Short-term Focused Inpatient Treatment Combined with Sensory Regulation of Sexual Trauma Victims – Summary of 100 First Hospitalizations

Shmuel Hirschmann, MD, MPA, LLB,[1,2] and Lilac Lev-Ari, PhD[3]

[1] *Sha'ar Menashe Mental Health Center, affiliated with the Technion Institute of Technology, Hadera, Israel*
[2] *Lev Hasharon Mental Health Center, Netanya, Israel.*
[3] *Psychology, Department of Behavioral Sciences, Ruppin Academic Center, Emek Hefer, Israel*

ABSTRACT

Background: Treatment of sexual trauma victims may be fraught with crises. In situations of de-compensation, the frequency of suicide attempts is high, and ambulatory treatment may not always provide the required response. In extreme cases, either in close proximity to the sexual offence or even years later, a more intense intervention is needed. This includes removing sexual trauma victims from their daily lives and hospitalization. Caregivers debate the type of hospitalization needed and the best type of treatment in times of decompensation and dissociation.

Method: This paper depicts a hospitalization model in Israel that has been created to provide a unique and focused solution for sexual trauma victims. The psychological principle of the hospitalization is based on Mann's short-term dynamic psychotherapy method. The patients are integrated in an acute psychiatric ward in which a variety of psychopathologies, men and women, are treated.

Results: The paper summarizes findings and understandings from the first 100 hospitalizations. The author's main conclusion is that sexual trauma victims need a focused specialized treatment plan to best deal with their complex issues and that hospitalization should be minimized to two weeks.

Conclusions: The author's main recommendation is that funding must be allocated for hospital beds for sexual trauma victims in each region in the country to produce adequate continuity of care for these patients.

INTRODUCTION

This paper presents an innovative hospitalization therapy inpatient model for sexual trauma victims. The aim of this paper is to present a descriptive intervention in the hospital setting. Upon undertaking the task of writing this paper, a comprehensive search of scientific literature was conducted concerning the treatment of sexual trauma victim patients treated in hospitals. The authors found no studies or research papers on this subject. This actually led to the authors' understanding of the necessity to publish the practice currently undertaken in Israel. In principle, the treatment of sexual trauma extends over a period of years, and should take place as part of the patient's ongoing life, namely ambulatory treatment in the community (1). However, treatment of sexual trauma is fraught with crises and encounters difficult experiences that raise questions concerning human existence and the will to live, and is often accompanied by depressive mood changes (2). In situations of decompensation, the frequency of suicide attempts is high, and ambulatory treatment cannot always provide the required response (3). Sexual trauma victims, in most cases women, usually perceive psychiatric hospitalization as a difficult experience in a system that is not suited to their needs.

Israel's Ministry of Health decided on a nationwide distribution of beds in psychiatric hospitals intended to treat sexual trauma victim patients. Sha'ar Menashe Hospital, in 2012, was the first to initiate the allocation of hospital beds for this purpose. Since then, three centers were added, and one more is supposed to open soon.

The hospitalization model was created to provide a unique and focused solution for sexual trauma victims

Address for Correspondence: ✉ Lilac Lev-Ari, PhD, Department of Behavioral Sciences, Ruppin Academic Center, Emek Hefer, 40250 Israel
ldlevari@ruppin.ac.il

in decompensation. Our accumulated experience from the first 100 hospitalizations is based on designated hospitalizations according to the model as well as hospitalizations of sexual trauma victims who were first admitted to general psychiatric wards and subsequently transferred to the designated ward. To this end, a task force was established to create a model for converting a regular open acute psychiatric ward to admit sexual trauma victims. The staff set itself the following goals:

1. To build a specific hospitalization program for female sexual trauma victims integrated in an inpatient ward in a regular psychiatric hospital, using existing resources and not disrupting existing admittance activities;
2. To create a tailored treatment program aimed at stabilizing their emotional state and facilitating their return to the community;
3. To comply competitively with the economic goals of the mental health reform transferring responsibility to HMOs (4).

THE TIME-LIMITED MODEL

The psychological principle of the hospitalization is based on Mann's (5) short-term dynamic psychotherapy method. This method is based on therapy limited in time, with the intention that the time limit is engaged to achieve the required psychological change (6). The admittance date and discharge date are set in advance, rigid, and the hospitalization is exactly two weeks long. The overt message to the patient is "you have reached a place of rest, where you can let go of the daily struggle to survive your mental pain." The explicit message is accompanied by an implicit message, rooted in Mann's perception that the end of the treatment holds an existential significance throughout the treatment. This message is "you cannot entirely let go and fall apart when you know that in a few days you have to return to the outside world."

