Creating Sanctuary: Practicing Nonviolence in a Psychiatric Setting

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Zusammenfassung:
Der Beitrag beschreibt die Grundlagen der Arbeit von *The Sanctuary*, einem für die besonderen Zwecke modifizierten therapeutischen Kurzzeitprogramm in den USA. Ziel des Programms ist die spezialisierte Behandlung traumatisierter Erwachsener. Weiterhin wird in das Behandlungsmodell SAGE eingeführt (abgekürzt für „Sicherheit - Affektmanagement - Trauer - Emanzipation"). - The paper describes the philosophical basis of *The Sanctuary*, a short-term modified therapeutic milieu program in the United States, designed to specialise in the treatment of traumatized adults. It also gives an introduction to the treatment model "SAGE", an acronym for Safety, Affect Management, Grieving, and Emancipation.

This paper outlines the fundamental building blocks used to develop an in-patient treatment milieu founded on the principles of nonviolence, therapeutic community, and an understanding of the way chronic stress and trauma play an important role in the evolution of many forms of chronic psychiatric dysfunction. The Sanctuary Model is a structured biopsychosocial model for treating patients in a short-term setting. The Sanctuary Model, while not ignoring the role of disordered psychobiology in understanding and treating our patients, places emphasis on an injury model of treatment, rather than a sickness or medical model. Emphasizing rehabilitation and recovery over stabilization or cure, our model leads to the development of patient empowerment balanced with personal and social responsibility.

Although the Sanctuary Model was based on experience gained in work with adults traumatized as children, it has been successfully applied to a state hospital population largely diagnosed as suffering from schizophrenia, bipolar disorder and mental retardation. In this setting, restraint, which had previously averaged sixty hours per month, was reduced to zero and the level of self-inflicted and other-inflicted violence was drastically reduced (Bills and Bloom,

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1998, 2000). In another hospital setting with a mixed population of designated and non-designated trauma patients, neither seclusion nor restraint were employed and only 75 episodes of self-harm, only one of which required sutures, were recorded among 3,000 patients.

For the past twenty years, we have been managing psychiatric units in community hospitals, private non-profit, and private profit-making hospitals. Since 1991, our inpatient program has specialized in the treatment of traumatized men and women over the age of eighteen. We call our program(s) *The Sanctuary* (Bloom, 1997; Bloom 1994, 447-491), a name reflecting our commitment to developing therapeutic environments that do not produce „sanctuary trauma" – i.e., finding only more trauma, having expected a safe environment (Bloom & Bills 1998, 2000; Bloom 1994, 1997, 2000). This model is currently being piloted in child and adolescent residential facilities and domestic violence shelters (Jewish Board of Family and Children's Services, 120 57th St, New York, NY).

The patients treated on *The Sanctuary* had been victims of torture, usually suffered at the hand of those upon whom they were supposed to be able to depend. They all share deep and pervasive experiences with the abuse of power. They had learned to survive and to cope with the overwhelming stress, but had paid for their survival with their mental health. They have been diagnosed with many different psychiatric disorders, including borderline personality disorder, dysthymic disorder, major depressive disorder, post-traumatic stress disorder, dissociative disorder, anorexia nervosa, bulimia, substance abuse, somatization disorder, schizoaffective disorder, panic disorder, agoraphobia, and impulse control disorder. Typical of all of them is a marked tendency towards self-destructive and often other-destructive behavior. Many of them have repeatedly been hospitalized, engage in self-mutilation, and are chronically suicidal. Irrespective of their formal diagnoses they all suffer from a clinical picture that has been termed „complex PTSD" and is characterized by seven major categories of dysfunction: alterations in the regulation of affective arousal, alterations in attention and consciousness; somatization; alterations in self-perception; alterations in perception of the perpetrator; alterations in relations to others; alterations in systems of meaning (Herman, 1992; van der Kolk, Roth, Pelcovitz, Mandels 1994).

Treatment on *The Sanctuary* is organized around three fundamental rationales: that we must share the same basic set of assumptions that lead logically to specific implications for treatment; that we must share the same goals for what we are doing together; and that we must agree on the same methods for achieving our goals. Our shared assumptions derive largely from traumatic stress studies and the nonviolent premises of the therapeutic community movement. Our goals and methods for achieving those goals are

based on a staged model of treatment we call „SAGE" (Foderaro, in press; Foderaro and Ryan, 2000). The program is oriented around a psycho-educational framework so that our patients become active collaborators in the treatment planning and process. Since our average length of stay is now down to nine days, the psychoeducational component within a shared context that insists on the achievement of safety have become critical treatment components.

