Nathanson, 1992). The child, totally helpless and dependent on the caretaker for survival, does not perceive the cause of the pain as being the caretaker but instead sees the cause as a defect in the self, resulting in a serious defects in self-concept and self-esteem that have far-reaching consequences.

The third area of function that is severely damaged as a result of childhood trauma is the development of a healthy social self and is inextricably related to the other areas of damage. Abused children have no conceptual framework for a healthy relationship. Consequently, their relationships with others tend to reflect and duplicate their most fundamental experiences with caretakers. This distortion inevitably affects every aspect of their social adjustment including school in their early years and vocational adjustment later in life. Some children identify with the victims and follow a life of repeated victimization experiences, often appearing in the health and mental health systems as adults, plagued with a sundry of physical and psychiatric symptoms. Others identify with the perpetrators, act violently towards others and often end up in the criminal justice system. Whatever the consequences, a large proportion of abused children end up as adults who are unable either to fulfill their social potential or who become social liabilities.

The fourth area of damage is to the child's sense of a moral self. Here, the concept of a "moral self" is meant to extend beyond a definition of moral as relating to right and wrong behavior and include instead a sense of moral philosophy, the study of human conduct and values. Children exposed to and exploited by violence at the hands of their caretakers must incorporate the acceptability of violence into their moral framework or risk losing the fundamental attachments upon which their lives depend. In this way children from violent homes become implicated in perpetuating a system of values in which violence is an acceptable standard of human conduct. For people who have been victims of violence, this leads to internal conflicts of conscience that also can lead to further impairment in the capacity for relationship and for improved self-esteem. It is exceedingly difficult to formulate a system of meaning that supports empathy for one's fellow beings, concern for other's welfare, a search for non-violent methods of problem solving, if one has been raised in a system of violence, cruelty, and perpetration. To do so means necessarily giving up what rudimentary attachments one has formed with the only human beings one can call "family". Rarely can this be easily accomplished. We are just not built that way.

Thus it is possible to see that the consequences of abuse in childhood are devastating and pervasive. Traumatized children certainly develop post-traumatic stress disorder, in the acute, chronic, and chronic, delayed forms. Additionally, the resultant post-traumatic symptoms and adjustments to those symptoms interfere with and desecrate normal development (Herman, 1992; Rivinus et al, 1993). Abused children grow up to become developmentally impaired adults. Unfortunately, but significantly, as a culture we only have clear definitions for impairment in intellectual development. Yet to be defined are generally accepted delineations of retardation in emotional, social, and moral development.

**SOCIETY'S ROLE IN MAINTAINING THE VIOLENCE**

There are a growing number of studies that show an etiological connection between traumatic experience, particularly in childhood, and many different psychiatric disorders (Beck, 1987; Briere, 1989; Bryer, 1987; Bulik, 1989; Herman, 1989; Jacobson, 1990; Morrison, 1989; Shearer, 1990; Sierles, 1983; Swett, 1990; Walker, 1988). Despite this, the cognitive frame of the general culture in its attitude towards victimization and psychiatric disorder remains largely unchanged. Psychiatric disorders do not claim the
"legitimacy" of medical disorders, as indicated most graphically by differential reimbursement for treatment, always a notable discrepancy in the United States (Fink & Tasman, 1992). Underlying this economic decision is a long-standing public and professional attitude that madness somehow is often a "punishment visited by God on the sinner" (Dain, 1992). Blaming the victim is a longstanding strategy for externalizing and denying one's own insecurity in the world and for disallowing any culpability one may have for creating the situations that allowed the trauma to occur (Janoff-Bulman, 1992). As long as we can find the injured person blameworthy, then we need carry no burden of responsibility for rectifying the inherent inequities in the situation that have caused the trauma.

Sadly, since such victimization has become a norm to these adults who have been abused as children, they grow into adulthood maintaining a conceptual frame within which they are the cause of their own hardships, not because there is anything fundamentally wrong with their family and social system's normative behavior, but because there is simply something fundamentally wrong with them. In this way the psychology of the scapegoat remains a fundamental social motif.

As long as the scapegoat phenomena persists as the predominant method of containing unpleasant effect, a phenomenon that Lloyd DeMause has cogently called "poison containment" (DeMause, 1982), we will be unable to make the philosophical and structural social changes necessary to prevent the continuing escalation of violence. Using other people as poison containers is the most virulent source of infection known to man. Trauma breeds little else other than more trauma, leading to a ever-repeating cycle of traumatic reenactment that can only lead to apocalyptic realities.

The present and pressing cultural challenge that lies before us is to develop methodologies that enable us to break the cycle of abuse. Although individual healing techniques are critical to the accumulation of a body of knowledge, individual efforts alone can never hope to meet the needs of entire traumatized groups, tribes, regions, and nations. We must develop a new cognitive framing system that encourages the evolution of new theories and methods to bring healing measures to ever larger groups of people.

THE THERAPEUTIC MILIEU: BUILDING HEALTHY COMMUNITY

In 1953, the British psychiatrist, Maxwell Jones, published his seminal work, The Therapeutic Community. In the introduction to that book, Dr. Goodwin Watson observed:

Psychiatry now verges upon another great forward step, one which may have consequences even more far-reaching than those flowing from psychoanalytic discoveries. In the field of mental health, most attention has been given to psychotherapy; some to mental hygiene, but very little as yet, to the design of a whole culture which will foster healthy personalities.

