

S.E.L.F.:

MAPPING THE COURSE OF RECOVERY¹

JOSEPH F. FODERARO, LCSW

RUTH ANN RYAN, MSN

WWW.SANCTUARYWEB.COM

The Sanctuary Programs address the specific clinical needs of children who have been profoundly injured through some form of physical, sexual or psychological trauma/or abuse. Trauma can have a long-term devastating impact upon survivors, and much of this impact is disruptive to the continued social functioning of the individual (Bloom, 1997). Because of the social disconnection that survivors exhibit, Sanctuary emphasises the therapeutic milieu's importance in communicating the necessary lessons and examples a child needs to construct a lifestyle that is less identified exclusively with a traumatic event. Sanctuary represents a social experiment for children who have been severely developmentally damaged psychologically, socially and existentially. Sanctuary offers, in addition to psychiatric and medical care, an opportunity for all participants to engage in a social exercise in which new ways of accessing and containing emotion are practised. The program employs group and individual clinical modalities in ways that are designed to teach, encourage, entice and protect people who are engaged in personal journeys of recovery.

A group of senior clinicians in the original Sanctuary program for adults set out to design a framework for use by clinicians and clients alike that would enable us to bring into focus the critical elements which needed to be addressed to effect recovery from trauma. Our goal was to design a program that would assist those engaged in trauma recovery work to stop repeating old and destructive patterns of behavior and to aim toward the goal of a life of choice and empowerment. We needed to create a model that could be easily understood, rapidly taught, and simply replicated. This model needed to provide a flexible map of recovery that children could use during their inpatient stay and continue to utilize in whatever outpatient setting(s) they pursued. This led to the development of the S.E.L.F. Model of Recovery.

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S.E.L.F. = SAFETY, EMOTIONAL MANAGEMENT, LOSS, FUTURE

The S.E.L.F. model of recovery has been in use in Sanctuary programs for the last decade in inpatient, residential, outpatient, and shelter settings. S.E.L.F. is an acronym for Safety, Emotions, Loss and Future. These reflect the recurrent themes that trauma survivors need to confront in order for healing to occur and are consistent with other staged models of trauma treatment, although S.E.L.F. is less about “stages” and more about critical and recurrent tasks of recovery (Herman, 1992; Janet, 1976). Given the complicated and multi-tiered nature of the effects of trauma, we needed to find a clear, concise, and easily applied model that could be understood and utilised by clinicians and clients alike. S.E.L.F. is designed to be used in both inpatient and outpatient settings to distil complex theoretical tenets of trauma and recovery into a practical road map that children can follow with their outpatient therapist. This map begins with the establishment of safety and ends with the individual feeling the empowerment that comes with being emancipated from the tyranny of the past.

The process of S.E.L.F. is not so much linear as it is spiral. Children achieve one level of safety, move on to become better at managing emotion, confront the loss that remains unresolved about those particular issues, and then experience an increase in personal freedom and empowerment, only to come to the next safety issue on their recovery map. When they come onto the program, the safety issues focus on physical safety. Over time, issues of psychological, social, and moral safety become more dominant, but the same recovery cycle is followed throughout every new turn on the spiral.

The children are taught the S.E.L.F. Model from the time they begin treatment through direct one-to-one education and through formal psychoeducational groups. The initial assessment and treatment planning process use S.E.L.F. as a way of looking at the child’s immediate problems and strategizing how to best help them make progress. Every progress notes reflects this S.E.L.F. evaluation, reviewing how the child is making progress through each one of the stages.

SAFETY

Safety has always been a fundamental construct upon which all other clinical goals must be based. Our ideas of safety reflect the four kinds of safety that we recognize: physical, psychological, social and moral safety. Without some reasonable assurance that one’s physical safety can be protected, higher-order psychological gains are easily disrupted or quickly lost.

This first step is the most important and fundamental of all of the S.E.L.F. steps. A child must be carefully assessed regarding his/her safety. The issue of safety is broadly defined. It includes not only interpersonal but intrapersonal safety and safety within the entire social community. Behaviors such as self-mutilation or aggressive acting-out are obviously unsafe for the individual and negatively impact the entire community, while sexually addictive behaviors are unsafe both for the individual and the other members of the community. Suicidal and homicidal behaviors are carefully evaluated and specific protocols for self-mutilation, suicidality, and homicidality have been established. The safety of every child that enters the program has become compromised in some way. For many children, the achievement of safety dominates the entire residential stay. For others, the structure of the residential setting rapidly restores them to a level of safety that allows them to more effectively deal with issues of Emotional Management or Loss.

