MENTAL HEALTH ASPECTS OF IPV/DV: *SURVIVORS, PROFESSIONALS, AND SYSTEMS*

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INTRODUCTION

What happens to a child or adult who are victims of or witness interpersonal violence? What can a health care provider, emergency worker, social service, teacher or law enforcement officer do to address the mental health needs of survivors? This is a particularly pressing problem because the physical, psychological, and social problems secondary to exposure to interpersonal violence are so intertwined and because the existing mental health system – embattled by the impact of decreased resources – may not be able to respond adequately to the needs of the survivors.

In this chapter we will first look at the long-term physical, emotional, and social toll that is taken by exposure to childhood adversity and the damage that results from severe and recurrent threat. The complex effects of interpersonal violence map out the tasks that must be completed if recovery is to occur. But no recovery process is likely to be simple or straightforward because human beings go through stages of change and find habits quite difficult to change. Overcoming the effects of violence are difficult in part because there are barriers inherent in the psychobiology of trauma that complicate the recovery process and because there are also significant personal, professional, and organizational barriers to recovery that must be addressed.

S.E.L.F. is an acronym referring to the key domains of trauma recovery: *Safety, Emotions, Loss* and *Future.* S.E.L.F. offers an organizing framework for the patient, family, practitioner and organization that systematizes a trauma-informed treatment plan and guides the process of change, while The Sanctuary Model of Organizational Change defines the type of organizational culture that is most conducive to positive transformational change for the whole system. The chapter closes with some concrete guidelines for professional activism aimed at changing not just our patients, but our systems as well.

Exposure to Childhood Adversity

As a result of over twenty years of research, we know that traumatic experiences can result in a host of chronic and often life-long physical, emotional, occupational, and social problems. The Adverse Childhood Experiences Study (ACEs) is the largest study of its kind to examine the health and social effects of adverse childhood experiences over the lifespan. The authors of the study asked over 18,000 adults in an HMO, to categorize their experiences with childhood adversity. The categories included: physical or psychological abuse by parents, contact sexual abuse by anyone, severe physical or emotional neglect as well as living in a household as a child (eighteen years of age or younger) where there was anyone who was: mentally ill, a substance abuser, a victim of domestic violence, or imprisoned. The ACEs score then represented a simple addition of the number of categories of adverse experience. In this list it is important to recognize that exposure to criminal victimization and community violence were *not* part of the study and therefore the results of the study are likely to have have even broader implications for an urban population.

Only 48% of this white, over 50 years of age, middle-class and educated population had an ACEs score of zero. One in four admitted to at least one category of childhood adversity while one in 16 had an ACEs score of four. *Sixty-six percent of the women reported at least one childhood experience involving abuse, violence or family strife.* The authors then analyzed the respondents' medical data and found clear and direct relationships between the ACEs score and a wide variety of physical, emotional and social diseases and disabilities. People exposed as children to adverse experiences are at much greater risk for heart disease, chronic lung disease, liver disease, diabetes, obesity and hypertension. Adults with childhood trauma have increased teenage pregnancy rates, divorce rates, depression, suicide attempts, post-traumatic stress disorder, alcoholism, IV drug abuse and dependence, school failure, and unemployment among many other problems. As children adolescents, and adults, people exposed to childhood adversity have a much higher probability of requiring the services of our expensive public systems including special education, child protection, mental health, health and criminal

justice services. The authors concluded that the ACEs study has demonstrated that childhood adversity appears to determine the likelihood of the ten most common causes of adult death in the United States [1]. [1-3].

Why is exposure to interpersonal violence so problematic across the lifespan? The authors of the ACEs study have proposed an explanatory pyramid to serve as a conceptual framework for understanding the impact of adversity across the lifespan. Exposure to violence in childhood frequently disrupts normal neurodevelopment. These disruptions of critical developmental pathways can result in a wide variety of social, emotional, and cognitive impairments in childhood and throughout adolescence. In late childhood and adolescence, these impairments put children at risk for the adoption of a number of health-risk behaviors like drinking, drugs, smoking, and promiscuity. Over time, these behaviors – and the lifestyles that support the behaviors – lead to disease, disability, social problems and ultimately premature death. In the past these linkages have often been overlooked because they are diverse, complex, and occur over a very long time-line.

