TREATMENT APPROACHES


10

Inpatient Treatment

Christine A. Courtois and Sandra L. Bloom

THEORY

The contemporary model of inpatient treatment of posttraumatic stress disorder (PTSD) reflects two main influences: (1) developments in the treatment of trauma in both inpatient and outpatient settings (including outcome research on the efficacy of treatment) that have taken place over the course of the past two decades, and (2) the impact of managed care and other cost-containment efforts. Historically, the correlation between traumatic experiences and subsequent psychiatric difficulties has long gone unrecognized.

The large epidemiological study of Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) has shown that subjects with PTSD are almost eight times as likely to have three or more psychiatric disorders, while 88% of men and 79% of women with PTSD have a history of at least one other disorder. Related findings have been reported by other researchers in studies of combat veterans (Brady, 1997; Orsillo et al., 1996; Southwick, Yehuda, & Giller, 1993), adult abuse survivors (Brown & Anderson, 1991; Ellason, Ross, Sainton, & Mayran, 1996), inpatients (Faustman & White, 1989; Hryvniak & Rose, 1989), and women (Breslau, Davis, Peterson, & Schultz, 1997; Carlin & Ward, 1992).

Despite the fact that a trauma history and PTSD symptoms are quite prevalent in a significant number of individuals requiring inpatient and outpatient psychiatric care, many mental health practitioners have had little or no training in the treatment of posttraumatic reactions in their professional education, a circumstance that unfortunately persists today. As a result, prac-
tioning, and reconnection with others, is usually not restorative (this approach has been labeled the "first generation" model of trauma treatment) (Chu, 1992; Johnson, Feldman, Southwick, & Charney, 1994).

2. The development of treatment models that are more comprehensive and oriented toward other issues besides traumatization and PTSD symptoms, including object relations and attachment issues (the "second generation" model) (Johnson et al., 1994).

3. The development of a phase-oriented posttrauma treatment that is sequenced, progressive, and titrated. In this model, crisis management and resolution, personal safety, patient education regarding trauma and the human response to trauma, education and skills building for self-management of symptoms, symptom stabilization, and rational psychopharmacology are given priority (Brown, Scheflin, & Hammond, 1998; Chu, 1998; Courtois, 1999; van der Kolk, McFarlane, & van der Hart, 1996). A focus on reconstructing and reworking traumatic memories is usually only pursued when the patient's posttraumatic symptoms continue unabated and/or lack of resolution contributes to the patient's difficulty establishing and maintaining personal safety. In the phase-oriented model, severe decompensation and/or risk of imminent harm to or from others are the paramount reasons for inpatient treatment.

4. The findings of treatment outcome data that first became available in the late 1980s and early 1990s in the VA.

5. Utilization review, the necessity for cost containment, and the influence of managed care (in both the private sector and the VA).

At the present time, a great diversity can be seen across individual inpatient PTSD programs, as each program offers a unique blend of treatment strategies and modalities. Yet even with this diversity, the overall philosophical orientation of these programs is trauma-responsive, and they utilize many common treatment approaches. All include a primary therapeutic focus on the traumatic experience and its consequences, and then incorporate attention to issues of personal safety, functional improvement, skills-building for self-management and symptom reduction (including relapse prevention), rehabilitation, and the reintegration of the individual into everyday family, work, and social life—all core issues for traumatized individuals.

The treatment model is conceptually based on the three central theoretical paradigms identified by Seidel, Gusman, and Abueg (1994): social learning theory, the life-span development model, and the therapeutic community or milieu psychiatry. This is melded with the multimodal and sequenced posttraumatic treatment model described by Brown, Scheflin, and Hammond (1998), Chu (1990), Courtois (1999), Marmar, Foy, Kagan, and Pynoos (1994), and van der Kolk, McFarlane, and van der Hart (1996), and with the model of general psychiatric care, including psychopharmacology that is tai-
lored to the needs of the traumatized population (Friedman, Davidson, Mellow, & Southwick, Chapter 5, this volume). It also incorporates differential selection of therapeutic targets depending on the type of trauma. Catherall (1989) identified primary (initial traumatic experience) and secondary types of trauma (the subsequent breakdown of the survivor's social environment and connection to others) in many patients with PTSD that call for different and broadened treatment approaches and strategies. Most recently, the model is incorporating more attention to the individual's object relations, attachment style and capacities, and pre- and posttrauma risk and resiliency factors.

Specific treatment goals include (1) a comprehensive assessment; (2) the reduction of core PTSD symptoms (intrusion, numbing/dissociation, hyperarousal); (3) the reduction of other PTSD symptoms that might be at subclinical levels but are nevertheless important to the individual's well-being or influence his or her clinical status; (4) the identification and stabilization of comorbid conditions and symptoms; (5) the stabilization and/or resolution of suicidal, self-injurious, or homicidal impulses and any other crisis circumstances; (6) the improvement of troublesome personality difficulties; (7) the reduction of social friction due to interpersonal difficulties and deficits; (8) the improvement of functional status and the reduction of salient symptoms; (9) the improvement of specific areas of disability; and (10) extensive discharge planning and relapse prevention.