(Jones, 1953)

Dr. Jones and his colleagues were the founders of a psychiatric movement that swept across the United States throughout the 1950's and 1960's and entailed the development of therapeutic milieu units in most psychiatric facilities. These settings rested on several assumptions: the patient should be responsible for much of their own treatment; the running of the unit should be democratic more than authoritarian; patients were capable of powerfully benefiting each other; the community, once established, would develop an all-inclusive identity of its own that could be utilized in service of the improvement of the individual just as the individual would enhance the function of the community (Almond, 1974; Cumming & Cumming, 1962; Wilmer, 1981). This emphasis on the social aspects of treatment fed and was fed by the movement towards community psychiatry in the United States that led to the development of nationwide community mental health treatment centers and the dissolution of the large state hospital systems that had been the primary focus of treatment for many of the mentally ill since their creation at the end of the eighteenth century.
But, beginning in the 1970's and continuing throughout the 1980's, the community mental health movement and its near-relation, the therapeutic milieu setting, founded on the horns of a major dilemma. The community mental health movement itself could only be understood in terms of a theoretical framework that became known as general systems theory. The implications of general systems theory are only now being recognized and imply such a major shift in paradigm at all levels of knowledge that the field was not yet ready to even imagine, much less implement or manage, the requisite changes necessary for community psychiatry to be truly effective. To do that would necessitate a society with the desire and will to get at the roots of poverty, crime, and violence and implement appropriate structural change. Instead, the psychiatric profession and its related fields took a critical but solacing regression back to the sixteenth century Cartesian duality of mind and body and embraced biological psychiatry as a savior from the social implications and responsibility of community-based treatment. Neither the profession nor the culture within which it is embedded were prepared for the need for wide-sweeping philosophical, deep-structural, and methodological change that they had glimpsed when looking at the world through the windows of the victims of social and cultural oppression. Instead, the chronically mentally ill were dumped onto the streets forming a large and visible proportion of the now endemic homeless population. The general hospital therapeutic milieu settings, faced with the demands placed upon them to simultaneously treat the acutely and the chronically mentally ill, were forced to turn voluntary units into locked, restricted units and for the most part, the advance of socially based forms of treatment was halted (Bachrach, 1981; Chiappa, 1981; Leeman, 1981; Pinsky, 1981; Schoonover, 1983).

In 1980 it was almost anachronistic to create a therapeutic milieu in a community hospital, but that is precisely what the author of this chapter and her colleagues decided to do. By 1982, Kirshner and Johnston were already cautioning that "as in prior periods, the pendulum has again swung towards 'doing something to the patient' towards medication and management, away from psychotherapy and milieu" (Kirshner, 1982). By 1985, Gutheil was warning that "Two pillars of the [analytically oriented therapeutic milieu of yesteryear] are both in danger of being discarded - the use of group process as a means of learning about the effects of patients on staff and the meticulous care taken to understand individual patients. Their loss and the loss of the theoretical foundations on which they are based, is to the detriment of good patient care" (Gutheil, 1985). Finally, by 1988, Adler was ready to say that, "Psychiatric residency programs are required to provide residents with training in so many different areas that there is relatively little time left over for them to gain firsthand experience in the management of the milieu. It is hardly necessary any longer for a candidate to know anything about milieu therapy to become certified in psychiatry... little in the way of careful scientific research has been or is currently being conducted in the field of milieu therapy (Adler, 1988).

Fortunately, throughout these years another theoretical and conceptual framework was developing through the combined efforts of researchers and clinicians from throughout the world working with and learning from survivors of natural and man-made disasters. In the United States, spawned largely from the work done on the psychiatrically disabled Vietnam War veterans, the field of post-traumatic stress opened up new vistas for understanding the reactions to traumatic experience and for reconceptualizing and redefining past experience of trauma and its after-effects. Around 1985 as a result of some particularly instructive patients, we began realizing that we had not been paying attention to the implications of severe childhood trauma in the histories of many of our patients. As we acquainted ourselves with the literature on PTSD, we began routinely asking different questions of our patients. As we changed our emphasis, we recognized that our experience was very consistent with a study done by Jacobson and Richardson in 1987 in which they discovered that 81% of 100 psychiatric inpatients had experienced major physical and/or sexual assault in their histories (Jacobson, 1987).

In 1986, Steven Silver published an article on the inpatient treatment of PTSD (Figley, 1986) In this article, Silver 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. Although firm upholders of the tenets of the therapeutic communities, we recognized that in denying the historical and social realities of our patients' past traumatic experiences, we were unwittingly but implicitly engaging in blaming-the- victim
psychology and in doing so, further traumatizing them. We began to imagine what a truly safe
environment would look like, feel like, act like. Ultimately, we began to define and operationalize what
has come to be called "The Sanctuary".
THE SANCTUARY

PROGRAM DESCRIPTION

At present "The Sanctuary" 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 patients are predominantly Caucasian, from a variety of lower-middle, middle, and upper-middle class ethnic backgrounds. Less than 10% of them are considered psychiatrically disabled. The remainder are generally employed, some in highly technical and professional careers. About 25% of the population are male. The largest age group covers the 25-35 year age range. Almost three quarters of the patients are married and the majority have children.

Their reasons for entering inpatient treatment are varied. Most of them have already had some experience in outpatient treatment. The most common precipitant for treatment is a severe exacerbation of symptoms secondary to the recall of traumatic memories and its attendant overwhelming affective experience. Most are involved in attempting to manage this affect through some form of self-abusive behavior ranging from self-mutilation, eating disorders, compulsive overworking, sexual compulsivity, and substance abuse to suicidal ideation and outright suicide attempts. Moderate to severe depression is virtually universal, as are impaired relational skills, anxiety, and any of a number of stress-related somatic complaints. All of the patients demonstrate impaired affective modulation and some form of dissociative symptoms pathognomonic for childhood abuse histories.

The staff of the unit 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 and 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. Groups that focus on traumatic reenactment help patients understand the ways in which they 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 individuated protocols are established on an as-needed basis. The average length of stay is about three weeks. If it becomes necessary, patients will often be readmitted over the course of their overall treatment experience and these readmissions are not viewed as an aspect of "recidivism". We must remember that formerly, many of the patients with similar symptoms filled the state hospitals for significant periods of their lives, and even if out of the hospital were chronically impaired and disabled. Post-traumatic symptoms are so pervasive and effect so many aspects of a person's
life that a sanctuary environment is frequently required at different stages in treatment or when there is relapse. Generally, however, there is a pattern of increasing function and productivity in between hospitalizations, and decreasing disability during the rehospitalization.

The intensity of treatment requires a commensurate intensity of management. The entire treatment team meets twice weekly to review each case. However, each smaller treatment team that is assigned to the individual patient collaborate daily. Each patient is assigned a social worker who coordinates family interventions and liaison with the outpatient therapist and any other involved agencies. Family sessions are usually performed conjointly with the social worker and primary therapist. Sessions involving the outpatient therapist frequently occur in preparation for discharge. In addition, the Medical Director, Assistant Medical Director, Program Director, Clinical Nurse Specialist, and Nurse Manager meet regularly to assess the overall treatment environment.