The Impact of Recurrent Stress

Children and adults who are exposed to interpersonal violence are not likely to experience only a single incident. Interpersonal violence is likely to be repetitive, haunting the lives of victims. It is the chronic nature of so many tortured life circumstances that creates lifelong problems. Let's briefly look at the complex problems presented by so many children, adolescents and adults who have been recurrently victimized.

[1] For more information about the ACEs study and a complete list of publications visit www.acestudy.org or http://www.cdc.gov/nccdphp/ace/index.htm

Table 1 IMPACT OF RECURRENT THREAT	
Disruptions	*Presentation*
Resets the CNS	Hypersensitivity to even minor threat, hair-trigger temper, anxiety
Hyperarousal interferes with cognitive development	Learning problems, easily confused under stress, poor problem solving
Extremist thinking becomes chronic	Catastrophizing, oversimplifying, loss of critical judgment
Attention to threat becomes chronic	On edge, inability to relax, inability to pay attention to positive aspects of a situation, sees threat everywhere
Loss of, or failure to develop, emotional modulation – further interference with cognitive development	Inability to control distressing emotional states that may over-influence or even cloud thinking
Lack of self-soothing	Inability to calm oneself down because emotions are too intense
Inability to manage affect leads to avoidance symptoms	Avoidance of people/places/things that trigger distressing memories/emotions – restriction of normal life activities; depressive syndromes; eating problems; sleep problems
Aggression becomes chronic	Verbal and/or physical violence to others or to the self
Dissociative defenses become chronic	Spacing out, forgetfulness, losing time, memory distortions, amnesia
Intrusive symptoms reinforce sense of helplessness, learned helplessness, failure of mastery	Flashbacks, nightmares, body memories – easily confused with hallucinations and misdiagnosed as psychosis
Defenses against flashbacks and highly distressing emotions	Attempt to manage highly distressing emotional states and stop the flashbacks through use of drugs, alcohol, self-harming behavior, risk-taking behavior, violence
Adaptation to adversity – change in	Abnormal circumstances/relationships/life choices

norms	redefined as “normal”.
Inability to self-protection	Inability to spot danger or respond appropriately to danger signals
Inability to self-correct	Difficulty in learning from experience
Traumatic reenactment	Tendency to repeat error, to be revictimized, to victimize others, to live a life of repetition
Effects sense of identity, view of self, social relationships	Demoralization, lowered self-esteem, learned helplessness, identification with the aggressor
Damages meaning, conscience, view of self and others.	Loss of or lack of moral intelligence
Disrupted attachment – failed trust, failed relationships	Unfulfilling, abusive, failed relationships; inability to trust others; trauma-bonding
Problems with authority figures	Difficulties at school, work in following orders, taking charge; bullying others, passive obedience; antisocial behavior, increased authoritarianism
Difficulties resolving conflicts	Chronic unresolved conflicts; compulsive appeasement
Inability to grieve	Chronic depression, physical problems, displaced anger
Addiction to stress	Risk-taking, sensation-seeking behavior
Progressive deterioration	Alienation, asocial or antisocial behavior
Foreshortened sense of future	Failure of imagination; hopelessness, resistance to change
Poor parenting practices	Subjecting children to repetitive adversity

Chronic exposure to trauma produces hypersensitivity to threat, so even small stresses produce large and inappropriate responses [4]. Extremist thinking, so characteristic of the acute stress response, becomes chronic and that combined with the constant attention to even the smallest threat interferes with cognitive development [5]. Aggression and poor impulse control, arguably

also normal parts of the acute stress response, become typical responses to a variety of situations, precipitating school, learning, and relational problems, particularly violence directed at the self, others, or both. Their inability to manage distressing emotions interferes further with cognitive development, producing even greater difficulties in intellectual and emotional domains. Levels of emotional arousal tend to be too high for the usual childhood self-soothing techniques to be effective and for these children, their attempts to achieve comfort from the adults around them backfire, so this increases the likelihood that the child will turn to some other method of managing distressing emotions: violence, drugs, alcohol, cutting, bingeing, purging, promiscuity, risk-taking or some other problematic behavior [6]. If aggressive responses have helped them to feel less helpless, more in control, and achieve a better sense of mastery, then aggression is likely to become chronic [7-10].

