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CHAPTER 7

THE TRAUMA DISORDERS UNIT

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Inpatient psychiatric units specializing in treating patients with a history of psychological trauma generally are organized to serve one of two populations: predominantly male active-duty soldiers or veterans with combat-related trauma or predominantly female civilians with trauma related to severe childhood maltreatment (Busuttil 2006). Despite the evidence that posttraumatic stress disorder (PTSD) and dissociative disorders are common in the general population (Kessler 2000; Waller and Ross 1997) and a history of childhood trauma is common in general inpatient psychiatric patients (Loewenstein and Putnam 2004), only a handful of specialized trauma units exist nationwide. Successful inpatient hospital treatment models exist that can help these patients sustain substantial recovery. Hopefully, knowledge from the trauma disorders unit (TDU) can be made more generally available so that these patients receive more appropriate and helpful treatment in all inpatient settings.

This chapter describes the characteristics of an inpatient TDU, specifically the TDU at Sheppard Pratt Health System in Baltimore, Maryland. Sheppard Pratt opened its "Dissociative Disorders Unit" in 1992 to specialize in the inpatient treatment of severe dissociative disorders, primarily dissociative identity disorder (DID) and related severe posttraumatic dissociative psychopathologies. In 1997, the program was renamed the "Trauma Disorders Program" to reflect the clinical reality that we were serving a broader spectrum of patients and to reflect our understanding of the dissociative disorders as part of a broader spectrum of trauma-related disorders (Davidson and Foa 1993; Loewenstein and Putnam 2004).

Excluding patients ultimately diagnosed with non–trauma spectrum disorders (e.g., psychotic disorders, factitious disorders), virtually all TDU patients fit criteria for complex PTSD (Courtois 2004; van der Kolk et al. 1996). Complex PTSD includes a range of disrupted functions beyond the core symptoms of PTSD and is found in survivors of repeated, sustained traumatic experiences occurring over long periods of time and/or multiple developmental periods (Courtois 2004; Putnam 1997). Complex PTSD symptoms include difficulties regulating mood, anxiety, and anger, resulting in severe affective dysregulation; problems regulating state stability and consciousness; difficulties

with sense of self and body image, resulting in identity problems, eating disorders, lack of attention to medical needs, and somatization; difficulties in forming stable relationships, with intense mistrust coexisting with vulnerability to victimization and exploitation; deformations in self-attribution and systems of meaning, with the world seen as dangerous and traumatizing and the self seen as damaged, shameful, defective, and responsible for traumatization; and a significant propensity for self-destructiveness, including suicide attempts, substance abuse, self-injury, and risk-taking behaviors (Arnow 2004).

Admission Criteria

Admissions to the TDU must be referred by a treating mental health professional. The admissions coordinator reviews an extensive questionnaire submitted by the referring clinician and discusses the prospective patient with the clinician. Then all potential admissions are reviewed with an attending psychiatrist for suitability for TDU admission, including medical necessity criteria for inpatient level of care. Currently, the TDU accepts both male and female patients, ages 18–65, with a history of psychological trauma. Male patients are screened carefully for their ability to manage in, and not be disruptive to, a mostly female hospital milieu. Given the realities of modern hospital reimbursement, most admissions must meet inpatient "medical necessity" criteria: imminent dangerousness to self or others and/or catastrophic inability to function due to disabling posttraumatic and/or dissociative symptoms.

Because patients must be motivated to participate actively in a demanding treatment program, we generally do not accept involuntary patients or patients referred for court-ordered treatment. Trauma patients with extensive histories of perpetrating childhood abuse, violence toward others, or sexual assaults or with significant antisocial personality features usually are excluded due to their potential negative impact on the TDU milieu and the difficulty in treating these problems in a milieu focused on recovery for abuse survivors. Not uncommonly, however, previously unknown histories of perpetrating child abuse or violence are revealed during TDU hospitalization.

Patients admitted to the TDU must be medically stable. Psychotic and/or manic patients are excluded because of potential disruption to the TDU milieu and difficulty participating in the treatment program. It has been our experience that patients with severe substance and/or alcohol abuse or dependence usually do not respond to the treatment milieu of the TDU until they have achieved sobriety and are motivated to maintain recovery. This is the case even if the substance dependence appears to be "treating" the patient's trauma disorder symptoms. Less severe forms of substance abuse, relapse by a trauma patient in active recovery, and/or recent increase in substance use to medicate trauma symptom exacerbations or distress due to acute life stress may be more treatable in a specialized trauma milieu. Similarly, because we do not have the resources to provide intensive specialized eating disorders treatment during a TDU stay, trauma patients with histories of eating disorders can be admitted only when sufficiently stabilized to manage their eating disorder symptoms.

Diagnostic Workup

TDU patients often present with complex diagnostic issues. Commonly, these include questions about the presence of a dissociative disorder, an intercurrent psychotic process, depression, bipolar disorder, comorbid cognitive disorder, factitious disorder, or personality disorder and the extent to which the clinical picture is influenced by these possible concurrent diagnoses. We also assess psychological factors that affect the patient's ability to undertake psychotherapy for severe trauma-related disorders, such as the ability to form a therapeutic alliance despite severe posttraumatic mistrust and specific transference themes that may occur in therapy. Differential diagnosis is important; DID patients average 6–12 years of psychiatric treatment before correct diagnosis (Loewenstein and Putnam 2004).

On admission, all patients undergo a complete psychiatric history, social and family history, trauma history (to the extent that the patient can tolerate disclosing it on initial interview), physical examination, and basic laboratory evaluation (complete blood count, comprehensive metabolic panel, and thyroid function tests; screenings for drugs of abuse and alcohol, syphilis, and therapeutic drug levels are obtained when indicated). Patients are routinely screened using the office mental status examination for complex dissociative symptoms, which includes assessment of dissociative, mood, somatoform, and PTSD symptoms (Loewenstein 1991).

Specific diagnostic assessment measures that we routinely use for the assessment of dissociative disorders include the Dissociative Experiences Scale (Bern-

stein and Putnam 1986), the Multiaxial Inventory of Dissociation (Dell 2006), and the Structured Clinical Interview for DSM-IV Dissociative Disorders (Briere et al. 1995; Steinberg 1994). For assessment of PTSD and more general trauma-related issues, we commonly administer the Trauma Symptom Inventory (Briere et al. 1995). More specific diagnostic instruments for PTSD rarely are required because most patients present with obvious PTSD symptoms on clinical evaluation.

More complete psychological assessment, by psychologists familiar with dissociation and trauma, may be needed to fully assess complex differential diagnostic questions. This may include the Wechsler Adult Intelligence Scale, the Minnesota Multiphasic Personality Inventory, the Thematic Apperception Test, neuropsychology screening, and the Rorschach.