The patients who are admitted must be sufficiently in control of their behavior that they can be maintained in an open and voluntary unit, and must not be a danger to others. Given these restrictions, patients with all kinds of symptoms may be admitted. The fundamental bases for admission is whether or not the physical, emotional, and social safety of the unit can be maintained and the person can be adequately treated using our therapeutic approach.

**TREATMENT PHILOSOPHY**

An abnormal reaction to an abnormal situation is normal behavior.

Victor Frankl
Holocaust Survivor

The treatment program is founded on this singular premise. We have changed our fundamental question from the implicitly derogatory "What's wrong with you?" to "What's happened to you?" (Foderaro, 1990) and in doing so, we have shifted our own attitude from one of blaming the victim to that of alliance with and compassion for the victim.

**TRAUMA-BASED ASSUMPTIONS**

The Sanctuary Model makes certain fundamental assumptions that are the underpinnings of the treatment philosophy and that form the basis of the psychoeducational curriculum (Herman, 1981, 1992; Nathan, 1992; Van der Kolk, 1987). The following is a summarized list of these assumptions. It is within this cognitive framework that all staff are expected to function and within which treatment decisions are made. This material is freely shared with patients in a patient handbook and serve to inform the entire treatment context.

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, social, and moral development.

3. Trauma has biological, psychological, 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 people distance themselves from overwhelming feelings by moving disturbing thoughts, feelings or memories out of 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, a situation inherently life-threatening. Continued dissociation, however, prevents the mind from functioning in a fully integrated way.

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 basis in reality. Exact details of memories can be distorted but the profound effects of trauma indicate that trauma has, indeed, occurred.

9. Human beings avoid feeling helpless above all else. Stressful events are more seriously traumatic when there is an accompanying helplessness and lack of control.

10. People who are repeatedly traumatized develop "learned helplessness" which has serious biochemical implications. This means that they learn that it is useless to try and get away from abusive situations and then even when they actually could get away, they do not do so.

11. Generally speaking, 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.

12. 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 distinguish between sources of danger. The result is that there is enhanced attachment to abusing objects. This traumatic bonding has been seen in all species studied so far, including man.

13. Child abuse is a fundamental empathic failure and results in serious emotional system dysfunction evidenced by poor affect containment, impaired affect modulation, a relative inability to metabolize emotion, and difficulties in resonating affectively with others.

14. Abuse in childhood leads to disrupted attachment behavior, inability to modulate emotional arousal, impaired thinking processes, impaired capacity to form stable relationships, and serious difficulty in regulating aggression towards self and others.

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

16. Most trauma survivors will also be perpetrators in some way, although usually the perpetration is against themselves, not against other people.

17. Trauma survivors often discover that addictive behaviors of all sorts restore, at least temporarily, a sense of control over intrusive phenomena like nightmares and flashbacks.

18. They may also develop addiction to their own stress response and as a result, compulsively expose themselves to high levels of stress and further traumatization. For many people this results in a
tendency to unconsciously create situations that repeat the trauma over and over again, and makes the person feel even more helpless. This is called traumatic reenactment.

19. Many trauma survivors will develop secondary psychiatric symptomatology and will not associate their symptoms with previous trauma. As a consequence they will sustain serious damage to their self identity and will be guilt-ridden, depressed, with low self-esteem, and feelings of hopelessness and helplessness.

20. Recovery from traumatic experience necessitates increased integration of affect, memory, thought, behavior, and meaning. The potential for higher level integration is inherent within every living system.

TREATMENT PRACTICE

STAGES OF RECOVERY

Judy Herman has defined three stages of recovery: Safety, Remembrance and Grieving, and Reconnection (Herman, 1992). The word "sanctuary" denotes the emphasis on the establishment of safety within the treatment context. Sanctuary refers to all levels of safety: Biological, psychological, social, and moral safety. The establishment and maintenance of a safe environment is the main 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. Agents that decrease autonomic hyperarousal or increase neuromodulation may be of significant benefit and increase the likelihood that the other forms of intervention will be effective (Van der Kolk and Saporta, 1993). Any treatable component of the clinical picture should be aggressively managed. Depriving a patient of an antidepressant or mood stabilizing medication which could benefit him is highly unfair and can interfere with and delay treatment. Caution in the use of medications must always be exercised in a population prone to substance abuse. But likewise, without treating the underlying post-traumatic symptoms, there is a higher possibility of relapse in the chemically dependent patient.

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.

It is clear, however, that patients who have been traumatized use self-destructive behaviors as stress relievers, not for a primary means of destruction. When confronted with the demand to substitute their learned stress relief mechanisms for other coping skills, patients occasionally discover that they are not yet willing to give up these behaviors. If this is the case, we will respect their decision and prerogative to pace their own treatment. We will not, however permit them to victimize the entire community with their self-destructiveness. On such an occasion the needs of the individual must be carefully weighed against the needs of the community since they are in conflict. 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 with the invitation to return for treatment on our unit should they
become ready to commit to our insistence on behavior substitution.

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.

For the unit to run effectively, the guarantee of biological safety is a minimum requirement. Patients and staff alike must feel safe from physical harm. Physical and/or sexual threats to other patients or to staff must never be tolerated. Post-traumatic stress reactions are typically characterized by difficulties with the modulation of aggression, but to benefit adequately from this particular treatment milieu, the patient must be able to manage his/her aggression sufficiently to be safely held accountable in the presence of others. If this requirement cannot be met then the patient must be transferred to a more restricted, structured, and contained setting until such time as they can be depended upon to exercise self-control.

**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. In order to feel psychological safe, a person must feel that they are emotionally safe from being overwhelmed by negative affect, particularly in the presence of other people.

The maintenance of a sense of psychological safety is dependent on the establishment of healthy boundaries. Trauma by its very nature, is a boundary violation. For many patients, the experience of the treatment milieu will be the first time that their own personal boundaries have been respected and where other people expect them to respect boundaries as well. A great deal of therapeutic work must go into the open discussion of boundary formation and normal boundary function as well as the continued negotiation and renegotiation about changes in boundaries.