Dissociative defenses that may have been life-saving at the time of the traumatic events may become chronically utilized, even under less stressful conditions so that other, more positive forms of stress management are not learned[6]. If they begin having sensory flashbacks and/or body memories along the way, then the intrusive symptoms are likely to create more stress, increase helplessness, and encourage the use of even more dissociation. A child for whom this picture has developed is likely to develop a negative sense of identity, trust, and place in the world. But human beings are adaptive, so children will adapt to adversity by changing their definitions of "normal" – and human beings resist changing anything that has come to feel "normal. One of many important consequences of this adaptation is an increased likelihood that the child will end up reenacting the trauma and in doing so, will be revictimized or may turn to victimizing others [11-15]. Reenactment is a vitally important concept to understand but may not always be straightforward. It may be useful to mention a few simple examples of reenactment behavior:

Tina was sexually abused as a child by several family members. Unable to adequately protect herself, she was gang-raped as an adolescent. In late adolescence she became heavily involved with drugs and began a life of prostitution. Tina's life is almost entirely based on reenactment.

Robert grew up in a household where beating children was called "discipline". Robert's father beat him regularly whether he needed it or not and his mother passively supported this behavior. Now Robert routinely beats his own children and his wife whenever he believes they are not doing what they should.

Tom was in a severe car accident five years ago, blind-sided by a car that was speeding through a red light driven by a drunk driver. Tom presents to his physician with severe and disabling anxiety and he is becoming increasingly agoraphobic and unable to work but makes no connection to the car accident. As the physician takes a careful history, he discovers that the anxiety has been progressive and early on was associated with driving and with the fact that Tom

found himself only able to make right turns. On farther probing, the physician uncovers that Tom was hit when he was making a left turn and that in his symptoms – unrecognized until now – he has been magically trying to undo the accident while reenacting the conditions of disability at the same time.

Moral intelligence is difficult to develop under these circumstances and the child's sense of meaning, purpose, view of self and others will be powerfully influenced by his or her exposure to violence and the support systems' failure to protect him from harm [16]. Exposure to chronic childhood adversity is like to produce profoundly disrupted attachment relationships that bode ill for future attachments, including later parenting skills [17, 18]. Children who have been exposed to the abusive use of authority are likely to have difficulty learning how to appropriately use their own personal authority with themselves and with others and are at risk for being victimized or becoming perpetrators, or both. Lacking appropriate emotional management they may have great difficulties learning good conflict resolution skills and may be unable to grieve for the multiple losses they are likely to experience [19]. They may become addicted to stress and therefore resist efforts to help them calm down or learn to self-soothe [20]. All of this– if left untreated – is too frequently associated with continued deterioration, alienation, a foreshortened sense of future, and an inability to imagine any better alternatives. When these children become parents, they are likely to have difficulty parenting. And the longer this goes on, the more normal it all may feel, and therefore the greater the resistance to change.

If children or adults who have suffered significant adversity come together to form groups – families, gangs, organizations – new threats may make them particularly vulnerable to typical human group behavior under threat. Leaders may become bullying and willing to direct aggression at others, projecting anxiety onto any available external enemy, leading to a chronic state of conflict. Extremist thinking may become chronic and develop into a group norm and "groupthink" may supplant meaningful dialogue. Attention to repetitive threat may lead to the exclusion of other possible group goals. The increase in authoritarianism leads to a loss of critical judgment. In order to protect group unity, the group is likely to silence dissent through deception or force, increasing intragroup violence. Such a group is likely to lose transparency and become more secretive over time. Social norms develop that support the status quo which continues to reinforce the conditions of chronic threat. In the process, democratic processes that are more flexible and responsive to complex demands are eroded and corruption increases as power becomes more centralized. The groups loses a sense of shared purpose and vision and becomes increasingly fragmented, conflicts are not resolved. New and complex problems cannot be adequately addressed and change continues to be resisted [21-26].