When children first enter the program, safety issues are the greatest concerns and a level system that reflects these concerns and is tied to the S.E.L.F. Model has been developed. Very concrete questions must be addressed by both child and staff - Is the child able to take care of his/her activities of daily living? Is the child communicating with other members of the community? Has the child created a "5-Step Safety Plan"? The 5-Step Safety Plan describes a series of behaviors the child will engage in when he or she is not feeling safe in order to get the help they need to control the self-destructive behavior.

This concrete cognitive-behavioral strategy, set within a much broader and more abstract theoretical system of meaning and values related to the therapeutic community has been enormously helpful in reducing the level of harmful behaviors in the therapeutic setting and dramatically reducing the level of restraint necessary.

Ann is a 15 year old child from a working class, alcoholic family. Both parents have severe substance abuse problems that have lasted throughout Ariel's life. Her father began an incestuous relationship with her when she was six. She also experienced severe physical violence as both victim and witness in her family of origin. She has been psychiatrically hospitalised on numerous occasions starting in late childhood and has been diagnosed as suffering from schizoaffective disorder as well as post-traumatic stress disorder.

When she was first admitted, Ann was very symptomatic, frequently self-mutilated, bingeing and purging and was actively suicidal. She was admitted to the program and a S.E.L.F. Assessment was performed. She was suffering from a thought disorder, characterized largely by paranoid ideation, as well as experiencing the intrusive symptoms of

PTSD. It was clear that major safety issues were current in her clinical picture. She agreed to contract with us for safety and was given the Self-Harm protocol and instructed to begin work on a Five-Step Safety Plan. She was rapidly integrated into the community and began the process of re-education by beginning to participate in community meetings, creative therapies groups, and psychoeducational activities. It also was clear that medication would be a critical adjunct to her care and her medications were adjusted to reflect the increased level of regression. Specific behaviors were targeted: self-mutilation, binge eating, purging and the suicidal thoughts. As with other children, Ann was assigned a level – Supervised – that reflects the S stage of S.E.L.F. and requires a higher level of monitoring and attention from staff and other children. Ann's behavior shifted rapidly under this regimen. She was particularly affected by the notion that her own violence against herself was a moral equivalent to the perpetration that she had experienced at the hands of others. This gave her a strong incentive for finding other options to handle her unmanageable feelings.

EMOTIONAL MANAGEMENT

An exclusive focus on establishing physical safety leads to highly restrictive environments within which safety is maintained through coercion and control rather through learning self-control. Achieving a sense of safety from destructive impulses within oneself and developing an ability to maintain a relatively safe external environment requires new learning, the establishment of self-discipline and self-control, and hope that there is life beyond trauma and mental illness. This can only happen if someone has learned how to manage the overwhelming emotion that is associated with repetitive trauma.

Emotional Management represents some of the most difficult work for anyone recovering from trauma. The powerful biochemical effects of chronic post-traumatic symptoms are most obvious in the alternating hyperarousal and numbing typically associated with PTSD and are often accompanied by flashbacks, nightmares, and dissociative episodes. Children commonly present with difficulties managing aggression, feeling “out of control”, overwhelming anxiety and panic, inability to tolerate any kind of emotional arousal, episodes of loss of memory, and dramatic mood swings (van der Kolk et al, 1996). These underlying difficulties with emotion modulation result in behaviors that result in outside placement: outbursts of rage and violence, revictimization experiences, self-mutilation, suicidal acts, substance abuse and addiction, sexual addictions, risk-taking behaviors, eating disorders. Such behaviors lead to serious relational and school difficulties that serve to create a downward spiral of dysfunction (Bloom, 1997).

The feelings that initially accompanied traumatic events - the fear and anger, and the sadness - are often repressed or dissociated from conscious awareness. The emotions remain hidden while the child repeatedly but unconsciously constructs complicated patterns of reenactment that keep therapy focused on basic issues of safety. Compulsive behavior patterns emerge as efforts to manage the emotion but safety requires that these behaviors be sacrificed in service of recovery. If safety can be reasonably assured, then the emotion becomes available for reconstructive therapeutic work. With this increased availability often comes a sense of overwhelming intensity that accompanies any energy or force that has been too long repressed or denied.

For the sake of simplicity we call the major emotions: “Mad, Glad, Sad, Scared – and Shamed”. Until the child can effectively utilize cognitive and language skills to more clearly articulate their internal emotional state, they are trapped in patterns of behavioral and emotionally-driven storms that are either perceived to be all-encompassing and overwhelming, or conversely, so threatening as to require emotional numbing and disconnection. As a result, childcare workers are usually faced with extremes of emotion, too much, or too little, but rarely appropriate to the context of the perceived threat.