In a recent article, Gutheil and Gabbard differentiated between boundary violations and boundary trespasses (Gutheil, 1993). This is an interesting and useful distinction to be made for staff and patients. Boundary violations are, by definition, harmful transgressions. They tend to frame the accepted standards of psychotherapeutic practice and are generally agreed upon if not always obeyed. Boundary trespasses are less easy to define, less agreed upon in professional practice, and more open to interpretation of time, place, and person. Patients who have been abused as children will have been exposed to routine boundary violations, to such an extent that they may not even have internally defined that behavior as illicit or proscribed. Generally, they are more able to acquire a sense of having been unjustly or even criminally violated once they become aware of what actually happened to them. But, in this context, they frequently have little or no conceptual scheme within which to understand the idea of boundary trespass. The more subtle violations of personal space, personal rights, freedom of action, choice, opinion, and intention or any sense of a framework within which to construct healthy adult relationships is simply absent. It is within this context that the therapeutic milieu can provide a safe psychological container for the expression of affect and experimentation with new individual thought, expression, and behavior never before experienced by the traumatized person. To perform this function, all members of the staff must be united in their intolerance for boundary violations and in their willingness to apprehend, discuss, and reformulate instances of boundary trespass.

John Bowlby through his work on attachment and loss (Bowlby, 1973, 1980, 1982), Margaret Mahler (Mahler, 1975) in her work on the early stages of child development, and Donald Nathanson
(Nathanson, 1992, 1993) through his work on affect theory have shown us how important the relationship between mother and child is in the development of the child's ability to modulate and contain affect. In normal development, the child moves from a primary attachment to mother on to attachment to father and then to an ever-widening circle of family members and peers. In the inpatient setting, attempts are made to duplicate and "miniaturize" this developmental process by immersing the patient in both individual and group psychotherapeutic experiences. Many victims of childhood trauma are so easily overwhelmed by human contact that they cannot immediately negotiate the intricacies of peer relationships and will first learn to trust the milieu through individual contact. Others find much more safety in the confines of their peer relationships and only later will take on the more arduous task of developing tentative outreaches towards the intimacy of one-to-one contact. By providing opportunities for many different kinds of social interactions we are able to accelerate the possibility that the patient will be able to find at least one other person who they can use as a substitute for whatever destructive affective modulatory coping skill they are presently using. Once they have been able to begin practicing a new skill such as substituting human soothing for cutting or binging, then they are encouraged to widen that skill to include other people including other patients, other staff members, and potential support people outside of the hospital, as well as neglected parts within themselves. Ultimately the survivor must be able to accept soothing expressions of positive affect from other people and from within him/herself.

SOCIAL SAFETY: CONTEXT AS TREATMENT

Social safety is a byproduct of the properly conducted therapeutic milieu and requires constant maintenance. Each patient must feel safe within the groups, with the other patients, and with the entire staff. In order to create a sense of social safety it is necessary to create an environment which is significantly different from the dysfunctional families within which these patients experienced their childhood lives of trauma. This presents a notable challenge to any group of professionals since there is not as yet a set of established principles that helps to guide us in the creation of healthy systems. We cannot necessarily draw intuitively on our own experience since there are relatively few individuals who have grown up in, or who have even seen, a healthy system. The concept of a system as an organic being that grows, evolves, and has specific definable characteristics like health or illness, analogous to an individual, has not yet even been well defined. Nonetheless, a theory and methodology must begin somewhere. There is a language and practice that derives from the work of the family systems approach that can be of service to us here. Christine Courtois has discussed the characteristics of the incestuous family system and we would suggest that these characteristics pose significant difficulties in the management of any system (Courtois, 1988).

A dysfunctional system, be it a family, an office setting, a school, or a psychiatric unit is one which is characterized by a denial that there is anything wrong. A dysfunctional system publicly and vehemently declares itself to be normal, and "just like everyone else" even if, in private, the individual members of the system quietly demonstrate their extreme suffering. Thus, duplicity and deceit actually become the norms for functioning within such a system, since no one is really safe to say what they see as the truth, and in fact will often be harshly censored or overtly punished for talking. Communication is minimal and highly ritualized; since there are so many secrets that cannot be told, only information that does not impinge on the barriers of the secrets can be passed along. Outsiders are a threat to the safekeeping of the secrets and therefore, the system must become increasingly socially isolated, sharing no information to the outside and receiving only highly censored information back within its walls. Reality to those within the system consequently looks very different than the reality seen by those outside the system. Other people and systems are seen as the enemy who pose a constant threat to the well-being or survival of the system. Within the system's rigid walls, however, there is massive role confusion and boundary problems. Since there is no healthy and practical concepts of who should do what to whom when, the choices of conduct that are made tend to be very inconsistent although rigid, overly moralistic even if criminal, irrelevant to the actual needs of each individual person, and highly unpredictable. In such a system there is little humor only contemptuous sarcasm, little play, and even less affection or compassion. Problems are never resolved because scapegoating and blaming is substituted for problem-solving. Punishment is cruel, often violent, capricious, and irrelevant in that it serves no useful purpose in modifying
behavior in a constructive way. Instead, punishment is used as a way of using other people as poison containers for unwanted affect, generating only more hostility and a desire for revenge.

An environment like the one described is toxic to all living things. Unfortunately, it does serve to describe aspects of many of the human systems we have created, which goes a long way towards explaining why the growing level of "toxic wastes" of all kinds is threatening to annihilate the species. This brief description of such a lethal landscape should provide us with a beginning conceptualization for developing a healthy treatment context.

For a system to function well, boundaries with the external environment must be clear and well-defined and internal boundaries must be managed in the same way. But these boundaries must be flexible enough to change with certain changes in the environment, in the needs of the individual members, in the changes that occur over time. A good analogy is to the healthy functioning of a normal living cell which is able to live in harmony and balance externally and internally. There must be a routine mechanism for addressing and resolving problems. Problem-solving needs to be seen as part of the daily routine, a pleasurable and challenging, life-giving experience, not a source of shame and despair. Within such a context, the need to maintain secrecy decreases since there is no need for duplicity or deceit if there is no punishment for saying what one sees as the truth. Communication must be promoted consistently and routinely and there must be no barriers to what can and cannot be discussed except those overt and stated limitations that are part of the maintenance of healthy boundaries. Within a system in which communication is highly valued, a consensual view of predictable reality is seen to exist and can be relied upon. The environment must respond to the needs of the group AND respect the needs of the individual and create a process within which those changing needs can be constantly renegotiated. In a healthy system there is no possible gain from finding someone within or outside the system to blame. Since every part of the system is part of the whole, and that whole is part of an ever larger whole, scapegoating and shaming one part of the system is like shaming all of the system. Such behavior not only serves no useful purpose but is a highly unpleasant experience and therefore is not reinforced. Again, a useful metaphor is that of the human body. If the right lung is infected with pneumonia, the left lung does not stand around and blame the other side for its ineptitude, weakness, or stupidity - it compensates for the deficit until its sibling is back in a state of health - otherwise the organism will die. When - or if - we reach the point at which our brains, our individual selves and our social systems exist in the same degree of harmony as the rest of our body, we may actually be able to continue to evolve.

