THE SANCTUARY MODEL:
RESURRECTING THE THERAPEUTIC MILIEU

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Introduction

Present trends in reimbursement for the hospital-based treatment of psychiatric patients suggest that the therapeutic community model of inpatient treatment may shortly become only a memory. The claim is made that other, less expensive forms of treatment can adequately substitute for intensive milieu treatment. There has been little open questioning of this assumption, or defense of the therapeutic milieu, despite its long and rich history. After a brief review of the historical context for the development of the therapeutic milieu, this presentation will briefly describe a short-term inpatient unit devoted to the treatment of adult survivors of childhood trauma and the underlying premises upon which treatment is based. The goal of this psychiatric unit is to provide a "sanctuary", a safe and healthy environment within which the patient can begin to re-establish sufficient bonds of trust with other human beings to make emotional and social healing possible. The claim will be made and defended that intensive, residential forms of treatment provide an opportunity for not just intrapsychic, but interpersonal healing that can be achieved in no other form of treatment.

HISTORY OF THE THERAPEUTIC MILIEU

In 1982, Kirshner and Johnston published an article about the current status of milieu treatment. In that article they said "It is possible to trace a line of optimism and enthusiasm towards social, environmental, interactional cures of mental illness from Pinel and Tukes through some of the voiceful treatments of the late 19th century . . . into the episodic surges of interest in specialized hospital units of the past fifty years" (Kirshner & Johnston, 1982). It is the "line of optimism" that this paper addresses.

Before the late 18th century asylum movement there were three methods of care for the insane: assistance, banishment, and confinement (Rosenblatt, 1984). Assistance was offered to family members who were well enough to be cared for in the home. Banishment occurred when family assistance was not possible. The mad were simply thrown out of the town and left to their own devices. Confinement had more in common
with imprisonment and torture than with treatment. The mad were frequently put on exhibition for the amusement of local residents.

Then, as a byproduct of the Enlightenment, Pinel released the insane from their chains. Around the same time, the Tukes in England and Rush in the U.S., created a form of institutional treatment that came to be characterized by kind and humane treatment, an emphasis on social interaction and the cultivation of latent faculties and healing processes. This form of treatment came to be called "moral treatment" and represented the state of the art when the asylum movement of the early 19th century gained impetus (Rosenblatt, 1984; Foucault, 1965; Porter, 1987).

It is interesting to read about the history of the asylum movement because there are some striking parallels to the 20th century therapeutic milieu dilemma. In brief, the asylums in America were designed to be humane environments for active treatment and initially there was enormous optimism about the possibility of cure. Within years of their opening however, the care began to deteriorate across the country. Hospitals designed to accommodate small patient populations were faced with demands for admissions of anyone considered deviant or unmanageable. The leaders of the asylum movement were eager and optimistic about cures. Unfortunately this promise of "cure" was not substantiated. As a consequence, legislatures grew increasingly unwilling to fund the asylums. Charismatic and inspired asylum directors gave way to men with the politically savvy to attempt political bargaining with state legislatures but who did not necessarily understand the initial goals of moral treatment (McGovern, 1985; Rothman, 1980; Dwyer, 1987).

With continued overcrowding, underfunding, lack of control over admissions or programming, and a public who wanted the insane out of sight and mind, the asylums deteriorated. By 1891, Burdett, an English physician surveying American institutions, depicted "overcrowding, deteriorated physical facilities, extensive use of physical restraint and manipulation, and only occasionally a hospital with a therapeutic orientation" (Almond, 1974). These were the huge and impersonal institutions that we have been busy disassembling for over twenty years.

During the 1920's and 1930's a more optimistic approach appeared again, in Germany, and was called "milieutherapie". The growth of this movement was abruptly terminated by the
appearance of the fascist state. Fortunately, the ideas were already in the air and influenced men like Aichorn, Menninger, Jones, and others (Almond, 1974; Gutheil, 1985).

After the war was over the psychiatric establishment was ripe for change. The ideas of psychoanalysis had become widely adopted. For years, Sullivan, Menninger, and others had been involved in doing intensive psychotherapy in hospital settings. The public and the profession were eager for an alternative to the large and impersonal state hospitals (Almond, 1974). In addition, many psychiatrists had gained experience through the military when called upon to develop rehabilitation programs for disabled civilians and members of the armed forces (Leeman, 1986; Busfield, 1986). Their interests were more geared towards those patients suffering from behavior problems and neurotic complaints than towards the chronically mentally ill patient.