Shared Assumptions and Implications

Research has demonstrated that the majority of patients who require intensive psychiatric treatment are victims of previous trauma. We have come to understand that many of their symptoms are the reactions of normal people to abnormal stress. This means that they need experiences with environments that can normalize their experience, while educating them about the long-term liabilities involved in continuing to believe that these protective responses are still necessary. While in other settings they have been blamed and labeled for their behavior, much controllable and socially irresponsible behavior has been condoned or supported. We neither blame nor condone, but expect our patients to conduct themselves as socially responsible and capable adults who have been injured and need help to recover from their injuries, as well as education about the enormous impact that trauma has had on every aspect of their lives.

We assume that a past history of psychological trauma has biological, psychological, social and moral effects and treatment interventions must therefore address and integrate all these levels of injury. This requires the achievement of safety and safety must address not just physical, but also psychological, social and moral safety. Since traumatic experiences are by definition experiences of utter helplessness, the environment must consistently promote mastery experiences that result in personal and social empowerment, while refraining from inducing further experiences of helplessness.

The hallmark signs of traumatic experience are hyperarousal, intrusive symptoms, dissociation, avoidance and the inability to manage affect. As a result we must create an environment that focuses on the need to learn how to manage affect without resorting to self-destructive behaviors. Essentially, our patients must learn how to substitute self-soothing coping skills and healthy relationships for dissociation, self-mutilation, risk-taking, avoidance, substance abuse, and other compulsive behaviors. Since exposure to overwhelming stress has a profound impact on the brain's capacity to take in and process verbal information, the therapeutic environment must promote the integration of memory and affect, making essential the availability of nonverbal and creative forms of therapy.

Traumatization results in loss – sometimes of loved human beings, other times of bodily parts, relationships, opportunities, idealized fantasies, wishes, hopes and dreams. This means that victims must find ways to grieve for losses that are sometimes decades old. Unresolved bereavement can present as chronic and unresponsive depressive and anxiety symptoms that must be worked through rather than avoided to achieve therapeutic resolution.

One of the most important challenges to the therapeutic environment is the successful management of traumatic reenactment. Traumatic reenactment is a term used to describe the tendency of traumatized people to behaviorally, compulsively, and unconsciously reenact their trauma, often in highly symbolized and disguised ways. Patients come into treatment exhausted after a period spent repeating an overwhelming and humiliating past. Trauma produces a fragmentation that results in the accentuation of a nonverbal and a verbal split between memory, affect, perception, and identity. The language of the nonverbal self is behavior and in the presentation of their symptoms, our patients tell the story of their most terrible experiences. The role of the treatment environment is to engage enough with the story to understand the script but then to change the automatic roles that are being cued for by the patient so that the story changes instead of being repeated. Traumatic reenactment can be seen in the shifting roles that patients assume in the „rescuer-victim-perpetrator" triangle. In our model, perpetration is broadly defined so that in a socially responsible community, violence to the self is also perpetration against the community and is not acceptable behavior.

Shared Goals

We share goals for the individual and goals for the community. The seven major goals of individual treatment include: gaining authority over the remembering process; the integration of memory and affect, the development of affect tolerance, symptom mastery, the attainment of a sense of self-esteem and self-cohesion, the ability to form safe attachments, a willingness to engage in the process of meaning-making, of putting the past into some sort of perspective that makes a viable contribution to the present sense of purpose and place in the world (Harvey, 1996). As an entire community, we must all share in a belief that recovery is possible, in other words we must mutually create an environment of hope. But this goal can only be accomplished by substituting healthy relationships and different normative environments for abuse. Healing requires that the injured people construct a coherent and meaningful narrative of their experiences and be willing to place their individual pain into a broader social context.

Another goal is to meet the needs of the patients and the staff as well as the institution running the program. To the extent that the needs of these various parties conflict, the institution will find it difficult to maintain a health promoting environment for any of its members. Given the present health care system, integrity is the most difficult challenge we face. There are deep and unresolved conflicts between the basic needs of patients / staff and the larger health care system that remain unresolved. Major decisions about admission, length of stay, and treatment course and methods are now made by employees of „managed care companies" who make decisions over the telephone without any contact with the patient. They frequently refuse hospitalisation, and there is an intensive effort to reduce costs by the preferential use of biological forms of intervention – electroshock and medication – rather than intensive individual and group therapies.