Reliability of Traumatic Memories

There is a debate about the reliability of memories of trauma, especially those that reportedly have been subject to lack of recall at some point in the patient's history. This is a complex topic, and the reader is referred to definitive reviews such as those of Brown et al. (1998) and Dalenberg (2006). In short, the current evidence supports the position that recall of trauma memory, like that of all autobiographical memory, is reconstructive, not photographic. Delayed recall for traumatic experiences has not been shown to produce memories that are any more or any less accurate than "continuous" memories. Either kind may be essentially accurate, a mixture of accuracy and confabulation, or entirely confabulated (Dalenberg 2006). Patients are also informed that memories recalled under hypnotic conditions should not be deemed any more or less accurate than memories recalled in their usual behavioral state (Cardena et al. 2000).

In general, TDU staff do not endorse belief or disbelief in any particular uncorroborated memory reported by a patient. Patients and, when indicated, families are educated about the complexity of human memory and the controversies in the field about trauma memory. Patients who report severe childhood trauma sometimes are ambivalent about their own recall, often believing themselves at some times and not at others. It is far more important for the clinician to identify conflicts the patient has about his or her own recall than to validate or discount a patient's memories. We tell patients that rather than offering belief or disbelief, we will do our best to help them begin the process of understanding and integrating memory material. The goal is to allow the patient him- or herself to resolve questions about what did or did not occur as fully as possible over the course of long-term trauma treatment.

Therapies

Psychotherapy

A variety of studies have shown efficacy of psychotherapy for PTSD and DID (Foa et al. 2000; Loewenstein and Putnam 2004). Evidence-based models support the use of psychodynamic, cognitive-behavioral, hypnotherapeutic, and progressive exposure therapies, among others. Studies of inpatient TDU treatment for DID generally have shown robust improvement using a trauma-/dissociation-focused treatment paradigm (Eliason and Ross 1997).

Stage-Oriented Treatment

Expert consensus, buttressed by a variety of evidence-based treatment models, strongly supports the notion of a phasic treatment structure for trauma patients (Brown et al. 1998; Foa et al. 2000). Although a number of models have been proposed, most authorities support the utility of a three-phase treatment structure (American Psychiatric Association 2004; International Society for the Study of Dissociation 2005). In the first phase, the patient works toward basic safety and stability. In the second, the focus is on the detailed and emotionally intense recollection and processing of trauma memories. In the third phase, the therapeutic work is directed toward "reintegration" and living well in the present. In this phase, traumas are relegated more and more to the status of "bad memories" rather than being "relived" as flashbacks, behavioral reexperiencing phenomena, or intense posttraumatic reactivity to current situations. For the DID patient, a major focus in the third phase may be fusion/integration of self states. Finally, the entirety of trauma treatment is directed toward the patient developing a better adaptation to current life.

Contemporary trauma programs generally opt for an inpatient TDU stay focused on developing safety and stability to permit better engagement in outpatient treatment. However, some patients are so mistrustful and demoralized that it may take several weeks for them to develop even a beginning sense of confidence that the TDU can help them. Sadly, at this point, these patients may become just "safe enough" to be discharged due to managed care limitations. This can result in the patient leaving the hospital be-

fore having internalized a sense of safety in treatment. Along with ongoing outside stress, this situation may precipitate repeated brief admissions that undermine definitive stabilization even more. Many patients referred to our program are so demoralized, and have such limited ability to manage their symptoms, that hospitalizations of 1–3 months are optimal to help them definitively stabilize and return to productive outpatient treatment.

Trauma Focus

Our treatment approach begins with a trauma focus toward the patient's difficulties. This involves a mixture of psychodynamic and cognitive therapy models. We attempt to understand the patient's problems as logically related to posttraumatic reactivity; trauma-based cognitive distortions, projections, and projective identifications; and traumatic transference to the staff, other patients, and the hospital environment (Loewenstein 1993). The patient is invited to understand his or her reactions as potentially "triggered" by posttraumatic reminders that set off intense reactivity, often in the form of "unconscious flashbacks" or "emotional flashbacks" (Blank 1985; Loewenstein 2006). This reactivity often leads to self-destructive behavior, maladaptive interactions with others, and emotional dysregulation, usually accompanied by marked cognitive distortions about what is occurring. Remarkably, through powerful projective identifications, others may be drawn into interactions with the patient that seemingly replay reported traumatic situations from the past—"walking into the flashback together," as one patient put it.

Elucidating the traumatic scenario that is being replayed allows the patient to begin to "separate past from present." The patient examines the extent to which current problems, maladaptive behaviors, troubled relationships, inexplicably intense emotional reactivity, and/or self-destructive behaviors result from unconscious "reliving" of past trauma scenarios or attempts at self-protection from anticipated traumas and betrayals based on past traumatic relationships. This task is fundamental to beginning successful treatment for this population. Remarkably, in many of these patients, this approach can ameliorate seemingly intractable problems and maladaptations relatively quickly (Loewenstein 2006). Patients are relieved to understand that behaviors experienced only as "crazy" or "bad" are logically related to past events. Unit staff feel more effective both by understanding better why patients act as they do and by helping to develop specific interventions based on this understanding.

Safety Focus

Within the overarching trauma framework, establishing safety is usually the central task for the inpatient TDU patient. TDU patients commonly are deeply involved in a plethora of suicidal, parasuicidal, or high-risk behaviors, some of which only become apparent with sequential observation and intensive history taking. Many of these behaviors will be reported to have begun in childhood or adolescence. Frequently, admission has been precipitated by escalation in suicidal or parasuicidal behaviors. Also, these patients may make suicide attempts in the hospital by any means that they find available, commonly strangulation, ingestions, and severe self-cutting.

In addition, most of these patients engage in self-injury that is not suicidal in intent, such as cutting, scratching, and burning, often over extensive parts of the body, including the genital area. Other common self-damaging behaviors include head banging; hitting objects, resulting in orthopedic injuries to the extremities; and nonlethal overdosing, among others. Because patients commonly use these behaviors in an attempt to manage their symptoms, treating these behaviors is one of the central tasks of treatment during hospitalization so that the patients can return to a less restrictive level of care.

Our primary approach to suicidal and self-harming behaviors is to reframe them as attempts at self-regulation and/or management of trauma experiences and related affects and cognitions. Attempts at controlling these behaviors without reframing them in this way are almost invariably doomed to failure, because they reinforce the patient's negative self-assessments. For example, among the manifold cognitive distortions that may drive self-injury is the idea that "I'm going to get hurt anyway, so if I control the timing and intensity of harm, it's less bad. If they [the perpetrators] see that I hurt myself, maybe they won't hurt me as much." These ideas can be reframed as an attempt to survive the helplessness and unpredictability of repeated maltreatment. They also underscore a core belief of many complex PTSD patients: that maltreatment is inevitable, and all one can hope to control is the timing and intensity of it. The therapeutic goal then becomes to exchange this "survival skill" for a "recovery skill" by developing adult non-trauma-based strategies for assessing one's current life situation and level of external danger; gaining a repertoire of skills to keep oneself safe from self and others; and creating overall safety and self-protection in one's current life.