In 1953, Maxwell Jones published a book entitled The Therapeutic Community that had a profound effect on the psychiatric community (Jones, 1953). Jones' therapeutic community focused on the long term inpatient treatment of patients with personality disorders. The most powerful influence of treatment was designed to be the community itself. The main values of the community were egalitarianism, permissiveness, honesty, openness, and trust (Almond, 1974; Leeman, 1978, 1986; Rapoport, 1960).

Through the 50's and 60's the therapeutic community model proliferated. Much was written about the complexity of structure and function on such psychiatric units (Almond, 1974; Caudill, 1958; Goffman, 1961; Stanton, 1954). The terms "therapeutic community" and "therapeutic milieu" became synonymous. However, most therapeutic milieu settings functioned with shorter-term patients and a much more mixed population than that originally described by Jones.

All therapeutic communities 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 helping each other. Treatment was to be voluntary whenever possible and restraint kept to a minimum. Psychological methods of treatment were seen as preferable to physical methods of control. Psychotherapy, individual and various forms of group therapy, were used routinely and were usually psychoanalytically informed (Almond, 1974; Cumming, 1962; Wilmer, 1981).
By 1969, Abroms was describing milieu therapy as a "treatment context rather than a specific technique ... a metatherapy" (Abroms, 1969). Tucker and Maxmen described the treatment milieu as a "laboratory wherein the patient may safely experiment with newly acquired adaptive skills" (Tucker & Maxmen, 1973). In 1974, Sacks and Carpenter talked about the modified therapeutic community whose aim was to "promote a corrective emotional experience, enhance personal understanding, and maximize healthy ego growth" (Sacks & Carpenter, 1974). Criticism began to be launched against the therapeutic milieu concept in the 1970's. Borderline personality disorder was becoming an important diagnostic category. Serious difficulties were noted in treating these patients in the permissive and intensive inpatient milieu settings (Adler, 1973; Gordon, 1983; Herz, 1979; Johansen, 1983; Johnson, 1983; Pardes, 1972; Raskin, 1971; Shershow, 1977; Van Putten, 1973; Zeitlyn, 1967).

Criticism also focused on the treatment of psychotic disorders in the therapeutic milieu and the treatment of involuntary patients. Some authors felt that the intensive nature of the therapeutic milieu was too stimulating for the schizophrenic (Herz, 1979; Kahn, 1989; Van Putten, 1973). Others felt that the therapeutic milieu could be destroyed if involuntary patients were admitted (Chiappa, 1981; Edwards, 1988; Leeman, 1981). This was debated by those who felt that units should be locked and everyone treated in order to be able to serve the entire community (Bachrach, 1981a, 1981b; Pinsker, 1981).

Several forces were converging here. Throughout the 70's and 80's hospitals were faced with increasing numbers of chronically mentally ill and psychotic patients due to the process of deinstitutionalization (Bachrach, 1981a, 1981b; Schoonover, 1983). Simultaneously, insurance companies were putting increasing pressure on providers for shorter inpatient stays. In addition, psychoanalysis as a technique and as a theory was coming under increasing attack. At the same time biological psychiatry was promising medical cures or at least symptom alleviation. The movement towards biological psychiatry brought with it a return to the medical model.

By 1982 Kirshner and Johnston were warning 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).
Gutheil, in an excellent 1985 review article, cautioned that "Two pillars of the [analytically oriented therapeutic milieus 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 were based, is to the detriment of good patient care" (Gutheil, 1985). In 1988, Adler said "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). Even more recently, Margo and Mannring in a 1989 review article state that "In the recent literature, inpatient psychotherapy is attracting much less interest than other aspects of the care of severely ill patients " (Margo, 1989)

MILIEU THERAPY TODAY

At its best, "a central characteristic of therapeutic milieus [is] that they recognize the need for - and provide support for - ongoing change in all of their members. This characteristic implies both an atmosphere which expects change and mechanisms within the social structure to make such changes in a reasonable and organized way" (Gunderson, 1978). Unfortunately, many inpatient programs no longer approximate the ideal. At worst they bear more resemblance to a short-term version of the defamed asylums of a few decades ago. Often there is an overemphasis on containment. This frequently occurs when there is a mixing of voluntary and involuntary patients on the same unit. When this occurs, the voluntary patients are not getting the mandated "least restrictive care" and often do not feel physically or emotionally safe. This also occurs when medications are used in preference to staff involvement as a means of restraint and when the expression of emotional distress is discouraged or overtly punished.

