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USING TRAUMA THEORY AND S.A.G.E. IN OUTPATIENT PSYCHIATRIC PRACTICE

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In this paper the author reviews case examples of how a thorough understanding of trauma and recovery combined with a coherent, nonlinear, phased approach to treatment called S.A.G.E., helps to provide a conceptual framework that is easily understood by clients and their families and allows the clinician to organize and measure treatment success, regardless of the complexity of the cases involved.

KEY WORDS: sanctuary; outpatient; psychiatry; trauma; PTSD.

SANCTUARY® AND SAGE IN EVERYDAY PSYCHIATRIC PRACTICE

The events of September 11, 2001 have helped clinicians and clients to see that life-threatening experiences have potentially serious physical and psychological consequences. This article is meant to help the practicing mental health or primary care clinician realize the benefit of understanding trauma theory for every day practice. You do not need to be a trauma expert in order to use the benefits of trauma theory. Trauma

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theory holds that there are biopsychosocial consequences to any individual when he/she sustains a serious threat. The person responds to what has happened in order to preserve physical and emotional integrity but there is a possibility that the physical, psychological, and social consequences may in fact become harmful to the individual.

There have been many gains in our biological understanding of the impact of trauma on the mind and body (1). Psychologists and psychiatrists have long observed that childhood abuse can lead to attachment disruption, self-defeating personality defenses, and arrested psychosocial development in adults. But more recent brain imaging studies reveal the possibility for permanent neuronal damage in the developing brain itself (2).

Since a majority of the population will experience traumatic stress during their lifetime, the impact of stress can be devastating to the individual and society (3). The more we understand about how a traumatic experience can manifest itself clinically, the better we can do with offering treatment approaches and prevention. A person who experiences a traumatic event can suffer from the following: a) cognitive dysfunction i.e. memory and attention deficits; b) emotional problems i.e. affective dysregulation, depression, severe anxiety; c) behavioral manifestations including self-mutilation, substance abuse, sex addiction, impulsivity and aggression; d) learning difficulties due to increased arousal and lack of attention or concentration i.e. state-dependent learning; and e) memory dysfunction from dissociation and the biochemical changes with memory processing during extreme stress. In order for a clinician to effectively assess and treat anyone, there is a need for thorough understanding of the stress response and its many presentations.

A simple way to remember key concepts from trauma theory is to understand SAGE. SAGE is a cognitive-behavioral translation of the Sanctuary Model. The Sanctuary Model is a trauma-based therapeutic milieu approach which has been applied in many different inpatient, residential, and school settings (4–8). It has also been used in the outpatient setting for both groups and individuals. SAGE stands for Safety, Affect Management, Grieving, and Emancipation. Much of the initial focus in treatment is on Safety and Affect Management. Our definition of Safety encompasses four domains: physical, psychological, social, and moral (9). Most of the problem behaviors and overwhelming emotions that present difficulties for clients, clinicians and behavioral health settings reflect problems with appropriate Affect Management. Grieving can be clinically recognized as a failure to move on, reenactment behavior, chronic depressive symptoms, sudden regression, and unresolved bereavement. Emancipation represents the objective—the

hopeful vision of what the future can look like as a result of recovery and includes the willingness to engage in transformation that would lead beyond the "sick" role. This nonlinear conceptualization of the essential tasks of recovery allows the clinician to be very comprehensive in the approach to the individual patient while keeping things simple. It is also possible to apply any of the many useful psychodynamic, cognitive-behavioral, analytical, biological, social, nonverbal/creative therapies to the patient in a way that he/she benefits from the wisdom of many models (10,11).

The examples that follow are all composite cases from outpatient practice. Each case is representative of a cluster of diagnostic symptoms which are not unique to any one person. These patients come from many different cultural and social backgrounds and their experiences are diverse, as are those of the clinicians who treat them. The unifying key is the SAGE model. The clinician and the patient can meet on common ground about the concepts of safety, affect modulation, grieving, and emancipation.