Despite our prescreening, some patients have significant current difficulties with aggression and/or vio-

lent dyscontrol (e.g., throwing furniture, threatening staff or patients). These behaviors may also have traumatic antecedents and may involve the patient being in a dissociative state, leading to disorientation to current circumstances. To the extent that this is the case, reframing and understanding the posttraumatic underpinnings of these behaviors may be critical in resolving them. Some violent behavior involves identification/introjection of the aggressor/perpetrator. Working with the patient on these dynamics may be helpful in reframing these behaviors as related logically to trauma dynamics and in helping the patient stop them.

A crucial milieu dynamic is maintaining the TDU as a "safe place" (or safe *enough* place, because no hospital unit is absolutely "safe"). Accordingly, milieu treatment interventions commonly are used to bring social pressure on actively self-destructive and/or violent patients to contain their behavior. Patients who have acted unsafely are required to process the behaviors through writing, discussions with nursing staff, and/or intensive evaluation in individual therapy and attending rounds. Patients also may process the behavior and their commitment to safe alternatives in therapy groups with other patients.

Safety crises and treatment stalemates sometimes result from the patient having been recently victimized in a relationship, or actually *currently* being exploited or victimized in a contemporary relationship. It is important to have a high index of suspicion for this because patients are often profoundly ashamed about these situations and actively conceal them. These destructive relationships can include current interpersonal violence, incestuous involvement with family members into adulthood, and exploitation by psychotherapists and/or medical professionals. Patients may experience contemporary betrayals as even more devastating than their childhood traumas ("I'm grown up. I'm supposed to know better now"). In addition, these situations bring up complex medicolegal issues for staff, as well as excruciating dilemmas for the patients who, just as in childhood, often are attached to those who hurt them. Milieu management may be made more complicated when these patients wish to continue contact in the hospital with individuals who have, or are currently, reportedly exploiting them.

With respect to abuse by current or prior treating therapists, most often patients will report relationships that involve boundary violations and role reversals. Unfortunately, in all too many instances, patients report sexual involvement with a current or former treating clinician. In these cases, for additional perspective on how to proceed, we generally seek consultation from forensic consultants familiar with trauma disorders and issues of professional misconduct.

Patients who threaten harm against others (frequently against reported perpetrators) are assessed with regard to the need to warn intended victims and inform police of their threats, as required by state law. The need to keep *everyone* safe from violence, even those who reportedly have harmed the patient, becomes an important treatment issue.

Finally, patients may report or be suspected of abuse or neglect of their own children. We evaluate these cases carefully, acquiring as much collateral information as possible to assess whether mandated reporting is required. It is optimal if patients collaborate with us in reporting themselves to social services. Mandated reporting may also be required if the patient reveals information about suspected abuse or neglect of children by current or former partners or reported childhood perpetrators who currently have access to minor children.

Psychotherapy Modalities

In the TDU, each patient has a psychotherapist, a social worker, and an attending psychiatrist. Patients are usually seen in 45- to 50-minute individual psychotherapy sessions three times per week. Individual psychotherapy is psychodynamically informed, emphasizing concepts such as transference, defense, resistance, projective identification, and therapeutic alliance, with optimal treatment drawing from a number of different psychotherapy models.

Patients have daily psychiatric attending rounds that necessarily focus on medication and medical issues as well as administrative issues such as observation levels and privileges. However, TDU attending physicians also carry out brief, focused psychotherapeutic interventions that facilitate goals of the overall treatment. These may include cognitive, psychodynamic, symptom management, and/or educational interventions (S. B. Wait, "Attending Rounds, or How to Establish a Therapeutic Relationship in 15 Minutes a Day," presented at Scientific Day, Sheppard and Enoch Pratt Hospital, Towson, Maryland, June 11, 2000).

Patients attend groups for 3 to 5 hours per day. Some groups are didactic or educational, whereas others focus more on psychotherapy issues and group process. In addition, patients participate in expressive therapy groups, including specialized art therapy and creative writing, as well as trauma-oriented occupational therapy groups.

Psychoeducation. Complex PTSD and dissociative disorder patients require extensive, ongoing psychoeducation. Psychoeducation goes on in all of the unit psychotherapies. Education about treatment risks and benefits primarily is carried out in individual therapy and in rounds.

First, patients are educated about the symptoms of PTSD, complex PTSD, and/or dissociative disorders. Clarification of how dissociative disorders and PTSD are diagnosed and how their symptoms may mimic or overlap those of other disorders is especially helpful to patients who have carried many and varied diagnoses. In addition, patients are educated about the current views of phasic trauma treatment and the risks, benefits, and controversies about current trauma treatment models, including pharmacotherapy. This includes discussing the nature of traumatic memory, delayed recall for trauma (if this is reported), and current controversies about these issues.

Patients who receive a dissociative disorder diagnosis also are educated regarding current controversies about diagnosis and treatment of dissociative disorders, particularly DID. Dissociative patients may have difficulty recalling educational and informed consent information. They may need frequent repetition of information, either because they have amnesia for the discussion or because alternate self states emerge who claim not to have "been present" when the information was originally imparted. The notion that informed consent is best viewed as an ongoing process is amply demonstrated in this population.

Patients are educated about conditioned fear responses and how these relate to PTSD reminders, PTSD reactivity, and intrusive PTSD symptoms. DID patients are educated that all self states make up a single human being and are not "separate people" and that all self states will be held responsible for the behavior of any other, regardless of whether the behavior is recalled and experienced as occurring under voluntary control. They are educated that all self states are adaptations to life circumstances and that there are no "good" or "bad" self states. The self states' harmful, abusive, violent behavior to self or others is not condoned but rather understood and reframed in its adaptive context, generally developed during childhood maltreatment. The clinician explores with the patient what problem the troubling behavior may originally have been intended to solve and what beliefs the self state may have about how the behavior solves the problem. Then more adaptive alternatives are explored.

Psychoeducation also involves discussing the importance of safety and bodily integrity; the nature of relationship boundaries; appropriate behaviors for adults and children; the nature of emotions such as anger, shame, sadness, and grief; the need for medical care; and many other aspects of life that most nontraumatized individuals take for granted. Severely traumatized patients may not believe that they can say "no" when someone wants something from them. Lacking full understanding of some of the most basic aspects of human relationships and of human safety and human dignity, they may be at greater risk for revictimization and exploitation.

Cognitive-behavioral psychotherapy. Cognitive therapy is an essential facet of psychotherapy in addressing the manifold and profound cognitive distortions found in this population (Fine 1990). Cognitive therapy interventions occur in psychotherapy as well as in the milieu and in groups. Most patients attend a weekly cognitive therapy group to help identify and challenge their cognitive distortions.

Basic cognitive distortions may include notions such as "anger is violence"; "self-harm is safety"; "sex is love"; "I made my abuser bad"; "sex is all I'm good for"; "if something good happens, it will just get taken away, so I should destroy it first"; and so on. In the trauma population, the apparent fixity of cognitive distortions may conceal significant trauma memory material that seemingly is held at bay by the cognitive distortion.