The creation of a supportive environment requires a great deal of active management and loving concern. These are not activities that are reimbursable or highly valued if the immediate goal of treatment is to get a patient discharged as rapidly as possible (Cournos, 1987). In
addition, if the theoretical bias is towards the alleviation of symptoms with medication, than the quality of the environment may well be considered unimportant if not irrelevant. Psychiatric units generally are efficient at creating structure. However, the structure does not necessarily bear any true relationship to the needs of the individual patient. At worst the structure meets the needs of the staff for control and the exercise of authority, but neglects to provide the patients with the opportunity for growth and self-expression.

The power of human beings to be of help to each other is boundless. So is the capacity to do harm (Greenspan, 1983). The emphasis on involvement can be mishandled in several ways. The atmosphere can be so conducive to violence that actual physical harm is done or at least feared. Occasionally, the limit-setting function is so impaired that staff permits or ignores sexual acting-out on the part of patients or between staff and patients. Inexperienced, though well-intentioned staff often become so overinvolved with patients that their effectiveness is diminished. Alternatively, staff risk no meaningful involvement with patients and encourage nothing but superficial involvement between patients.

Implicit in many psychiatric units is a lack of validation. Since most psychiatric theories locate causality for illness within the individual, most theory - and practice - ends up blaming the victim (Greenspan, 1983; Chesler, 1989). More obviously, programs can be invalidating by their emphasis on the biological or physical aspects of illness to the exclusion of the psychological or social, or the reverse. Invalidation occurs when the internal hierarchy is fixed and patriarchal and only certain members of the staff have any power, usually the physician. The environment is also invalidating when abreaction is considered regressive and the suppression of emotional pain preferred to its expression.

MAINTAINING THE MILIEU CONCEPT: INHERENT PROBLEMS

The "line of optimism" towards socially enriching therapeutic environments has been periodically asserting itself for the last two hundred years. Why then does the line so frequently again become blurred and indistinguishable? Why does the pendulum always swing back to "doing something to the patient" and away from intensive
psychotherapeutic milieu?

There appear to be several reasons for this movement. There are certain external factors that bear notice. Deinstitutionalization has presented acute psychiatric units with overwhelming numbers of chronically, and seriously mentally ill patients who have nowhere to go other than the community hospitals. These units then have to dramatically alter their programming to accommodate populations that they were not initially designed to reach (Bachrach, 1981a, 1981b; Schoonover, 1983). Increased governmental regulation and insurance company pressure has led to a demand for fewer inpatient stays, a practice that is not always conducive to good patient care (Sederer, 1986). Hospital administrators and boards often have little comprehension of the fundamental differences between psychiatric care and medical/surgical care and often will not appropriately staff a psychiatric unit.

Arching over all other reasons, however, is the fact that as a profession we have no comprehensive and agreed upon theoretical structure for understanding human behavior. The underlying assumptions upon which we construct practice are confusing, contradictory, and divisive. Biological psychiatrists often pay only lip service to the unconscious; analysts turn a blind eye to the body and the psychoanalytic jargon often mystifies patient and practitioner alike. Family therapists minimize the impact of the individual; behaviorists avoid focusing on dynamics. Psychiatrists and psychologists battle for their own economic turf and both try to minimize the impact of the social worker, psychiatric nurse, and counselor. Outpatient therapists perceive hospitalization as a failure of their treatment, inpatient staff concerns itself little with outpatient continuity. The mental health field is rife with theoretical and practical splits which are confusing to the public, damaging to patients, and stultifying to the professionals. On the surface the majority of therapists probably consider themselves to be practicing some kind of "eclectic" treatment. However, the splitting continues since there has been no meaningful change in the underlying paradigms upon which all practice is overtly or covertly based.

All mental health professionals are seeing an increasing incidence of patients suffering from severe character pathology who demonstrate a propensity towards extreme self-destructive behavior that often becomes unmanageable in an out-patient setting. Although the economic climate is finally
forcing the creation of long-overdue alternatives to long-term inpatient care, this is being done at the expense of, rather than as an adjunct to, high quality hospital-based treatment. There appears to be an implicit and unproven assumption that twenty-four hour a day, intensive, residential, inpatient care can be completely eliminated.