In the S.E.L.F. Model of recovery, Emotional Management is the stage following Safety in which children learn the skills required to more effectively modulate their emotional responses. The identification of the feeling is the first step when learning how to modulate emotion. One of the common accompaniments of chronic trauma is the development of alexythymia – the inability to put feelings into words (Krystal, 1988). Children are taught how to describe their feelings and how to assign values that range from 0 (feeling no anger, sadness, fear, etc.) through 10 (feeling overwhelmed by the emotion). Learning how to recalibrate the “volume control” of emotion is an essential part of learning how to apply an emotionally variable response to different types of problems.

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

After years of being emotionally depleted, disconnected, or overwhelmed, the concomitant use of appropriate medication is often necessary to achieve biological stability. The complex nature of the trauma-related disorders often necessitates the use of unusual combinations of medication requiring careful monitoring and excellent psychopharmacological management. Physiological stability is crucial if the child is to do the necessary reconstructive work in both internal and social/interpersonal spheres. The ability to self-soothe during an emotional storm and the ability to arouse emotion during times of emotional disconnection are both critical elements in the ongoing efforts of the child to learn how to constructively and creatively use the emotional energy that accompanies the therapeutic process. Victims of trauma must also be taught how to manage the dissociative experiences that so often accompany a history of trauma and are a result of the earliest attempts to manage overwhelming emotion. They gradually must assume responsibility for their dissociative experiences and learn how to integrate memory and emotion so that they can remain conscious and utilize all their resources, even when under stress.

Many different therapeutic modalities may be used to help manage emotion. The milieu is designed to be a container for all of the overwhelming emotions that surface once a group of trauma victims begins to work through their traumatic stress. Direct psychoeducational groups deal with emotional education and provide cognitive-behavioral interventions. One-to-one therapy and groups 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 child to focus on the area of Emotional Management that is most problematic for them. Learning anger management is particularly important for many children in residential care since their experience of anger tends to be overwhelming and uncontrollable, a mirror of the uncontrolled rages that they often witnessed. As a result, they tend act-out aggressively or over-control and deny their anger, while taking it out via self-destructive behavior. Some children 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 emotion, 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.

As Ann became able to inhibit her self-destructive behavior and therefore manage her safety issues more adequately, her emotions began to increase. The symptoms of PTSD actually increased, a quite common occurrence once the compulsive behaviors are arrested. She became more hyperaroused and began to have increasingly florid flashbacks that became almost continuous.

She was flooded with memories of the previous traumatic events and experienced an increase in both depression and paranoia. But, at the same time, she was able to share the relief she felt in having some way of understanding these symptoms, now that she was learning about the effects of trauma. She and her therapist worked closely around regulating her medication more effectively so she could get some relief. With the help of the staff and other members of the community, Ann began rehearsing some new ways of coping with the flashbacks including using a journal, talking to other people, participating actively in the groups, drawing her memories in art therapy, and acting out ways of venting her anger at those who had hurt her through the psychodrama groups. As she used these therapeutic modalities she learned that she could gain control over feelings, thoughts, and behaviors that had previously held her in a helpless grip. She began to talk about a future that did not require staying in a residential placement.

LOSS

As safety issues become less predominant, and a degree of emotional stability is achieved, the child is more adequately prepared to address the issues of loss that invariably accompany a life beset by traumatic events. The impact of such loss is enormous. Unresolved grief accompanies unresolved trauma and is an underlying source of many chronic psychiatric symptoms. Many children are arrested at this stage of treatment and unable to move further without a more structured and coherent approach to care. Instead, they stay stuck, fluctuating between failures in maintaining safety and an inability to modulate emotion (Herman, 1992; Jacobs, 1999).

Loss, in the case of a trauma victim, is made difficult by the fact that the loss is often not as tangible as the death of a beloved person. Loss of innocence, of childhood, of a sense of meaning, of hope, of a part of the self, of God, of a potential alternative life or career or love or family, all cause symptoms of unresolved grief without ever achieving the social acceptance of mourning that is so vital for human beings. In its most extreme forms, survivors of early and chronic trauma can lose an entire childhood. Compared to the agonising reliving of this type of loss, loss of life can be seen as a blessing. This helps to explain why so many survivors of trauma gravitate towards chronic suicidality as a reasonable alternative to dealing with the profound sadness and pain that accompanies realisation of the long-term consequences of their particular personal tragedy.

Most world cultures have ritualized standards and customs that facilitate the act of mourning. Some even have a set period during which mourning and social paralysis is expected. However, when addressing issues of physical and sexual abuse, especially in Western cultures, there is an attitude that supports premature closure without processing grief and loss. This attitude is oftentimes

promoted through such platitudes as "let bygones be bygones", or "it happened a long time ago, just get over it", "let sleeping dogs lie", or, most dramatically, "that can't possibly be true!" With such social prohibitions against processing loss, it is little wonder that many survivors of traumatic events as well as the clinicians who treat them, often fail to appreciate the profound impact that loss engenders. Sadness, rage, and fear are all very real and very appropriate reactions to traumatic losses. Such losses can be losses of parts of the self (e.g. physical traumas), losses to one's social support system (e.g. family or even community structures), or losses to one's psychological integrity, such as loss of one's sense of safety and trust of others.

