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CREATING SANCTUARY: HEALING FROM SYSTEMATIC ABUSES OF POWER

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Abstract

This paper describes a short-term modified therapeutic milieu program called *The Sanctuary,* designed specifically for the treatment of trauma-related disorders in adults. The relationship between a trauma-based model and the therapeutic milieu model are explored. The fundamental assumptions that inform the treatment model are outlined as well as the goals of treatment.

Introduction

If one reviews the general psychiatric literature of the past decade, it would be relatively easy to conclude that the therapeutic community model of treatment has died what many of us would consider an "untimely death" – at least in the United States. In a search of U.S. literature databases for the last five years for the therapeutic community and the therapeutic milieu, less than twenty-five articles focus on the inpatient psychiatric aspects of these topics. However our growing awareness of the long-term consequences of unresolved traumatic experience combined with the disintegration of communities of meaning, encourages a new look at the established practice and principles of the therapeutic milieu model.

Our program is called *The Sanctuary* and is now located at two sites, one in suburban Philadelphia and another in New Jersey. It is a program designed to meet the needs of adults who have been traumatised, usually as children. We treat men and women over the age of eighteen. Given the constraints of the current health care environment in the United States, the lengths of stay for our patients is very short – down to around nine days (See Bloom, Introduction, this volume). Frequently however, patients are hospitalised several times over the course of a year, an outcome we do not see as an increase in "recidivism", since they rarely have the time necessary to accomplish appropriate goals during their initial admission. In between admissions, patients are followed by their outpatient therapist who has usually become familiar with the treatment regimen, goals, and practices of the inpatient setting and is thereby able to utilise the hospital as a part of an overall treatment continuum when necessary.

In this paper, I will outline how our practice has changed as a result of the demand to shorten lengths of stay while functioning with fewer staff to help patients who are suffering from higher acuity conditions. We have responded to these challenges in a number of ways, while still maintaining a sense of community. Given the short lengths of stay, it

would be a mistake to think of our program as a traditional therapeutic community (TC). We tend to use the term "therapeutic milieu" in the sense of a carefully arranged environment for the treatment of our patients, a milieu designed to begin reversing the effects of growing up in situations characterized by interpersonal violence (Bloom, 1997; Leeman, 1986). However, we adhere as best we can to the tenets of the TC, including an emphasis on an informal and communal atmosphere, the central place of group meetings in the program, a belief in the therapeutic role of everyone in the environment, and a sharing of authority, responsibility, and the tasks of maintaining the community (Kennard, 1998). We also share a system of values and beliefs that will be discussed in this paper. It is more accurate to call *The Sanctuary* a trauma-based, nonviolent, therapeutic culture that emphasizes what Haigh has described as the five ingredients of a such an environment: 1) attachment: a culture of belonging; 2) containment: a culture of safety; 3) communication: a culture of openness; 4) involvement: a culture of participation and citizenship; 5) agency: a culture of empowerment (Haigh, 1999).

Background

In 1980, we – a psychiatrist, clinical nurse specialist, and social worker - founded a psychiatric unit in a general hospital using a therapeutic milieu approach in an open, voluntary setting. Our patients suffered from a variety of different problem and usually stayed in the hospital for about three weeks. Around 1985, consistent with the observation of other clinicians (Jacobson and Herald, 1990; Jacobson and Richardson, 1987; Jacobson et al, 1987), we began to recognise that a majority of our patients had been exposed to severely traumatising environments as children. They had learned to survive and to cope with overwhelming stress, but the price of their survival had been paid with their mental health. Our patients were victims of torture, usually suffered at the hands of those upon whom they were supposed to be able to depend. In order to survive under such abnormal conditions they had been forced to adopt extremely twisted norms for self-in-relation-to-other.

We were compelled to rethink our conceptualisations of treatment and to re-evaluate our basic assumptions, goals, and practice. Out of this process emerged our conceptualisation of a "sanctuary" which I have described in several articles and a book (Bloom 1994a, 1994b, 1997). The name itself derived from the concept of "sanctuary trauma", defined as that which occurs when an individual who has suffered a severe stressor next encounters what was expected to be a supportive and protective environment and discovers only more trauma (Silver, 1986).

In 1991, we moved our program to a private psychiatric facility in suburban Philadelphia and named it *The Sanctuary,* in order to specialise in the treatment of adult survivors of trauma and abuse. We continued to develop our treatment philosophy and practice from 1991-1996, but then were forced to move again because of the deteriorating economic position of the institution. From 1996-1999 we located our program at an urban not-for-profit institution, encountering an even more severely impaired and diverse population. Meanwhile, the health care environment had become increasingly hostile to intensive, psychotherapeutically-driven care and in the Summer of 1999, we simultaneously moved our program to yet another private suburban hospital and opened a sister unit in the neighbouring state of New Jersey. These moves have been disruptive but have also compelled us to think about and plan for program replication.

Our patients enter the hospital for a number of different reasons and carry many different psychiatric diagnoses. Most of them are engaged in some form of self-destructive behaviour such as self-mutilation, addictions, eating disorders, suicidality, risk-taking behaviours, and involvement in violent relationships. They are labelled as suffering from major depressive disorders, anxiety disorders, dissociative disorders, and personality disorders. Some of them claim to have been involved in satanic cults, some have been involved in religious organisations that could be considered cults. Many of them come from families in which terrible deeds have been perpetrated under the veil of secrecy, tied by the bonds of loyalty and obedience that an abusive family system demands. Virtually all of them share in common deep and pervasive experiences with abuses of power.

We call our shared value base the "trauma model". When we looked back on the changes we had made before and after we had come to recognise the impact of repeated overwhelming stress on the development of our patients, we realised that we had made some major shifts in what we believed about the causes of mental illness, in our stance towards our patients, and in the way we understood their communication to us and our communication to them.