This assumption actually flies in the face of several centuries of experience in managing the mentally ill within institutional settings. At present, the psychiatric field as a whole appears to be riding the wave of economic panic about the cost of health care treatment, rather than defending long-established methods for the alleviation of suffering in the psychiatric population. Rather than take an honest look at the inherent problems and past injustices that have occurred in institutional settings and using that evaluation to reframe and modify treatment approaches, we are in the process of "throwing out the baby with the bathwater". Given the present "managed care" climate, it is conceivable that the next decade will witness the death of the therapeutic milieu. It is time to look at the unique treatment opportunities that can only be provided within an intensive therapeutic setting.

PSYCHIATRIC ILLNESS AND HISTORY OF TRAUMA

Many studies have been published establishing a firm connection between psychiatric illness and childhood and adult trauma (Briere, 1989; Bryer, 1987; Jacobson, 1990; Shearer, 1990; Sierles, 1983; Swett, 1990). Recently, Herman, Perry, and Van der Kolk documented that 81% of their borderline patients had major childhood trauma (Herman, 1989) confirming previous studies citing 75% and 67% incidence in borderline patients (Herman, 1986; Stone, 1981). Other studies indicated increased incidence of childhood physical and/or sexual abuse among bulimic women, women with somatization disorder, chronic pelvic pain (Bulik, 1981; Morrison, 1989; Walker, 1988). In a study of female state hospital patients with chronic illness and active psychosis, 46% reported histories of childhood incest (Beck, 1987). Among psychiatric inpatients in a study by Jacobson, 81% had experienced major physical and/or sexual assault, although that history was obtained on the chart for only 9% (Jacobson, 1987a, 1987b).

There can be little doubt that a significant proportion of the psychiatric population, particularly the inpatient
population, have a history of significant trauma in their background. When repression and dissociation are taken into account the numbers of probably even higher than have been measurable thus far. Despite this clear evidence, mental health workers still resist the connection between trauma and psychiatric disorder and resist the notion that post-traumatic stress reactions are essentially normal reactions to abnormal stress. Silver and others (Haley, 1978; Lindy, 1986; Silver, 1986; Summit, 1988; Wilson, 1990) have said that the greatest single reason for this is clinician’s fear –fear that we too, could experience such trauma.

THE TRAUMA-BASED APPROACH

For years knowledge has been accumulating about the effects of catastrophic experience. It is interesting to note how frequently treatment innovations appear to be connected to experiences with war and all its trauma. After World War II, studies of "shell shock" patients, studies of the holocaust survivors, refugees, survivors of Hiroshima and Nagasaki and other victims of war contributed greatly to our knowledge base. Subsequent studies of survivors of natural disasters, victims of torture and terrorism, rape and other crime victims have proven that there is a common human response to overwhelming life events that is called the post-traumatic stress response. Attempts to shed light on the mechanisms behind this response has led researchers into areas of research as diverse as cellular neurotransmission and anthropological field studies. This accumulating body of knowledge we here call, the Trauma-Based Approach.

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; Nathanson, 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.

These then are the basic assumptions that inform the Sanctuary Model of inpatient treatment. We have found it useful to use these as a working hypothesis for all patients. In this way, formerly incomprehensible symptoms become comprehensible, explicable, and often treatable.

SANCTUARY MODEL OF INPATIENT TREATMENT

Background

The Sanctuary Model is an elaboration of the therapeutic milieu concept using the trauma-based approach as a philosophical structure for organizing treatment and a feminist-informed systems approach for organizing the milieu. We have applied these concepts both within a short-term, general hospital unit and within a private psychiatric hospital setting. Short-term is defined by a length of stay of less than thirty days, an average length of stay of approximately seventeen days.

The model, which is still evolving, grows out of a thirteen year history of the development and implementation of a modified therapeutic community. For the first eleven years the treatment setting was located within the confines of a rural community hospital and it was in this setting that the original premises of this model were defined. Throughout those years we treated a mixed population of adults and adolescents with many different psychiatric profiles. Always excluded were patients who could not be handled in an open setting - involuntarily committed patients and patients found to be an unmanageable danger to themselves or others.
Around 1985, as a result of experience with some rather remarkable patients and the simultaneous exposure to concepts of psychological trauma, feminist thought and a long-standing interest in systems theory, we began to ask our patients more seriously about their own history of previous childhood abuse. We stopped asking, in any number of ways, "What's wrong with you?" and began asking "What happened to you? (Foderaro, 1990). When we began asking different questions we became astounded by the answers we got back. The discovery that a majority of our patients were victims of serious and significant childhood physical and sexual abuse led to a broadening of our treatment perspective and an on-going search for more effective modalities of treatment.