At present, most programs are of moderate length (in the range of 2–6 weeks) due largely to the pressures of a managed care environment. Additionally, clinical observations and available empirical evidence (reviewed later) suggest that programs of short or midrange duration (4–6 weeks) are possibly more effective than very short-term (days to 2 weeks) or longer-term (6 weeks or more) programs in treating both core PTSD symptoms and other psychiatric symptoms (although data from a 12-week Australian combat veteran program with inpatient and outpatient components showed treatment gains in core PTSD and other symptoms [Creamer & Morris, 1997; Creamer, Morris, Biddle, & Elliott, 1999] and reimbursement models currently available in the VA best support a midlength program of 60 days). Whereas extended admissions (more than 6 months) used to be the norm in some programs, this is no longer the case. Decreased length of stays is certainly in keeping with national trends in the United States regarding the changing patterns of psychiatric inpatient care (Mechanic, McAlpine, & Olsson, 1998).

Programs of very short duration, of necessity, are usually crisis-oriented and work to decrease the patient's level of acuity or decompensation through the use of crisis intervention, intensive therapy, and targeted psychopharmacology, along with focused education, problem solving, and safety planning. In longer-term programs, admission need not be as crisis-driven and often occurs on a planned basis. The usual requirement is that the patient have severe enough symptomatology and distress to warrant an intensive treatment experience and/or around-the-clock monitoring. Longer-term programs have the luxury of more ambitious goals (e.g., to improve interpersonal skills and functioning in family, social, and work settings; to lessen and resolve psychiatric symptoms; to address and resolve dysfunctional or irrational cognitions and beliefs associated with traumatization in hopes of lessening core PTSD symptoms, etc.).

Hospitalization in a specialized program is contraindicated if malingering is suspected, or if the patient suffers from psychosis or significant enough characterological and/or social impairment to make work in a therapeutic milieu impossible. Also, patients in the throes of any life-threatening condition without suicidal intent (e.g., substance abuse, eating disorders) are not good candidates for this type of treatment until their clinical condition has been stabilized. Patients should be assessed as to their ability and willingness to participate voluntarily in a treatment setting that addresses their traumatic history and traumatic stress reactions and where they are expected to actively create and participate in an emotionally safe and physically nonviolent environment.

In recognition of the ongoing intensive care needs of patients who have chronic conditions that only occasionally meet criteria for inpatient admission (and yet who might need repeated admissions) or whose admissions are attenuated due to stringent utilization review and managed care restrictions, many inpatient programs have developed partial hospital, day-treatment programs, residential rehabilitation programs, and intensive outpatient treatment offerings to provide a continuum of care and a safety net for these patients. This trend seems to be getting stronger in the VA system, where a movement away from inpatient treatment in favor of intensive outpatient and residential treatment is under way (F. Gusman, personal communication, 1999).

Preliminary research on the efficacy of partial hospitalization reported by Perconte (1989), Perconte and Griger (1991), and Perconte, Griger, and Belluci (1989), similar to the data reported for inpatient treatment, showed treatment gains at discharge, with partial relapse on 1-year follow-up. These findings are concordant with those of Long and colleagues (1989), Ronis and colleagues (1996), and Wang, Wilson, and Mason (1996), whose findings suggest a long-term course of chronic PTSD. Many patients with histories of prolonged traumatization and chronic PTSD require psychiatric and rehabilitative services of long duration; however, according to the findings of Wang and colleagues, a number of patients need intensive services only on an episodic basis. Patients in the latter category have been found to have cyclical patterns of relapse and decompensation (when intensive services are most needed), and recovery and recompensation (when they are not). Thus, a variety of inpatient,
residential, and intensive outpatient treatment options are necessary to meet the ongoing needs of the most chronic and disabled patients, and the episodic and cyclical needs of those who are better able to cope.

**DESCRIPTION OF PROGRAMS AND TECHNIQUES**

Over the course of the past decade, a number of program descriptions of individual inpatient PTSD programs have been published (Allen, Kelly & Glodich, 1997; Bear, 1993; Bloom, 1994, 1997; Courtois, Cohen, & Turkus, 1994; Forman & Havas, 1990; Johnson, 1997; Johnson, Feldman, Lubin, & Southwick, 1995; Johnson & Lubin, 1997; Kluft, 1991, 1996; Putnam, Loewenstein, Silberman, & Post, 1984; Ross, 1987, 1996; Sakheim, Hess, & Chivas, 1988; Seidel, Gusman, & Abueg, 1994; Solt, Chen, & Roy, 1996). Only in the past 5 years have programs been systematically surveyed and assessed as to their treatment components and techniques. Two such studies are available. The most comprehensive survey of inpatient programs for the treatment of adult survivors of sexual abuse (n = 22, out of a total of 70 programs identified and contacted) was published by the Safer Society Press (Bear, 1993). This survey, which relied on a convenience sample of program directors who chose to respond to a detailed questionnaire, is therefore not necessarily a representative sample. It is likely that the results are already outdated, because many of the surveyed programs have closed due to market demands and changes; nevertheless, the document provides useful descriptions of program components that defined the treatment model and are likely to apply to existing programs, and are therefore of interest in this review.

In the VA, a comprehensive assessment of program structure, content, and social climate in specialized residential PTSD programs (n = 19) was conducted in 1991 to determine whether they differed from general psychiatric units (n = 18) (Johnson, Rosenheck, & Fontana, 1997). The content and structure of each type of unit were defined by the program directors, and the social climate was assessed by veteran/patients with a PTSD diagnosis. A review of inpatient treatment for war-related PTSD over the course of 20 years was published by Johnson and colleagues (1996) and Rosenheck, Fontana, and Errara (1997).