Our extensive experience in a ward that admits various psychopathologies has taught us that at the beginning of hospitalization, no matter its reasons, patients are still attached to their life outside the hospital. Usually, by the second or third hospitalization week, the totality of the institution with its staff, ready meals, dictated activities, etc., creates increasing separation from responsibilities and demands of the outside world, and a process of regressive hospitalization begins. Studies have shown that mental distress declines during hospitalization, and is maintained for a short period following discharge (7). Experience of many years has shown us that decreased distress can be achieved within two weeks if the hospitalization experience provides a critical enough mass of individual and group psychotherapy. The importance of shortening the hospitalization period is in finding the break-even point between the patient's separation from her daily life and the ability to receive comprehensive treatment that addresses all mental and medical aspects.

REFERRAL METHOD

Unlike regular hospitalization in a psychiatric hospital, which is open 24 hours a day, referral to this program is elective. Admittance is possible if the following prerequisites are met: 1. A psychotherapist of some sort is available outside the hospital; 2. Psychiatric care (outside the hospital); 3. A ready rehabilitation framework (at least a place to live). Referral is performed by the therapist's application and transfer of materials beforehand (following the patient's consent). We have found that the prerequisites often cause the community-based treatment array to create solutions that had not been provided previously (such as emotional therapy or a place to live). The patient is expected to read about the program on the hospital's website, which was created specifically to provide answers about the program. The website also includes a page with practical advice and tips (such as bring your own toothbrush or you should not bring sharp objects that would not withstand a security check), written by a former patient in the program. When the patient arrives for her prearranged hospitalization, she is received in the ER by a social worker, who is a member of the staff and stays with her throughout the admission process. This procedure was created due to accumulated experience of the difficulty of the initial ER encounter, which is not adjusted to sexual trauma victims. The patient is examined in the ER by the attending psychiatrist and risk assessment is performed. If the materials sent to the hospital beforehand and the examination results do not match, hospitalization in an open ward is reevaluated. There is an unequivocal directive to ER physicians not to ask the patients anything about their sexual trauma. This rule is valid throughout the hospitalization, and will be explained later.

CREATING A TREATMENT ARRAY FOR SEXUAL TRAUMA VICTIMS IN A PSYCHIATRIC HOSPITAL

The common perception is that a psychiatric hospital creates labeling more than a general hospital does, and these women are very sensitive about the wider philosophical view of the gender issue and their definition as psychiatric patients. The psychiatric health reform, in which sexual

trauma victims were not given their own diagnosis, and they have to be classified as PTSD or depression or anxiety patients, exacerbates the problem. Psychiatric hospitals are perceived as paternalistic, male institutions that echo the existing internal conflict between control and gender. Therefore, psychiatric wards in general hospitals have an inbuilt conceptual advantage over psychiatric hospitals. On the other hand, from a practical point of view, psychiatric hospitals in Israel are usually large rural campuses. The hospital grounds are surrounded by a fence, and entrances and exits are monitored. In contrast, in general hospitals, suicide means are highly accessible and monitoring is low. There are endless possibilities for self-injury. Therefore, in order to create a safe environment, the psychiatric wards would have to be locked, and this is a contradictory philosophical concept. The balance between the desire to provide a place that does not feel like a prison – to prevent re-traumatization – and the desire to provide safe surroundings dictates that a rural psychiatric hospital is the preferable choice.

INTEGRATION IN AN ACTIVE MIXED WARD

The hospitalization is integrated in an active psychiatric ward in which a variety of psychopathologies, men and women, are treated. Each gender has separate living quarters (transgender patients are housed according to their main external genitalia and self-definition). During the day, departmental activities (such as a departmental community group that includes all patients and staff, led by the department head) are held. Additionally, individual and group sessions specifically designed for sexual trauma victims are organized. Typically, at any given time, between one and six sexual trauma patients could be found in a ward of 30 patients. In the afternoons, when there is no specific staff activity, a women's club in the occupational therapy unit provides a secure space for sexual trauma victims.

The other patients in the ward are aware that the ward specializes in sexual trauma victims. This affects the general population in two ways. First, patients who are hospitalized for other reasons often encounter the content of sexual trauma, and are able for the first time to reveal their own sexual traumas, which they had never shared. (It is known that 50% of female psychiatric patients were sexually traumatized in their past [8-10].) Second, due to these patients' enhanced sensitivity, special emphasis is put on restraining behavior and speech by other patients who might be offensive.