At present "The Sanctuary at Northwestern" 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.

**Patient Characteristics**

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. They usually make no connections
between their present problems and earlier, often still completely repressed -traumatic experiences.

Some may still be in abusive relationships and their present need for immediate safety outweighs concerns about the past. Many will enter treatment manifesting the so-called "negative symptoms" of PTSD - denial, numbness, depression, withdrawal, anhedonia. Others will only seek treatment when they begin experiencing the "positive" symptoms of hyperarousal, irritability, inability to control rage, flashbacks, behavioral re-enactments, pseudohallucinations. Regardless of the reason for entering treatment, most feel defective, demoralized, fearful of "going crazy" and losing control. Most have serious deficits in the capacity to trust. Their ability to form stable and satisfying, mutual relationships is seriously impaired because of their early experiences with caretakers who were abusive.

Thus far, there has been relatively little written about the inpatient treatment of post-traumatic stress disorder. That which has been written comes mainly from two sources - clinicians working with combat veterans and clinicians working with victims of the Holocaust, terrorism, torture, and war (Arnold, 1985; Sax, 1985; Scurfield, 1990; Silver, 1986; Woods, 1985). Many of the issues that these researchers raise are relevant to the assessment and treatment of adult survivors of childhood trauma. However, a significant difference in focus revolves around the issue of pre-existing psychopathology - for adults traumatized as children there is often little if any significant time prior to trauma. The effects of trauma have therefore infiltrated and skewed normal development. As a result, the symptoms of PTSD will be embedded in a morass of secondary symptoms and developmental deficits which seriously complicate and compromise treatment.

In addition, many adult survivors have already had retraumatizing experiences, both through further trauma as adults and through therapeutic experiences where they have been mislabeled, misunderstood, and disbelieved. Silver has called this latter effect "sanctuary trauma" and it is from this term that we have developed our concept of sanctuary. Silver described "sanctuary trauma" as "what occurs when an individual who suffered a severe stressor next encounters what was expected to be a supportive and protective environment and discovers the environment is not as imagined or expected. It may be that one defense used to deal with the original trauma experience was to build an idealized mental model of what the sanctuary. .... as the protective
alternative to the trauma environment would be like. In addition, the defenses raised against the [original] trauma are dropped so thoroughly after leaving the trauma environment that the "normal" and perhaps necessary harshness of the new environment is perceived and experienced as a second trauma" (Silver, 1986).

Adult survivors of childhood abuse all suffer from a disturbance in the capacity to comprehend normal boundaries, both intrapersonally and interpersonally. Trauma, particularly trauma suffered at the hands of other humans, is by definition a boundary disorder. Adults abused as kids will have a difficult time establishing and maintaining normal, protective boundaries around their sense of self and will frequently misinterpret the meaning of the more normal boundary operations of others. As a consequence their quality of relating is often overly intense and unrealistic. They will also be extremely sensitive to boundary incursions of all kinds while attempting to re-enact them compulsively. The problems with boundary differentiation is linked to the impaired capacity for trust. For most adult survivors, the people into whose care they were entrusted are the very same people who abused them. As a result there is frequently a tendency to trust those of whom they should be more suspicious and to mistrust those whom they could safely trust. Obviously, this is a situation that often causes difficulties in the therapeutic relationship.

Adult survivors often present for psychiatric treatment after years of fairly adequate coping. Sometimes, in fact, their successes in specific areas of function are remarkable in contrast to the severity of the symptoms with which they live. At some point in time, often due to a current overwhelming stressor, a retraumatization, or a developmental impasse, their defenses are overwhelmed and their symptoms become so disabling that they require hospitalization. Once they are in a safe and structured setting they may actively dissociate and show many forms of what are considered regressive behaviors that test the patience of all concerned.

