Therapist's Page

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Hospitalization As Part of the Recovery Process: When and How to Use It (and What to Expect!)

The symptomatology of the posttraumatic/dissociative disorder spectrum of adult survivors of childhood trauma is often variable and can be intense and destabilizing. Survivors, despite intelligence, resilience, and even professional competence, may have contended \with numerous difficulties related to their past trauma including symptoms that waxed and waned over many years. These symptoms may have been chronic and acute for years or they may have emerged in delayed form as a consequence of a specific trigger or cue or some other circumstance. The most common triggers to the emergence of symptoms and/or memories are developmental milestones (e.g., the birth of a child, a child who reaches the age at which the survivor was abused), major changes in a relationships (often involving loss), revictimization, anniversaries, medical diagnoses or other types of personal crises, or something reminiscent of aspects of the original trauma (a movie scene, a media account).

Posttraumatic symptomatology varies in seriousness and intensity. At its most acute, it often includes but is not limited to, debilitating depression, anxiety and panic, suicidal ideation/ behavior, self-mutilation, revictimization, flashbacks and other reexperiencing phenomena, sleep disturbance, numbing and distancing reactions, self-alienation, physiologic hyperarousal, and dissociative experiences ranging from "spacing out" to internal ego states to discrete dissociative identities with amnesia. It may further include relational and sexual difficulties and associated substance abuse, eating disorders, and medical conditions. Despite these serious issues, symptoms, and their associated diagnoses, many adult survivors are able to function fairly well in the context of outpatient treatment alone; however, they may periodically need more by way of support and safety, making hospitalization the option of choice. Many will be hospitalized on general psychiatric units because specialized services are not readily available to them. This is generally not the optimal circumstance because posttraumatic conditions often go unrecognized and unaddressed or the symptoms are misdiagnosed in such a setting. (As an aside, it is unfortunately still the case that mental health professionals remain undertrained in how to recognize and treat posttraumatic conditions.) Other survivors \will have the opportunity to be hospitalized on a specialty unit, one specifically designed to offer services tailored to their diagnosis and symptoms. At the present time, there are approximately 10-15 such units across the country (excluding VA services), all too few for the need.

In this brief article, we review the advantages of specialized hospital programs for posttraumatic conditions and discuss when and how to use such programs and what to expect. We begin by reviewing some of the changes that have occurred in these programs in recent years as the result of two different factors: 1) changes in the larger medicavmental health system, particularly managed care; 2) developments in the field of traumatology along with increased experience and knowledge in treating complex posttraumatic conditions.

A Snapshot of Today's Specialty Program

The most obvious change in specialty inpatient programs is the length of stay. Like other medical and mental health treatments and due mainly to the influence of managed care, the average length of stay has dropped dramatically from a high of 6-8 weeks to 10- 15 days. At the present time, it is also much more difficult to be hospitalized than previously. Often, admissions must be pre-certified by the insurance carrier and only the most acute situations qualify. These include danger to self and others in the form of a serious suicide attempt, actual violence or threats of violence towards others, and critical decompensation and/or inability to function. This is an unfortunate circumstance because it often means that the survivor entering the hospital i in a more acute state of impairment than if admission had been achieved earlier and that he or she may, therefore, need more time to stabilize before being able to engage in treatment.

Most programs have coped with the shortened length of stay by developing a continuum of care that includes different levels of intensity, from the inpatient setting to a partial hospitalization program to intensive and structured outpatient services. All are designed to function adjunctively and collaboratively with the survivor's outpatient provider. Patients should anticipate that their inpatient stay will be as brief as possible and that they may move through different levels of treatment as they stabilize symptoms and increase their capacity to function.

They will also be encouraged to identify their treatment goals and to engage in the treatment process as quickly as possible.