The findings of both studies emphasized this type of specialized treatment program’s relative newness and rarity, and its distinctiveness from more general psychiatric units. Most programs operate as discrete units, although some are a specialized part (or treatment track) of a more generic unit. The data generated by both studies are used here to describe the program components and techniques most likely to be incorporated in inpatient PTSD programs. By and large, this multimodal treatment model is provided by a multidisciplinary team (psychiatrists, clinical nurse specialists and nursing staff; psychologists, clinical social workers, counselors, expressive arts therapists, occupational and recreational therapists). As noted earlier, this model uses the trauma-based approach as a philosophical foundation to elaborate the concept of the therapeutic milieu as a major part of what differentiates it from the more general psychiatric unit. This orientation stresses the concept of “social healing for social wounds” (Bloom, 1997) and recognizes the critical role of the therapeutic community of peers in offering support to counteract the effects of interpersonal victimization and traumatization. Within the community, patients have the opportunity to be with others who have had similar traumatic experiences and posttraumatic aftereffects in a context that is normalizing, instructive, and supportive. The therapeutic milieu also offers the context for learning new coping and relationship skills, and for reworking some of the problematic interpersonal issues that are so often a consequence of traumatic injury suffered at the hands of other human beings or within institutions.

In specialized programs, attempts are made to provide an intensive therapeutic milieu that, first of all, is physically as well as emotionally safe for its members, all of whom are admitted on a voluntary basis. Clear expectations exist about participation and boundaries, about what is acceptable behavior and what is not. Aggression and violence toward self or others (including staff) are expressly not allowed and the admission is contingent on the agreement to interact safely and without aggression and violence. Violations and boundary testing are quite common, however, and are to be expected in a subset of traumatized individuals. Aggression toward self or others is often part of the posttraumatic aftermath that, paradoxically, may occur in the interest of personal safety and self-soothing. When such safety violations occur in a treatment setting, they must be handled promptly, firmly, and decisively by staff, lest they compromise the safety of all and the integrity of the community and the treatment team (Bills & Bloom, 1998).

Patients are expected to take personal responsibility for their behavior and to attempt to substitute healthier coping skills (that are actively taught to them as part of the treatment, as described later) when they experience compulsive, self-destructive, and/or violent urges. Social safety in the context of the community is also stressed and actively worked on in these programs. Patients are taught about dysfunctional interpersonal behavior that has been found to be associated with traumatization (i.e., common boundary and interaction difficulties; the roles of victim, victimizer, rescuer, and bystander, and reenactment dynamics) and taught new, more assertive, functional, and empowered ways of interacting with others.

To summarize the predominant program structure: The milieu is designed to be predictable, safe, nonrigid and nonauthoritarian, and community-based. It is respectful of the patient, encourages personal empowerment and communal responsibility, collaborative treatment, and clear and open patient-to-patient and patient-to-staff communication. In some programs (VA programs in particular), staff members themselves are trauma survivors.
who have worked through the effects of their combat experience, a situation that may give them additional credibility with patients while offering them hope for their own recovery. In contrast, the personal trauma history of staff members in adult abuse survivor programs is not as explicitly acknowledged to the patient population.

Some programs have selective admission criteria, most having more to do with the patient's ability to function safely within a therapeutic community than with specific diagnostic criteria. Most programs require voluntary admission (some units are open and unlocked, although most are locked) and a suspected or diagnosed posttraumatic condition (in addition to comorbid conditions and other diagnoses). The most common comorbid Axis I diagnoses are major depression, anxiety disorders, alcohol/substance abuse, eating disorders, somatization disorder, dissociative disorders, atypical psychosis, and intermittent explosive disorder. Consistent with the established connection between trauma and personality disorders (Ellason, Ross, Sainton, & Mayran, 1996; Herman, Perry, & van der Kolk, 1989; Perry, Herman, van der Kolk, & Hoke, 1990; Sabo, 1997), many patients are diagnosed with Axis II disorders, most commonly, borderline, obsessive-compulsive, avoidant, dependent, paranoid, self-defeating, antisocial, and mixed types. Axis III medical conditions are common sequelae for many traumatized patients, since a past history of physical and sexual abuse, and other forms of traumatization have all been correlated with major health consequences (Davidson, Hughes, Blazer, & George, 1991; Friedman & Schnurr, 1995). Patients may also enter treatment due to significant and ongoing psychosocial stressors such as homelessness, unemployment, continued exposure to violence, episodes of revictimization, and so on.

VA programs are obviously open to all veterans who qualify but Johnson, Rosenheck, and Fontana (1997) found that specialized units had stronger external boundaries than more general units and were more likely to screen patients before admission, control admissions, admit in cohort groups for defined lengths of stay, and maintain waiting lists. Bear (1993) reported much less consistency and wide variation in the steps of the admission process among the various adult abuse survivor programs included in her survey. Most of these programs were housed in private, for-profit hospital chains, making it difficult, if not impossible, for destitute adult survivors without some sort of insurance to participate. Some attempts have been made recently, with some gratifying results, to introduce trauma-based programming into general units of state hospital systems serving a mixed treatment population (Bills & Bloom, 1998), but this kind of approach requires ongoing and consistent leadership that can be difficult to maintain in financially stressed hospital systems. (However, at the present time, both New York and Maine are planning and implementing trauma-based programmatic emphases into their respective state mental health systems, including inpatient units.)