As a part of this very complicated picture and as a direct result of PTSD, they will have difficulty modulating affective experience including feelings of rage, fear, and grief and will manifest extremes of emotional expression. They may also experience intrusive phenomena and flashbacks which can easily be mistaken for psychotic symptoms. There will be a great temptation on the part of the treating physician and pressure from the staff to try and control all
of these symptoms with antipsychotic medications, a practice which can be quite harmful. The survivors will know little or nothing about the connection between their symptoms and their past history. The history of child abuse is frequently offered up only with great reluctance, guilt, and self-blame. Even more commonly noticeable in this population is partial or total amnesia for the traumatic events of childhood. It is the job of the clinician to recognize the tell-tale signs and begin searching out the meaning of the memory gaps and discrepancies. Adult survivors who present as psychiatric patients feel hopeless, helpless, and have serious questions and doubts about the meaningfulness of life, the existence or viability of God, the potential for loving kindness in their fellow man.

It is our firm belief, substantiated by the studies mentioned above, that our experience is not unique, nor is our population. Although we are developing a specialty program so that we can study the adequacy of treatment in more depth, we do not believe that such specialty programs will ever be able to meet the needs of such a large population. It is much more important that new standards be developed for hospital psychiatry that will more adequately, effectively, and humanely meet the needs of adults abused as children.

Program Description

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 individualized 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 jointly 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.

The Unique Benefits of the Therapeutic Milieu

It is the premise of this paper that there are important treatment gains that can only be attained within the unique, intensive, organized, and highly interactive context of a residential setting. To be discussed are the overall provision of safety encompassing biological, psychological, social, and moral safety; the provision of a ritual healing experience; the opportunity to redirect the traumatic reenactment scenario; the opportunity to have a truly corrective emotional and cognitive experience.

Underlying all of these descriptions is an assumption that must be stated. This assumption accentuates and extends the longstanding interpersonal inclination of American psychiatry by stating that human beings are fundamentally social creatures, that trauma suffered at the hands of other humans produces profound wounds to the social self, and that social wounds require social healing. Further, 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 so profoundly wounded.

Stages of Treatment

Several authors upon studying PTSD treatment have recognized that there appears to be a discernable recovery process from trauma. This concept of recovery is a significant shift in perspective for psychiatry, if not theoretically than pragmatically. It avoids the notion of "cure" as being almost undefinable in psychiatric terms and instead puts forth a notion that emphasizes process and
rehabilitation. Cure denotes something that is done to a suffering person. Recovery denotes a process with which the sufferer is intimately connected and ultimately responsible for maintaining.

Useful attempts have been made to divide the recovery process into stages that reflect the need for different kind of treatment approaches and expectations. Horowitz (1986) has discussed a phase-oriented treatment of stress response syndromes. Lifton has talked about "confrontation, reordering, and renewal (1988). Herman has simplified treatment into three stages: Safety, Remembrance and Grieving, Reconnection (Herman, 1992). No matter how the stages are defined however, it is clear that there is interpenetration of all the stages and that recovery proceeds along a continuum of treatment experience that includes outpatient individual, group, and frequently, inpatient experience.

The Establishment of Safety

For psychotherapeutic treatment to be effective in any setting it appears that the provision of a safe environment is absolutely essential. In the treatment of adults abused as children it is impossible to overemphasize the importance of the provision of a safe environment. This sense of safety must encompass safety on all levels including the biological, the psychological, the social, and the moral. The inherent difficulty in such a discussion, however, is in the definition of what exactly comprises a "safe" environment.

First is the issue of biological safety. In this treatment context this refers to the necessity of providing an environment within which patients will not be further traumatized, either by themselves, by other patients, or by the staff. This requirement raises serious questions about the viability of mixing voluntary and dangerous involuntary patients within the same physical space. Additionally, there must be firm, clear, and consistent limits set on the expression of unmodulated aggression in any form. Patients who are unable to manage their aggression within the confines of established safety requirements must therefore be transferred to more confined settings.

Biological safety also necessitates physiological stabilization. Most patients who suffer from post-traumatic disorders experience the accompanying physiological dysregulation symptoms that may respond to antidepressant or
anxiolytic medications if appropriately administered. Additionally, most patients who enter inpatient treatment are engaged in life endangering self-destructive behaviors that they are using to provide some form of affective and physiological stabilization. It is the responsibility of the milieu to provide an overall environment within which human attachments and their attendant soothing qualities are substituted for the self-destructive behaviors.