CASE ONE

Bobby was a 28 y/o male referred for medication management of mood swings by a therapist who had only been seeing him for several months. He had a history of forced psychiatric hospitalization at age 9, substance abuse, physical and emotional abuse by both parents as a child. He had a family history of bipolar illness, and obsessive-compulsive disorder. As a child he had been forced to see several psychiatrists who he felt had betrayed his trust by revealing everything he discussed with his parents and failing to recognize the abuse he was suffering at their hands. Over the years he had been tried on a number of medications but his general distrust of psychiatry made compliance a problem.

Bobby presented with prominent irritable, intense, dysphoric mania. He was extremely intelligent, but very impulsive with poor concentration and attention, and severe sleeplessness along with some psychotic symptoms. I diagnosed him with bipolar disorder, manic episode. He was placed initially on valproic acid and olanzepine. His family had been begging him to see a psychiatrist for the past twelve years, but he had consistently refused because of his negative experiences with psychiatric care as a child.

Although on the surface this appears to be a straightforward case of someone with a clear bipolar disorder who has never had adequate pharmacotherapy and just needs good medication management, his problems were compounded by his past negative experiences with the

mental health system layered on top of childhood abuse. When I interviewed this patient initially, it was very obvious that he had avoided treatment because of his previous treatment experiences. Additionally, he had suffered significant attachment disruption in his preadolescent years due to the relational chaos of his dysfunctional parents. He had good insight about his severe mental illness, and knew that if he could get his mood disorder regulated his life would become much better. However, in a manic and vulnerable state his presentation was that of a scared, impulsive, angry adolescent, not unlike the state he was in when his mother had forced psychiatric treatment upon him around age 9. But since he did not present with the obvious symptoms of PTSD, the impact of the past trauma could be easily overlooked. Bobby illustrates why understanding trauma theory and using SAGE makes treatment with an apparently noncompliant patient possible. In order to adequately medicate him for the bipolar disorder, I had to make up for his bad hospital experiences and avoid any potential reenactment with an abusive parent.

In S.A.G.E. terms, Bobby was not Safe because he suffered with mood swings, impulsivity, insomnia, and other symptoms of bipolar disorder. He was also using drugs like opiates, alcohol, and street diazepam to slow down his mind and this behavior was also not safe. His affect was intense and he would often become destructive because he could not contain his emotions. I would have much preferred having this patient in the hospital and discussed this with him on several occasions. He never gave me any reason to force him into the hospital and that action would have been ultimately extremely damaging, a reenactment of the helplessness and betrayal of trust he felt as a child. He would have experienced a loss of trust, a loss of control, and he could have reacted aggressively to the staff as a result, and perhaps have become the victim of intentional or unintentional abuse. He was willing to engage with me in treatment as a partner, but it was also clear that he would have to test whether or not I was a trustworthy adult. He was very intelligent but unable to work in jobs that suited his education because of his inability to manage mood swings and his impulsivity. He needed help to understand his mental illness and how taking responsibility could improve his life and make him feel safer in the world.

As I discussed with him the ways in which medication could help him with both Safety and Affect Management issues, he finally agreed to take medication and rapidly improved. He continued to learn about his illness in therapy. He was also able to give up alcohol, prescription drugs he abused, and even the pot. I saw my role as one of helping him to be safe and to begin the process of affect management. Within

about eight weeks his mood was significantly improved. He was able to sleep more regularly with the help of mood stabilizers. He began to search for a job. He interviewed for several jobs, and finally accepted a position. Once his mood became more stable and he was not as irritable and impulsive, he began to work in individual therapy on the family dynamics that had complicated his life and compromised his Safety. He learned about his tendency to regress and become helpless when he was sicker either physically or mentally, behavior that would always prompt contact with his mother and replicate numerous childhood dynamics.

CASE TWO

Wanda is a 66 y/o single female with a long history of alcohol dependence, recurrent depression, and severe generalized anxiety. She has never been able to keep a job and requires fairly continuous support. She grew up in an alcoholic family with very few dependable attachment figures. She has numerous serious but stable chronic medical conditions including hypertension, peripheral vascular disease, and coronary artery disease. Wanda lives with one of her alcoholic sisters. She has been hospitalized numerous times for recurrent depression and suicide attempts. She has had long periods of sobriety, but has been hospitalized for alcohol treatment as well. She was raised by alcoholic parents. She was sexually abused by a brother, and suffered physical abuse in a Catholic school as a child.

