THE SANCTUARY MODEL:

DEVELOPING GENERIC INPATIENT PROGRAMS FOR THE TREATMENT OF PSYCHOLOGICAL TRAUMA

BY
SANDRA L. BLOOM, M.D.

FROM: MB WILLIAMS & JF SOMMER, JR (EDS): HANDBOOK OF POST-TRAUMATIC THERAPY: A PRACTICAL GUIDE TO INTERVENTION, TREATMENT, AND RESEARCH. WESTPORT,CN: GREENWOOD PUBLISHING, SPRING, 1994

BACKGROUND

Most psychiatric unit directors today would state that their programs are based on the concept of the "therapeutic milieu" described by Gunderson (1978) as a methodology characterized by five functional variables: containment, support, structure, involvement, and validation. As is the case with many other areas of human endeavor, a wide gap between the real and ideal concept of the therapeutic milieu often exists. (Abroms, 1969; Almond, 1974; Gabbard, 1988; Gutheil, 1985; Kirshner, 1982; Leeman, 1986; Margo, 1989; Wilmer, 1981). Because there has been no comprehensive and agreed upon theoretical structure for understanding human behavior, underlying assumptions upon which practice is constructed are confusing, contradictory, and divisive. The corollary of this lack of theoretical cohesion is a lack of agreement on treatment goals.

There is no longer any doubt about the strong connection between childhood trauma, disturbed development, and adult psychiatric illness (Beck, Van der Kolk, 1987; Briere, Saidi, 1989; Bryer, Nelson, Miller, Krol, 1987; Bulik, Sullivan, Rorty, 1989; Herman, 1986; Herman, Perry, Van der Kolk, 1989; Jacobson, Herald, 1990; Jacobson, Koehler, Jones-Brown, 1987; Jacobson, Richardson, 1987; Morrison, 1989; Shearer, Peters, Quaytman, Ogden, 1990; Sierles, Chen, McFarland, Taylor, 1983; Stone, 1981; Walker, Katon, Harrop-Griffiths, 1988). These studies have

shown 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 underlying this response have led researchers into areas of research as diverse as cellular neurotransmission and anthropological field studies and to the development of a body of knowledge operationalized as the Trauma-Based Approach.

The Trauma-Based Approach to treatment, foundation of the Sanctuary Model of inpatient treatment, makes certain fundamental assumptions about those patients who have survived significant traumatic experiences: (Herman, 1981; Van der Kolk, 1987):

1. Patients begin life with normal potentials for growth and development, given certain constitutional and genetic predispositions, and then become traumatized. "Post- traumatic stress reactions are essentially the reactions of normal people to abnormal stress" (Silver, 1986).

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

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

4. Many symptoms and syndromes are manifestations of adaptations, originally useful as coping skills, that have now become maladaptive or less adaptive than originally intended.

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

6. Victims of trauma become trapped in time, their ego fragmented. They are caught in the repetitive re- experiencing of the trauma which has been dissociated and remains unintegrated into their overall functioning.

7. Dissociation and repression are core defenses against overwhelming affect and are present, to a varying extent, in all survivors of trauma.

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

9. Stressful events are more seriously traumatic when there is an accompanying helplessness and lack of control.

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

11. Attachment is a basic human need. Enhanced attachment to abusing objects is seen in all studied species, including man.

12. Childhood abuse leads to disrupted attachment behavior, inability to modulate arousal and aggression toward self and others, impaired cognitive functioning, and impaired capacity to form stable relationships. **13.** People who are repeatedly traumatized develop "learned helplessness" a condition which has serious biochemical implications.

14. Trauma survivors often discover that various addictive behaviors restore at least a temporary sense of control over intrusive phenomena.

15. Survivors may also become addicted to their own stress responses and as a result, compulsively expose themselves to high levels of stress and further traumatization.