Psychological safety is first established through the creation and maintenance of a system of healthy interpersonal boundaries within the milieu. Boundary violations as defined in a recent article (Guthel & Gabbard, 1993) can not be tolerated. Boundary trespasses must be discussed, worked through, and understood by both patients and staff, as well as the overall community. By definition, childhood abuse is a boundary violation and most patients suffering from the results of these behaviors have been raised in families where there was little if any sense of healthy boundary formation. The therapeutic milieu is uniquely designed to provide the opportunity for the experience of what it is like to live and function within a healthier system where boundaries are clear, consistent, and adequately flexible to meet the changing needs of each individual.

Patients who suffer from the primary and secondary effects of childhood trauma all suffer from attachment disorders, often of serious magnitude, which make the formation of stable adult intimate relationships virtually impossible. One of the inherent difficulties for them in the establishment and maintenance of social relationships is their difficulty in modulating and containing negative affect. The therapeutic milieu provides the opportunity for the entire milieu to bear the burden of becoming a holding environment for resonating with, containing, and metabolizing this negative affect. In doing so, the milieu becomes, at least temporarily, the vehicle for a corrective emotional experience that should have been provided by the family of origin, but was not due to the dysfunctional nature of the family. The therapeutic milieu can provide this opportunity in a way that individual or even other forms of treatment cannot by providing not one, or even two, but a multitude of attachment opportunities over the course of each day. This effect serves to attenuate the often overly intense and often dysfunctional transference problems that arise in the course of individual treatment.

Social safety reflects the need we all have to be able
to live and work within settings that feel truly safe. This level of safety is even more difficult to define because it arises as an "emergent" quality of the overall milieu, unpredicted by the individual components of the system, reflecting the wisdom that the whole is greater than the sum of the parts. It hinges on the creation of a value system within which dysfunctional behavior (Courtois, 1988) is not tolerated and where there is an established and active process to constantly define and support functional behavior instead. Consistent with our growing understanding about the underlying nature of reality, the emphasis here is on understanding the interconnectness of all beings, the need to create integration instead of fragmentation on all levels, the establishment of balance between the needs of the community and the needs of the individual, the creation of an overall attitude that substitutes problem-solving for scapegoating and blaming, and a relative absence of hypocrisy and deceit. Additionally, the therapeutic milieu must embody human positive attributes that can replace post-traumatic degradation: humor, hope, playfulness, pleasure, love of beauty, creative expression, tolerance, kindness, compassion.

Closely related to social safety is the establishment of an atmosphere of moral safety. Victims of childhood abuse, and all victims of human violence, have been betrayed by their own social system. The accompanying shattering of a sense of meaning and purpose to life may ultimately prove to be the most damaging aspect of interpersonal violence. The therapeutic milieu has the unique opportunity to create a climate of moral safety within which issues of life meaning, spirituality, philosophy, justice, revenge, and the social implications of human behavior can be explored and discussed. To be morally safe, however, the environment itself must be intolerant of hypocrisy and self-deceit on the part of its own staff and on the part of the various ramifying systems within which it is embedded.

The Ritual Healing Process

The origins of psychiatric treatment can be found in the ancient healing rituals that are a fundamental part of every culture. Van der Hart has explored the concept of rituals in psychotherapy (Van der Hart, 1983). He notes that rituals offer a behavioral framework in which the changes surrounding a transition can occur and make possible movement to the next stage of development in a relatively stable way.

The therapeutic milieu offers a unique opportunity for
the creation of specific healing rituals. However, it is our premise that the intensive therapeutic environment embodies a ritual passage that cannot be duplicated by any other form of treatment for reasons inherent in the nature of ritual. The act of coming into a hospital is itself the first stage of a ritual called the separation phase, in which the interactions with one's normative group are strongly reduced or cut off. Suddenly the patient is separated from all of the sources of refuge in their environment that serve to hold them "in place", and which therefore also discourage change. The entry into the hospital should represent not "stabilization" of symptoms, but active therapeutic and life change. They are then immersed in a new peer group which has specific goals, norms, and processes quite different from the norm.

In the second stage of ritual, called the threshold stage, the person is in a state of limbo - the old condition no longer exists, but the new has not yet been reached. It is during this stage in both transition rituals or "rites of passage" and healing rituals when the person undergoes whatever trials or experiences are necessary to make the transition. In this stage the rules of normal functioning are usually overturned and "all bets are off". The opportunity for change is present but so is danger.