Cognitive distortions also interconnect with profound shame scripts that dominate these patients' cognitive/affective universe. One should never underestimate the importance of shame in the psychotherapeutic approach to these patients. Recognition of, systematic psychotherapeutic attention to, and education of the patient about shame-based cognitions and behaviors best described by Nathanson's "compass of shame"—attack self, attack other, avoidance, and withdrawal—may lead to significant clinical leverage (Nathanson 1992). Attack-self scripts typically take forms such as "I'm a loser"; "I'm disgusting"; "I'm hideous and loathsome"; or "I wish I could disappear off the face of the earth." In attack-other mode, patients may wish vengeance to get back at reported perpetrators for the humiliations caused by childhood abuse, but they commonly turn this back on themselves (Lewis 1990).

Dialectical behavior therapy. Dialectical behavior therapy (DBT) was developed by Marsha Linehan (1993a) primarily for outpatient treatment of patients diagnosed with borderline personality disorder. It is a staged treatment that focuses first on modifying life-

threatening behaviors; second, on modifying behaviors that interfere with therapy; and then on modifying a defined hierarchy of problematic behaviors. In its establishment of priorities, it has much in common with the stages of treatment for complex PTSD and similarly advocates deferring intensive treatment of traumatic memories until initial safety issues are well controlled. In Linehan's model of treatment, the DBT skills group is only one component of the treatment. However, in our program, it is the one most adaptable to an inpatient setting with a constantly changing patient group. In our program, the DBT skills group meets twice a week for 45 minutes, and each group focuses on one of the four basic skills: mindfulness, distress tolerance, emotion regulation, or interpersonal effectiveness.

Group sessions start with a 2-minute mindfulness practice, followed by group leaders discussing one of the skills. We use handouts from Linehan's DBT manual (Linehan 1993b). Patients read sections aloud and give examples from their own experience of situations where they might find the skills useful. The group leaders are active and positively reinforce patients' participation in group discussions and use of the skills being taught. Patients have homework assignments to practice the skills and to discuss in individual therapy how they are using them.

Symptom management skills training. "Grounding" is the most basic skill taught to TDU patients. This relates to patients frequently experiencing themselves as depersonalized, detached, spaced out, out of their bodies, not oriented to current circumstance, "lost" in memories or internal experiences, rapidly switching among alternate self states, and so on. Grounding techniques are methods to counter these experiences, often by attempting to accomplish simple orienting tasks using all the senses. These may include helping the patient to keep his or her eyes open, to become aware of his or her feet touching the floor or arms touching the chair, and to look around the room, identifying where he or she is and with whom he or she is speaking. Patients with marked difficulties maintaining orientation to current circumstances, for example, continuously going into spontaneous self-hypnotic states, can be given a "15-Minute Check-In" sheet. Here, the patient fills out a rating scale every 15–30 minutes to assess feelings, behaviors, and degree of orientation. Severely dissociative patients may be so ungrounded as to forget to do the task as often as mandated. Nonetheless, patients can find this helpful in "staying present" and gradually becoming more grounded in reality.

DID patients have the highest hypnotizability of any clinical group on standardized assessment measures (Frischholz et al. 1992). Many non-DID PTSD and complex PTSD patients are also highly hypnotizable. Accordingly, hypnotherapeutic imagery and relaxation interventions may be particularly useful for symptom management in the acute management of TDU patients (Brown et al. 1998; Kluft and Loewenstein 2007).[1] Hypnosis represents a set of adjunctive therapeutic techniques that vary widely and may be used for many different clinical problems (Spiegel and Spiegel 2004). Formal hypnotherapeutic interventions must only be performed by those with specific training in hypnosis and additional training in hypnosis for traumatized/dissociative patients.

Patients may be taught to use images in formal hypnosis. TDU patients also can be taught self-hypnosis for a variety of symptom containment purposes. Induction of self-hypnosis may increase the potency of imagery for this population and allow a greater depth of relaxation and symptom control. Patients with DID and dissociative disorder not otherwise specified in particular may be able to use imagery to reduce the intensity of traumatic intrusions without formal induction of hypnosis. Typically, patients are taught to visualize themselves in a "safe place" where they experience a reduction in panic, flashbacks, and hyperarousal. Patients may learn to visualize "containment" of traumatic memory material in imagined vaults or boxes in outer space or at the bottom of the sea, for example. Some patients visualize a "remote control" that can take away intrusive trauma images and superimpose benign images. Patients can be taught to imagine a volume control to "dial down" intense affects and intrusive symptoms.

Safety Agreements

Agreements to maintain safety are frequently used with TDU patients by the therapist, attending physician, and nursing staff. These agreements have *no* le-

[1] We do not have space to review the controversies over use of hypnotic techniques in this population. See Brown et al. (1998) and International Society for the Study of Dissociation (2005). See also guidelines of the American Society of Clinical Hypnosis Committee on Hypnosis and Memory (1995). However, in general, in the TDU patient population these techniques are used to *attenuate* and *contain* intrusive traumatic memories, not explore them.

gal force and should *never* be substituted for the judgment of the clinician or nursing staff about the actual state of the patient's safety (International Society for the Study of Dissociation 2005; Loewenstein and Putnam 2004). However, they have considerable therapeutic utility. It is best to conceptualize these as *delaying* agreements rather than as safety agreements per se. These agreements emphasize the patient's ambivalence about self-harm or suicide, greater awareness of the impact these behaviors have on the patient and others around him or her, and development of honesty about the state of one's safety.

These agreements are most effective when paired with a "safety plan"—a repertoire of alternatives to acting unsafely. Alternatives to unsafe behavior include grounding, not isolating from others, using imagery or self-hypnosis, or going to staff and asking for help with psychotherapeutic interventions or as-needed medication. Some patients find it frightening to verbalize a need for help, based on past traumatic experiences in which they attempted to do so and were rejected, disbelieved, or additionally mistreated. We provide a "help chair" where patients can sit to nonverbally indicate their need for staff assistance. Some patients write their need for help on index cards if they are posttraumatically terrified of speaking but are less "triggered" by conveying their needs in writing.

Pharmacotherapy

Here we give a brief overview of pharmacotherapy for the TDU patient. The reader is referred to reviews of neurobiology and pharmacotherapy of PTSD and dissociative disorders (Friedman 2000; Loewenstein 2005). Complex PTSD may involve extreme fear states, terror, profound existential despair, grief, guilt, self-loathing, and shame, among other extreme emotions, none of which may be clear-cut targets of current psychopharmacology.

Psychopharmacological treatments for PTSD for the most part have excluded complex PTSD and DID patients in their protocols. In addition, studies suggest that the more trauma exposure, and the more long-standing the PTSD, the less robust the pharmacological response (Loewenstein 2005). Nonetheless, double-blind studies in male combat veterans support the specific efficacy in PTSD of the selective serotonin reuptake inhibitors (SSRIs) sertraline, paroxetine, and fluoxetine (there also was a successful fluoxetine trial in childhood trauma patients); the tricyclic antidepressants (TCAs) amitriptyline and imipramine; and the monoamine oxidase inhibitor (MAOI) phenelzine (Friedman 2000) Also, in controlled studies, the antihypertensive prazosin has been found to reduce PTSD nightmares in combat veterans (Loewenstein 2005). Our clinical experience supports this indication in TDU patients with severe, recurrent nightmares who can tolerate the hypotensive effects of the medication.