16. Many trauma survivors develop secondary psychiatric symptomatology and do not connect their symptoms with previous trauma. They become guilt-ridden, depressed, and exhibit low self-esteem and feelings of hopelessness and helplessness.

17. Trauma victims have difficulty with the appropriate management of aggression. Many survivors identify with the aggressor and become victimizers themselves. A vicious cycle of transgenerational victimization often ensues.

18. Although it may require lifelong processing, recovery from trauma experience is possible. Over the course of recovery, survivors may temporarily need safe retreats within which important therapeutic goals can be formulated and treatment can be organized.

These and other basic assumptions under gird the Sanctuary Model of Inpatient Treatment. They serve, as well, as working hypotheses for all

patients. In this way, formerly incomprehensible symptoms become comprehensible, explicable, and often treatable.

THE SANCTUARY MODEL OF INPATIENT TREATMENT: TREATMENT CONTEXT

The Sanctuary Model is an elaboration of the therapeutic milieu concept. It uses the trauma-based approach as a philosophical structure for organizing treatment and a feminist-informed systems approach for organizing the milieu (Belenky, Clinichy, 1986; Engel, 1977; Gilligan, 1982; Marmor, 1983; Menninger, 1963; Miller, 1976; Ruddick, 1989; Wilkinson, O'Connor, 1982). These concepts are applied to short-term, general hospital care. Short-term is defined as a length of stay of less than thirty days, on an open, voluntary, nineteen bed general psychiatric unit.

The evolving Sanctuary Model grew out of a twelve year history of the development and implementation of a modified therapeutic community. Since the unit was created a mixed population of adults and adolescents with many different psychiatric profiles have been treated. Excluded patients could not be handled in an open setting, i.e. involuntarily committed patients and patients found to be an unmanageable danger to themselves or others.

A combination approach, utilizing daily individual treatment, group therapies, community meetings, family therapy, psychopharmacology, in the context of a highly managed milieu has been used. Group therapies include art therapy and psychodrama, discharge planning groups, compulsive disorders groups, self-help groups, and a nightly "optional" group which is flexible enough to meet spontaneous needs of the community.

Several years ago, 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, staff began to ask patients more seriously about their histories of previous trauma including childhood abuse.

Staff stopped asking, in any number of ways, "What's wrong with you?" and began asking "What happened to you? (Foderaro, 1991). When they began to ask different questions they were astounded by the answers they received. The discovery that a majority of patients were victims of

serious and significant childhood physical and sexual abuse led to a broadening of the treatment perspective and an on-going search for more effective modalities of treatment.

Most survivors enter psychiatric treatment because of self-destructive, self-abusive behaviors ranging from addictions of all kinds to self-mutilation, suicidal ideation, social withdrawal, self-sabotage, and impaired capacities for intimacy. They usually make no connections between present problems and earlier, often still completely repressed, traumatic experiences.

Some individuals may still be in abusive relationships and their present needs for immediate safety outweigh concerns about the past. Many enter treatment manifesting the "negative symptoms" of PTSD: denial, numbness, depression, withdrawal, anhedonia. Others only seek treatment when they begin to experience the "positive" symptoms of hyperarousal, irritability, inability to control rage, flashbacks, behavioral re-enactments, pseudohallucinations.

No matter the reason for entering treatment, most feel defective, demoralized, and fearful of "going crazy" or losing control. Most have serious deficits in the capacity to trust. Hence, the ability to form stable and satisfying, mutual relationships is often seriously impaired. Also, many suffer from a disturbance in the capacity to comprehend normal interpersonal boundaries.

Trauma, particularly trauma suffered at the hands of other humans, is by definition, a boundary disorder. Thus, trauma survivors have difficulties establishing and maintaining normal, protective boundaries around the sense of self and 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 are also extremely sensitive to boundary incursions of all kinds, while attempting to re-enact them compulsively.