Tasks of Recovery

I suspect that in these descriptions many readers can easily locate many of the children, adults and families you have seen over the years in one setting or another. As clinicians it is understandable that we would want to select out just one, or a few of these problems because the complex needs are so overwhelming. If we look at the list of disruptions traumatized people may experience the implications for recovery can look staggering. All of our helping systems have to recognize and be able to respond to chronic hyperarousal. We must accurately assess the degree of threat that the child or adult poses to us, personally and professionally because violent acting-out is always a real potential. At the same time, we must minimize the threatening conditions that surround the person and buffer him or her with a sense of surrounding safety. Safety, however, turns out to be a complex subject in itself. Adequate safety planning must include teaching the child or adult how to become physically, psychologically, socially, and morally safe. We have to help the body in any way we can, particularly to minimize physiological hyperarousal. But no one can be with the person all the time, so each survivor has to be taught how to self-soothe. People who dissociate need to learn how to keep themselves grounded in order to stop dissociating as a habitual behavior. As we know from the ACEs study, chronic stress is likely to be already taking a toll on the child's body so we must attend to physical health, illness, and fitness.

But all that is just the beginning. We have to find methods to improve cognitive skills, treat whatever addictive or compulsive behaviors have arisen, teach emotional management skills and encourage the use of words, rather than behavior, to express feelings. We have to teach the survivors conflict resolution skills, alter their attitudes toward authority, address and redirect reenactment behavior. Many traumatized people require specific trauma resolution techniques to stop flashbacks and dissociation. When the time is right, trauma victims need help in working through the grieving process and learning how to let go and say goodbye to the only past they may have ever known. This must happen in the context of learning how to make and sustain healthier relationships with peers. And none of this is possible without the child or adult being pulled toward a better, alternative future that can only happen if the other people around him or her have inspired hope and encouraged the transformation of pain into what has been called a "survivor mission" [18].

Recovery from Trauma

Recovery from trauma, particularly chronic or repetitive trauma, can be a long and difficult journey, particularly because over time, the comorbid problems associated with prolonged exposure tend to accumulate and pose secondary and tertiary challenges to each person's recovery. For example, when a trauma

survivor uses drugs or alcohol in an attempt to cope with overwhelmingly distressing emotions, they may end up with symptoms of post-traumatic stress AND addiction AND loss of employment, family, social supports AND learning problems AND serious medical problems. It is difficult enough for any of us to change even one of those problems but the compounded and interactive nature of what has been called "complex PTSD" makes recovery all that much more difficult [27].

What is so inspiring and promising is that so many survivors of interpersonal violence do walk the road of recovery and go on to live productive and fulfilling lives. To be effective helpers, we have to recognize the obstacles to change and assist people through the stages of change.

The Transtheoretical Model of change was developed by Dr. James L. Prochaska at the University of Rhode Island Cancer Prevention Research Center [2]. It is a theoretical model that describes the stages that a person goes through in order to make changes in problematic behavior, whether it is quitting smoking, losing weight, substance abuse, self-harming behavior or any other behavioral problem that must change if the person is to recover from traumatic experience. Teaching staff and clients about the Stages of Change Model helps take away some of the pejorative attitudes that accompany a lack of success in immediately changing bad habits (See also Asher, this volume). In reality, no one changes habits easily or quickly – that is what makes habits habitual – they resist change. This model was called "transtheoretical" because the authors discovered similarities among many different schools of therapeutic change [28, 29]. The poem "Autobiography in Five Short Chapters" by Portia Nelson captures the heart of how challenging change is for all of us.