Clinical experience by TDU psychiatrists suggests that other SSRIs and serotonin–norepinephrine reuptake inhibitors (SNRIs) such as venlafaxine and duloxetine, TCAs, and MAOIs are equally as effective as those that have been studied in double-blind trials, although the U.S. Food and Drug Administration (FDA) has approved only sertraline and paroxetine for use in PTSD. Other medications represent off-label uses. In particular, a subgroup of these patients presents with significant obsessive-compulsive symptoms and may respond preferentially to clomipramine or fluvoxamine (Loewenstein 2005).

Open-label studies using anticonvulsant mood stabilizers (carbamazepine, valproate, topiramate, and gabapentin) primarily in male combat veterans suggest these agents may alleviate PTSD symptoms (Friedman 2000). In addition, one small double-blind study supported efficacy for lamotrigine in PTSD (Friedman 2000). In several double-blind studies, the benzodiazepines have not been shown to have specific effects for PTSD, although they improved sleep and general anxiety responses. However, many TDU patients report significant symptom relief with benzodiazepines.

The benzodiazepines are safe and effective anxiolytic agents that have generated significant concern about their use, overuse, and misuse in psychiatric practice in general and in the treatment of patients with trauma-related disorders specifically. Their safety and efficacy are flawed by their potential for dependence and tolerance. It is important to caution patients about this and warn them against stopping these agents suddenly or without the advice of a physician. Not all patients develop tolerance, however, and many can use benzodiazepines successfully at the same dosage for long periods of time (Soumerai et al. 2003). The risk of tolerance may be higher in patients with histories of alcohol abuse or dependence and with family histories of alcoholism.

Clonazepam and lorazepam are the most commonly used benzodiazepines on the TDU; they are both relatively long acting and as such are preferable to alprazolam, which can cause rebound anxiety between doses and life-threatening withdrawal symptoms due to its short half-life. Diazepam is occasionally used as well; it is often less expensive than other benzodiazepines in its generic formulation, which may be a con-

sideration. In addition to decreasing anxiety, the benzodiazepines are sedating and cause skeletal muscle relaxation. Patients sometimes associate the skeletal muscle relaxation with the antianxiety effect and seem to experience it as an indicator that the medication is "working."

Benzodiazepines may be given as scheduled medications, as needed, or both. Patients often have difficulty asking for as-needed medications and wait until their anxiety is extreme to do so, which makes the medications less likely to help. A twice-daily dosing regimen with as-needed doses available seems to help keep anxiety at a more manageable level. A rule of thumb for clonazepam and lorazepam is to limit the total daily dosage to 4–8 mg. If a patient requires more than this, especially if there are repeated requests for dosage increases, it is likely that tolerance is developing, and other classes of medications should be considered, including neuroleptics and agents that decrease sympathetic response, such as propranolol or clonidine.

One study of a small group of complex PTSD patients treated with risperidone showed this medication was helpful in reducing intrusive symptoms of PTSD (Reich et al. 2004). Again, clinical experience in the TDU shows that subgroups of patients respond to each of the atypical antipsychotics, and a smaller subgroup responds preferentially to some of the older typical antipsychotic tranquilizers, primarily for reduction of thought disorganization caused by repeated intrusive PTSD and dissociative symptoms; reduction in repetitive, severe flashbacks and behavioral reexperiencing episodes; and severely disrupted sleep. TDU patients with true comorbid psychotic symptoms (as opposed to dissociative pseudopsychotic symptoms), subtle thought disorder, pervasive lack of reality testing, or particularly bizarre PTSD or dissociative symptoms, especially with lack of robust response to other antipsychotics, may respond to a trial of clozapine.

Other medications found to be helpful for PTSD symptoms in open-label trials include α_2 agonists such as clonidine, β-blockers such as propranolol (especially for hyperarousal symptoms), and the μ- and δ-opiate receptor antagonist naltrexone, for reduction of compulsive self-injury, particularly when accompanied by a "high" (Friedman 2000). We find each of these agents helpful in subgroups of TDU patients.

Pragmatics

It is particularly vital to make the trauma patient a partner in psychopharmacological management. The complex PTSD patient is informed that pharmacological treatments are primarily "shock absorbers" in this context and unlikely to be curative. Patients may be more readily able to identify helpful medication treatments in this context: "I don't feel 'good,' but if I wasn't taking this medication and all this stuff was happening to me, I wouldn't be able to get out of bed." In the DID patient, it is important to assess the attitudes toward medications of different self states; some may seek medications in an addictive way, whereas others are medication phobic. Some complex PTSD/DID patients report being drugged as part of abuse, creating even more complex reactivity to medication management. Accordingly, in DID patients, assent of the whole alter self state "system" may be important in adherence to a medication regimen. In DID, symptoms such as depressed mood that are found only in one or a few self states, not across the "whole human being," are less likely to be medication responsive (see Loewenstein 2005 for additional discussion).

Because there are few good studies of psychopharmacology in the complex PTSD/dissociative disorders population, there are no formally developed algorithms for medication management. However, commonsense principles can guide clinical decision making. The most important first step is a careful assessment of the symptom picture to assess the contribution of comorbid affective, PTSD, and dissociative disorders, among others. Next it is vital to take as complete a medication history as possible. It is common in this population that a medication works for a period of time and then appears to become ineffective as the patient is overwhelmed by additional life stress. Reintroduction of the medication at a later time may lead to a response.

A logical first step is to maximize dosages of medications that the patient is already taking. Medication subtraction also can be important, because patients commonly arrive on multiple medications, often stating that they have been put on several medications at the same time, confounding assessment of efficacy and side effects. Next, augmentation strategies may be useful, such as adding bupropion to an SSRI, especially if there is significant motoric retardation; a low-dose TCA to an SSRI (carefully monitoring TCA blood levels); or mirtazapine to an SSRI. Addition of an anticonvulsant mood stabilizer may be indicated if there is significant irritability or agitation as part of the symptom picture. Lamotrigine may be useful due to its preferential effects on depressed mood.

Addition of a neuroleptic, either typical or atypical, usually in low dosages, may be helpful for intrusive symptoms, posttraumatic panic, loss of reality orien-

tation, thought disorganization due to PTSD and repeated dissociation, and sleep. Neuroleptics may also be given on an as-needed basis, although some, like risperidone, have a relatively slow onset of action that may limit use as an as-needed medication.

Pharmacological interventions for sleep may involve any of a number of medications, including trazodone, mirtazapine, benzodiazepines, and related sedative hypnotics such as zolpidem, sedating antihistamines, low-dose TCAs, prazosin (for nightmares), and low-dose neuroleptics (Loewenstein 2005).