Victims of previous trauma often present for psychiatric treatment after years of fairly adequate coping. Sometimes, in fact, their successes in specific areas of functioning are remarkable in contrast with the severity of the symptoms with which they live. At some point in time, often due to current overwhelming stressors, retraumatizations, or developmental impasses, their defenses are overwhelmed and their symptoms become so disabling that they require hospitalization.

As a part of this very complicated picture and as a direct result of PTSD, trauma survivors have difficulty modulating feelings of rage, fear, and grief and manifest extremes of emotional expression. They may also experience intrusive phenomena and flashbacks, manifestations easily mistaken for psychotic symptoms.

Survivors often know little or nothing about the connection between symptoms and their past histories. A history of child abuse or other early trauma is frequently offered up only with great reluctance, guilt, and self-blame. Even more common is partial or total amnesia for the traumatic events of childhood.

STAGES OF TREATMENT

Horowitz (1986) discussed a phase-oriented treatment of stress response syndromes. Lifton talked about "confrontation, reordering, and renewal (1988). Herman has simplified treatment into three stages: Safety, Reconstruction, and Reconnection (1991). No matter how these stages are defined however, it is clear that interpenetration of all the stages occurs and recovery proceeds along a continuum of treatment experience that includes outpatient individual, group, and many times, inpatient treatment.

It is quite useful to discuss inpatient work with victims of trauma in terms of Herman's three stages of safety, reconstruction, reconnection - although all three stages are often being addressed simultaneously.

SAFETY

The essence of trauma is that a person's sense of safety in the world, and of self, is seriously compromised. It is impossible to overemphasize the importance of the provision of a safe environment for the victims of trauma. This sense of safety must encompass physical, emotional, and social levels of care.

Many psychiatric units mix voluntary with involuntary patients (Chiappa and Wilson, 1981; Leeman, Sederer, Rogogg, Berger and Merrifield, 1981). Excluding involuntary admissions does not guarantee safety, but it does improve the odds. When voluntary patients are mixed with noncompliant, involuntarily committed patients, care usually sinks to what is required to keep the level of violence and disruption to a minimum. This is NOT adequate care for persons who have already

been victims of violence. Screening out involuntary patients helps screen out violence.

Clear expectations about the unacceptability of violent acting out as an intrinsic part of the therapeutic milieu, must also exist. If violence does erupt, the behavior must be handled promptly, firmly, and decisively, and may necessitate transfer of the offender to a more restrictive environment. Clear rules and effective response to sexual acting-out applies to patients and staff alike. Sexual acting out must not be tolerated because, like violence, it is an act of boundary trespass.

An intensive therapeutic milieu is not appropriate for everyone. It can be too stimulating for acutely psychotic, manic, and chronically psychotic patients and can promote further deterioration (Kahn and White, 1989). These patients need special treatment programs designed to meet their needs and stabilize their illness as effectively as possible.

The first stage of treatment often helps the survivor become safe from his/her own self-injurious behavior. Before treatment can proceed to the next stage, the survivor must achieve some degree of control over his/her symptoms and form enough of a treatment alliance to substitute the "holding environment" for compulsive behaviors including addictions, self-mutilation, and suicide gestures.

Although patients may push for immediate reconstruction and family confrontations, encouraging premature confrontation can be a serious therapeutic error. A primary responsibility of staff is to provide protection and ensure safety, even protection for the survivor from him/herself.

Open discussion with the patient helps to define what level of safety must be reached before they are ready to reveal memories to self and others. Often the first goal of treatment is the stabilization of initial unsafe practices. Achieving this goal may become the purpose of the entire hospitalization. The patient is then encouraged to continue outpatient therapy.

Patients must also feel safe in the hospital environment with other patients. The use of traditional therapeutic community techniques including twice daily community meetings with patient government promotes this sense of safety. The staff also participate in meetings because of the short length of stay and rapid turnover of population. Responsibility for maintaining confidentiality is reviewed repeatedly and

infractions of rules are dealt with promptly via community confrontation and special staffings. Continued infractions are considered grounds for discharge or transfer.