Ultimately, our shared goal is to end violent perpetration. We share a belief that the therapeutic milieu does offer a true "experimental laboratory" for conscious social change. We have come to believe that retraumatizing people by placing them in environments that reinforce helplessness, scapegoating, isolation, alienation and violence must be viewed as antitherapeutic, dangerous, immoral and a violation of basic human rights. And yet this is what happens to many of the most vulnerable and damaged people in our society - the mentally ill and the criminally disturbed are placed in environments that are frequently retraumatizing. To the extent that workplaces are alienating, and even dangerous to the worker, and schools are viewed as violent, undemocratic, and restrictive to children just learning their place in the world, then antitherapeutic environments can be seen all around us. The "experimental laboratory" of the therapeutic milieu provides us with an opportunity to view democratic principles in practice, to see the vital necessity for constitutionally-based self-government, to practice conflict-resolution skills, and to develop a clear understanding of how vital it is that human beings learn to support, tolerate, and listen to each other instead of judging, blaming, and punishing each other.

Shared Practice

The heart of *The Sanctuary* is the practice of creating a safe, nonviolent therapeutic community. The sense of safety that we are creating for each other – staff and patients – is something that we are doing – or not doing – all the time, every moment of every day. It is a choice, an active constructive behavior that we all must participate in if it is to remain viable. All violence is perceived as an effort to destroy sanctuary, and violence is broadly defined as anything

that hurts the self or the community. Given the short-term nature of the program, and the decreases in staffing secondary to managed care cut-backs, we have shifted a great deal of the burden for maintaining safety onto the patients. This is an expectation and a responsibility that is articulated from the moment the person is accepted for admission and throughout the hospital stay. This expectation counters the regression that is typical on hospitalisation and is a community norm that is carried and enforced by the entire community.

We also share the active and ongoing process of resolving both conscious and unconscious conflicts. Deliberate conflict resolution measures are extremely important and for the most part are learned behaviours, quite different from the skills developed within the context of the dysfunctional systems that have been the childhood and often adult environments of our patients. Patients are encouraged to verbally engage other patients, staff, and physicians in problem resolution through verbal negotiation and staff are expected to participate actively in this process without resorting to abusive authority. Unconscious conflicts are harder to address because they are hidden. Unconscious conflicts within the individual manifest as reenactment behavior in which the patient nonverbally cues the environment to provide experiences that repeat the past. Although this can lead to a simple reenactment of the past in which the patient is retraumatised, with careful direction, such a traumatic scenario can provide the opportunity for an entirely different, redirected experience in which the unconscious pain can be surfaced, verbalised, and resolved. But there are also unconscious conflicts within a group that manifest through the acting-out behaviour of the patients, individual staff members, or the entire group. When the group can recognise that something uncomfortable needs to be surfaced instead of suppressed, rather than attempting to scapegoat an individual for the problem, significant movement ahead can occur.

S. A. G. E.

SAGE is an acronym for the four important aspects of recovery that we believe are the most important if people are to recover from trauma and which are consistent with other staged models of trauma treatment (Herman, 1992; Janet, 1976). SAGE stands for safety, affect management, grief, and emancipation and is designed to be used in both inpatient and outpatient settings.

People who have been traumatized have lost the sense of *safety* in their lives. The first step in recovery is to re-establish the feeling of being safe. This is always where treatment begins and recovery can not progress until safety has been established. In the community context we work on the basis of four

domains of safety that exist side by side and interact dynamically: physical safety, psychological safety, social safety, and moral safety.

Affect refers to the biological equivalents of emotional experience most obvious in the alternating hyperarousal and numbing and often accompanied by flashbacks, nightmares, and dissociative episodes (van der Kolk et al, 1996). *Affect management* deals with the stage of recovery in which people must learn how to manage their emotional arousal in a less destructive way. The identification of the feeling is the first step when learning how to modulate affect. One of the common accompaniments of chronic trauma is the development of alexythymia – the inablility to put feelings into words (Krystal, 1988).

There is often a tendency for a survivor of trauma to confuse the emotions, thoughts, and behaviors demanded by current events with responses demanded in the past, during and after the traumatic events. This over-responsiveness to or disconnection from emotionally charged events then tends to lead the individual into making familiar, but unproductive decisions in response to such events. This is the essence of patterns of reenactment in which survivors become trapped. These patterns of utilising familiar responses to new events that are mistakenly interpreted as being exactly similar to the original traumatising events, is what perpetuates a sense of being time trapped in time. This emotional and cognitive entrapment deprives the individual of many of the cognitive and intrapsychic skills that could be available to the adult survivor.