Initially when I met Wanda, I was very impressed by the severity of her attachment disorder, level of anxiety and level of dysfunction. It became clear to me with the help of supervision that she needed to do reattachment repair work with a clear and benevolent authority figure. I soon realized that Wanda's problems with Safety included active alcohol abuse, suicidality, and problems with not feeling safe with her family. She had sudden and extreme affective outbursts that repeatedly led to psychiatric admission. Sometimes she would be very depressed or severely anxious. Her anxiety could present itself as somatic or panic attacks, compulsive cleaning, intoxication, or a suicide attempt.

Wanda had really never been able to have meaningful relationships. She was always saddened by not feeling loved by her parents, especially her mother. She never finished school, and did not feel as though she could contribute to society. There were plenty of things she could Grieve over. Her view of Emancipation would be to live on her own away from her alcoholic siblings. She has accepted that she will never be able to independently support herself. But Wanda does want to teach others

about the perils of alcoholism, or why support and medication can be so helpful, or why her faith is so important to her.

The SAGE model helped me to recognize why it has been important to allow Wanda to attach to me and other professionals and not always view that as regression. It has helped me to supervise her therapist and case manager, and assist them with the realization that this woman will make very, very slow and subtle changes towards health. She has gained insight into the connection of the dysfunctional alcoholic family, childhood abuse, and her own problems with instability and alcoholism. She has greatly benefited from the 12-step model of Alcoholics Anonymous for support, structure, and consistency. Wanda's treatment plan at this point focuses on the following: 1) Safety—maintain sobriety, consider looking into supported living so she can be out of the chaotic family household, continue with her current psychotropic regimen, continue with regular supportive therapy to maintain a strong attachment; 2) Affect management—support small challenges to her anxiety with increasing social interaction at AA meetings, increase her repertoire of healthy behaviors which she can use when she does become overwhelmed by family stressors; 3) Grieving—help her to acknowledge the losses she has suffered at the same time that she recognizes the gains she has made in terms of self care; and 4) Emancipation—encourage her continued independence from the dysfunctional alcoholic sisters while at the same time helping her to acknowledge that she does derive some type of support from them, and fostering her spiritual growth as a reasonable way for her to feel successful about her life gains. I view a period of four years with no psychiatric hospitalizations as a great success. In fact she has learned to manage her affect successfully under most conditions. She still occasionally has a relapse with alcohol, but will bounce back quicker. She will require chronic psychotropic medication and chronic supportive psychotherapy, but the intensity of her treatment has lessened because of her ability to reach the stages of Grieving and Emancipation.

CASE THREE

Harvey is a 38 y/o married white male, quadraplegic following a severe traumatic brain injury from a gun shot wound. He was shot while at work as a police officer after his partner had been killed by the same assailant using Harvey's gun. A wife and three sons survived the partner and Harvey had not seen them since before the accident. He had required extensive medical and surgical treatment. His initial psychiatric presentation was for recurrent nightmares and flashbacks of the

gunshot wound. He was in a physical rehabilitation hospital, but his doctors did not believe that he had the cognitive ability to process what had happened to him. His doctors went so far as to inform his wife that he had sustained too much brain damage to have symptoms of PTSD. After all Harvey had lost most of his right temporal lobe and parts of both parietal and frontal lobes. His wife, however, was very convinced that he needed therapy to deal with this tragedy. When his cognitive function improved to the point that he could hold coherent conversations, he began to have severe mood swings and periods of psychosis along with his posttraumatic symptoms. When I began seeing Harvey initially he was constantly irritable and depressed, and suffering with classic PTSD symptoms. He was also more continuously paranoid, feeling that I or someone else in an authority position had planned the shooting. His physical limitations made suicide attempts difficult but he did try to talk his wife into killing him. He was psychiatrically hospitalized twice in one year, about four years after the gun shot injury.