We came to call these our "shared assumptions", the underlying constitutional basis for doing the work we do together. These assumptions derive directly from an understanding of what trauma does to individuals and therefore of what the treatment environment needs to reflect if it is to correct these biopsychosocial disruptions. But the assumptions also derive from our understanding of how groups work together, particularly in light of the fact that trauma always occurs within a social context and social wounds require social healing. We recognised that all that we had previously learned about group influence and community milieu treatment was more important than ever. In fact, the evidence-based knowledge about the effects of trauma gave us a scientific underpinning for the principles of good milieu management that we had routinely applied in the past and also gave support for actively confronting the abusive use of power that is such an inherent part of both dysfunctional families and dysfunctional institutions.

We also realised that we had become far more definitive about what we expected from our patients and about the goals of treatment. In retrospect, we saw that we had previously been very unclear about what we expected from ourselves and from them. Because our goals were unclear, we had often given inconsistent messages, sometimes excusing irresponsible behaviour because of "mental illness" and at other times becoming irritated at our patient's failure to make more progress. By necessity, and as an outcome of our theory development, our goal setting became clearer, more specific, more focused, and more quantifiable.

In a similar way, it became easier to talk about our practice, the natural outgrowth of our shared assumptions and our shared goals. It also became simpler to understand, discuss, and manage the inevitable conflicts that emerge when what we do is not consistent with what we believe and what we are trying to accomplish. In the remainder of this paper I will summarise these shared assumptions, goals, and practice as they have emerged in the course of our endeavours thus far.

Shared Assumptions

The growing body of knowledge about the impact of overwhelming and repeated stress, known as traumatic stress studies, provides a way of understanding the complicated

biopsychosocial and existential syndromes that characterise so many of the patients who challenge the mental health system in any country. The long-lasting effects of trauma and abuse also lead to some practical implications for any treatment environment hoping to address these effects successfully.

Sickness vs. Injury

The starting point of a trauma-based approach is that it serves to normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance. In such a model, dissociation, self-mutilation, abnormal eating behaviours, chronic suicidality and many other forms of compulsive, self- and other-destructive behaviours are seen as "normal responses to abnormal stress", originally useful coping skills for a besieged child, struggling to survive. In this way, the philosophical emphasis shifts from a sickness to an injury model of human dysfunction.

In a sickness model, the cause of the illness is safely lodged within the individual, whether the attributed cause is faulty genes, biochemical dysregulation, or basic badness. In an injury model, the individual certainly brings basic constitutional features into the situation, but then something, or more usually somebody, else, injures the person thus connecting the personal and the sociopolitical environments. In a sickness model, the individual is largely passive, waiting for expert advise or help, expected to understand relatively little about the nature, causes, or cure of his own problems. In an injury model, the injured person is expected to learn about the nature of her injuries and how to promote her own recovery. A sickness model may imply a "magical" cure, or at least stabilisation of symptoms, while an injury model implies recovery and rehabilitation, even if the person needs to learn to function with certain limitations or disabilities. In a sickness model, the individual has relatively little personal responsibility for either the cause of his illness or its treatment, nor does the social environment have much responsibility for the cause or the treatment outcome. In an injury model, the individual and the social environment have a shared responsibility both for the causes of, protection from, and relief of the individual's symptoms. Viewing our patients as adults who experienced primary injuries as children and then often secondary and tertiary injuries as adults shifted our understanding of how to view their problems and shifted our interactions with them.

Developmental Injuries

There is a growing understanding of the profound developmental threats posed by a child's exposure to repeated, overwhelming stress. We now know that traumatised children have disruptions in their basic biological regulatory systems and attachments systems (Ito et al, 1993; Perry, 1994; Perry and Pate, 1994; Trickett and Putnam, 1993). We came to recognize that we were attempting to treat these same children grown up, witnessing the transmutation of childhood stress response syndrome into adult pathology. Years, and sometimes decades later, our adult patients were continuing to behave as if the childhood abuse was ongoing, as if their perpetrators were still an ever-present threat. Their bodies were still reacting to even minor provocation with extreme symptoms of hyperarousal and cognitive distortions. Most of them had internalised the perpetrator and were themselves engaged in destructive acts of violence towards their own bodies and toward others. Frequently, they did not even remember what had happened to them and only through their

behaviour – and the symptoms of their bodies - were they able to tell the story of their pain. The past was haunting them through flashbacks, nightmares, and body memories that were unrelenting in their intensity, as were their own attempts to shut-off the overwhelming nature of these intrusive experiences with whatever substances or behaviours were available. Although carrying many different traditional diagnostic labels, we came to see our patients as suffering from the complex disorders related to exposure to overwhelming stress (Herman, 1992; van der Kolk et al., 1994). All of this meant that we had to simultaneously approach them as functional adults and injured children. Since we could not undo the past, we had to learn how to teach the adult how to "reparent" the child that lived within.

Undoing the Damage of Dysfunctional Systems

This kind of teaching and reorientation process cannot be successful if the treatment environment mimics the behaviours of the dysfunctional systems our patients experienced as children. Given this background, it was necessary to design a treatment program and treatment strategies that could potentially undo some of the damage of living in a dysfunctional system. A dysfunctional system is characterised by a number of traits (Courtois, 1988). These characteristics define many of the system attributes of an abusive family, an abusive religious group, an abusive therapy group, an abusive educational or occupational institution and an abusive government. Typically such systems are riddled by collective denial of problems and shared and shameful secrets. There is a lack of honesty between system members and a web of lies that is difficult to penetrate. The system tends to stay isolated from other systems so that information is not easily shared. The isolation helps maintain the atmosphere of secrecy and ignorance. Those who have power in the system control information and manipulate the information that is available to other members of the system. In doing so, they define reality for everyone. There are often very unclear and shifting roles between members of the system so boundaries are diffuse and confusing and personal boundaries are often violated. There is a poor tolerance for differences among members of the system and no good mechanism for conflict resolution. Instead of resolving conflicts they are kept submerged for as long as possible and if they finally rise to the surface they are dealt with in a highly moralistic, and usually hypocritical way. The open expression of emotion, most importantly the positive emotions that lead to joy, laughter, play, relaxation, friendship, affection, tolerance, forgiveness, and mutual self-regard, are discouraged or actively inhibited. Negative emotional experiences of anger, shaming, ridicule, cynicism, and humiliation are far better tolerated or even encouraged in such systems. Violence or the threat of violence is tolerated, encouraged, and used as an on-going method of controlling the behaviour and experience of others. This violence can come in the form of humiliation and shaming, verbal threats, verbal abuse, sexual abuse or exploitation, physical violence, and threats to the integrity of attachment relationships.