Many different therapeutic modalities are used on the unit to help manage affect. The milieu is designed to be a container for all of the overwhelming affects that surface once a group of trauma victims begin to work through their traumatic stress.

Direct psychoeducational groups deal with affective education and provide cognitive-behavioral interventions. One-to-one therapy and group therapies provide opportunities for the development of insight and the rehearsal of new behaviors and cognitive strategies. Individualized problem identification and goal setting helps each patient to focus on the area of affect management most problematic for them. Learning anger management is particularly important for our patients since their experience of anger tends to be overwhelming and uncontrollable. As a result, they tend to over control and deny their anger, while expressing it via self-destructive behavior, or they act out aggressively in a more direct manner. Some people alternate between the two styles. The therapeutic challenge is to help them find constructive and healthy ways of both expressing and containing anger. Creative therapies such as movement therapy, art therapy, and psychodrama offer opportunities to integrate dissociated affect, rehearse new patterns, and rework the past.

Community meetings and informal community interactions offer numerous opportunities for trying out new behaviors and developing a deeper understanding of how the present relates to the past and how past relationships are being relived in the present.

Grieving refers to the inevitable sense of profound loss, sadness, and despair that accompanies a traumatic experience and that must be experienced and worked through if normal life is to be restored.

It does not mean forgetting the past, but moving on from the past. It means not continuing to live in the past by perpetuating past traumas through patterns of reenactment, but learning to use affect, rituals, and social and interpersonal resources to facilitate new and creative responses to loss that allow for real transformation to proceed.

Emancipation encompasses all that goes into full recover from trauma – social reconnection, finding meaning, establishing a survivor mission.

This model is meant to provide a structure and framework for the evaluation and treatment of people who have been traumatized as children and/or adults. SAGE represents aspects of recovery, and although Safety is always the first step, and Emancipation usually the last, in actual life, these aspects tend to intertwine, interconnect, and present on-going challenges at each life stage. Future episodes of danger or grief are likely to reawaken old wounds. Therefore, the goal of recovery is to provide the tools necessary to guarantee that a person will be equipped to deal with future experiences without turning to behavior that is destructive to self or others.

The needs and problems of people who have been traumatized can vary greatly. Using the SAGE model provides an approach that is flexible and useful to the patient and clinician. It is designed to change with the needs of the patient. An important component of this model is the belief that people who have been traumatized can help themselves throughout the process of recovery and that in helping themselves, they are promoting their own recovery. There is also an assumption that an important part of recovery – and an important part of finding meaning – is to be found in helping others. Trauma occurs in a social context and social wounds require social healing. The most important part of the therapy experience may be in helping a traumatized person recover a sense of trust in other people, but this is only effective if that sense of trust can be generalized to other people outside of the therapy context. Therapy is a tool, an educational experience, not an end point. Therapy can only be proven useful if the result of the treatment is a healthier, better educated, socially proactive and constructive human being.

When things are not going well in a person's life and/or therapy, the treatment should be reevaluated. Part of the SAGE model includes thorough evaluation and reassessment when indicated. Progress in therapy can become stalled for a number of reasons, including the inherent difficulties in exchanging comfortable, albeit dysfunctional behaviors, for behaviors that are more frightening, challenging, but ultimately health promoting. Ultimately, healthy behavior is the personal choice of the person who is seeking help. The issue of choice will come into play for all steps of the SAGE model. A person must be willing to engage and consider the steps of SAGE and change behavior or he/she will be unable to benefit from this model. This question should be addressed early in treatment and may need to be looked at periodically throughout the course of treatment, particularly when progress appears to be halted or regression to previous forms of destructive thinking and behavior has occurred.

Conclusion

The Sanctuary Model is a practical synthesis of the old and the new. Using the time-proven methods of the therapeutic community as context, the Sanctuary Model integrates the extensive and still growing evidence-based foundation of trauma theory to produce a coherent system that promotes recovery, reduces violence, and changes social norms. S.A.G.E. provides a clear, cognitive-behavioral schema for assessing, evaluating, and motivating change. This model can be applied to any treatment setting interested in reducing the use of seclusion and restraint and lowering the level of interpersonal violence.

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