According to this model, to make significant changes, people go through a series of five fairly distinct stages, beginning with the denial that anything needs to change, to contemplating some change, to preparing and taking action, and finally to maintaining the change. At any stage, the person may relapse back to an earlier stage and then move ahead again. In order to help people move through these stages, helpers need to respond to them in different ways, depending on the stage of change each person is in at the time of their interaction. Trying to push someone toward action when they are still in the precontemplation stage of change will simply push them to leave the office and never return. At the same time, holding back or discouraging action when someone is ready to take action, may also be problematic. And since relapse can occur at any stage, it is important for the helper to predict this

[2] For more information about TTM including psychological measures available for research use go to http://www.uri.edu/research/cprc/transtheoretical.htm

possibility and help the person prepare for moving on again, even if they must go backwards first.

The authors also have described nine processes that people engage in when they attempt to modify their behaviors. These include both covert (less conscious) and overt (conscious) activities and experiences. The processes were identified by asking people how they changed, what helped and what made change more difficult.

Table 3

TRANSTHEORETICAL MODEL PROCESSES OF CHANGE

Processes of Change	Definition / Interventions
Consciousness Raising	Efforts by the individual to seek new information and to gain understanding and feed-back about the problem behavior / observations, confrontations, interpretations, bibliotherapy.
Counterconditioning	Substitution of alternatives for the problem behavior / relaxation, desensitization, assertion, positive self-statements.
Dramatic Relief	Experiencing and expressing feelings about the problem behavior and potential solutions / psychodrama, grieving losses, role playing.
Environmental Reevaluation	Consideration and assessment of how the problem behavior affects the physical and social environment / empathy training, documentaries.
Helping Relationships	Trusting, accepting, and utilizing the support of caring others during attempts to change the problem behavior.
Reinforcement Management	Rewarding oneself or being rewarded by others for making changes / contingency contracts, overt and covert reinforcement, self-reward.
Self-Liberation	Choice and commitment to change the problem behavior, including belief in the ability to change / decision-making therapy, New Year's resolutions, logotherapy techniques, commitment enhancing techniques.

Self-Reevaluation	Emotional and cognitive reappraisal of values by the individual with respect to the problem behavior / value clarification, imagery, corrective emotional experience.
Social Liberation	Awareness, availability, and acceptance by the individual of alternative, problem-free lifestyles in society / empowering, policy interventions.
Stimulus Control	Control of situations and other causes which trigger the problem behavior / adding stimuli that encourage alternative behaviors, restructuring the environment, avoiding high risk cues, fading techniques.
Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change. American Psychologist **47**: 1102-1114.	

As the list shows there is a wide range of helpful interventions and this is important to keep in mind if you are determined to help someone who has been psychologically scarred by interpersonal violence. There are many routes to recovery and regardless of your training or the role you play in a person's life, there is always something you can do that will help them recover. In medical, social service, mental health, and law enforcement settings one of the most important and accessible interventions that can be offered is universal psychoeducation about the impact of trauma in all its forms. This can be done through pamphlets, books, videotapes, audiotapes, DVD's that are now available through private and public sources and that are appropriate for different age groups encountering a variety of problems[3]. Likewise, many settings can offer emotional management tools such as relaxation techniques, breathing exercises, yoga, meditation training, exercise programs and wellness programs. All of these are tools that enable a trauma survivor to develop better emotional management skills. Offering space for self-help groups enables survivors the opportunity to build supportive social networks. Providing opportunities for trauma survivors to share their experiences in order to help others can provide methods for transforming personal pain into something of value to others [30].

[3] Useful educational videos have been produced by: Cavalcade Productions, 800-345-5530 http://www.cavalcadeproductions.com/index.html; Gift From Within, 207-236-8858 http://www.giftfromwithin.org/index.html#info. Useful trauma information and links to many resources can be located at http://www.trauma-pages.com

Barriers to Recovery

But still, as if it were not complex enough, there are also a number of barriers to recovery, even under the best of circumstances. A number of these barriers are directly related to the psychobiology of the traumatic experiences – dissociation, fragmentation, amnesia, emotional number, intrusive re-experiencing, and avoidance.