I used the SAGE model to guide and structure his treatment. His speech has a mildly altered form and cadence, but nevertheless is very clear and understandable. At times, he can have loose associations, tangential and circumstantial thought patterns, paranoid delusions, and severe irritability. He is on no maintenance psychotropic medication, but when he feels particularly stressed or is facing a significant event he sometimes requests to be given a depot neuroleptic. His Safety problems affected many levels of his life. His physical safety was compromised due to his injury; his psychological safety was impaired secondary to the psychosis, depression, and irritability; his sense of social safety had been radically altered in losing a partner/friend, enduring changed roles as a father and husband, and losing the ability to engage with others as he had before because of his injuries; and he lost his sense of moral safety because he lost faith in the system of justice and experienced problems with the Catholic church while still experiencing overwhelming guilt, coming to believe that his previous sins were the cause of this tragedy.

He required hospitalizations and more intensive outpatient individual and couples therapy because of his problems with Affect management. He resisted taking psychotropic medications. He was on an SSRI for a short time to treat his depression and PTSD symptoms. He was given an antipsychotic periodically for his most severe psychotic episodes. Despite his cognitive limitations, he was able to do cognitive and nonverbal processing of the shooting as a traumatic event. I methodically processed the events of this tragedy using a structured nonverbal cognitive processing method technique called "Trauma Art" (12).

This therapy was very helpful in reducing his symptoms and also reintegrating him into his family unit. Even though his physical injuries precluded him from performing normally with the task of drawing the traumatic events that is a component of the Trauma Art technique, what seemed to matter most was his ability to move his hand, scribble the images flooding his mind and put some structure and order to what had happened. It was also helpful for his wife in increasing her level of understanding what had happened to him.

Working through the Grieving and loss was a more challenging process. He really functioned best as a partner and not alone. He had been with his current wife since they were in seventh grade. He had his police partner for thirteen years, and he had been his best friend. He could not focus on Emancipation and being able to accept his physical and mental limitations until he could deal with the loss of his partner. I conceptualized his problem with Grieving and Emancipation as a refusal or denial of his loss both physically and with his marriage. He was observed to have brief psychotic episodes when there was severe conflict with his wife. This was very upsetting to her, but I soon realized that this was his only defense. The only way he could have any control in the relationship was to become "crazy" and to tell his wife that she was not the real wife. He would repeatedly tell her that she was not real, and she would become so upset that she would leave the house for awhile. If I lacked an understanding of trauma theory this behavior would not have made sense to me. He was reenacting the loss of his partner with his wife. Over time he has done this less and less frequently because I have made both he and his wife consciously aware of this pattern. He has also needed to deal with his Catholic guilt. With my support he was able to meet with a priest who heard him confess his sins in order that he could be more accepting of this tragedy. Harvey also symbolically reunited with his partner-his wife-by ceremonially repeating his marriage vows in a church.

SAGE provided the structure to guide me through this very complicated case to a place of stability. Harvey sees me for a medication check and brief psychotherapy about once every two to three months. He has volunteered to speak to nurses who deal with head injured patients, and spends the rest of his time with his wife and son.

CASE FIVE

Pam is a 40 year old married incest victim. In the prior three years, unresolved issues around the incest with her father had surfaced. Her parents were still married, and her father had admitted to the incest.

Pam and her husband have two sons and two daughters who are all healthy and very bright. Her marriage had been filled with the stress of raising children, meeting financial demands, dealing with both sets of in-laws and Pam's recent awareness of her incest experience. Pam's family was well aware of Pam's anxiety problem and she severed contact with her father after realizing the incest. This change put severe strain on both Pam's family and that of her siblings.

She came seeking help for her severe anxiety and significant PTSD symptoms. She suffered with severe hyper vigilance and arousal, recurrent nightmares and flashbacks, and increasing avoidance of social situations and any encounter that would remind her of her father. Her anxiety was profound. She had severe obsessive ruminations and compulsive cleaning and checking rituals. These obsessions and compulsions were primarily focused on her work routine and cleaning the house. Her goal was perfection, and she in fact was literally driving her entire family crazy with the severe focus on cleanliness. Pam's husband began marijuana after getting home from work. He had a family history of substance abuse and his own problems with anxiety, but the stress of his wife's severe compulsive behaviors was too much for him. Pam also had extreme affective meltdowns where she would hysterically cry and panic. She would become very depressed and unable to eat or sleep.