The trauma-based understanding that is found in specialized programs is evident from the time of initial evaluation and admission, when the emphasis is on "What happened to you?" as opposed to "What's wrong with you?" (Bloom, 1994). Yet, even with this emphasis, the necessity for a comprehensive multidisciplinary evaluation is recognized. Chronically traumatized patients have complex clinical conditions. Some symptoms and disorders have been found to mimic or obscure others (e.g., PTSD symptoms overlap with symptoms of other psychiatric and medical diagnoses) in ways that make differential diagnosis difficult and misdiagnosis common. Assessment in specialized programs, in contrast to assessment in general units, is more likely to incorporate questions and objective psychometric instruments that assess traumatic experiences and trauma symptoms to assist in differential diagnosis. Conversely, specialized programs may be better able to ascertain if patients have primary diagnoses that are not trauma-related, such as cases of complex comorbid, hysteria, or malingering.

The treatment offered in specialty programs is transtheoretical and multimodal. No single theory of therapy is primary, although psychodynamic and cognitive-behavioral perspectives are at the foundation of most, if not all, of the programs. Techniques and strategies are drawn predominantly from the following: insight/self-discovery, posttraumatic stress, cognitive-behavioral (including anxiety management strategies), psychodynamic, and psychosociocultural treatment models. Cognitive-behavioral approaches include structured psychoeducation about trauma and the normal human response to traumatization. Specialized approaches focus on the identification of feelings, emotional expression and debriefing, anxiety management, cognitive restructuring, imaginal flooding techniques, exposure and desensitization, skills training, behavior modification, and relapse prevention. (In some programs, newly developed techniques such as eye movement desensitization and reprocessing [EMDR] are being utilized.) Hypnosis and guided imagery may be used in some programs for the purposes of ego strengthening and self-soothing but are not used or recommended for either memory retrieval or abreaction. Expressive therapies are critical components of inpatient trauma treatment, since they provide patients with a safe way of expressing the nonverbal and emotionally charged aspects of their experience, while providing them with tools they can continue to use after discharge. A variety of expressive/creative therapies, including art, psychodrama, poetry/writing, video, and movement/dance, are utilized in different programs in recognition of the difficulty that some traumatized individuals have in verbalizing their experiences. In some programs, field trips and other off-unit activities are included, since they provide excellent opportunities for the rehearsal of developing skills. Unfortunately, activities of this sort are not in keeping with managed care limitations, so they are rarely utilized anymore.

Optimally, treatment planning occurs very early in the admission and with the patient's collaboration. Both VA and adult abuse survivor programs
stress an intensive treatment milieu that fosters the patient's personal responsibility and active participation. Most programs are highly structured and include some combination of the following in addition to a preliminary multidisciplinary psychosocial assessment: individual therapy (daily or several times per week); several group experiences per day (including community meetings, group therapy, didactic and skills-building groups, expressive therapy, and occupational/recreational therapy groups); psychopharmacology; case management and social work services; attendance at 12-step meetings (as warranted), and, couple and family meetings and therapy sessions. Moreover, in many programs, active efforts are made to closely coordinate treatment goals with the outpatient provider to avoid precipitating splits between providers and to provide the patient with consistency in the transition back to the outpatient setting. Since this population is so complex and demanding, management of acute episodes in the outpatient setting can be quite difficult. Inpatient hospitalization often provides the outpatient therapist with the opportunity for specialized professional input and consultation that is usually unavailable in the outpatient setting. Planning for discharge begins almost immediately upon admission to emphasize to the patient that the length of stay is relatively short and that he or she must settle in and work immediately, because the return to residential or outpatient treatment is imminent.

To summarize, inpatient treatment is a vital, often life saving part of a complete continuum of care, particularly when used as a short-term and limited part of an individual's overall treatment, most of which is expected to occur in an outpatient setting. Many of the programs have evolved to become more comprehensive in their approaches due to the chronicity and corresponding complexity of the needs of this patient population. Additionally, although many programs emphasize reentry into mainstream life, many also recognize that the needs of these patients may be lifelong and episodic, and so they have devised more residential and outpatient treatment modalities, where the bulk of the treatment is expected to occur. Table 10.1 summarizes many of the components of specialized inpatient PTSD programs that differentiate them from general psychiatric units.

A limited number of empirical investigations of inpatient programs have been undertaken to date and others are underway. We next describe the completed studies.

**METHOD OF COLLECTING DATA**

The data for the following review of the empirical literature were collected in two ways. The first involved a comprehensive literature search of the PILOTS, MEDLINE, and PsycINFO databases of studies published through spring 1999. The second involved a request for data from directors of inpatient trauma programs. Many of the papers identified in the literature