The fact that the ward is defined as a general psychiatric ward is an advantage for the declared goal of the hospitalization, namely to create stability rather than to process the trauma. The sexual trauma is not constantly "on the table," which helps maintain the calm atmosphere. The concern is that if sexual trauma victims are segregated, like in emotional support groups, it creates endless circles of trauma from one to the other.

Sexual trauma victims cannot live in a world without men. We found that a mixed ward (men and women) has its advantages and disadvantages. The grouping facilitates discourse vis-à-vis men in a controlled framework with high awareness of trauma and gender sensitivity and their needs, aimed at female empowerment, and thus rehabilitating in the wider sense than just improving their de-compensation state. Empowerment occurs because they are in an environment that is extremely sensitive to mutual respect, regulation of offensive behaviors, and the reaction to offensive behaviors, which allows the patient to become stronger in a way that influences beyond her specific stabilization. For example, in the departmental community group, a sexual trauma patient raised the question of men's presence, which led the staff to focus on this issue in her individual therapy. She said, "These situations reflect similar situations that happen to me outside. Here I am more in control. Now I feel more in control of my other impulses, including theft for instance," or "Concerning men, I expect them to see my feelings and take care of me," or "Externally it seems that I am making progress, but I'm afraid that outside I won't be able to control myself."

Although sexual tension is monitored, sexual trauma victims are extremely sensitive to sexual tension and this may lead to disadvantages of a mixed ward. This makes it difficult to take a break from the exhausting stress and conflicts outside the hospital. A mixed ward might not be suitable for some patients. Nevertheless, we should keep in mind that even in single-gender wards, tension or sexual assault might occur.

The therapists in the sexual trauma victims array believe that a mixed ward has a restraining effect on violence, and even encourages functioning and socialization. Furthermore, in a recent poll examining inpatient satisfaction conducted by the Israeli government, women reported greater overall satisfaction in mixed wards compared to women-only wards (4).

In summary, the way to moderate the multi-gender implications is to build a departmental culture that is very aware of behavior norms and mutual respect. Every patient, no matter his or her diagnosis, signs a behavioral-social treaty, which includes mutual respect with an

emphasis on this element, and the issue is discussed in meetings, doctors' rounds, and group sessions.

RECOMMENDATIONS FROM OUR CLINICAL EXPERIENCE

- Individual psychological therapy sessions, three times a week; the therapist can be a clinical social worker, psychologist or psychiatrist.
- Individual or group expressive therapy, for instance music therapy or art therapy (the patients clearly prefer individual therapy).
- Community group once a week with all the patients in the ward and the staff, led by the department head; this group discusses any issue that concern all patients.
- Occupational therapy; for high functional patients continuing their academic tasks or continuing tasks that pertain to their actual work place.
- Family session; only if it is beneficial to the patient and with her consent. This includes significant people in her life with the focus of helping her reconnect to her life outside the ward.
- Drug therapy stabilization (with attending psychiatrist).
- Rehabilitation evaluation; if necessary, with participation of the rehabilitation social worker (such as social security rights, etc.)
- If possible, a meeting with the main therapist in the community, and/or other support factors in the community.

FOCUS OF TREATMENT

When they arrive in the ward (on the first day), an intake session is conducted by a small team composed of the treating physician, the coordinator (the same social worker who received her), and a senior psychologist. The intake starts with a general explanation about the ward, the principle that she is not obligated to speak about her sexual trauma, and that she will not be asked about it during her hospitalization, unless she wants to talk about it. This is part of the inpatient rationale, namely to stabilize the patient rather than treat her core trauma. This does not mean that breakthroughs in treatment of the core trauma do not occur during hospitalization, rather that it is not defined as a goal of hospitalization. During intake, types of treatment are evaluated. An important element of intake is having the patient characterize her dissociative states and identifying when she controls them. The ways in which the ward can help her handle her dissociative episode using external regulation techniques (in addition to finding the patient's personal regulation in her own experience) is also explained. Lastly, she is asked to sign a consent form to allowing the use of sensory regulation (which will be further discussed later in the study).

During intake, an individual treatment focus is formulated according to Mann's (11) principles. The focus is based on four main components: the support component, the time component, the relation-to-self component, and the emotional component (12). This treatment focus is communicated to the entire staff, and serves as a unifying element between the various therapies.