Pam was intelligent and it was clear that she needed to resolve her incest experience with her father and be able to empower herself to move on in life. Using SAGE helped Pam focus on safety and the need to maintain healthier boundaries. Pam was effectively recreating her incestuous family of origin within her own family. She was intrusively interfering with her husband's and children's lives, crossing their boundaries, intruding on their privacy. Her worry, doubt, and fear were contagious. Pam's husband was unable to intervene and thus filled the role of the helpless bystander.

Pam was a very confusing and difficult to manage case. Her shifting symptoms along with her problematic behavior toward her children made a consistent treatment plan difficult to maintain. I would often meet with both she and her husband and another colleague because there would be such a vast difference between what she was reporting, what I observed, and what her husband reported. Through trauma theory it is possible to see that she unconsciously wanted to repair the family of origin and fix the trauma. She behaviorally was willing to sacrifice her own family of choice to do so. Her husband was considering a divorce, and all four kids were already beginning to distance themselves in order to lessen their own stress. Once Pam gained insight into her

reenactment, she was willing to engage in changes that would make her feel safer and provides clearer boundaries.

The chaos in her own life and its impact on her family is a fair representation of her childhood chaos. As long as I "chased her symptoms," her progress was stifled. I attempted to apply more standard cognitive behavioral strategies for her splitting and compulsive defenses, but she would just seem to change symptoms and become hyper-focused or obsessive about following rules. In order to help Pam make herself and her family feel safe, she needed to be the one to change things, to take control of her life, not me. Using S.A.G.E. as a coherent framework helped her realize this. I had to step back and help her to make decisions to stop the reenactment with her current family that could possibly end in divorce resulting in significant stress to her entire family.

Pam already was aware of many aspects of her traumatic experience. She wanted to forgive her father, repair the family, and skip the Grieving process and the anger that accompanies it. Her treatment plan included the following: 1) reduce the severe obsessive and compulsive anxiety with psychotropic medication; 2) recommend couple's therapy for Pam and her husband to focus on stress management and ways to cope with their sons; 3) reduce contact with her parents, and limit visits by her mother; 4) begin daily stress management to lessen anxiety and focus more energy on self-soothing; and 5) gradually begin the process of grieving and anger work regarding the incest experience while helping Pam to realize that she could make new connections with her family of origin as long as it is safe and in the present not the past.

Pam greatly benefited from medication to reduce her severe PTSD anxiety. She began couples therapy and started applying boundaries to all of her family relationships. She was able to return to work, and begin some basic self-care. She decided to try yoga for improved body awareness and to help her learn to slow her thoughts down. She realizes that she still needs a lot of help to deal with grieving about her incest, and continues to struggle with guilt about any anger directed towards her parents, but she is at least willing to consider this as opposed to manifesting her affect as a psychotic regression.

CASE SIX

Denise is a 40-year-old businesswoman referred because of severe dissociative symptoms including derealization, loss of time, depersonalization, and memory dysfunction. She began to have these dissociative symptoms about one year prior to seeing me, but they were more

sporadic until about three months prior to our initial contact, precipitated by her father's death. She had a history of childhood physical and sexual abuse but did not describe or complain specifically of flashbacks or nightmares. Instead she was suffering with increasingly severe physical problems related to her gastrointestinal and genitourinary tract.

Over the previous year she had been extensively evaluated for severe and chronic constipation as well as an inability to urinate. Her problem with urination had started about two and a half years earlier and about a year prior to this, she began having severe abdominal and pelvic pain followed by severe constipation. Medical studies had demonstrated no clear explanation for her symptoms and the recommendation was for her to perform daily bladder catheterization for herself. She was evaluated with endoscopy, lab tests, X-rays, and MRI for the colon problems and no evidence of any pathology was found. She was seen and evaluated at a tertiary medical center with a recommendation given for a colon resection.