In an attempt to provide a corrective systems experience, the community aspects of the program are primarily maintained by the staff through the explicit and implicit norms that have become a part of the Sanctuary program. During their stay, each patient partakes in this therapeutic milieu, and has the taste of what he or she can feel in an alternative environment. Intensive individual psychotherapy is constrained in such a setting due to time and staffing limitations. Despite these limitations, we have been surprised to discover just how much can actually be accomplished in a short period of time if the patient is a willing partner in the therapeutic exercise. Most importantly we can use the time to provide the patient with a completely different cognitive framework for understanding themselves, their

symptoms, and the world around them. The consequent shift in meaning paradigm often has a dramatic and long-lasting impact.

Our sense of comfort and safety in any setting is largely determined by factors outside of our conscious, verbal awareness. The pressures to conform in any group setting are likely to be conveyed through nonverbal channels and not through information that is verbal, logical and therefore easily analysed or critically appraised by the individual. Human beings adapt to even very adverse conditions quite rapidly and once an abusive environment has become normalised for them, attempts to change these norms will be met with resistance. The more dangerous the environment is and the more normalisation of that environment has been mandatory to survival, the greater the resistance to change, as long as the individual has remained blind to the discrepancy between what is said and what is done within that environment. People who are exposed to lengthy periods of immersion in such dysfunctional systems internalise the norms of these systems in order to survive and remain safe. Within such systems the normative behaviour of denial, coercion, secrecy, and manipulation may be cloaked and given other words like "privacy", "loyalty", "self-sacrifice", and "obedience" so that the individual who is subject to such norms becomes cognitively confused – accepting of the verbal interpretation while nonverbally sensing the more hostile aspects of the environment. Psychological or physical safety may require that the contradictory nonverbal information be denied. Additionally, a coercive system makes it clear that there is no tolerance for questioning this double and contradictory level of meaning and any attempt to do so is labelled as "disloyalty" or "disobedience" and is summarily punished.

This is what makes individual, one-to-one therapy so difficult for people who have been exposed, particularly for a prolonged period of time in childhood, to such "sick" systems. Although the therapist may provide an entirely different normative experience of relationship for the patient, the therapy situation becomes the exception to the rule, while the rule – the normative internalised dysfunctional system – remains intact. People who have been exposed to such pervasive influences can benefit from an immersion in an entirely different environment so that the experience of a reversal of the dysfunctional norming behaviour can occur. Clinical research on such a "laboratory for experimental change" was first explored beginning in the 1940's with the birth in England and the United States of the "therapeutic community".

The therapeutic community norms were consciously designed to be different from those of dysfunctional systems. Safety with oneself and each other was considered paramount. The entire environment was designed to create "living-learning" opportunities for everyone involved – staff and patients alike. The role of the community was to educate its members through a process of conscious problem solving in the midst of critical interpersonal difficulties and conflicts. Decisions were to be made democratically and communally. Each individual was expected to control his or her impulses and to express a need for assistance if these impulses threatened to get out of control. Everyone in the community was expected to behave with dignity and respect toward every other individual, regardless of their status. Authority could safely be questioned and those in authority were expected to learn from experience along with the patients. The community was designed to provide multiple opportunities for all participants to have new experiences in learning how to trust self and others. The environment was to be as least restrictive as possible and every individual was expected to recognise that the community had a responsibility for providing the maximum freedom for the individual while simultaneously enforcing the sense of shared

social responsibility that allowed such freedoms to safely flourish (Jones, 1953, 1968a, 1968b; Main, 1946).

Safety - The First Pillar of Sanctuary

The concept of "sanctuary" refers to the important emphasis we place on the active and conscious development of a sense of safety within the context of a therapeutic milieu (Bloom, 1997). Safety, however, is not a particularly easy subject to define. Haigh has described this fundamental necessary attribute of the therapeutic environment as "containment", and in doing so focuses on the bimodal aspect of true safety: the "maternal" sense of support, tolerance of distress, and connection along with the "paternal" sense of limits, discipline and rules (Haigh, 1999). We found that to adequately talk about safety in the community context, we had to understand four levels of safety simultaneously and dynamically: physical safety, psychological safety, social safety, and moral safety.

Physical safety is the easiest aspect of containment to describe, largely because it relies on tangible and concrete factors. Physical safety is usually what people think of when describing the sense of being safe, since without it, other forms of safety are difficult to achieve. Psychiatry has always recognised the importance of physical safety. Locked doors, bars on the windows, straitjackets, seclusion and restraints have all been used – and misused – in the service of physical safety. Unfortunately, however, an exclusive focus on the maintenance of physical safety tends to result in the creation of environments more like prisons than therapeutic spaces. As we discovered, our refusal to tolerate violence of any sort constituted our best defence against any breach in physical safety. Physical safety alone does not constitute a safe environment for growth. Likewise, breaches in physical safety generally do not occur until the other forms of safety have already been violated.

Psychological safety refers to the ability to be safe with oneself, to rely on one's own ability to self-protect against any destructive impulses coming from within oneself or deriving from other people and to keep oneself out of harm's way. This ability to self-protect is one of the most shattering losses that occur as a result of traumatic experience and it manifests as an inability to protect one's boundaries from the trespass of other people. Another loss is a sense of self-efficacy, the basic sense of experiencing oneself as having the ability to relate to the world on one's own terms without abusing power and without being abused by it. A sense of personal safety is achieved as the injured individual learns how to be effective in protecting themselves from violations of their personal and psychological space.