The sadness, rage and fear that accompanies such loss, if not given appropriate structure and context for processing, often leads one to feel emotionally aroused. This level of arousal can lead to a familiar feeling of having a lack of safety, thus perpetuating a cycle of circular therapeutic motions between therapist and child that never seems to be adequately resolved. When therapy is "stuck" it is often because of this arrested grief. The role of the therapist must be to help provide a context within which grief work can be done and to assist in the construction of appropriate ritual passages for the achievement of a completed Loss process. A commitment to the process of mourning and to addressing issues of loss while practising the management of all the emotion that accompanies such loss, is all preparation for the child to do that which is absolutely necessary for "full" recovery. To free oneself from the tyranny of the past means not forgetting the past, but moving on from the past. It means not continuing to live in the past by way of perpetuating past traumas through patterns of reenactments, but learning how to use emotion, rituals, and social and interpersonal resources to facilitate new and creative responses to loss that allow for real transformation to proceed.

Ann was released from residential care with a fairly clear map of recovery and went to live with a loving foster family. She had some idea of what lay ahead for her and knew that therapy was a vital part of promoting her continuing progress. She worked for several months in outpatient therapy and then appeared to regress as the holidays approached, during which time she was going to have to see her family again. She had a brief acute inpatient hospital stay because of suicidal ideation and an increase in depression, though she had been able to forestall the inclination to harm herself. As her therapist began to work with her around this regression in the face of significant therapeutic gains, it became clear that she had indeed been making more sense out of her life, but as a result, she had been hit hard by the reality of her present and past existence. The horrors of her childhood were not something she could no longer avoid by covering up her pain with drugs, by cutting herself or fantasizing about suicide. By beginning to wrestle with the stages of Loss, she started to come to terms with all that she had lost in her life, the terrible price she had paid – and was still paying – for being a member of such a

dysfunctional family. As she did grief work in individual and group therapy and through creative therapies, she began to be able to envision life after trauma.

FUTURE

Such transformative processes can lead to a vision of a different Future. It is important to note that Future is not an idealized end point. Rather, in the course or journey through the recovery process, Future is, instead, the very beginning of a life that allows for real choices to be made. Such choices can now be made with a developing sense of personal empowerment as opposed to a prior assumption that outcomes were dictated by one's traumatic past. The successful management of safety fosters this growing sense of empowerment, emotion and loss accomplished in the preceding phases of S.E.L.F. The child's recognition of personal empowerment is both liberating and challenging for they are then facing an unfamiliar opportunity to manage freedom and create a present and a healthier future. This stage of recovery is characterized by an ongoing process of self-discovery and self-definition accompanied by an evolving sense of mastery. Some children adopt the identity of "thrivers" instead of survivors, people who have learned to transform their personal tragedies into experiences of benefit to themselves and to their society. Future, while providing an opportunity to manage freedom, also presents one with the challenge to engage in responsible choice. Survivors are intimately familiar with the irresponsible and tyrannical exercise of power with its concomitant destructive outcomes. Their lives were often rendered meaningless by those who victimized them via abuses of power. Perhaps the most critical challenge faced in this stage of recovery is that of restoring meaning to one's life through the responsible utilization of power.

In therapy it was clear that Ann's Loss process was alternating with a vision of what life could be like without trauma. She began to make plans for taking more responsibility for her life, not allowing her family or origin to continue to control her behavior through their criticism and finding ways to prepare to adequately support herself. She continued her outpatient therapy, improved her performance at school and responsibly using her medication, she began working at a part-time job, sought out new and healthier relationships with people, became more able to reach out for help and to accept feedback and even criticism.

CONCLUSION

This is where the journey through S.E.L.F. both ends and begins. It began when there was a critical need to identify central therapeutic themes in recovery, and then formulate them in a way that was both understandable and applicable. S.E.L.F. provides a framework for the therapeutic process that not only applies to those who have been abused or otherwise traumatized by horrific events,

but to those who need to work through other, perhaps less destructive, life events. Who among us has not experienced the increased sense of vulnerability, sadness tinged with anger, and sense of profound loss that accompanied the loss of a significant relationship? Those who suffer from other forms of mental illnesses also can benefit from the application of S.E.L.F. principles to the general therapeutic agenda. S.E.L.F. is a model that can be applied to inpatient, outpatient, shelter and other clinical settings.

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