Group Therapy

TDU patients attend a large number of groups on a daily basis. Groups are led by nursing staff, physicians, psychology postdoctoral fellows, social work staff, rehabilitation therapists, and the consulting pharmacologist. Groups include those with a more didactic focus: Containment I (a group that educates patients about PTSD, dissociation, and symptom management strategies), Medication Education, DBT Skills, Cognitive Therapy, Health and Stress Management, and Ask Anything (a group led by the service chief in which the patients can ask anything), among others. Process groups that have a more psychodynamic structure include Family Issues, Transitions (related to a variety of life transitions but especially to discharge issues), and Containment II (a group focused on patients' processing thoughts and feelings related to issues that brought them into the hospital, problems with symptom management strategies, and so on).

Patients also attend a daily Goals Group in the morning to establish goals for themselves for the day and to discuss living together on the unit. Patients may process safety problems that have affected the whole hospital community as well. Evening groups include a Community Meeting and a smaller group for each team (half of the patients), primarily directed to identifying containment skills and safety strategies for evening and nighttime, usually times of day that childhood trauma survivors have heightened PTSD reactivity.

Certain groups require a referral by the treatment team; these include Tension Reduction, an occupational therapy group involving leather work; Journal Making; Family Issues; and Applied Containment. The latter is a group in which patients developing skills using symptom containment strategies discuss the application of those skills to specific problem areas in life. In order to be referred to these groups, patients must demonstrate the ability to manage their safety and to use containment skills to tolerate discussions of potentially triggering topics.

Groups provide an opportunity for patients to assist each other in work on common issues and problems. In addition, therapeutic groups represent a potential laboratory for interpersonal skills for trauma patients. Patients often have difficulty with self-assertion, confusing this with aggression and avoiding it at all costs. This can be helpfully addressed "in vivo" in group settings where patients can see that the feared consequences of assertiveness do not occur. Additionally, patients who are repeatedly harming themselves may more readily hear about the impact of these behaviors when challenged by their fellow patients rather than staff.

Not all patients can tolerate groups equally. Very disorganized, overwhelmed patients or cognitively limited patients may find process groups destabilizing. These patients can be frustrating to the patients who are more insight oriented, and it may be necessary to remove the former from process groups until they are more stable and can participate in these groups more effectively. Nonverbal groups such as art therapy or occupational therapy may be particularly helpful for these patients.

Family Therapy/Psychoeducation

Family interventions are discussed in treatment team meetings and are organized around what will benefit the *patient*. The goal is to help the patient move toward stabilized symptoms and improved ability to use outpatient therapy. Interventions that seem unlikely to result in these outcomes are deferred, with recommendations as to when they might be revisited (including "never," with an appropriate explanation of the rationale for this recommendation).

We eschew "confrontation" by patients in our program with reported intrafamilial perpetrators of abuse. In general, these are disastrous for patient and family members alike, no matter in what stage of therapy they occur. In particular, patients who are so unsafe and symptomatic as to require inpatient TDU treatment for stabilization are not in clinical circumstances to work through the complex psychodynamics that usually underlie a wish to confront reported perpetrators. In general, the patient harbors a fantasy that the reported perpetrator will apologize or acknowledge wrongdoing when confronted, an event that rarely occurs and that, even if it does, almost never leads to the immediate positive resolution imagined by the trauma patient. Typically, when the desire to confront arises, we attempt to educate the patient about the complexity of this issue, the risks of engaging in a confrontation, and the need to focus on the goals of stabilization in the hospital while

postponing the question of confrontation until fully worked through in long-term treatment.

Increasing effective family communication is another important goal of the family meeting. Openness, clarity, honesty, and directness are the ideals. The social worker gives feedback about communication styles and helps family members to explore what seems to work and what does not. Family members are encouraged to find their own sources of support for the feelings evoked by the patient's illness rather than making the patient responsible.

Boundaries are often problematic for the patients and their support systems, particularly with respect to the disclosure of details of traumatic experiences. It is hard for patients and families to believe that therapy is the only place these details should be discussed, and then only when significant stability has been achieved. Setting limits on these discussions is an important way of making a patient's support system more supportive. It is important to clarify that the patient is responsible for managing his or her own safety issues, with the help of the therapist, and that this mostly is not a responsibility to be shared with the family.

Expressive and Rehabilitative Therapies

Expressive and rehabilitation therapies may be particularly helpful for complex PTSD/DID patients because these patients often have particular difficulties putting their experiences into words. Observing the patient's creations can provide understanding of traumatic experiences, coping strategies, safety issues, and specific posttraumatic reminders, among others. Art therapy has developed a rigorous system of diagnostic indicators, including an assessment for DID (Cohen et al. 1994). Accordingly, art therapy may be particularly helpful in differential diagnosis of dissociative disorders.

In the TDU, the occupational therapy assessment provides crucial information about the adverse effects of trauma disorders and symptoms on personal hygiene, meal preparation, money management, work, school, leisure, and unstructured time as well as the patient's social life or lack thereof. This may bring vital information into therapy that the patient finds too shameful to discuss and that may contrast with the patient's outward presentation of apparent competence in everyday activities. It can help the patient begin to develop specific strategies to alleviate critical hidden difficulties. For example, a patient who avoids bathing may be reacting to intrusive memories of sexual assaults in the family bathroom. He or she can be helped to develop specific symptom management and past/present separation strategies to allow better hygiene with decreased posttraumatic reactivity. Usually this is accompanied as well by relief of deep shame, not only about experiencing the traumas but also about having had such difficulty with routine personal hygiene.

Journaling

Pennybaker (1993) and others have studied rigorously the clinical utility of therapeutic journaling for the improvement of symptoms in a variety of disorders. Significant benefit in psychological well-being and improvement in stress management, medical symptoms, and even immune function have been shown to occur by using this intervention (Spiegel 1999). Accordingly, journaling tasks may be very helpful in the treatment of complex PTSD/dissociative disorder patients. Benefits can include access to dissociated thoughts and feelings, more coherence of experience, ability to track the relationship between behaviors and consequences, expression of negative affects, and better concentration. In DID, journaling can assist in identification of, and communication and coordination among, self states.

Milieu Management

Management of the therapeutic milieu is critical for functioning of the TDU. As in every true therapeutic milieu, all members of the milieu, staff and patients alike, must participate in ensuring a safe and therapeutic environment.

Staff Management Issues

It is important that the TDU staff be a functional team with mutual respect between individual members and between disciplines. The staff team must be able to model interactions that are different from those experienced by TDU patients in their traumatic relationships—for example, there should be clarity of roles and boundaries between staff members. Staff education is crucial, and we work on it continually. In addition to teaching opportunities in regular team meetings to discuss patient management, we hold weekly hourlong educational meetings for nursing staff, either with the nurse manager or with the attending staff. In addition, more experienced staff members mentor newer staff to help them develop facility at working with symptom management and cope with the stress of the milieu. A weekly hourlong "Service Conference" is designed to foster discussion of milieu issues, management problems regarding spe-

cific patients, and staff discussion of their coping with the milieu. At times, a specific weekly meeting has been held, either with one of the TDU psychotherapists or with an outside counselor, to assist staff with discussing group process issues that they might be reluctant to discuss with program leadership.