Social safety describes the sense of feeling safe with other people. Victims of trauma-particularly interpersonal trauma - have serious difficulties in their ability and willingness to trust other people. Experience has taught them that people are dangerous, betraying, and duplicitous. If they have been injured as children, then they have come to expect bad treatment and are often suspicious of kindness. They expect that other people will violate their boundaries and may have learned that the way to get along in the world is to violate the boundaries of others. They will exert pressure on the other to conform to their normative expectations of abuse. The miracle is not that so many are distrustful; it is, instead, that so many are willing to try trusting again, and again, and again, despite past experience. But for victims of trauma, interpersonal relationships continue to pose enormous challenges. Creating a safe social environment requires a shift in perspective away from viewing only the individual, towards viewing the individual-in-context. In so doing, the entire community serves as a model of "organisation as therapist" (Whitwell, 1998) so that all of the chaotic,

impulsive, and painful feelings of the members can be safely contained and defused. A strict emphasis on the individual is exchanged for the work of creating and sustaining a well-bounded structure within which all the therapeutic interactions can safely take place (Campling, 1999). It is also the social milieu that provides our patients with the very necessary "reality confrontation". As our patients inevitably recreate the relational patterns they have learned as children within a social context, they are afforded the opportunity to change those patterns in order to achieve a higher degree of psychological and social safety.

How many of us have ever felt truly safe in a social setting, a setting in which we felt secure, cared for, trusted, free to express our deepest thoughts and feelings without censure, unafraid of being abandoned or misjudged, unfettered by the constant pressure of interpersonal competition and yet stimulated to be thoughtful, solve problems, be creative, and be spontaneous? Yet this is the kind of setting that human beings need to maximise their emotional and intellectual functioning in an integrated way. Our social system is created to produce human beings who will fit into a highly industrialised, competitive, often cutthroat capitalist environment that still prepares at least half of us for mortal combat. Our social system is not designed to maximise the human potential for growth, self-exploration, mutual co-operation, nurturing of the young, artistic endeavour, or creative expression and exploration.

Moral safety is a subject that is even more difficult to describe. It is a search and a process. It is an attempt to reduce the hypocrisy that is present, both explicitly and implicitly, in our social systems. It is a fundamentally important quest for patients who are victims of abusive power because their internal systems of meaning have become confused and contradictory (Janoff-Bulman, 1992). A morally safe environment engages in an on-going struggle with the issues of honesty and integrity.

Our attempt to create a morally safe environment began with a self-evaluative look at our therapeutic presumptions, our training, our rationalisations, and our fixed beliefs, as well as our practice. We had to look at our own issues with authority and become willing to participate in, not just manage, the relational web that forms the structure of the program. We were forced to ask ourselves, "What do we really believe in?" "What is it that we are actually doing, and what are we trying to achieve?" "Will the means get us to the desired ends?" "Do the means *justify* the ends?" "Do the activities we are prescribing lead to autonomy, connectness, and empowerment or dependence, alienation and helplessness?" These were tough and embarrassing questions with answers that were, at times, noxious. In an era of managed – some would say, mangled – care a morally safe environment demands that we be honest with our patients about our limitations, about our increasing inability to provide them with what we know they need, while continuing to offer them hope for the future and encouragement to keep on with the struggle towards recovery, even when they cannot get the support they deserve.

Similarly, our patients must confront the breaches in moral integrity that characterise the specific systems within which their normative behaviour developed, be it their family, a religious organisation, another form of a cult, or an institution. This breach in moral integrity also relates to the fundamental reasons for hospital admission – a clear and present danger to oneself or others. Victims internalise the role of perpetrator and a fantasy of rescuer. In hurting themselves, they act out the role of the perpetrator, thus re-enacting the past. Self-destructive behaviour creates a moral climate that is as degrading as violence against others While it is essential to express understanding and compassion towards the self-mutilating or

suicidal patient, requirements for physical, psychological and social safety demands that this fundamental moral discrepancy be confronted.

Additionally, we are all forced to look at the ways in which are culture reinforces the messages conveyed by the institutions within which we all are socialised. This entails looking at the way our society is organised around unresolved traumatic experience – what I have called the "Nine A's of Trauma" - and manifests this dysfunction through disrupted attachments, unmodulated affect, poorly managed aggression, abusive authority, diminished awareness, multiple addictions including an addiction to trauma, automatic repetition of destructive behaviours, avoidance of feelings and accountability, and alienation from self and others (Bloom, 1997; Bloom and Reichert, 1998).

Out of this process of self and systems examination, we developed an understanding about the underpinnings of our practice as that practice is informed by three key foundation concepts: trauma theory, the practice of therapeutic community principles, and the active creation of non-violent environments. These key concepts have practice implications in any setting that chooses to be a "living learning" environment for human healing and growth (Jones, 1968b).

Trauma-Based Assumptions and Milieu Implications

Research has demonstrated that the majority of patients who require intensive psychiatric treatment are victims of previous trauma, usually originating in childhood. We have come to understand that many of their symptoms are the reactions of normal people to abnormal stress. This means that they need experiences with environments that can normalize their experience, while educating them about the long-term liabilities involved in continuing to believe that these protective responses are still necessary. While being blamed and labelled for their behaviour in other settings, much controllable and socially irresponsible behaviour has been condoned or supported. We neither blame nor condone, but expect our patients to conduct themselves as socially responsible and capable adults who have been injured and need help recovering from their injuries as well as education about the enormous impact that trauma has had on every aspect of their lives.

We assume that a past history of psychological trauma has physical, psychological, social and moral effects and treatment interventions must therefore address and integrate all these levels of injury. This requires the achievement of safety and safety must address not just physical, but psychological, social and moral safety as well. Since traumatic experiences by definition are experiences of utter helplessness, the environment must consistently promote mastery experiences that result in personal and social empowerment while resisting inducing further experiences of helplessness. If a human being has enough experiences of helplessness, they will rapidly learn that nothing they can do will affect the outcome of events. As a result, even when put in situations where they could bring about successful change, they fail to do so having "learned helplessness" (Seligman, 1992). This counsels us in the need for therapeutic patience and repetition.