It is mandatory that all members of the therapeutic community including the physicians, respect the integrity of the group process meetings. Community feeling is fostered and the true therapeutic action of the community manifests itself within the context of the groups. Therefore, groups are not to be interrupted and physicians must plan their visits around the functions of the groups, rather than the usual reverse situation in which physicians are permitted to pull patients from group meetings at any time. Such a practice is a disruption of boundaries and must be curbed.

Reconstruction

The second major stage of the recovery process involves the reconstruction of lost memories, including the physical, affective and cognitive aspects of traumatic experiences. The onset of this stage is often characterized by the appearance, or reappearance of positive symptoms of PTSD including hyperarousal, flashbacks, nightmares, increased dissociative experiences, sleep and concentration problems, psychosomatic symptoms. In most cases of trauma, memory retrieval and abreaction are necessary.

The inpatient setting can provide the intensive level of care demanded through this acute phase. Emotional demands on the therapist during this period of overt emotional expression can be too much for one person to manage successfully . The inpatient unit provides enough staff to diffuse the emotional intensity, while continuing to allow the patient the opportunity to work through the trauma.

In addition, the inpatient structure provides the patient with some extremely reassuring external limits when enduring an abreactive experience. Regression can be planned, organized, and controlled to offer support and guidance as well as to maintain physical and emotional stability. The built-in cycles of work and relaxation, withdrawal and socialization are important to prevent physical and emotional collapse.

Reconstructive work is only a part of the overall treatment plan. Many levels of trauma may correspond to different ages of traumatic experiencing, different perpetrators, different ego states, or different

developmental impasses. The reconstructive experience therefore, may occur in cycles with intervening periods of high function. When at all possible, reconstructive work therefore should be planned between the patient, the outpatient therapist, and the inpatient staff. Experienced survivors can set specific goals and time limits for themselves to help prevent further deterioration.

The goal of reconstructive work is to get beyond the need for the compulsive re-experiencing and re-enactment of trauma. Catharsis, while important is not an answer in and of itself. Ultimately the survivor must integrate the traumatic experience into a new definition of and attitude towards life that transcends that experience.

Reconstructive work is emotionally - and morally - draining to staff and patients. Treatment during this phase must be highly individualized. Survivors who feel shame and guilt as they retrieve memories may need time alone with supportive staff who monitor them for safety and comfort. Others require personal contact with a staff member or members during the re-experiencing, but are overwhelmed by a group interaction. Still others feel most comfortable and safe within the confines of a group with whom they have already established meaningful relationships.

Reconnection

Reconnection, the third stage, occurs when the survivor begins to reconnect in a real and symbolic way, with the outside world and begins to reconstitute his/her reality without trauma as the central core of identity. Memories begin to become actual memories and no longer carry the same power to control thought, action, and feelings.

This stage of recovery actually interpenetrates other stages and is promoted through the community milieu and group experiences. In addition, there is an implicit assumption in the philosophy of the unit that survivors are capable of transcending their pain.

However, the unit offers no set formula for such a transformation -that is the mission of the survivor. However, perhaps the most essential function of the therapeutic community is to provide an atmosphere of hopefulness and multiple mastery experiences.

HOSPITALIZATION AS RITUAL PASSAGE

Van der Hart (1983) noted that rituals offer a behavioral framework in which changes surrounding a transition can occur. This ritualized passage makes movement to the next stage of development possible in a relatively stable way.

The act of coming into a hospital is, itself, the first stage of a ritual called the separation phase, a stage in which the interactions with the survivor's normative group are strongly reduced or cut off. 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. During this stage, when the survivor 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 that of danger.

Most of the patient's hospital stay is spent in this threshold state, a state 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 to support the expression of emotion. Even high functioning adults must subject themselves to restrictions that they would not tolerate at home.