Most of the patient's hospital stay are spend in this threshold state. The rules of hospital functioning are quite different than normal conduct. Unlike "normal" functioning, patients are expected to talk about the most personal and intimate details of their lives with virtual strangers. They are expected to allow and support the expression of emotion. Even high functioning adults must subject themselves to restrictions that they would not tolerate at home.

A level system is instituted by which patients' earn privileges and which is based on successes through the symbolic ritual passage. Markers for an increase in privileges include participation and openness in individual and community group functions, the expression of affective experience, cognitive restructuring, and behavioral change. The program is set up so that patients enter treatment and begin by simply observing the progress of other patients. During this initial phase, the multiple assessments are occurring, the patients and staff are getting to know each other. The working phase is signaled by the patients beginning to serve as "auxiliaries" in other patients' psychodramas, active work in individual and group psychotherapy, the planning of family sessions, and active
involvement in the overall life of the community.

During this phase of treatment, if and only if, safety has been established, the patient becomes intensely involved in the reconstruction of lost memories, including the physical, affective and cognitive aspects of the traumatic experiences. It appears that in most cases of childhood trauma, memory retrieval, abreaction, and catharsis are necessary. This understanding about the importance of strong emotional arousal in psychotherapeutic cure goes back to primitive man, was defined by Freud, and has been emphasized by many schools of therapy since. These are the trials of transition, the painful initiatory experiences that the patient endures, with the help and support of their social group, in order to experience the ritual "rebirth", the change into a new being that is the goal of all psychotherapy.

In a 1986 paper in which he explores change agents, Karasu said that "the major roles and functions of affective experiencing may thus be to set the emotional stage for receptivity to change, to ease the cathartic release of repressed material, and to facilitate patient accessibility by reducing resistance and breaking down defenses. In short, the patient, through dislodging of persistent chronic attitudes, may be made more available to a new cognitive paradigm (Karasu, 1986).

Only the inpatient setting can provide the intensive level of care demanded through this vital phase of treatment. The emotional demands on any individual therapist or family member during this period of overt emotional expression are simply too much for one person to successfully manage. The inpatient unit provides enough staff to afford a diffusion of the emotional intensity, while continuing to allow the patient the opportunity to work through the trauma in a social setting. In addition, the inpatient structure provides the patient with a safe ritual setting within which external limits can be established that are extremely reassuring when enduring an abreactive experience. Regression can be planned, organized, and controlled so that the survivor can be supported and guided through the experience in a way that maintains physical and emotional stability. The built-in cycles of work and relaxation, withdrawal and socialization are important in preventing physical and emotional collapse.

Reconstructive work is emotionally - and morally -draining to
staff and patients. Treatment during this phase must be highly individualized. For some survivors there is so much shame and guilt involved in their memory retrieval that they need time alone, with staff supportively monitoring them for safety and comfort. Others require personal contact with a staff member or members during the re-experiencing, but are overwhelmed by the idea of a group interaction. Still others feel most comfortable and safe within the confines of a group with whom they have already established meaningful relationships. Again, it must be re-emphasized that boundaries must be respected. The emotions aroused by traumatic re-experiencing of child abuse are heartrending, rage-producing, and empathetically draining. Countertransference problems can easily develop during this phase of treatment and the open and relatively nonprivate nature of the therapeutic milieu provides a level of safety and support for the staff as well as for the patients.

Karasu has claimed that "perhaps a major role of affective experiencing is to emotionally prepare the patient for new cognitive input." An important part of the entire reconstructive phase, and the trauma-based approach is to help place the traumatic experiences into some kind of a cognitive framework that is different from the framework within which the patient is trapped:

Thus, cognitive mastery as a universal therapeutic agent may be defined as acquiring and integrating new perceptions, thinking patterns, and/or self-awareness, whether this is effected through interpretations, explanations, practical information, or direct confrontation of faulty thoughts and images. In contrast to affective experiencing, it serves as a rational component of treatment to inform, assess, and organize change and to establish or restore ego control (Karasu, 1986).

But affective reexperiencing and cognitive mastery are purposeless if they do not lead to behavioral change. Throughout the course of treatment, the inpatient unit provides multiple experiences with the opportunity for behavioral change. A significant step is taken when the patient decides to be the protagonist for their own psychodramatic experience—which may be done in the general patient group or may be just with staff. Often there is at about the same time, the most difficult family sessions or confrontations. Quite noticeably, the patient denotes this experience as a significant stepping over a symbolic