The hallmark signs of traumatic experience are hyperarousal and intrusive symptoms. When the body is exposed to extreme states of emotional arousal leading to a potentially life-threatening level of physiological hyperarousal, the brain rapidly employs strategies of self-protection. It appears that normal, verbally-based information processing is shutdown, replaced by a nonverbal form of data input characterized by images, strong emotions, and all kinds of sensory and kinaesthetic information. These fragments of experience then serve as

the "fuel" for the nightmares, body memories and flashbacks that make up the intrusive symptoms. There is a timeless quality to nonverbal experience, so an intrusive memory or flashback is experienced as happening in the present, not the past. In this way, the terror of the original experience can be repeatedly evoked by stimuli that the mind connects to the original trauma, even though in the present, there is nothing to fear (van der Kolk and Fisler, 1995; van der Kolk et al., 1997).

As a result we must create an environment that is soothing and that responds to high levels of stimulation with calming, rather than escalating, responses. Staff members must learn to recognize the "flashbacks" that accompany the re-experiencing of traumatic events and be able to differentiate such intrusive phenomena from psychosis. Medical personnel must avoiding the overuse of medication while recognizing that the physiological hyperarousal that accompanies post-traumatic states often "reset" the nervous system so dramatically, that only medication can bring even partial relief. Additionally, patients need to be taught techniques for managing their own affect and soothing themselves safely when an intrusive experience occurs, without resorting to self-destructive behaviours. Many of the behaviours that serve as criteria for treatment originate in the person's attempts to cope with the overwhelming nature of the intrusions and states of unacceptably high levels of arousal. Substance abuse is frequently an overt attempt to self-medicate and to alter overwhelming anxiety states. Self-mutilation, bingeing, purging, risk-taking, stealing, gambling and violent acting-out are all ways that a traumatised person may attempt to cope with overwhelming states when both internal and external resources fail.

People who are repeatedly traumatised may become "addicted to trauma", unable to function properly unless they are constantly exposed to highly stressful situations and occupations. Like other compulsive behaviours like self-mutilation, the addictive aspect of behaviours may be related to problems in the body's opiate system since the body's natural opiates, the endorphins, are a fundamental part of the normal stress response. Under conditions of repetitive hyperarousal and fear states, it has been hypothesized that the individual may become accustomed to an abnormally elevated level of endorphins and then experience any decrease in the level of stress as a physiological state of withdrawal (van der Kolk et al., 1985, 1989). Hence, they must elevate the environmental stress in order to achieve a state more like their abnormal "normal".

Dissociation – the loss of normally integrated mental functions – is another common characteristic of traumatic experience. When dissociative defences originate in childhood, the adult may only be able to cope with stress – even relatively minor stressors – by utilizing this splitting (Herman, 1992). Our patients must learn how to identify their own dissociative coping skills, learn what environmental and internal stimuli "trigger" dissociation, and then learn ways they can "ground" themselves as they gradually learn to control their own practiced tendencies to dissociate from feelings, memories, or consciousness itself. Usually they have been using avoidance as a tool for protecting themselves against overstimulation, but the habitual use of avoidant techniques can rob them of normal and health-promoting experiences. Essentially, our patients must learn how to substitute self-soothing coping skills and healthy relationships for dissociation, self-mutilation, risk-taking, avoidance, substance abuse, and other compulsive and self-destructive behaviours. Since exposure to overwhelming stress has a profound impact on the brain's capacity to take in and process verbal information, the therapeutic environment must promote the integration of memory and affect, making essential the availability of nonverbal and creative forms of therapy.

All of our patients have been exposed to interpersonal violence of some variety – physical, sexual, verbal or psychological. This exposure to unhealthy forms of aggression leaves them without the ability to adequately cope with their own aggression or the aggressive feelings and behaviours of others. As a result, the treatment milieu must be prepared to cope with aggressive feelings before they escalate to violence and thus be able to contain, deflect and metabolise the rage before it erupts. Patients need assistance in learning how to manage their own anger without turning to violence and how to express anger in a healthy way that protects their own boundaries without violating the boundaries of others.

Traumatisation results in loss – sometimes of loved human beings, other times of bodily parts, relationships, opportunities, idealized fantasies, wishes, hopes and dreams. This means that victims must find ways to grieve for losses that are often decades old. Unresolved bereavement can present as chronic and unresponsive depressive and anxiety symptoms that must be worked through rather than avoided for therapeutic resolution to occur (Herman, 1992). Since healthy grieving is related to the ability to form attachments in the first place, working through the stages of grief can be particularly difficult because of the universal disruption in attachment that accompanies interpersonal violence. Grieving is a social process, a ritual passage supported by one's community. This presents particularly difficult problems for our patients because it is difficult to grieve for events, relationships, or losses for which there is no social understanding or acceptance, particularly when one's capacity to make and sustain healthy attachments and to work through the loss of meaningful attachments, is severely compromised. The ability to create, maintain, and work through the loss of attachment relationships is complicated by another aspect of the profound alterations produced by exposure to trauma. Victims of prolonged torment – hostages, political prisoners, domestic violence and child abuse victims – often form strange, rigid, pervasive, and destructive relationships with their captor – a phenomenon known as "trauma bonding" (Dutton and Painter, 1981; Herman, 1992; James, 1994; van der Kolk, 1989).

One of the most important challenges to the therapeutic environment is the successful management of traumatic reenactment (van der Kolk, 1989). Trauma demands repetition. Patients come into treatment exhausted after a lifetime based on repeating an overwhelming and humiliating past. Trauma produces a fragmentation that results in the accentuation of a nonverbal and a verbal split in memory, affect, perception, and identity. The language of the nonverbal self is behaviour and in the presentation of their symptoms, our patients tell the story of their most terrible experiences (van der Kolk, 1994). The role of the treatment environment is to engage enough with the story to understand the script but then to change the automatic roles that are being cued for by the patient so that the story changes instead of being repeated. Traumatic reenactment can be seen in the shifting roles that patients assume on the "rescuer-victim-perpetrator" triangle. In our model, perpetration is broadly defined so that in a socially responsible community, violence to the self is also considered to be an act of perpetration against the community and is not acceptable behaviour.