So far, this is highly theoretical. Let us look for a moment at how this actually works in practice. On a psychiatric unit, communication between staff must be frequent and intense. Intellectual, affective, and intuitive content must all be respected. Staff are valued for their insight and abilities, not just for their professional degrees. Although there are clearly defined responsibilities that are dependent on job description and professional credentials, we are all one among equals. Problem-solving is largely democratic and consensual, with leadership effective enough to make unilateral, tie-breaking decisions when necessary. Leadership must never be autocratic or capricious, basically "ruling by consent of the ruled", repeatedly earning the respect of those led by conveying an attitude of mutual respect, knowledge, care and compassion, and limit-setting.

As in a healthy family, there are clearly established boundaries between staff and patients as there are between parents and children. These boundaries must be explained and justified to the patients who enter treatment so that they understand that they are giving consent to entering the milieu for a specific form of treatment which involves experiencing what it is like to actually exist within a relatively healthy system. Their consent to play the role of the "children" while the staff plays the role of the "adults" must be understood as temporary, experiential, a particularly interesting form of group psychodrama, not as indicative of a lack of respect or infantilization of the patient.

Within such a context there are to be no secrets, no deceits. Contradictions, mistakes, shortcomings, failures of response, failures of empathy all are to be seen as a normal and inevitable part of human interaction which are admitted to as problems and seen as opportunities for problem-solving. It is
not the goal of the therapeutic milieu to create a utopian atmosphere since this would in no way promote growth or teach the skills necessary to survive more successfully in the outside world. The goal is to provide an experience of "good-enough" human interaction since our patients have had little or no experience of "good-enough" parenting. We do not have to be perfect - we just have to be sanely, predictably, and consistently responsive. And we have to have a sense of humor. Trauma is serious. The stories of our patients' lives are filled with despair, horror, terror, disgust, and shame. Nathanson has said that "no psychological event can be considered traumatic unless it triggers intense and enduring negative affect....traumatized people... cannot trust themselves to experience the positive affects of interest and enjoyment, the pleasant experiences that are also the seed bed of shame" (Nathanson, 1993). Part of the role of the therapeutic milieu is to give the long-suffering and existentially despairing trauma victim at least a "taste" of positive affect, of pleasure in other people's company, of laughter and simple silliness, of gentle soothing, of tender regard, of the release of tears.

As in any family, there must be a shared set of values, basic assumptions, a context of meaning, a framework within which all treatment decisions are made and problems are resolved. These assumptions must be explicit, able to be articulated and taught. Earlier in this chapter the underlying assumptions that make up the philosophy of treatment for the Sanctuary Model were summarized. These form the basis of a psychoeducational program that is shared and discussed by both staff and patients, and are constantly in the process of being further elaborated and defined. In this model of treatment, knowledge is seen as power and empowerment of the patient is the ultimate goal. In service of this goal, psychiatric jargon is kept to a minimum and cognitive reeducation is seen as vital in correcting the extremely faulty and damaging education that these patients received within their families of origin.

This is a regrettable brief description of an artificially created environment within which we aim to "promote a corrective emotional experience, enhance personal understanding, and maximize healthy ego growth" (Saks & Carpenter, 1974). Nathanson has noted that "when we talk about parenting, we refer to two functions - affect modulation and cognitive education" (Nathanson, 1993). The entire milieu is designed to meet these goals. The psychoeducational piece, both formal and informal, as well as the overall experience of existing for a brief period of time in an alternative environment, aims at producing cognitive restructuring. The overall milieu and the specific treatment orientation and methods are designed to provide an entirely different experience in affective modulation. Let us now look briefly at some of the specific methods we utilize to bring about this "corrective emotional experience".

REMEMBRANCE AND GRIEVING

Once safety is in the process of being established, reconstructive work can begin. As Dr. Herman has so beautifully articulated (Herman, 1992), this involves the powerful experience of remembering the traumatic experiences, 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.

The staff must never try to "read minds", tell the patient what happened to them, who hurt them, how it happened, or make any other assumptions about the past experience of the person. This is a boundary
trespass, a refusal to respect the defenses of the patient, defenses that have been put there for self-protection, no matter how deficient those defenses have been. However, like any other medical diagnosis, the stigmata of post-traumatic stress disorder particularly in its more complex form that is associated with character change and trauma in childhood, is fairly obvious and does not originate out of imagination. Where there is smoke there is fire, but it is up to the patient, not the therapist, to describe the nature and boundaries of that fire.

It is probably not the memory retrieval itself that is as vital as the corrective emotional experience that accompanies the memory retrieval when the therapeutic process converts flashback phenomena to verbal narrative. It is possible that early memories, experiences associated with head trauma or the use of substances, and perhaps other kinds of memories are not accessible to direct retrieval. In no way does this prohibit the possibility of recovery, since the emotional healing can certainly move ahead, even in the absence of complete remembrance.

One of the most vital functions of the inpatient setting is to provide structure and format within which the traumatic reexperiencing can change from the automatic, uncontrolled intrusiveness of flashbacks and somatic and sensory experiences, to controlled, shared, and verbalized expressions. For this to happen, the experiences themselves must be placed in some kind of meaningful and comprehensive cognitive framework that can be shared by patients and staff. We have found the concept of traumatic reenactment to be helpful into providing just that kind of a framework.