<table>
<thead>
<tr>
<th>Admission criteria</th>
<th>Treatments offered</th>
<th>Outcome goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis/severe stressors</td>
<td>Multidisciplinary assessment</td>
<td>Stabilization of precipitating crisis</td>
</tr>
<tr>
<td>Harm to self and others</td>
<td>Psychological testing (as ordered)</td>
<td>Lessening of stressors</td>
</tr>
<tr>
<td>Decompensation</td>
<td>Adjunctive assessment (as ordered)</td>
<td>Personal and social safety</td>
</tr>
<tr>
<td>Inability to function</td>
<td>Nursing</td>
<td>Lessening of symptoms</td>
</tr>
<tr>
<td>Psychiatric conditions and diagnoses</td>
<td>Psychopharmacology</td>
<td>Increase in functioning</td>
</tr>
<tr>
<td></td>
<td>Social work and case management</td>
<td>Discharge to outpatient treatment</td>
</tr>
<tr>
<td></td>
<td>Group treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual therapy (some units)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General cognitive-behavioral interventions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expressive therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational/recreational therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Couple/family education/consultation/treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collaboration with outpatient providers</td>
<td></td>
</tr>
</tbody>
</table>

**Specialized unit**

<table>
<thead>
<tr>
<th>Admission criteria</th>
<th>Treatments offered</th>
<th>Outcome goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis/severe stressors</td>
<td>Multidisciplinary assessment</td>
<td>Stabilization of precipitating crisis</td>
</tr>
<tr>
<td>Harm to self and others</td>
<td>Psychological testing (as ordered)</td>
<td>Lessening of stressors</td>
</tr>
<tr>
<td>Decompensation</td>
<td>Adjunctive assessment (as ordered)</td>
<td>Personal and social safety</td>
</tr>
<tr>
<td>Inability to function</td>
<td>Specialized philosophy for all interventions/specialized staff training/psychotherapy orientation: “What happened to you?” versus “What’s wrong with you?” “Social healing for social wounds” Posttraumatic understanding of symptoms Social and personal safety Personal empowerment Nursing</td>
<td></td>
</tr>
<tr>
<td>More selective admission and ability to select: PTSD symptoms/diagnosis</td>
<td>Psychopharmacology</td>
<td></td>
</tr>
<tr>
<td>Willingness to be safe on the unit</td>
<td>Social work and case management</td>
<td></td>
</tr>
<tr>
<td>Willingness to participate in the milieu and in the treatment process</td>
<td>Milieu treatment</td>
<td></td>
</tr>
<tr>
<td>Willingness to discuss trauma with others</td>
<td>Group treatment</td>
<td></td>
</tr>
<tr>
<td>Willingness to wait for opening on unit and/or for cohort group to form</td>
<td>Individual treatment (many programs)</td>
<td></td>
</tr>
<tr>
<td>Stronger external boundaries to the rest of the hospital</td>
<td>Specialized and general cognitive-behavioral interventions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focused expressive therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational/recreational therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Couple/family/education/consultation/treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collaboration with outpatient providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialized techniques, by program</td>
<td></td>
</tr>
</tbody>
</table>
search were descriptive; however, several available outcome studies (most conducted within the VA) are reviewed in the next section.

**SUMMARY OF LITERATURE**

The studies reported here, with several exceptions, attempted to investigate the efficacy of the entire treatment program versus program components. A problem is immediately evident in studies of milieu therapy: defining a specific technique and attempting to study the impact of that technique separate from the impact of other techniques and the general influence of the therapeutic community itself. Milieu therapy, rather than being a discrete and separate technique, is actually a setting within which specific and nonspecific techniques are integrated and delivered. Moos's (1974) work on evaluating treatment environments has demonstrated that a consistent treatment philosophy maintains environmental stability over time; therefore, the philosophical underpinning of a program based on trauma may have a large—and difficult to measure—influence on treatment outcome. An additional challenge to the evaluation of a program's overall effectiveness comes from admissions that are crisis-driven versus those that occur on a planned basis. They, too, may result in changes that are difficult to measure (i.e., other crises such as deaths or serious injuries that were averted or prevented by the hospitalization). Despite various difficulties of this sort that can confound evaluation efforts, a number of studies have researched entire programs and specific program components.

Next, we review the available studies, categorized into the two main program types: those for combat veterans and those for adult abuse survivors.

**Empirical Studies**

**Level A**

No randomized control study of the efficacy of inpatient treatment for veterans or adult abuse survivors is currently available.

**Levels B and C**

Evidence from well-designed clinical studies without randomization or placebo comparison for individuals with PTSD (Level B) and from service and naturalistic clinical studies, combined with clinical observations that are sufficiently compelling to warrant use of the treatment technique or recommendation (Level C), is as follows:

1. **Veterans**. Thirteen studies have been identified (6 at Level B and 7 at Level C) and are listed in Table 10.2. All involve convenience samples of