Complicating all this is the astonishingly high rate of comorbidity associated with trauma-related disorders. Comorbid conditions can be expected and treatment for both psychological and physical comorbid problems must be offered and integrated with any treatment directed at the treatment of post-traumatic stress. Men with post-traumatic stress disorder are 6-10 times more likely to have an affective disorder, while women are 4-5 times more likely (Kessler et al., 1995). Anxiety disorders in men with PTSD are 3-7 times more likely, in women 2-4x more likely. Of those seeking treatment for substance abuse, 25-58%

also have PTSD. In a study by Breslau and colleagues (1991), those with PTSD were more than six times as likely to have some other psychiatric disorder. Even in the most conservative study, those with PTSD were two to four times more likely than those without PTSD to have virtually any other psychiatric disorder, particularly somatization (Solomon and Davidson, 1997). The large epidemiological study of Kessler and colleagues (1995) showed that those with PTSD are almost eight times as likely to have three or more disorders and 88% of men and 79% of women with PTSD had a history of at least one other disorder.

According to one study, somatisation was found to be 90 times more likely to occur in those with PTSD than in those without PTSD (Davidson et al., 1991). Hypertension, fibromyalgia, irritable bowel syndrome, chronic pain syndromes, skin diseases, migraines, chronic pelvic pain have all been associated with post-traumatic stress (Bloom, in press). Felitti et al.(1998) have recently demonstrated a strong correlation between various categories of adverse childhood experience and adult diseases including heart disease, cancer, liver disease, chronic lung disease and skeletal fractures.

Group-Based Assumptions as the Key to Nonviolence

"Creating Sanctuary" refers to the shared experience of creating and maintaining safety within a social environment - any social environment. This means that the standards of care – of how human beings should behave towards each other to create safety - will be similar in any environment within which people gather to live, to work, to learn, or to play and should apply to all members of the community, without exception. From the very beginning of the therapeutic community movement, the idea that there is no fixed boundary between "normal" people and the mentally ill has been a fundamental concept (Spielman, 1998). In a healthy human setting, all members of the community share two kinds of equality: *human equality,* which is the belief that we should treat others as we would like to be treated, that we should not exploit others or unduly restrict rights or freedom and *psychological equality,* describing the recognition that all members of the community share many of the same psychological processes and no one is completely "well" or completely "sick" (Kennard, 1998).

The foundation question that the mental health community addresses to the patient, and that the general community addresses to anyone in distress is *"What's wrong with you?"* regardless of whether that question is explicit and spoken or implicit and simply implied. The Sanctuary Model changes that fundamental question to *"What's happened to you?"* a position of connectedness and compassion rather than distance and judgment. This is essentially a deep philosophical movement from an illness or badness model of human deviance to an injury model. Instead of viewing people as sick or bad, we view disturbed behaviour as being a response to a previous injury that can be understood if we recognize the total context and experience of the person's existence.

All human systems are open and complex, interacting within themselves and externally with other systems and parts of systems, producing a whole that is greater than the sum of the parts. This whole emerges from the elements of the system and cannot be predicted by just looking at or even understanding, the system elements (Gray, 1969). As a result, focusing therapeutic attention only on the individual will not resolve the complex problems that emerge when any individual interacts with a system. Instead we have to understand and work with the individuals, the context they exist within, and the interactions between the elements of this context and the individual. This means that every member of

the staff and patient community plays a role in creating or failing to create a non-violent, health-promoting atmosphere.

All human development occurs within a social context and therefore providing people with a corrective emotional and relational experience should also occur within a group context. This "social learning" describes the process of change that may result from the interpersonal interaction when some crisis or conflict is understood as emerging from and having potential solutions discovered within a group context (Jones, 1968b). Social influence is a powerful force that can be used both negatively and positively. Victims of family violence have been subjected to the most insidious, persistent, and devastating forms of negative social influence originating in their home environments. A healthy environment will maximize the positive and minimize the negative, providing injured people with corrective relational experiences. The negative affects associated with exposure to violence are so noxious that the individual cannot contain them without resorting to protective defenses that are often destructive. As a result, the entire group needs to serve as the container for unmetabolized affect and help the individual find constructive ways of channelling, sublimating and transforming the negative affect.

The social influence of leaders is a particularly potent force in mobilizing social change (Jones, 1953, 1968b). In any group situation, leaders emerge and in general follow two courses – creating hierarchical power structures with centralized authority or creating structures that encourage a more democratic and consensus-based form of group functioning. Hierarchical power structures are more able to rapidly respond in emergency situations, but if left unchecked lead to the abuse of power and a "dumbing down" of individuals lower in the hierarchy. This is a particularly critical issue for victims of violence, all of whom have been exposed to the abusive use of power. A healthy environment can respond to emergencies by instituting a centralized authority structure, but rapidly shifts back to a non-hierarchical, network model of democratic functioning when the crisis has passed in order to promote creative and complex problem-solving. The relationship between those who lead and those who are led is a dynamic, dialectical one. In our existing institutions, conflict tends to originate near the top and interpersonal conflict can be followed down through the staff and into the patient community (Stanton and Schwartz, 1954). Those in positions of authority are often threatened by the openness and dispersed accountability of group process, while those who are subject to authority are often intimidated and fearful about assuming the shared responsibility that democratic functioning requires.

Open communication is vital in order to avoid the build-up of tension around conflictual issues in any community setting. If communication is blocked, failure to deal with a source of collective tension will result in a mutual withdrawal of staff and patients and ultimately, this will manifest as a collective disturbance of some sort (Stanton and Schwartz, 1954). Victims of violence have grown up in families who inhibit direct communication and channel unresolved tension and conflict onto destructive pathways that lead to violence. These patterns will be repeated in the inpatient setting. Therefore the therapeutic milieu must be prepared to counteract the forces of secrecy, while protecting the right to privacy. Episodes of collective disturbance can be predicted if the signs are recognized, and therefore can be prevented from escalating to violent acting-out. But to do this, violence must be viewed as a symptom of a breakdown in the social order, not just a problem of the individual. Every act of violence must be analysed as a problem of and for the entire community, including the use of seclusion, restraint, or any other form of coercive control.