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. We each compulsively repeat the drama of our early lives throughout our lifetime, using figures in our present environment to play the part of the significant people in our childhood lives. Freud’s recognition of this led to the development of the concept of the repetition compulsion. This innate compulsion must be seen as evolution’s conservative way of guaranteeing that what kept us alive today will most likely keep us alive tomorrow as well. This otherwise effective survival system works quite efficiently until there is a change in the definition of what further survives. If you have been fortunate enough to be raised in a “good-enough” childhood environment and only develop a traumatic response to situations that are rare and potentially dangerous like a tiger walking into your village, then reacting dramatically, automatically, unconsciously, and repetitively to tigers will not pose a substantial interference with your life, as long as you stay away from employment in zoos.

However, if the major figures in your life drama are also the ones who produce traumatic arousal, then you will be constantly triggered by environmental cues throughout your everyday life, no matter where you go or how old you are. You will feel compelled to see all authority figures as your threatening and sadistic father, you will be drawn to women who are overbearing and smothering as your insecure mother, you will unconsciously pick men who will demean and degrade your body like your sexually abusive stepfather. It is important to understand that everybody reenacts their own psychodrama, over and over, usually totally unconsciously. Because this information is unconscious and therefore denied, it is not available to linguistic interpretation or understanding. The lethality of the reenactment is determined directly by the lethality of the early childhood experiences combined with the increasing emotional and physical exhaustion of the person over time. This is not just strange human psychology; it is also biology and our only defense against it is consciousness.

The positive aspect of the compulsion to repeat trauma is that it presents the opportunity for creative new experience. Unfortunately, it appears that the redirection of the traumatic reenactment scenario can only occur within a social context. We do not have “corrective emotional experiences” in isolation. We cannot see our own unconscious mind, only the tracks it leaves behind us, and then it is too late to change the outcome. No matter how much we would like to deny or reject this in our never-ending
toddler search for independence and autonomy, in actual fact, no man - or woman - is an island. Our evolution has determined that we are "gregarious to a fault, noisy, quarrelsome ... bossy, sexy, clever, tool-using, with prolonged childhoods and tender regard for [the] young" (Sagan & Druyan, 1992), a highly social and interdependent species. Our refusal to accept this vital reality threatens to keep us on an inevitable path to species annihilation.

The therapeutic milieu provides a unique opportunity to rapidly understand, intervene, and redirect a traumatic reenactment scenario. It is far superior to anything that can be accomplished in the individual setting because it allows the individual to "choose" from a variety of characters who can play the various important roles in his/her previous life experience in a highly controlled, visible, and temporary setting. It is to be expected, however, that when twenty-two traumatized people are put together under one roof, and begin to unwittingly and symbolically recreate their individual traumatic scenarios with the inpatient unit as the stage, that the situation will present quite a challenge to the inpatient staff. 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.

There are occasions on which we have had to transfer patients to other units because their reenactment behavior was so destructive to the overall milieu and unresponsive to our direct interventions. This can occur when a patient continues to self-mutilate even on the special protocol that is created for them, or if a patient becomes sexually inappropriate or aggressive with other patients or staff, or is in other ways so disruptive to the group process that they are interfering with other's treatment, as in some forms of uncontrolled dissociative states. When this occurs, transfer is framed as a need to reestablish safety and set limits. The patient is making it clear to us that the environment is too stimulating for them to be able to establish self-control and that in traumatizing other patients they are retraumatizing themselves and that it is our job to prohibit any form of perpetration. The patient who is perpetrating, although initially quite angry with us, usually apprehends the importance of having an experience in a system that simply will not permit the perpetration of others. After transfer, members of the treatment team continue to meet with the patient while they are on another unit, and ultimately they are usually successful in negotiating a reentry into the original therapeutic milieu, having now created an entirely different outcome to the traumatic reenactment scenario. After such an experience treatment often makes quite rapid progress. Obviously, it is easy to see how important collaboration with other units and systems must be for this strategy to be effective.

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 liaisons formed. This form of reenactment must be inhibited as readily as the former, because in these cases the price the patient feels compelled to pay for this specialness is further shame and abuse. These reenactments can be much more difficult to spot or understand because the behavior of these patients is so much more socially acceptable and pleasing to the caretaking staff.
There are times when the entire community can collude to reenact a common scenario, often with one patient assuming the victim role (interestingly often someone who has been a perpetrator as well) and other members of the community becoming quite vocally abusive, while the rest - often the healthier members of the community - stay quiet. This latter phenomenon, "The Silence Of The Bystander" as well as the classical victim-victimizer cycle, must then be understood and confronted on a community level. It is often tempting to the staff to join in with the "mob" sentiment and scapegoat the member of the community who is being chosen for that role, often because that particular member arouses the same sentiments in the staff as in the other patients. This is another test of professional behavior and understanding since it is essential for there to be a consistent intolerance for perpetrator behavior, no matter what guise it comes in. When this collusive, ganging-up behavior occurs, it is usually because a significant proportion of the community have reached the point in treatment where they must begin to experience the traumatic affect, and the preoccupation with incidental community issues becomes yet another resistance to accomplishing that difficult work. Often the patients who have the most horrific trauma to face are the ones who are the leaders in finding another community scapegoat as a source of distraction. This must be addressed at the level of the community, and the healthier, but more silent members of the community must be morally urged to speak out against what they perceive as injustice. Such an intervention has a profound effect on all members of the community and provides a corrective emotional experience for the perpetrator, the scapegoat, and the bystanders, but it takes an enormous amount of will and force of leadership on the part of the staff once this sequence of events has been set into motion. When you have personally experienced the enormous and joined effort it takes to reverse this cycle it becomes quite easy to understand why so much therapeutic effort must go into reversing the massive resistance of the repetition compulsion, particularly when this is being manifested not just at the level of the individual but at the level of social action.

Many traumatic reenactment scenarios are routinely handled in the normal course of treatment by virtue of the treatment philosophy and practice. However, the more profound the trauma that the person has experienced, the more difficult the reenactment scenario often is to manage. One of the methods we use to manage these situations is what we rather unimaginatively call "staffings". When a problem is arising with a patient, the team meets together and discusses the situation. This work is intensely provocative and conferring together provides the staff members with an opportunity to vent feelings of frustration, fear, anger, and guilt in an atmosphere of safety and acceptance.