In addition, we have periodic half-day retreats to work on program development, team building, and problem solving. We also have sponsored daylong didactic training programs with lectures and other learning activities for all program staff. This has been especially important when there has been a critical level of new staff members who need basic overall education.

Many new staff members have limited knowledge and understanding of basic psychological concepts such as transference, countertransference, and defense mechanisms. Staff members working with trauma populations are continuously exposed to traumatic material. Patients often go into flashbacks, lose reality orientation, harm themselves, and describe or reenact horrific trauma scenes. Staff may be pulled between patients' negative transference responses to staff and their direct or indirect entreaties to staff for rescue. New staff members often have difficulty setting limits with patients, at some level believing that the patients are fragile and will be harmed by firm limit setting. In addition, staff members may be fearful of provoking patients' anger or of precipitating a more extreme crisis. It is important to allow staff to talk about their reactions to patients' self-harm and suicidal behaviors and to help staff achieve therapeutic distance from, and insight into, the posttraumatic origins of patients' frequent negative transference reactions to helpers. Staff need help understanding that, fundamentally, limits and boundaries provide safety and protection.

In terms of helping staff work most effectively with patients, use of the trauma frame of reference can be of great assistance. This model tends to help make explicable behavior that otherwise seems incomprehensible, alienating, and exasperating. For example, patients' overreactions to minor medical issues may be enervating for staff. However, the understanding that many TDU patients suffered some form of medical neglect may be helpful in reframing the behavior. In the overreacting patient's history, he or she may report not getting medical attention unless it was a life-or-death matter. Accordingly, the patient, fearing neglect, adopts the strategy of complaining as loudly as possible for any problem, no matter how small. In addition to feeling less blaming, staff members can also let the patient know that he or she is shouting so loudly that no one can hear him or her and that decent medical care will be provided routinely in the TDU.

Patient Management Issues

A functional TDU milieu provides a significant healing component to treatment of trauma patients. Issues that have been enumerated previously in the sections on psychotherapy are applicable to milieu management of trauma patients. The milieu program is focused on making the unit as safe a place as possible for all members to do the serious work of recovery, but this is always a work in progress. The TDU is an open system, with stabilized patients being discharged and new unstable patients being admitted, concerned others visiting and coming for family meetings, fire alarms going off, and so on. A focus on safety includes developing honesty about the state of one's safety, recognizing the impact of one's unsafe behavior on the others in the community, and learning to take real responsibility for one's behavior in the interest of genuine change.

In addition, traumatic transference themes are continuously made explicit in the milieu, with patients helping one another recognize out-of-place and posttraumatic reactions to current situations. Patients are encouraged to follow the "golden rule": to behave toward others as one wishes they would behave toward oneself. Patients can help challenge one another's cognitive distortions, including cognitive distortions regarding safety, such as "If I hurt or kill myself, it's not hurting anyone else; it doesn't involve anyone else."

Community members may play out many core traumatic transference themes. For example, TDU patients, like other survivors of childhood violence, may enact interpersonal themes of "victim-perpetrator-rescuer" (Davies and Frawley 1994) and of victim and uninvolved, uncaring "co-abuser" (Loewenstein 1993). All these attributions may shift between individual patients, patient subgroups, individual staff members, and the staff group as a whole. Frequent group interpretations and confrontations in Goals Group, Community Meeting, and process groups, among others, may be needed to move the community toward a functional milieu.

Behavior that undermines others' treatment must be vigorously challenged and confronted directly as such by staff. This is true of repeated self-harm as well as aggression toward others. For example, "staff bashing" is confronted as verbal aggression toward other patients who may be inhibited by this peer pressure from working with staff for their own recovery. The patient community is invited to look at the possibility

that they are re-creating the dynamics of a violent family: the aggressive or self-harming patient may be unconsciously replaying the idea that no one can, or will, take a stand to stop violence that family members perpetrate on one another. Here, as in individual therapy, we emphasize the tasks of separating past from present and discovering safe, non-trauma-based alternatives to problem solving.

When there has been a prolonged or repeated failure of patients to use their ability to control their behavior and a failure to respond to other group and individual interventions, we may "shut down" the community, an intervention that has been used fewer than 10 times in 15 years. It is important that the TDU leadership not overuse this type of intervention and reserve it for only the most serious, prolonged community breakdown. In general, this is a highly successful intervention to restore safety and a renewed focus on treatment goals.

This intervention involves an extended community meeting with *all* patients required to attend and all available staff, including individual therapists, joining the meeting. All other groups and individual therapy sessions are cancelled. Each patient is required to speak. Here, the task is not to rehash old difficulties or engage in mutual recriminations. Each patient is asked to identify problems that are contributing to the current situation in the community, including how he or she is contributing to the difficulties, and to describe practical steps that he or she can take to work toward meaningful change. During this meeting, the leadership maintains a tight focus for the group. This may involve vigorously confronting patients who have been undermining the community's function and redirecting patients who are having difficulty following the group task. The group only ends after all members of the community have spoken. After the group, community members focus on making changes based on goals generated in the meeting.

Management of Patient Boundaries in the Milieu

Boundaries between TDU patients are a continual challenge. This has led to a series of unit rules for behavior between patients and specific rules for DID patients. Some examples are given in the following sections.

Touch

Sustained touch such as hugging, hand holding, and so on is forbidden between TDU patients. Although many of our patients hunger for touch and feel "untouchable," they also may react with anxiety, panic, and even physical discomfort when touched. In DID, some self states may seek repeated hugs or touch, but others are phobic of touch, recalling that, in the past, "nice" touches may have progressed to inappropriate touch. Some patients take issue with this rule; they may accuse staff of "being mean" and thwarting what they "know" will help them heal. Discussion in individual and group therapy can help educate the patients about the complex issue of touch in the complex PTSD population. Other patients may be particularly articulate about the complexity of the problem for them and may help their peers understand that if the TDU staff really thought this was a helpful intervention, we would encourage it, not eschew it.

Triggers

Patients are enjoined from a variety of topics that may engender significant PTSD reactivity in their peers, in part due to the nature of the topics and in part due to the natural high hypnotizability and consequent liability to experiencing vivid visualization in the TDU population. Discussing details of one's traumatic experiences is considered potentially damaging to others and, if persistent, is viewed as a form of verbal aggression in the milieu. In TDU patients, increased PTSD intrusive symptoms, dissociative episodes, and/or deterioration in safety are virtually an inevitable outcome of detailed descriptions of trauma experiences by peers.

In general, TDU patients are asked to be sensitive to each other's idiosyncratic PTSD reminders or "triggers." Many everyday, apparently neutral topics may be upsetting to individual milieu members due to increased PTSD reactivity. On the other hand, patients are asked to work on developing resilience in coping with all manner of "triggers" because attempts at restricting life to avoid PTSD triggers usually result in the patient being deeply inhibited from engaging in many quotidian activities. Managing the dialectical tensions involving the problem of "graphic" language is an ongoing task for patients and staff. There is no clear line that shows where graphic discussions or triggers begin and end. Patients and staff must struggle with the "gray" areas that inevitably arise in attempts to work with these issues. These patients commonly struggle with polarized, "all or nothing," "black and white" thinking (Armstrong 1995). Accordingly, as in other aspects of trauma treatment, it is usually a productive endeavor to work on the "gray areas" and the dialectical tension inherent in the recovery.