<table>
<thead>
<tr>
<th>Study and rating</th>
<th>Program type and length</th>
<th>Study purpose</th>
<th>Long-term outcomes</th>
<th>Findings and effect size</th>
<th>Control and follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumstance-Matching (C)</td>
<td>Australian</td>
<td>To study treatment outcome in combat veterans</td>
<td>18 month follow-up</td>
<td>Little evidence of relapse or reemergence compared with baseline</td>
<td>No control, 6 mo follow-up</td>
</tr>
<tr>
<td>Matters of Life (M)</td>
<td>Vietnam</td>
<td>To study the effectiveness of a group treatment program</td>
<td>6 mo follow-up</td>
<td>Significant improvement in PTSD symptoms and social functioning</td>
<td>No control, 6 mo follow-up</td>
</tr>
<tr>
<td>Fish &amp; Lilac (F)</td>
<td>Vietnam</td>
<td>To study the impact of a group treatment program on PTSD and social functioning</td>
<td>6 mo follow-up</td>
<td>Little evidence of relapse or reemergence compared with baseline</td>
<td>No control, 6 mo follow-up</td>
</tr>
<tr>
<td>Johnson et al. (J)</td>
<td>Vietnam</td>
<td>To study the impact of a group treatment program on PTSD and social functioning</td>
<td>6 mo follow-up</td>
<td>Little evidence of relapse or reemergence compared with baseline</td>
<td>No control, 6 mo follow-up</td>
</tr>
<tr>
<td>Study and rating</td>
<td>N</td>
<td>Subjects</td>
<td>Program type and length</td>
<td>Study purpose</td>
<td>Control and follow-up</td>
</tr>
<tr>
<td>------------------</td>
<td>----</td>
<td>----------</td>
<td>-------------------------</td>
<td>---------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Ragsdale, Cox, Finn, &amp; Eisler (1996) B</td>
<td>24</td>
<td>Vietnam vets</td>
<td>Short-term</td>
<td>To study outcome of treatment in a short-term intensive inpatient program versus weekly outpatient group therapy.</td>
<td>Control group of wait-list veterans in outpatient group therapy. No follow-up</td>
</tr>
<tr>
<td>Hammarberg &amp; Silver (1994) B</td>
<td>39</td>
<td>Vets</td>
<td>Long-term</td>
<td>To track patient from admission to discharge (90 days) and to compare with two control groups: (1) PTSD vegetative out of treatment and (2) non-PTSD non-treatment (over 12 wk).</td>
<td>Two control groups 1-year follow-up of treatment completers</td>
</tr>
<tr>
<td>Munley, Bains, Frazier, &amp; Schwartz (1994) B</td>
<td>14 and 35</td>
<td>Vietnam vets</td>
<td>Short-term</td>
<td>To study if there are pretreatment differences between patients who complete versus those who do not complete a specialized inpatient PTSD program, and between completers and noncompleters rated by their therapists as having the highest versus lowest ratings on overall response to treatment.</td>
<td>Random sample of treatment completers vs. treatment dropouts ($n = 14$) and highest vs. lowest therapist ratings ($n = 35$) No follow-up</td>
</tr>
<tr>
<td>Funari, Pickenski, &amp; Sherwood (1991) C</td>
<td>45</td>
<td>Vietnam vets</td>
<td>Long-term</td>
<td>To study changes on the Millon Clinical Multiaxial Inventory in completers of a specialized inpatient treatment program.</td>
<td>No control No follow-up</td>
</tr>
<tr>
<td>Boudeyns, Hyer, Woods, Harrison, &amp; McCranie (1990) C</td>
<td>58</td>
<td>Vietnam vets</td>
<td>Long-term</td>
<td>To study any pretreatment differences between successful and unsuccessful outcome after inpatient treatment on a specialized unit and to study whether those treated with direct exposure therapy (DET) have better treatment outcomes than those treated with standard treatment (ST).</td>
<td>No control 3-mo follow-up: DET versus ST (random assignment)</td>
</tr>
<tr>
<td>Scurfield, Kenderdine, &amp; Pollard (1990) C</td>
<td>86</td>
<td>War zone veterans</td>
<td>Long-term</td>
<td>To establish a baseline of clinical data on application to the specialized inpatient program versus post-discharge follow-up.</td>
<td>No control 4- to 16-mo postdischarge follow-up</td>
</tr>
<tr>
<td>Starkey &amp; Ashlock (1984, 1986) C</td>
<td>5</td>
<td>Vietnam vets</td>
<td>Short-term</td>
<td>To determine pre- and posttest scores on the MMPI and Post-Vietnam Stress Index (PVS).</td>
<td>No control No follow-up</td>
</tr>
<tr>
<td>Bills &amp; Bloom (1998) C</td>
<td>24</td>
<td>Inpatients in a state hospital ward</td>
<td>Long-term</td>
<td>To determine change in minutes of seclusion/restraint per mo and self-harm, aggressive, and accident episodes per mo after implementation of Sanctuary® model general and safety interventions.</td>
<td>No control No follow-up</td>
</tr>
</tbody>
</table>

(continued)
### TABLE 10.2. (continued)

<table>
<thead>
<tr>
<th>Study and rating</th>
<th>N</th>
<th>Subjects</th>
<th>Program type and length</th>
<th>Study purpose</th>
<th>Control and follow-up</th>
<th>Findings and effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ross (1997)</td>
<td>134</td>
<td>Adult survivors of childhood trauma with PTSD diagnosis</td>
<td>Long-term</td>
<td>To evaluate whether differences in DSM-IV personality clusters as assessed by MMPI-2 affect outcome for a 6-wk specialized unit for adult survivors of childhood trauma.</td>
<td>No control 3-mo and 1-yr follow-up</td>
<td>Data indicated the program was effective in reducing PTSD and associated symptoms at discharge. Personality type not found to influence treatment gains.</td>
</tr>
<tr>
<td>Wright &amp; Woo (1997)</td>
<td>134</td>
<td>Adult survivors of childhood trauma and PTSD diagnosis</td>
<td>Long-term</td>
<td>To study the outcomes of adult survivors of childhood trauma who enter a 6-wk specialized unit for adult survivors of childhood trauma.</td>
<td>No control 3-mo and 1-yr follow-up</td>
<td>At discharge, frequency and intensity of symptoms did not meet threshold for PTSD diagnosis or for frequency and intensity of symptom clusters B, C, and D. Overall symptom frequency and intensity ratings significantly decreased although declines in gains were also identified at follow-up.</td>
</tr>
<tr>
<td>Ellason &amp; Ross (1997)</td>
<td>54</td>
<td>Adults with DID</td>
<td>Unknown</td>
<td>To study treatment outcome in DID patients following treatment in a specialized PTSD/DID inpatient program.</td>
<td>No control 2 yrs</td>
<td>Patients showed marked improvement in SRF-S and SSS, symptoms of depression, and anxiety disorders. Psychological measures of symptoms did not meet threshold for PTSD diagnosis or for frequency of symptom clusters B, C, and D. Overall symptom frequency and intensity ratings significantly decreased although declines in gains were also identified at follow-up.</td>
</tr>
</tbody>
</table>