After this, the staff members begin to construct the outlines of the patient's traumatic scenario and figure out how their countertransference feelings fit into the script. Once they have developed a working hypothesis, a time is set to meet with the patient. The staff meets with the patient, reformulates the problem with the patient, and specific actions are recommended to deal with the problem behavior. This strategic management of what is usually an uninterrupted cycle of self-destructive behavior produces a totally unique experience for the patient and gives the staff a sense of empowerment as well. This redirection of the usual and predicted outcome interrupts the compulsive cycle and usually produces the desired effect. It is designed to be a sought-after "corrective emotional experience".

THE ESSENTIAL POWER OF CREATIVE EXPRESSION

A therapeutic milieu is best served by providing various kinds of groups which serve different needs to different people. Most of the groups focus on specific issues or use specific modalities to achieve their ends. But all of the group experiences foster changes away from trauma and towards a new relationship with self and others. Early in treatment, participation in the groups necessitates sharing of shame-laden memories and experiences. The subsequent validation by peers is profoundly supportive.

As treatment continues, the experiences within the groups support a cognitive restructuring of trauma-bound thought processes enabling the patient to evaluate their present situation in a new context. This then can lead to deliberate attempts to change behavior, which brings along with it, different affective experiences. As patients share their memories within the groups, they learn to tolerate and modulate affect.
within a comforting circle of people who understand through their own experience.

The group process allows the ongoing processing of reenactment behavior as it manifests in the group setting. When this behavior is understood, patients can begin taking more risks with each other and experiment with new behaviors. The groups also provide a setting within which atonement behaviors can be practiced, and forgiveness can be offered. As recovery proceeds, patients take increasing risks in trusting others, experiment with new kinds of behaviors, and ways of relating to others, and assume more responsibility for their own behavior. As patients witness each other struggling with similar issues, and see each other making significant strides towards recovery, hope and empowerment become realities. In the course of their stay, the junior members of the group become senior members of the group, assuming more responsibility for the community, experience themselves as empowered people who can make a difference in other people's lives for the better. All of this produces a sense of social reconnection that has usually been missing from the individual's experience.

Groups that use creative expression are essential in the treatment of victims of trauma, particularly childhood trauma. Art therapy, movement therapy, psychodrama all access the traumatic experience in a way that verbal therapy alone never can. It is likely that traumatic childhood experiences that occur before the brain is fully operational in an adult sense, become encoded, as do even adult traumatic memories, in the form of images, body sensations, smells, tastes, and sounds, not in any form of linguistic equivalent. Often the recalled memories are absent of anything but the barest speech from the participants. It has been postulated by R. Joseph and by L. Tinnin that traumatic childhood memories are actually encoded in the nonverbal hemisphere and not accessible to verbal expression (Joseph, 1993; Tinnin, 1990). Such a mechanism could explain why traumatic memories are so visual and somatic, why there is such a timelessness about the memories since the nonverbal hemisphere does not apparently function sequentially, why so many trauma victims are completely or partially alexithymic, and the frequent observation that integration of the traumatic experience does not occur until the verbal narrative formulation of the experience has occurred.

This could also help explain why the creative, nonverbal therapies are so rapidly effective in eliciting dramatic and radical change when the person is properly supported and prepared. The nonverbal therapies may access the nonverbal hemisphere using the language of that part - images, movement, bodily expression, social roles. Through the effect that is created in the group experience, it is possible that the patient is able to more readily enter those states of consciousness that existed during the trauma when the logical, verbal part of the brain became completely disoriented, confused, and disabled as a result of the overwhelming emotional and physiological arousal. In this altered state induced by the group, the patient can access both memories and experience, and then with the support of the group, is helped to verbally articulate and share those experiences, producing a spontaneously induced integration. This may also be the basis for the quite evident ritual healing that occurs in many of the more "primitive" tribal rites (Van der Hart, 1983), and may, in fact, be the basis for all healing. Often, however, the patient perceives the group as initially being unable to contain the overwhelming rage that the trauma victim experiences. This calls for specific work aimed at assisting the person in learning how to manage their own internal arousal as a result of anger.

ANGER WORK

The world needs anger. The world continues to allow evil because it isn't angry enough.

Bede Jarrett
The House of Gold

One particular aspect of reconstructive work is "anger work". Victims of trauma do not have a comfortable working relationship with their own anger. For them, anger = rage = violence. Anger means
being out of control. It means being a perpetrator. In their past experience no differentiation has been made between anger as self-protection and boundary-protector and rage as violence and boundary-trespasser.

As a consequence, anger is expressed either passively at the self, passive-aggressively towards others, or aggressively towards self or others. It is not enough to verbally differentiate between anger and rage, between self-protection and violent acting-out. Using various Gestalt and psychodramatic techniques patients are guided towards ways of expressing physical rage without inflicting harm. Anger is physiologically arousing, preparing us for fight-or-flight and survivors must learn to manage the physical expression of anger first. Once they have accomplished this, they are then able to see how cognitively disorganizing anger is, and how the mind reorganizes itself when the rageful affect has past. 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.

Patients who have been repeatedly victimized are unable to prevent themselves from being revictimized until they have learned self-protection. Self-protection cannot occur without the ability to appropriately mobilize and modulate anger. Self-protection leads to empowerment. Only when a person feels empowered instead of helpless can they really begin to take charge of their lives again. It is often at this point in therapy, when patients have begun to experience a sense of safety with their own anger, that they are prepared to actively address family issues.

ROLE OF THE FAMILY: THE EXTERNAL SOCIAL GROUP

There are two important aspects to family work that begins while the patient is an inpatient. The family that the patients have created for themselves are denoted as family-of-choice as opposed to the family-of-origin. The therapeutic work that ensues is quite different depending on which family system is being addressed. By the time the patient has entered inpatient care, the family-of-choice is often feeling embattled, threatened, angry, insecure, and ashamed. Family meetings that focus on psychoeducation and family support are very helpful in reestablishing a sense of safety for the family system, which is extremely helpful to the patient who must return to a supportive, not a rejecting system. A time of crisis can be an excellent opportunity to engage a family in the process of therapeutic change that can then have a profoundly positive impact on the next generations as well as the present parents. Relieving the family of blame and instructing them in the multigenerational aspects of trauma is often very useful and shame-relieving. This opportunity to make shifts in the larger social network should never be missed.