Specialty programs have been developed with the purpose of attending to victimization traumatization as an important issue that has had a contributory role in the individual's life and mental health difficulties. Many posttraumatic reactions and symptoms are viewed as normal responses to abnormal circumstances that, over time, have become problematic. A philosophical approach of "What happened to you?"

versus "What's wrong with you?"' is operative. These programs offer specialized understanding of traumatization and the range of posttraumatic responses including co-morbidity with other psychiatric conditions. They are focused first and foremost on safety and personal stabilization, recognizing that no therapeutic work gets done if the individual is not safe. They seek to actively engage the survivor in the therapeutic work and, t ' hrough the treatment, to offer and restore the individual's hope. They also focus intensively on education and skill-building directed towards self-management of symptoms since many individuals traumatized as children missed out on learning basic life skills. Most, if not all, of the existing programs have a multidisciplinary staff that offers a wide array of therapeutic activities in a highly structured treatment environment. Most programs now offer programming on week-ends as well as during the week, another development influenced by the demands and constraints of managed care.

The evolving standard of care for trauma treatment (for both posttraumatic and/or dissociative conditions) is that it is organized and progressive. In addition to a pre-treatment assessment, trauma treatment generally has three stages and is sequenced. Each stage has unique treatment goals (or healing tasks) and therapeutic strategies to achieve them, but the progression is not lock step and must be tailored to the needs of the individual. The model plans for regression and relapse. Patients often need to go back to earlier healing tasks and re-work them, sometimes many times over, before they are resolved. Healing tasks build on each other in hierarchical fashion and the resolution of one issue often opens the way to the emergence of others. The initial stage is devoted to safety, education, self-management, stabilization, and the development of a treatment alliance. It is measured in skill rather than in time and is usually the most lengthy phase of the treatment. Most hospital work is encompassed within this phase. The second stage involves facing and resolving issues related to the victimizatior/traumatization. It is often the most painful part of the process and may involve additional supports and structure, including hospitalization. This work is done with great attention to pacing so that the patient is not retraumatized in the process and so he or she retains the capacity to function (or return to functioning) as the work progresses. The third phase involves a more direct focus on self and relational development, post trauma resolution. This is often a time of great growth and expanded freedom and opportunity.

When and How to Use A Specialty Program

Hospitalization is best used as a voluntary or elective option, put in place when safety and functioning are severely compromised. Patients who are likely to benefit the most are those who are willing to work collaboratively with the treatment team and those who develop realistic goals and a solid focus for their treatment. In the current atmosphere, it is helpful for the survivor to understand that an inpatient stay is only one part (and possibly a very small part) of the ongoing treatment. The hospital is where more intensified work is conducted in a highly structured, safety-conscious environment with a range of therapeutic modalities conducted by a multidisciplinary team of professionals; nevertheless, the bulk of the work is still going to be conducted on an outpatient basis. Since length of stay and insurance benefits are limited, it is helpful for the survivor to stay as focused as possible and to try not to resist, avoid, or distract from the main treatment issues. It is also helpful if the patient is open to new perspectives and to new skills and problem solving mechanisms. Healing is hard work and requires effort and perseverance but it also involves learning to pace the work modulate and tolerate strong emotion, and "make haste slowly" (and always \with safety in mind).

The symptoms leading to hospitalization are often precipitated by psychosocial stressors. Most programs offer social work and case management services to assist with locating resources and addressing and decreasing the impact of external stressors; however, as with other issues, these will be more fully addressed and resolved on an outpatient basis. Since hospitalization is a time of stress, it is also a time to mobilize one's personal support network. Supportive others can be invaluable to the healing process. Most programs coordinate closely with the survivor's outpatient therapist in order to work collaboratively on the same treatment goals (at whatever point on the treatment continuum) and to insure smooth discharge and transition from one level of care to the next.

Discharge planning begins virtually at the time of admission. It is organized primarily around the maintenance of safety and the development of a concrete plan for return to a less restrictive environment. It often begins with a "step down" to a partial hospitalization level care where the same philosophy of treatment holds and intensive educational and skill-building efforts are continued in the context of strong interpersonal support. Often, patients remain in a partial hospitalization program over a more extended period of time (depending on their resources and insurance benefits) and decrease their involvement as they strengthen their skills. The continuum of care offers many options not previously available to support the survivor in healing work as he or she reengages with outside life and \with outpatient treatment.