---

3 utilized PTSD, treated in a specialty or general psychiatric unit. Only 4 studies met criteria for inclusion. In these studies, PTSD and social functioning at admission and discharge were measured using standardized psychological instruments. The studies included 118 patients, and data were analyzed using a mixed-effects model. The analysis included a total of 118 patients, with 58 patients in the treatment group and 54 patients in the control group. The results indicated a significant improvement in PTSD symptoms and social functioning for the treatment group compared to the control group. The effect size was 0.8, indicating a large effect. The follow-up period was 6 months, with data collected at baseline, 3 months, and 6 months. The results were consistent across the follow-up period, with a significant improvement in PTSD symptoms and social functioning for the treatment group compared to the control group. The findings were consistent with previous research, suggesting that treatment for PTSD in a specialty or general psychiatric unit is effective in improving PTSD symptoms and social functioning.
indices" (p. 547). These authors were explicit in their agreement with Johnson and colleagues (1996) that long-term inpatient PTSD treatment should not be seen as the certain and only approach to the rehabilitation of chronic PTSD, and that many patients may be better served by ongoing outpatient, residential, or community-based care that promotes community reintegration (à la "second generation" and secondary trauma conceptual models) and selected interventions (see Rogers [1998] for a critique of this model and additional suggestions for treatment strategies and research). Following this line of reasoning, inpatient admissions would be reserved for serious remissions, crises, and intensive evaluation and/or treatment efforts with interventions tailored to the individual's needs at the time of admission. The findings of the study of a 12-week inpatient–outpatient treatment program for Australian Vietnam veterans (Creamer & Morris, 1997; Creamer, Morris, Biddle, & Elliott, 1999) also supported the use of a short inpatient stay with outpatient follow-up as a better option than traditional long-stay programs. The findings of this study indicated highly variable treatment gains, with considerable pathology remaining at completion of the therapeutic programs.

In contrast to these findings concerning the treatment of traumatized veterans, it is impossible to draw any definitive data-based conclusions about the treatment of adult survivors of childhood abuse due to a dearth of outcome studies and data. Ellason and Ross's (1997) study of the treatment of patients diagnosed with dissociative identity disorder (DID) is of significance because it found positive treatment outcome (marked improvement on Schneiderian first-rank symptoms, mood and anxiety disorders, dissociative symptoms, and somatization, with a significant decrease in the number of psychiatric medications prescribed). In this study, patients treated to the point of personality integration were significantly more improved than those who had not yet reached integration; however, the inpatient treatment model, or its possible impact on the findings, is not discussed in the article. Thus, it is unclear what techniques or mechanisms (including other inpatient and outpatient treatment in the intervening 2 years from discharge to follow-up assessment) accounted for the treatment gain. Bills and Bloom's (1998) findings involved a tabulation of a decline in the number of violent incidents and number of minutes of restraint/seclusion used per month following the implementation of a Sanctuary® model program stressing safety agreements and a secure environment in a state hospital unit. Their findings highlight the importance of a nonretraumatizing environment to personal recovery from traumatic stress disorders. Wright, Woo, and Ross (1996) and Wright and Woo (1997), in the most methodologically sound study of adult survivors to date, reported significant decreases in intensity and frequency of PTSD and associated symptoms, 1-year postdischarge from a 6-week traumatic stress program for self-identified survivors of childhood trauma. The program was organized around a strategy of stabilization and a present-centered focus versus a past-oriented cathartic traumatic recollection strategy. Thus, these findings are similar to those of the veteran samples. The authors highlight the significance of their findings in light of the fact that one-third of the study population met criteria for the diagnosis of borderline personality disorder in addition to the diagnosis of PTSD. Another component of this study examined whether differences in DSM-IV personality clusters as assessed by the Minnesota Multiphasic Personality Inventory—2 (MMPI-2) affected treatment gains for program participants. When findings from instruments measuring PTSD and associated symptoms were compared with MMPI-2 personality clusters, no significant differences were found between personality subtype and treatment gains. Results suggested that personality type did not influence treatment gains (Ross, 1997).

**Clinical Studies**

**Levels C, D, E, and F**

Evidence based on naturalistic and clinical studies (Level C), long-standing and widespread clinical practice (Level D), long-standing practice by circumscribed groups of clinicians not subjected to empirical tests (Level E), and recently developed treatment not subjected to clinical or empirical tests in PTSD (Level F) is as follows:

1. **Veterans.** Several studies (included in Table 10.2) and anecdotal articles have been identified that describe and assess the philosophical orientation, structure, content, and perceived social climate of specialized inpatient treatment for PTSD. These provide descriptions of how specialized programs differ from generic psychiatric units, as described previously.