The survivors participate in a level system in order to earn privileges. This system 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, expression of affective experience, cognitive restructuring, and behavioral change.

Patients enter and begin treatment by simply observing the progress of other patients. During this initial phase, multiple assessments occur and the patients and staff get to know each other. The working phase occurs when the patients begin to serve as "auxiliaries" in other patients' psychodramas, are actively work in individual and group psychotherapy, plan family sessions, and become actively involved in the overall life of the community.

A significant step occurs when patients decide to serve as protagonists for their own psychodramatic experience This 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 are held. Quite noticeably, patients often denote this psychodramatic experience as the stepping over of a symbolic threshold and afterward

more rapid change occurs, behavior alters, affect lightens, and patients prepares more actively for discharge.

The final stage of ritual occurs when the participants step out of the threshold stage and commence a new life via the reunion with their social group. Often just prior to discharge, the other members of the group organize some kind of ritual good-bye that may include a special meal, flowers, cards, or other expressions of congratulations. Patients recognize the ritual nature of this passage back to "normal" life.

TREATMENT PITFALLS

INADEQUATE LEADERSHIP

The issue of milieu management has been given insufficient attention. The inpatient system must be viewed as an ecological system, an organic whole which is completely interdependent. An inpatient psychiatric system can be as dysfunctional as the most disturbed family system. Effective functioning of the system can only be achieved if a universal recognition that the whole is greater than the sum of the parts exists.

Effective functioning can only be accomplished if the unit is highly and visibly managed. Leadership of the unit must be provided by members of the various treatment disciplines, including, but not limited to, physician leadership. All managers must provide for the unit what the unit must provide for patients: protection, nurturance, and training. (Ruddick, 1989)

All staff must feel physically AND emotionally safe within the environment. This sense of safety can only be achieved if there are clear although not rigid boundaries between the unit and the outside world as represented by the medical staff and the hospital administration. Well-defined internal boundaries established through the ongoing process of policy development and implementation must also exist.

It is important that management also nurture and support staff and each other. Conflicts must be resolved, hurt feelings attended to, chronic rage addressed. Staff will inevitably serve as role models for the patients thus it is unrealistic to expect the patients to behave in a more mature manner than the staff.

An active inservice training program must be implemented by management . However even more vital is an attitude that is conducive to learning and recognizes that learning usually occurs from mistakes. Therefore the unit leadership must have an attitude of respect. consideration and basic benevolence towards the staff and each other.

In healthy inpatient units, as in healthy families, rules are clear but flexible, lines of authority and responsibility are well-defined, conflicts are actively resolved, power is

shared, decisions are made as democratically as possible and are arrived at through a certain amount of compromise and negotiation with all parties.

DECENTRALIZED ADMISSIONS

The inpatient milieu, as a social system, must create adequate structure to function to insure effective functioning while allowing for the flexibility to adjust to individual needs. On many units, a physician may admit anyone if a bed is available and insurance is adequate. In this case, decisions are made based on the needs of the individual -patient or physician -rather than the needs or requirement of the system.

No milieu can be totally flexible. If the milieu cannot define whom to treat and how to treat a patient, it is put in the untenable position of having responsibility without authority. When this situation is in effect, the milieu must devote more time to defending itself and responding to inappropriate admissions than it does to active treatment, it functions most of the time in a crisis mode and, as a result, often develops overly rigid and excessively primitive defenses.

Responsibility without authority can be avoided by centralizing admissions within one department -usually social service -and granting staff the final authority on admissions under the supervision of the medical director of the unit. It is then the responsibility of social service to evaluate the overall needs and responsibilities of the milieu and base admission decisions on what is in the best interest of the patient AND the treatment environment.