One of the staff's most difficult challenges is to maintain integration among various staff members in an attempt to adhere to this focus. This is done by noting the "main issue" on notes that go along with the patient to all ward stations – she has a note, and each staff member (nursing, occupational therapy, personal therapist, and expressive therapists) has such a note. Usually, an attempt is made to address all of the patient's interactions with the hospital staff through the prism of her main issue. Situations of unaccepted behaviors are also processed through this prism.

At the end of the intake process, the patient is requested to sign a contract that specifies the rules she must follow, her personal treatment plan including medication, the sensory regulation means that will be used, the "main issue," her discharge date, and consent (if given) to contact others (such as family members).

The distinctiveness of the focused treatment program requires the therapist in the community to be involved in the treatment plan, and they are even invited to visit the patient in the hospital in order to help maintain the primary therapeutic relationship. The family intervention is aimed to recruit the family as a source of support that allows for rest in the hospital and a smooth return to the community. (The family is at times the cause or silent witness of the sexual trauma, so the extent to which the family is involved at all is always considered very carefully.) Every family that is part of the therapeutic process is invited to an open-ended therapy group of unlimited duration with an emphasis on support, in addition to the individual sessions.

RESTRAINT OF DANGEROUS BEHAVIORS

Our belief is that each psychiatric treatment has the potential and risk of re-traumatization, and that everything must be done to prevent further damage. On the other hand, severe dissociation can be very dangerous to others and especially to the sexual trauma victims themselves. Situations of depression and de-compensation may rein-

force suicidal tendencies, self-injury including cutting, knocking one's head against a wall or floor, self-hanging attempts, and more. Our clinical experience indicates that 22.7% of the patients (a patient could be hospitalized multiple times) had dissociation episodes that did not warrant an intervention; 40.9% of the patients had dissociation episodes that warranted an intervention; and 36.3% of the patients had life threatening dissociation episodes. Of the 100 reviewed hospitalizations, three ended with breach of the therapeutic contract. They were discharged, but no one was transferred to a closed ward. Two were discharged because of violence and one because of increased uncontrolled behavior including excessive suicide tendencies, which was perceived as reconstruction of the aggressor-victim relationship: 68% of the patients threatened to commit suicide during hospitalization, and 23% actively made a suicides attempt; 72.7% of the patients had self-injuring behavior.

When treating such situations, closed wards might seem safer and more protective of sexual trauma victims. The concern about additional trauma, or unconscious reconstruction of the aggressor-victim relationship, makes this solution problematic, and it is kept for extremely difficult cases. However, the patients described in this paper do not fall under the jurisdiction of the Mentally Ill Treatment Law. As such, they cannot be committed to a mental hospital without their consent. No patient expressed a desire to be transferred to a locked ward, it was not possible to transfer them against their will, and the staff found no justification for doing this. Furthermore, our clear policy is that sexual trauma victims are not transferred to a closed ward! To this end, special methods were developed (details follow).

SENSORY REGULATION METHOD

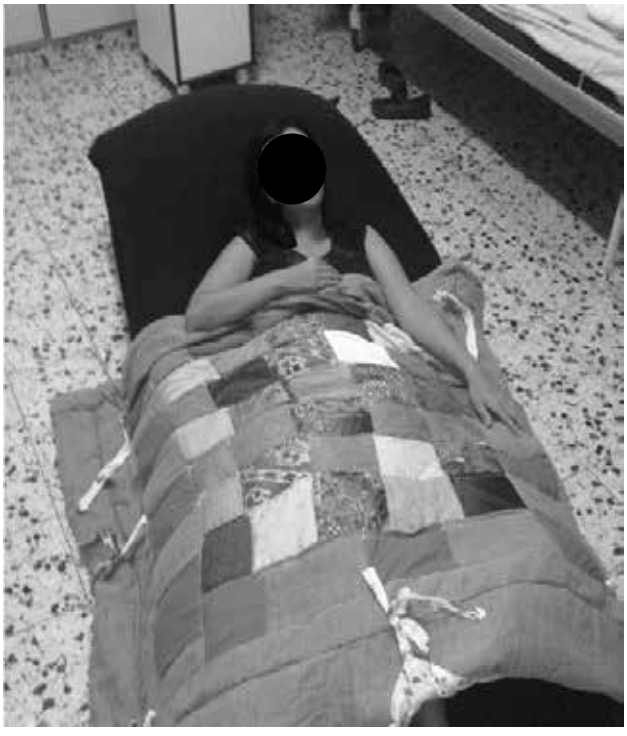
The aim of this method is to regulate dissociative states and dangerous suicidal tendencies so as not to necessitate transfer to a closed ward and to preserve the patients' security and quality of life. As mentioned, at the end of the intake process, the treatment procedures are explained, and the patient consents to sensory regulation.