Additional Milieu Rules for Patients With Dissociative Identity Disorder

Management of DID patients in an inpatient TDU milieu requires additional guidelines and rules. Patients are required to use *one* name consistently in the milieu, no matter which self state is "out." Also, the patient must be responsive to his or her legal name when this is required for administrative purposes, even if that is not the preferred name for regular usage. The various names of self states may be used in individual interaction with treatment team members, including nursing staff, but not in the milieu.

Management of Acute Behavioral Dyscontrol

TDU staff manage acute episodes of impending or actual dyscontrol and/or dangerousness to self or others with a hierarchy of interventions. First, they attempt psychotherapeutic interventions to discuss precipitants of problems (upsetting phone call, being triggered by something in the milieu) and to talk through the problem to find alternatives to help settle down. Other interventions may include using symptom management techniques such as relaxation, deep breathing, and imagery. Patients may be asked to journal or to use the quiet room to reduce stimulation. Staff may work with DID patients to encourage a safe self state to "come forward" and a dyscontrolled self state to "step back" within the mind.

Staff may then offer as-needed medication such as oral benzodiazepines or neuroleptics. If the patient already has lost control of his or her behavior, or acutely appears to be doing so, staff may administer parenteral medication to reduce anxiety, agitation, and dyscontrol. Commonly used medications for acute dyscontrol are listed in Table 7-1.

If the patient cannot stabilize acute serious danger to self or others with psychotherapeutic or pharmacological methods, or is so acutely agitated and unsafe that he or she refuses or cannot use these interventions, staff is urged to quickly move to physical methods to control the patient to provide optimal safety for all. In most cases, going "hands on," and giving medication, with the patient secluded in the quiet room with an open door, is sufficient to change the patient's state to a safer and more grounded one. However, in some cases, physical restraint may be needed. In many cases, TDU patients rapidly de-escalate and can be safely moved out of the quiet room or restraints quickly. Often, a period of sleep induced by medications allows the patient to become less overwhelmed and/or permits a more grounded and safe alter self state to come forward.

Intensive Observation Levels

Overall, TDU patients are managed at the least restrictive observation level possible. Despite the severity and chronicity of some TDU patients' self-destructive behavior, we attempt to avoid interventions such as constant observation and intensive suicide observation, although we do place acutely, intractably suicidal or severely, acutely, or violently self-injurious patients on these levels. In our experience, the chronicity of many patients' dangerousness to self and many patients' tendency to externalize and look for outside solutions for safety may make it difficult to find an endpoint for these intensive observation levels. Also, other patients may see these patients as receiving more staff time and may attempt to find ways to get staff to observe them more closely as well. Accordingly, we almost never place patients on these levels for parasuicidal behaviors, preferring to move them, as well as less acutely suicidal patients, to areas where staff can observe them more or less continuously but not necessarily on a one-to-one basis. The overarching safety focus on the unit means that staff are skilled in anticipating, evaluating, detecting, managing, and developing longer-term treatment strategies for dangerousness to self or others, often obviating the need for intensive one-on-one observation.

Discharge Planning

Basic discharge planning is the same for the TDU as for other inpatient units, with a few salient differences. Many of our patients come from outside the local region or state. Therefore, the logistics of discharge planning with family and the referring providers may be more complex than for local patients. Family involvement may have been done mostly by phone, and discharge may allow the first face-to-face family psychoeducation meeting.

Patients, especially those who have had a longer-term hospitalization, may need careful preparation to reenter the everyday world. Due to managed care standards for inpatient care, in most cases therapeutic passes are no longer a possibility to help prepare the patient for the impact of stepdown. TDU patients should be carefully counseled that stimuli will increase and that the "speed" of life outside the hospital

TABLE 7–1. Commonly used medications for acute dyscontrol in patients with complex PTSD or dissociative identity disorder

Benzodiazepines
Lorazepam 0.5–2 mg po or im every 2–4 hours
Clonazepam 0.5–2 mg po every 2–4 hours
Diazepam 5–10 mg po every 6 hours
Neuroleptics
Haloperidol 2–5 mg po or im every 4 hours
Fluphenazine 2–5 mg po or im every 4 hours
Chlorpromazine 25–100 mg po or im every 4 hours
Olanzapine 2–5 mg po, im, or sl every 4 hours
Ziprasidone 5 mg po or im every 4 hours*
Droperidol 5 mg every 1–4 hours (can only be given with electrocardiographic monitoring)
Other
Hydroxyzine 25–50 mg po or im every 4–6 hours
Diphenhydramine 25–50 mg po or im every 4–6 hours

Note. im = intramuscular; po = by mouth; sl = sublingual; PTSD = posttraumatic stress disorder.
*Requires electrocardiogram to assess QT interval for safety from arrhythmias.

may seem disconcerting. Patients are encouraged to practice their symptom management "skills" sets. The most common cause that patients cite for relapse and rehospitalization is "I stopped using my skills. I stopped communicating with my 'parts'" (in DID patients).

Patients may regard the TDU, notwithstanding their complaints about the staff and the program, as the safest place they have ever known. They feel understood by staff and surrounded by patients who share their difficulties. They may feel "at home" in ways that they never have before. They may live a solitary existence or be enmeshed in chronically problematic, unsatisfactory relationships. They may feel ashamed of deficits in functioning that they can avoid facing while in the hospital. Some patients may attempt to thwart discharge by acting unsafely whenever discharge looms or by insisting that they will commit suicide upon discharge, although they can maintain themselves safely with the support of the hospital setting.

In the past, we were more able to consider transferring patients like these to other units in our hospital or to other hospitals or trauma programs. Discussion of transfer was often sufficient to motivate the patient to resolve issues seemingly blocking discharge. However, transfer is very difficult to accomplish in the current psychiatric care environment. We discuss directly with patients their inhibitions and fears of discharge and gently confront their anxiety over returning to problematic outpatient situations. More direct confrontation may be needed to focus patients about failure to use skills or failure to be honest about their core safety. Patients may need to be restricted from TDU readmission, and told so, if they do not make good-faith efforts to "work the program" and move toward discharge when this is a reasonable expectation. Discussion of future restrictions from readmission may help galvanize some of these patients toward discharge.

Conclusion

PTSD and dissociative disorders are common in the general population (Kessler 2000; Loewenstein and Putnam 2004). In addition, history of childhood trauma is common in general inpatient psychiatric patients (Carlson et al. 1998). Despite the difficulties presented by these patients, there are inpatient and partial hospital treatment models, as well as outpatient treatment models, that can help them sustain substantial recovery. Hopefully, knowledge from the TDU can be made more generally available, so that these patients receive more appropriate and helpful treatment in all inpatient and day hospital settings.

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