UNIDIMENSIONAL ASSESSMENT

In many psychiatric settings only one assessment is heavily weighted. It may be the psychiatric opinion; at other times it may be the nursing assessment. Whatever the case, a lack of integration of all points of

view -including the patient's - defeats the purpose of a multidimensional milieu. It is through the combined result of several independent evaluations by which clinicians can get closest to an understanding of the truth and reality of the patient. Only then can treatment goals be made relevant to the whole person.

INCOMPLETE PROGRAMMING

Often the psychiatric program revolves around the needs of the physicians, staff, hospital administration, or insurance companies rather than around the needs of the patient. Relegating patient needs to a secondary position replicates many dysfunctional families in which the children were used to satisfy the needs of the parents.

The Sanctuary program makes attempts to address all the needs of the individual patient. Patients who are victims of trauma usually require the safety and security of an individual psychotherapy relationship. Yet they also need different kinds of group experiences including psychoeducational groups which facilitate the cognitive processing of traumatic experience, evocative groups which provide the opportunity for catharsis and rehearsal of new behaviors, and focus groups which can flexibly and spontaneously respond to specific issues, i.e. women's groups, men's groups, eating disorders groups.

No inpatient program is complete if it does not address the physical needs of the patient. Physicians must be available to prescribe appropriate medications and to interface effectively with other medical specialists, especially since the rate of somatic symptoms is so high in this population.

The family of the survivor cannot be ignored. Family evaluations and the initiation of family therapy should be an essential part of every treatment program. Family therapy may focus on the present family or it may involve the family of origin, particularly in cases of childhood abuse (Courtois, 1988).

NONSPECIFIC, OVERGENERALIZED TREATMENT GOALS

A great deal of individual variation in what each patient can or will accomplish during a short-term hospitalization exists. While some patients surprise themselves, and the staff, and make major intrapsychic and behavioral changes, the common therapeutic mistake is that they try to do too much, too fast. The key word to emphasize is process.

Inpatient goals must be specific, focused, and attainable within the short-term structure of the unit. Recovery from trauma is a long, multidimensional process and inpatient hospitalization must be seen as simply an integral part of that recovery process.

OVEREMPHASIS ON CATHARSIS

Abreaction appears to be a necessary, but not totally sufficient, aspect of treatment. A push for reconstructive work can be dangerous if the patient has not yet established an internalized sense of safety. The patient has developed symptoms as a defense against affect. If defenses are prematurely overwhelmed by affect, staff can anticipate an increase in self-destructive symptoms. This inevitable increase does not mean that reconstructive work should be avoided. However, it does mean that the burden must be on the patients to "prove" to the staff that they are ready to assume the responsibility for their feelings without becoming destructive to themselves or others. Several hospitalizations and extensive individual and group psychotherapy may be necessary before patients are ready to move from being "victims" to being "survivors".

ENCOURAGING DEPENDENCY

There is a paradoxical and implicit danger in the sanctuary concept. The nurturance of the inpatient unit is often the first experience that a survivor has had with a safe environment. For someone whose inner and outer life is routinely chaotic, the structure and limits of the inpatient setting can be tremendously reassuring.

Some patients appear to be making progress until discharge becomes imminent. Their behavior may then deteriorate and self-destructive behavior may again be threatened or acted-out. These patients obviously are manifesting symptoms related to trauma, yet they may deny memories until just before a scheduled discharge and then begin to have threatening flashbacks. These patients can be considered "discharge-resistant" and often have suffered extreme and prolonged abuse in childhood. Significant countertransference problems (Main, 1957) may arise as the staff splits in disagreement. One half of the staff may empathize with the patient's distress over leaving the hospital and focus on the patient's apparent willingness to work on therapeutic issues in the face of the former resistance. The other half of the staff recognizes the need for the patient to move on, is often angry at the

patient's dependency, and frequently uses words like "manipulative" to describe the patient's behavior.