Since order and law is the basis of all civilization, every community must create its own constitution comprised of shared assumptions, shared goals and a shared practice. A basic tenet of such a constitutional process must be that of non-violence. In using this term, we are moving away from a context within which violence is expected, even while techniques are used or policies developed to prevent it. We mean the creation of environments that see non-violence as the norm and that practice non-violence regularly through practices of de-escalation, conflict resolution, mediation, and consensus driven problem-solving, all behaviours that are expected to occur between patients, staff members, and administration. In a true therapeutic community, patients can share extensively in the development, implementation and maintenance of such a constitutional government. In our short-term milieu, the patients are usually only involved in the maintenance of a body of rules that constitute the values structure of the program. As they learn how we have adopted these principles in response to an understanding of the traumatizing nature of their native environments, they rapidly embrace these values as their own and carry the culture into all of the group settings, holding even the staff accountable for upholding these tenets.

Goals of Treatment

We also attempt to be quite clear about the goals of our work together. In the short period of time we have available to us to hospitalise people, we must focus on achievable goals for the short time of their inpatient stay, while providing them with a map of recovery that will continue throughout outpatient treatment. If people seek admission to our program then they must be committed with us to the achievement of these goals. Mary Harvey (1996) has articulated seven of the major goals of treatment: gaining authority over the remembering process; the integration of memory and affect, development of affect tolerance, symptom mastery, attainment of a sense of self-esteem and self-cohesion, the ability to form safe attachments, a willingness to engage in the process of meaning-making, of placing the past into some sort of perspective that makes a viable contribution to the present sense of purpose and place in the world. These represent the goals for the individual victim of unresolved traumatic experience.

There are also goals we share as an entire community. First, we must all share in a belief that recovery is possible by mutually creating an environment of hope. This goal can only be accomplished by substituting healthy relationships and different normative environments for abuse. Healing requires that the injured people construct a coherent and meaningful narrative of their experiences and be willing to place their individual pain into a broader social context and in service of this goal we regularly relate the microcosm of the individual's family pathology to the macrocosm of the larger socio-political and historical environment. Since conflict resolution is so vital to the healthy operation of any community, we seek to resolve conflicts together in non-violent ways through the development of "group mind", recognizing that decisions and problem solutions that arise out of a consensus process are usually far better than those that originate in typical authoritarian structures.

Institutions function properly only if they meet the needs of all of the people who are a part of them. Therefore another goal of the program is to meet the needs of the patients and the staff as well as the institution in which the program is located. To the extent that the needs of these various parties conflict, the institution will find it difficult to maintain

a health promoting environment for any of its members. Given the present health care system in the United States, achieving this goal of system integrity is the most difficult challenge we face. There are deep and unresolved conflicts between the basic needs of patients/staff and the larger health care institution that remained unresolved.

Ultimately, our shared goal is to end violent perpetration. We share a belief that the therapeutic milieu does offer a true "experimental laboratory" for conscious social change were the learning to be transferred to all of our institutions instead of applying only rarely, and then only to those labelled "mentally ill" (Tucker and Maxmen, 1973). We have come to believe that retraumatizing people by placing them in environments that reinforce helplessness, scapegoating, isolation, alienation and violence must be viewed as antitherapeutic, dangerous, immoral and a violation of basic human rights.

The Shared Practice of Sanctuary

In service of these goals, we engage in a shared practice that is routinely informed by our four-stage recovery model, SAGE© (See Foderaro and Ryan, this volume). To achieve the goals for each individual, treatment focuses on individual and group kinds of psychotherapy of all kinds, ranging from psychodynamic, explorative therapy to art therapy, movement therapy and psychodrama. We have also begun using techniques like "trauma art" and "video dialogue" to help address the specific dissociative breaks that are so problematic in this population (Tinnin and Bills, 1994).

At the same time, the entire community is constantly engaged in the process of establishing and maintaining alternative norms. We call this activity "creating Sanctuary" to indicate that "Sanctuary is not just a place" but a process. The sense of safety that we are creating for each other is something that we are doing – or not doing – all the time, every moment of every day. It is a choice, an active constructive behaviour that we all must participate in if it is to remain viable. All violence is perceived as an effort to destroy sanctuary, and violence is broadly defined as anything that hurts the self or the community, including self-mutilation and other forms of self-destructive behavior. Given the short-term nature of the program, and the decreases in staffing secondary to managed care cut-backs, we have shifted a great deal of the burden for maintaining safety onto the patients. This is an expectation and a responsibility that is articulated from the moment the person is accepted for admission when they agree to a contract for safety and is reinforced throughout the hospital stay. This expectation counters the regression that is typical of hospitalisation and is a community norm that is carried and enforced by the entire community.

We also share the active and ongoing process of resolving both conscious and unconscious conflicts. Deliberate conflict resolution measures are extremely important and for the most part are learned behaviours, quite different from the skills developed within the context of dysfunctional systems. Patients are encouraged to verbally engage other patients, staff, and physicians in problem resolution through verbal negotiation and staff are expected to participate actively in this process without resorting to abusive authority.

Unconscious conflicts are harder to address simply because they are so hidden. Unconscious conflicts within the individual manifest as reenactment behavior in which the patient nonverbally cues the environment to provide experiences that repeat the past. Although this can lead to a simple reenactment of the past in which the patient is retraumatised, with careful direction, such a traumatic scenario can provide the opportunity for an entirely different, redirected experience in which the unconscious pain can be surfaced,

verbalised, and resolved. The management of traumatic reenactment requires skill and cohesive teamwork. A reenactment is in process when a team becomes split, when a staff member begins to behave atypically, when the patient fails to respond to individual interventions and begins to escalate negative behaviour – all the behaviors described by Main in his seminal paper about the "special patient" (Main, 1957). When this occurs, the first breakthrough for the staff and the patient is to recognize that it is, in fact occurring. This recognition is often in itself a therapeutic triumph. When recognition is slow in coming, bringing together the involved parties to look at the presumed conflict, its roots in the past, and to plan for how to shift the action in another direction can be a profound revelation for the patient in learning how to manage and control affects and experiences that have been considered previously impermeable to change.