The family-of-origin often poses more difficult therapeutic problems, particularly when the family of origin has been the source of the abuse. Although the patient, fresh from anger work, will often urge family confrontation, such a measure is usually ill-advised (Courtois, 1988). It is safe to assume that the abusive members of the family have even more trauma to hide than the patients, and more rigid defenses, given the multigenerational transmission of trauma. Once one develops some sophistication in this field it is impossible to divide the world into victims and perpetrators. The perpetrators have been victims as well and it is this cycle of abuse that maintains the dysfunctional and traumatic system. Our job is to intervene at as many levels of traumatic reenactment as possible and this includes restraining our impulse, and the patient's impulse, to find an emotional scapegoat in place of promoting true healing. Healing can only come out of compassion and empathy, including empathy for the previous generation. It is too much to expect that the patient will be able to contain all that ambivalent feeling when they are new to the process of recovery. It is our job to protect them from premature disclosure and confrontation. Often patients engage in confrontation in a search for justice and atonement, but usually, if the preparation of the family has not been adequate, the patient is met with denial, betrayal, and more lies. This can be devastating to the patient because their attachment bonds are still quite strong and unaltered on an unconscious level, no matter how angry they are overtly and the whole experience becomes a reenactment of their childhood pain. Unless there is active and on-going abuse that is interfering with the progress of treatment, family confrontation should be delayed until the patient has established a strong support network and is truly prepared for the worst outcome.
THE SEDUCTION OF PATIENTHOOD

Victims of childhood trauma suffer from an emotional deprivation that is profound, a hunger for love and nurturance that is never satisfied. In losing the innocence and safety of childhood, they have suffered a loss that can only be filled by self-love and future gratification. The time spent on the inpatient unit is, for many patients, their first experience with a relatively caring and nurturing environment. It is understandable 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 to 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, in fact, 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.

Many people who have been abused as children have spent decades of their lives within the psychiatric system, their most intimate moments spent not with family members or friends but with therapists. A major part of their identity is based on their identification with a certain diagnosis or disorder. The potential loss of any identity, no matter how degrading or shameful, is experienced as terrifying. Life becomes much less predictable and consistent. Humans love a routine and we hate change, while at the same time we deplore boredom. The more unstable the childhood home has been, the more difficult will be the adjustment to any change. Patients who are sophisticated managers and jugglers of twenty different alter personalities may be overwhelmed by the apparently simple tasks of going to a supermarket or a movie, or a cocktail party. The inpatient milieu can provide the opportunity for the rehearsal of new strategies and techniques for managing difficult situations that patients would be too embarrassed to admit to as problems to anyone outside of an understanding social support network.

MORAL SAFETY: CONTEXT AS TREATMENT

"There is no suffering, no torture anywhere in the world which does not affect our everyday lives. Today, tragedy is collective."

Albert Camus

The concept of moral safety has been saved as the final topic for exploration because it requires introducing the concept of the therapeutic milieu as a system within an ever-widening concentric circle of
systems that must function with similar values or health and safety are impaired. Moral safety requires that the milieu in practice, reflect the standards verbalized in theory. We have to practice what we preach. This means that if we are going to talk about a model based on empowerment, then the patients must see us sharing power with each other and must notice themselves being afforded the opportunity to assume increasing power over the course of their hospitalization. It means that if we are talking to patients about problem-resolution and adult behavior, then we must demonstrate problem-solving and adult behavior. It means that if we are telling patients that they must give up self-destructive behaviors, then we must be prepared to do the same.

A morally safe environment must be a place wherein it is safe to freely and openly discuss issues of life purpose and meaning, existential dilemmas, ethical quandaries, and spiritual impulses without fear of condemnation or censure. There 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. As mentioned previously, if we were 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 a socially active citizen provides a useful model for larger social change.

The implications of this, of course, is that to be morally consistent we cannot function adequately embedded in a system which is recurrently traumatizing to us and resist passing this traumatization on to our patients. Just as they require a certain environment within which to achieve maximal healing, so to do we need to function within a safe and growth-promoting system. It is at this point that we encounter resistance and which can - if it is permitted - be the undoing at all attempts at truly effective healing of our patients, ourselves, and the planet.

Presuming that one is still not in denial about the epidemiological work performed by Diana Russell and many others (Russell, 1986), it is clear that trauma, particularly childhood trauma, is a normative human experience. Anyone familiar with the work done on the history of childhood knows that this has always been the case and that "The history of childhood is a nightmare from which we have only recently begun to awaken" (DeMause, 1982). That means, as Roland Summit has put it "we ignore the implications of a society populated by the walking wounded" (Summit, 1988).

For all intents and purposes, the development of the therapeutic milieu was terminated by the advent of what has become known as "biological psychiatry". This regression to an atavistic and dichotomized view of human functioning, consistent with our tendency to divide the world into good and evil, male and female, east and west, body and mind serves only to confound the further evolution of knowledge. This regression is understandable, however, when one is confronted with the enormous implications that accompany an alternative view of psychotherapeutic and social change.

Our expanding understanding about the effects of trauma provides a theoretical structure that demands all-inclusiveness, that necessitates a "field theory" of human nature. Quantum theory teaches us that there is no true objectivity, that all events are effected by the observer, as the observer is effected by events. Reality is subjective. In psychiatry, our progress is limited by our own embeddedness in a social context which must be changed in order for progress to occur, and which makes it impossible for us to be
objective and uninvolved participants in the therapeutic task. As we endeavor to create change in our patients, so too must we engender changes in ourselves and within the society that supports us.

Change is frightening to our patients and is fervently resisted. Most of the labor involved in psychotherapy is focused on overcoming this resistance to change. Change is just as frightening to the rest of us and is just as fervently resisted. Human beings are conservative creatures and are hard-wired for survival, not for joy or integrity. Joy, hope, love, compassion, integrity, union all are apparently part 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. Even much of our art, literature, and films show a significant failure of imagination and vision, in that the world portrayed is so one-sidedly dismal, violent, cruel, ugly, hopeless, and traumatized. 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 was presciently correct when he told us that today tragedy is collective.

The future for the world beyond trauma, like the future for the patient 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 - should we manage to get there - will look entirely different than the world we live in today. To get there every aspect of our social network will have to undergo significant change.

The further development of social milieu, social laboratories, 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.
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