Discharge resistance can be a crucial turning point for the patient if handled properly. The hospital experience temporarily provides the ideal parenting experience from which the traumatized patient has been banned, often since early childhood. Understandably the patient is reluctant to give up that kind of support. Unfortunately, because of the very nature of the hospital experience, continuing to receive that nurturing requires that the patient must remain in a sick, dependent, needy and self-destructive role.

It is vital that staff members recognize their own internal splitting as early in the hospitalization as possible and use it as a way to predict which patients may have difficulties with discharge. In resisting discharge, the patient endeavors to avoid dealing with the extremely painful grieving process that accompanies finally giving up the hope of ever recovering the idealized parents. Ultimately, survivors must come to the recognition that the capacity for safety and security resides within themselves. Each must find a means to cease his or her compulsive traumatic re- enactments while transforming the pain of trauma into some form of personal transcendence.

BURNOUT

When therapists allow themselves to share in the experience of the survivor, their own assumptions about the nature of the world may also be damaged. The contagion of traumatic experience is a real and serious professional liability. Little has yet been written about preventing or dealing with the consequences.

Probably the most effective coping method against burnout is consultation with other clinicians and when possible or necessary, co-therapy. Thus, in this model, the treatment team must meet several times weekly. Meetings that include all the attending physicians reviews the progress of each patient should be reviewed. The key to successful treatment is TEAMWORK.

CONCLUSION

Inpatient treatment is a powerful tool in the psychiatric armamentarium that can be used for good or ill. The recognition that a large proportion

of psychiatric inpatients have a significant history of serious traumatic experiences must influence the future course of inpatient care. Much is to be learned from the specialized care of trauma victims on an inpatient basis. Ultimately, the knowledge gained will have a positive influence on the entire field of inpatient treatment.

REFERENCES

Abroms GM: Defining milieu therapy. Arch Gen Psychiatry 1969; 21: 553-560

Almond R: **The Healing Community**. New York, Jason Aronson, 1974

Beck JC, Van der Kolk BA: Reports of childhood incest and current behavior of chronically hospitalized psychotic women. Am J Psychiatry 1987; 144: 1474-1476

Belenky MF, Clinchy BM, Goldberger NR, Tarule JM: **Women's Ways of Knowing: The Development of Self, Voice and Mind**. New York, Basic Books Inc., 1986

Briere J, Saidi LY: Sexual abuse histories and sequelae in female psychiatric emergency room patients. Am J Psychiatry 1989; 146: 1602-1606

Bryer JB, Nelson BA, Miller JB, Krol PA: Childhood sexual and physical abuse as factors in adult psychiatric illness. Am J Psychiatry 1987; 144: 1426-1430

Bulik CM, Sullivan PF, Rorty M: Childhood sexual abuse in women with bulimia. J Clin Psychiatry 1989; 50: 460-464

Chiappa FW, Wilson SJ: The effect of a locked door on a psychiatric inpatient unit. Hosp Comm Psychiatry 1981; 32: 801-802

Courtois, CA: **Healing the Incest Wound: Adult Survivors in Therapy.** New York, W.W. Norton & Co., 1988.

Engel GL: The need for a new medical model: A challenge for biomedicine. Science 1977; 196: 129-136

Foderaro JF: Personal communication

Gabbard GO: A contemporary perspective on psychoanalytically informed hospital treatment. Hosp Comm Psychiatry 1988; 39: 1291-1295

Gilligan C: **In a Different Voice: Psychological Theory and Women's Development**. Cambridge, Mass, Harvard University Press, 1982

Gunderson, JG: Defining the therapeutic processes in psychiatric milieus. Psychiatry 1978; 41: 327-335.