There are also unconscious conflicts within a group that manifest through the acting-out behaviour of the patients, individual staff members, or the entire group. When the group can recognise that something uncomfortable needs to be surfaced instead of suppressed, rather than attempting to scapegoat an individual for the problem, significant movement ahead can occur, collective disturbance can be uncovered before it spirals out of control, and violent acting-out can thus be avoided. This practice of viewing the group-as-a-whole as something different from the individuals who comprise the group is a challenging practice that needs to be continually reinforced. Coming from a culture of extreme individualism as we do, functioning within the context of the group is not something that seems to come naturally for most of us and requires constant vigilance and repeated reminders.

At all times we are seeking integration. In order to gain authority over the remembering process, victims often need to dig into the past and surface forgotten and split-off memories and feelings that are a by-product of the "speechless terror" of traumatic experience (van der Kolk, 1994). The objective of this expedition is the integration of memory, affect, and behaviour in the context of safe attachment. Memory recovery without such a contained context can do more harm than good. This kind of intensive work often requires the use of adjunctive forms of nonverbal therapies such as art therapy, video therapy, movement therapy, psychodrama, poetry, writing and any form of intervention that serves to bridge the gap between the nonverbal affective experience and the verbal, cognitive, conscious mind.

There is an ongoing agreement that we are all vulnerable to emotional contagion and that a significant element of healing is learning how to modulate and manage overwhelming emotions within oneself and within a group. This requires the analysis and negotiation of what defines a healthy boundary between people. We share a willingness to participate in an empathic exchange between people that can be a healing experience, while refusing to become emotional toilets for other people's unacceptable and hostile impulses. This requires the development of a special consciousness of what it means to be a victim and what it means to be a perpetrator. All forms of violence, including self-mutilation, self-starvation, and suicidal behaviour are considered a violation of the self and a violation of the community. Special contracts and protocols are utilised to help patients gain control over these kinds of self-destructive behaviours. Sometimes we must protect ourselves and the community against a patient who is locked into an identification with the perpetrator, trapped in a repetitive cycle of re-enacting the perpetrator role thus forcing the staff, the other patients and the entire community into shifting roles of victim and rescuer. In such cases our admonitions are not enough and we are compelled to behaviourally demonstrate our ability to self-protect. Our own capacity to protect ourselves and the people who need our protection mirrors and models the kind of protection that the re-enacting individual should have had as a child and

needs to discover for himself or herself now. This may mean that the reenactor is administratively transferred or discharged if that is the only way of protecting the integrity of the therapeutic environment. Although this rarely happens, it is critical that the community has the power to adequately protect itself from abuse, even if that abuse is coming from one of its own members.

S.A.G.E.

SAGE is an acronym for the four important aspects of recovery that we believe are the most important if people are to recover from trauma. SAGE stands for safety, affect management, grief, and emancipation. People who have been traumatized have lost the sense of safety in their lives. The first step in recovery is to re-establish the feeling of being safe. This is always where treatment begins and recovery cannot progress until safety has been established. We use "affect" to refer to the biological equivalents of emotional experience. Affect management deals with the stage of recovery in which people must learn how to manage their emotional arousal in a less destructive way. Grieving refers to the inevitable sense of profound loss, sadness, and despair that accompanies a traumatic experience and that must be experienced and worked through if normal life is to be restored. Emancipation encompasses all that goes into full recover from trauma - social reconnection, finding meaning, establishing a survivor mission.

This model is meant to provide a structure and framework for the evaluation and treatment of people who have been traumatized as children and/or adults. SAGE represents aspects of recovery, and although Safety is always the first step, and Emancipation usually the last, in actual life, these aspects tend to intertwine, interconnect, and present on going challenges at each life stage. Future episodes of danger or grief are likely to reawaken old wounds. Therefore, the goal of recovery is to provide the tools necessary to guarantee that a person will be equipped to deal with future experiences without turning to behaviour that is destructive to self or others.

The needs and problems of people who have been traumatized can vary greatly. Using the SAGE model provides an approach that is flexible and useful to the patient and clinician. It is designed to change with the needs of the patient. An important component of this model is the belief that people who have been traumatized can help themselves throughout the process of recovery and that in helping themselves, they are promoting their own recovery. There is also an assumption that an important part of recovery - and an important part of finding meaning - is to be found in helping others. Trauma occurs in a social context and social wounds require social healing. The most important part of the therapy experience may be in helping a traumatized person recover a sense of trust in other people, but this is only effective if that sense of trust can be generalized to other people outside of the therapy context. Therapy is a tool, an educational experience, not an end point. Therapy can only be proven useful if the result of the treatment is a healthier, better-educated, socially proactive and constructive human being.

When things are not going well in a person's life and/or therapy, the treatment should be re-evaluated. Part of the SAGE model includes thorough evaluation and reassessment when indicated. Progress in therapy can become stalled for a number of reasons including the inherent difficulties in exchanging comfortable, albeit dysfunctional behaviours, for behaviours that are more frightening, challenging, but ultimately health promoting. Ultimately, healthy behaviour is the personal choice of the person who is seeking help. The issue of

choice will come into play for all steps of the SAGE model. A person must be willing to engage and consider the steps of SAGE and change behaviour or he/she will be unable to benefit from this model. This question should be addressed early in treatment and may need to be looked at periodically throughout the course of treatment, particularly when progress appears to be halted or regression to previous forms of destructive thinking and behaviour has occurred.

Conclusion

Ultimately, the purpose of our shared assumptions, shared goals, shared practice and shared vision is to create what Maxwell Jones described as a living-learning environment within which healing, growth, and creative expression can occur (Jones, 1968b). This is as urgent a calling today as it was half a century ago. Over thirty years ago Jules Henry asked a question that is as relevant today as it was then. "*Cruelty has an institutional structure that sustains, teaches, and may even glorify it. But where are the institutions - the organisations - that sustain and teach tenderness?"* (Henry, 1965, p.367). Our patients who have suffered extraordinary violence at the hands of others have much to teach us about both individual and social healing, about how to change our institutions to reflect actual human needs rather than the distortion of unresolved trauma.

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