As soon as a patient complains that she feels the imminence of a dissociative state, a number of sensory regulation actions are taken. The first is "*Grounding*" by the nurses (13, 14). When using this technique, the nurse helps the patient avert her focus from reconstructive traumatic memory by helping her focus on her body while feeling she is in a safe environment. For instance, the nurse can sit with the patient and quietly remind her where she is, what day it is and what she has done today. The nurse may tell the patient to plant her feet firmly on the ground and then sit up in her chair. She may then instruct the patient to listen to people speaking outside the door and other such calm instructions that are aimed to help focus on her surroundings instead of on the traumatic experience.

If these measures do not help the patient maintain her full consciousness, she is then laid on a very large down blanket which gives the sensation of sinking into it. Then, she is covered by a heavy 10kg blanket (1.2 X 1.4 meters, see Figure 1). This combination provides a sense of a protective hug, fully under the patient's control, without having to touch her physically. The goal is to create the feeling of a hug without touch, to prevent any possible reconstruction of the aggressor-victim relationship.

If dissociation occurs despite the preventive measures, and deteriorates (a stronger sense of detachment from the environment), the nurses place ice on the patient's temples. If it seems the patient is regaining some contact with reality, the nurse asks her to hold the ice to her sternum. The ice blocks are ready with wooden handles. However, if the dissociative state becomes more severe, a doctor is called in to administer an intramuscular injection of Phenergan 50mg (with previous patient consent).

Figure 1. *"Grounding" technique for severe dissociative episodes*



Throughout the episode, the nurse continuously repeats calming statements regarding time, place and safe surrounding, and the patient is not left alone.

TREATMENT OF CONSCIOUS IRREGULAR BEHAVIOR EPISODES THAT BREAK THE DEPARTMENT RULES

In cases in which the patient intently breaks the rules, we developed a multi-station method to deal with it. The patient receives a list of five therapists she must talk to immediately. She has to explain to each one separately what she did. The last on the list is always the department director.

This process has a number of goals. First, it forces the patient to take responsibility for her actions. In addition, the event is processed massively, which facilitates a shift from possible resistance and denial of the event's severity to understanding the behavior's damage to the patient's individual therapeutic process and that of the departmental therapy group. In most cases, the final outcome is that the patient understands, internalizes, and regrets the act, and realizes that the behavior affects her adversely.

SUMMARY

This paper presents a description based on experience accumulated from 100 hospitalizations of sexual trauma patients in an acute psychiatric ward. Over the described three-year period, no completed suicide report was received for any former patient in the program. Some patients returned for an additional hospitalization period, but abided by the rule that they could not return to this specific program unless three months had passed since they were last discharged. It should be stressed that this type of treatment involves considerable investment in the treatment staff.

CONCLUSIONS

- Standard treatment for patients being hospitalized in acute conditions does not apply itself in cases of sexually traumatized patients.
- Tailor made treatment methods that have been specifically modeled for these patients will best help them in these complicated situations.
- Focused inpatient psychiatric care is the most efficient way to facilitate ambulatory care in sexually traumatized patients.
- Integrating sexual traumatized patients into an acute psychiatric ward has many benefits and may allow a speedy reorganization and return to personal specific treatment.
- Treatment in a mixed ward allows for gender specific complications to arise and to be addressed in a timely fashion. This may not be preferential for every patient.
- Treatment success is dependent upon building a structured treatment focused plan that is professional and specific for this population.
- This treatment plan is appropriate for mental health systems in which psychiatric wards are found in general hospitals as well as in psychiatric hospitals.

This paper depicts one hospital in a specific region in Israel and may not be easily generalized to other geographical areas. It should also be stated that this method of treatment requires much investment in staff training and much attention to how these patients effect staff members and other patients on the ward. Furthermore, we did not differentiate between different types of sexual trauma in the patients (i.e., complex childhood abuse, one-time sexual trauma during childhood or adulthood) and this distinction may warrant further investigation. The authors recommend that the Israeli mental health system direct specific wards throughout the country to adjust themselves to suit sexual trauma victim patients. These wards would be part of the continuum of treatment already in place for these patients. These wards should have specialized staff members to deal with specific problems arising from the complex treatment of sexual trauma victims.

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