Gutheil TG: The therapeutic milieu: changing themes and theories. Hosp Comm Psychiatry 1985; 36:1279-1285

Herman JL: **Father-Daughter Incest**. Cambridge, Mass, Harvard University Press, 1981

Herman JL: **Trauma and Recovery**. New York, Basic Books, Inc. 1992

Herman JL: Histories of violence in an outpatient population: an exploratory study. Am J. Orthopsychiatry 1986; 56: 137-141

Herman JL, Perry JC, Van der Kolk BA: Childhood trauma in borderline personality disorder. Am J Psychiatry 1989; 146: 490-495

Horowitz MJ: **Stress Response Syndromes**. Northvale, NJ, Jason Aronson, 1986

Jacobson A, Richardon B: Assault experiences of 100 psychiatric inpatients: evidence of the need for routine inquiry. Am J Psychiatry 1987; 144: 908-913

Jacobson A, Koehler JE, Jones-Brown C: The failure of routine assessment to detect histories of assault experienced by psychiatric patients. Hosp Comm Psychiatry 1987; 38: 386-389

Jacobson A, Herald C: The relevance of childhood sexual abuse to adult psychiatric inpatient care. Hosp Comm Psychiatry 1990; 41: 154-156

Kahn EM, White EM: Adapting milieu approaches to acute inpatient care for schizophrenic patients. Hosp Comm Psychiatry, 1989; 40: 609-614

Kirshner LA, Johnston L: Current status of milieu psychiatry. Gen Hosp Psychiatry 1982; 4:75-80

Leeman CP: The therapeutic milieu and its role in clinical management in **Inpatient Psychiatry**. Edited by Sederer LI. Baltimore, Md, Williams & Wilkins, 1986

Leeman CP, Sederer LI, Rogogg J, Berger HS, Merrifield J: Should general hospitals accept involuntary psychiatric patients? Gen Hosp Psychiatry 1981; 3: 245-253

Lifton RJ: Understanding the traumatized self: imagery, symbolization, and transformation in **Human Adaptation to Extreme Stress: From the Holocaust to Vietnam**. Edited by Wilson JP< Harel Z, Kahana B. New York, Plenum Publishing, 1988

Main TF. The ailment. Br J Med Psychology 1957; 30: 129- 145

Margo GM, Manring JM: The current literature on inpatient psychotherapy. Hosp Comm Psychiatry 1989; 40: 909-915

Marmor J: Systems thinking in psychiatry: Some theoretican and clinical implications. Am J Psychiatry 1983; 140: 833-838

Menninger K: **The Vital Balance**. New York, Viking Press, 1963.

Miller JB: **Toward a New Psychology of Women**. Boston, Beacon Press, 1976

Morrison J. Childhood sexual histories of women with somatization disorder. Am J Psychiatry 1989; 146: 239-241

Ruddick S: **Maternal Thinking: Towards a Politics of Peace**. Boston, Beacon Press, 1989

Shearer SL, Peters CP, Quaytman MS, Ogden RL: Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline inpatients. Am J Psychiatry 1990; 147: 214-216

Sierles FS, Chen JJ, McFarland RE, Taylor MA: Posttraumatic stress disorder and concurrent psychiatric illness: a preliminary report. Am J Psychiatry, 1983; 140: 1177-1179

Silver SM: (1986) An inpatient program for post-traumatic stress disorder: Context as treatment in **Trauma and Its Wake, Volume II**. Edited by Figley CR.

Stone MH: Borderline syndromes: a consideration of subtypes and an overview, directions for research. Psychiatric Clin North Am 1981; 4: 3-13

Van der Hart O: **Rituals in Psychotherapy: Transition and Continuity**. New York, Irvington Publishers, 1983

Van der Kolk BA: **Psychological Trauma**. Washington, D.C., American Psychiatric Press, 1987

Walker E, Katon W, Harrop-Griffiths J et al: Relationship of chronic pelvic pain to psychiatric diagnosesd childhood sexual abuse. Am J Psychiatry 1988; 145: 75-80

Wilkinson CB, O'Connor WA: Human ecology and mental illness. Am J Psychiatry 1982; 139: 985-990

Wilmer HA: Defining and understanding the therapeutic community. Hosp Comm Psychiatry 1981; 32:95-99, 1981