When she came to be evaluated by me, she was concerned about this impending colon surgery and having to recurrently catheterize herself. She was scheduled to have surgery within the next six weeks. In the process of all of these medical exams, Denise had become increasingly anxious and she began to have more severe dissociative symptoms. Her husband had closely observed her dissociative episodes and could describe in detail her regression. According to him she would become most dissociated following a physical symptom. She would have severe abdominal or pelvic pain and then regress and become very childlike. She might cry or scream, but she would be very difficult to understand. Later, she recalled nothing of these episodes. As a last resort before surgery she decided to see if it was all "in her head."

Denise's psychiatric evaluation revealed a mild depression, some psychomotor agitation, and mild anxiety. She did not have any suicidal ideation, any hallucinations or paranoia. She seemed disturbed by descriptions of her dissociation. Because she had such a focus on her physical problems, and there had been no real pathology discovered from her extensive medical work-up, the possibility that her medical problems were body memories of the previous trauma had to be considered. As we began probing her history, her physical symptoms escalated as did her level of dissociation. She had to take a medical leave from her job, and she had become increasingly isolated.

Trauma theory provides a possible explanation for things, which on the surface do not make sense. The possibility of a psychosomatic explanation of bladder dysfunction and constipation was explained to Denise. She was skeptical at first but then she was able to recognize that the

onset of her dissociative symptoms and the worsening physical problems coincided with her father's illness. She had already admitted to a history of childhood abuse by her father and her husband was able to validate this history independently. I presented a concrete explanation about the possibility that if she had been sexually abused the fundamental damage was a loss of personal control. With this in mind, I asked Denise to observe that her body currently had total control. She was controlling both her bowel and bladder to such a degree that the only alternatives were catheterization and surgery. This was evidence to me that her mind was quite powerful and that she had no intention of loosing control ever again. I had previously read case reports about sexually abused patients who had problems with incontinence and bladder dysfunction. She was neurologically intact, so there was no reason to consider something "more" organic like a brain tumor, there was no evidence of ongoing domestic violence, and she was not psychotic.

The SAGE model was explained to her. We discussed how she could remain in control and still be able to let her body function normally. In fact, I suggested that if she kept herself from having normal bowel and bladder function that she was in fact being as controlling and abusive to herself as her father had been when she was a child. Although a dramatic metaphor, I didn't think that Denise's catheterization and potential surgery were any less drastic.

Denise used art, psychodrama, and movement therapy to help her nonverbal mind describe and explain some of the trauma she had suffered with her father. She did make literal connections between her body memories and specific traumatic events with her father. Her ability to have normal bowel and bladder function was directly connected to her conscious cognitive acceptance of her own childhood sexual abuse. She began to focus on Safety and Affect management. Denise and her husband were aware that she had much more work to do in the realm of Grieving for her lost childhood and for the death of her father, and Emancipation—holding a vision of herself as a recovered person. She also gained insight about her patterns of dealing with stress. As she reduced the body memories by feeling safer, the dissociation also lessened. She learned to recognize dissociation and also became more sensitive to physical symptoms as possible warning signs of stress. The SAGE model helped the patient, her husband, and me to remain focused on the goal of getting her to be able to function independently again. As long as she was dissociating, catheterizing herself and planning for a colon resection, she had lost her independence. And as long as she felt dependent and helpless, she emotionally remained in the childhood victim position at the hands of her father. With this insight and support,

she was able to resume normal bowel and bladder function and the need for surgical intervention was eliminated.

CONCLUSION

This paper has presented a number of case examples relevant to a general psychiatric practice in using trauma theory in general, and the S.A.G.E. model specifically, to more adequately address the complex needs of trauma survivors who have various serious comorbid conditions. Focusing on the four aspects of trauma recovery—Safety, Affect management, Grieving, and Emancipation, has allowed the clinician and the client to share a simple understanding of very complex problems, to formulate mutual treatment goals based on this understanding, and to measure progress through the recovery process.

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