2. **Adult abuse survivors.** A number of individual program descriptions are available that delineate the similarities in philosophical orientation to treatment and milieu management in both specialized inpatient treatment programs for adult survivors of sexual abuse and specialty units for the treatment of patients diagnosed with multiple personality disorder (now dissociative identity disorder). Many write-ups describe special elements and emphases of the program and how they seem to impact the patients and the management of the milieu. As described earlier, the survey of treatment programs for adult abuse survivors conducted by the Safer Society (Bear, 1993) provided the most comprehensive data to date. That report specifically highlighted the dearth of outcome research and data at that time, a situation that, unfortunately, is not very different today.

**SUMMARY**

Outcome research on specialized inpatient trauma treatment is more developed and more available for programs housed in the VA that treat combat
veterans than for programs in freestanding hospitals that treat adult abuse survivors. Although the available findings have value and suggest directions for program design and modification, they are only preliminary and are not strong. Additional outcome studies that use more rigorous methodology involving randomization, control groups, and long-term follow-up are sorely needed.

It is recognized, however, that the very characteristics of inpatient treatment make assessment difficult and call for creative research solutions. Inpatient trauma treatment can best be viewed as a “metotherapy,” the provision of a safe and health-promoting context, rather than one specific modality. Inpatient PTSD treatment integrates a posttraumatic perspective with various therapeutic modalities that have been demonstrated to be effective into an overall coordinated treatment plan conducted in a stable, nonviolent environment. When most effective, a coherent system of meaning can emerge from the therapeutic milieu that helps the patient to restore a sense of social connection and purpose. The complex and rich nature of this treatment can provide an opportunity for the rapid acquisition of new knowledge and skills, but it is this complexity that makes careful quantitative research so difficult and so scarce. Prolonged, chronic PTSD is a complicated (and, in some cases, difficult and resistant) disorder to treat; it has a host of associated comorbid disorders and medical conditions that must be given treatment consideration.

The risk of suicide and other behaviors that are destructive to self and others is very high in this population and often necessitates hospitalization.

Available research findings to date regarding cost, effectiveness, and satisfaction generally suggest specialized programs of 2- to 12-weeks’ duration as the inpatient option of choice for the treatment of chronic PTSD. Within a structured inpatient setting, it is possible to provide the patient with a coherent cognitive framework within which treatment can be planned and carefully orchestrated in stages. The first stage of treatment in any inpatient setting is the establishment of safety, and this step usually dominates specialized PTSD treatment today. In this model, validating and understanding the past are considered to be important, while attempts to treat prolonged PTSD by revisiting the trauma without first establishing safety are recognized to be potentially harmful. The “second-generation” approach of carefully sequenced multimodal milieu treatment in a context of personal and social safety with a present and future orientation is recommended as the model of choice. It is recognized that, whatever the program, most inpatient treatment encompasses the tasks of Phase 1 of the posttrauma treatment model. Psychopharmacology is an important component of inpatient care and the management of distressing symptoms, although medication alone has not been demonstrated to be effective in the treatment of trauma-related disorders.

Findings of available studies suggest the need for careful assessment and treatment planning, with differential goals and treatment strategies determined by the individual’s object relations, ego strength and self-capacity, pre-

and posttrauma risk and resiliency factors, severity of symptoms, degree of social connection, and level of functioning and disability. Inpatient treatment should be considered when the individual is in imminent danger of harming self or others, has decompensated or relapsed significantly in the ability to function, is suffering from debilitating symptoms of PTSD and/or comorbid diagnoses, is in the throes of major psychosocial stressors, and/or is in need of specialized observation/evaluation in a secure environment. It is contraindicated for individuals who are unwilling or unable to participate in milieu treatment based on a posttrauma treatment model, for those who are actively psychotic and/or characterologically impaired to such a degree that they are unable or unwilling to maintain safety within the therapeutic context, and for those who have life-threatening conditions (e.g., substance abuse, eating disorders) that require preliminary stabilization.

A shorter-term model of inpatient PTSD treatment (ranging anywhere from 2 to 12 weeks’ duration) has several significant advantages. It assists in and complies with utilization review and cost-containment efforts, and encourages patients to move to a less restrictive (and less regressive) level of care once their crisis and symptoms are stabilized. It operates in collaboration with the patient’s outpatient provider(s) and functions as one component (albeit a very crucial one in times of crisis and decompensation) of the continuum of treatment options for chronic trauma survivors. It responds to the long-term treatment needs of patients with chronic PTSD and associated comorbid and medical conditions by anticipating the need for episodic intensive treatment in a secure environment. Within the environment, it provides to the traumatized patient a philosophy and tailored treatment model that is not usually available on more general units. This orientation assures that the traumatic origin of the patient’s difficulties and pathology is not ignored, yet it has a whole-person focus that extends beyond the traumatization. A focus on the past trauma is only in the interest of the future, to a life less encumbered by the trauma or what Shalev (1997) labeled “healing forward.”

REFERENCES


EFFECTIVE TREATMENTS FOR PTSD

Practice Guidelines from the International Society for Traumatic Stress Studies

Edited by
Edna B. Foa
Terence M. Keane
Matthew J. Friedman

THE GUILFORD PRESS
New York  London