Table 4

POST-TRAUMATIC BARRIERS TO RECOVERY

Barrier	*Possible Presentation*
• Trauma survivors frequently make no connection between any of their symptoms and previous traumatic experiences	• Focus on here-and-now issues without making meaningful connections to past experiences; resistance to anyone else making those connections; strong resistance to suggestion that physical symptoms may be psychologically influenced – here this suggestion as "you are telling me it is all in my head"
• They are unlikely to want to talk about their previous bad experiences	• Redirecting the conversation; becoming angry and defensive when the interviewer persists; dissociation into altered state; minimizing the harm done; fleeing from the conversation; exacerbation of symptoms as a way of nonverbally saying to the interviewer "stay away from those areas"
• They are likely not to remember the worst parts of the experiences	• Denial of any past problems; pattern of "lying" that is easy to uncover but is still denied by the survivor; memory gaps; psychogenic fainting; regression to childlike state; non-organic altered states of consciousness
• They will want to stay emotionally numb rather than feel the pain of the previous experiences	• Avoidance of meaningful history taking exchange; defensive posture of "it didn't bother me"; use of numbing substances – legal and illegal drugs and alcohol; avoidance of intimacy of any kind
• They are likely to feel protective toward violence that occurred in	• Lying or misleading information about the family system; idealization of abusive family

the family	member; self-blame – "I deserved it"; fear of harming other family members now about events in the past.
• The violence may still be going on – their families do not want to talk about it	• Change conversation away from family issues; protective of family members; obvious signs of current fear that is not attached to anything or anyone; lying and concealment; family members will not allow patient to be interviewed alone; truth may be revealed only in nonverbal, creative ways
• We don't want to talk about it either	• Failure to do trauma assessment; failure to remember trauma history in on-going treatment; changing the subject when it comes up; minimizing the harm the person has experienced; getting angry at the person for their failure to act; never giving sufficient time to the person to allow sharing of highly-charged information
• Our helping systems have not incorporated knowledge about trauma into their policies, procedures, operations, or knowledge base	• Lack of trauma-informed policies; lack of mandatory trauma assessments; lack of policies to address vicarious trauma in staff; lack of in-service training on trauma-related disorders for staff; lack of specific treatment approaches to address traumatic impact; exclusive focus on use of medications and DSM-IV diagnostic classification; absence of a recovery framework for treatment.

Neither children nor adults usually make a connection between their symptoms and previous experiences and they are unlikely to want to talk about these experiences, even if they have the words for such painful feelings. Many times they cannot remember the worst parts of the experiences as a result of what happens to the brain's information processing system under conditions of extreme stress and they would prefer to stay emotionally numb rather than feel the pain that is attached to their traumatic memories [31]. They are likely to remain loyal to their families, even when the family is the source of the trauma, and in many cases, unbeknownst to those who are trying to help, the violence or dysfunction in the family is still going to – and no one wants to talk about it.

But there are other barriers too. As mental health, health and social service providers, we haven't wanted to talk about the traumatic lives that so many of the people we treat have actually experienced. Certainly most mental health systems have not thus far incorporated knowledge about trauma, nor have

other social service systems or school systems. In fact, our helping systems themselves are often fragmented, lacking a common set of basic assumptions, a shared language, clear goals, and a positive vision of the outcomes for the children, adults and families who have been exposed to interpersonal violence. There are complex interactions that occur between traumatized clients, stressed staff, pressured organizations, and social and economic environment that resist positive, trauma-informed change. As a result our helping systems frequently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to treat.

Professional Resistance to Addressing the Impact of Trauma

Twenty years ago my colleagues and I were just beginning the creation of a trauma-informed short-term inpatient treatment program that we operated from 1980 to 2001, that came to be called The Sanctuary. Over those twenty years we treated thousands of trauma survivors, most of them suffering from some variant of "complex PTSD". We watched "miracles" occur, as people – men and women most diagnosed as chronically mentally ill and many of whom had terrible physical problems - became committed to the process of recovery and turned their lives around. These miracles were not the result of our expertise, since in the early years of understanding the issues around trauma treatment we were back to "beginner's mind" – learning as much from our patients as they were learning from us [32].

Radical changes occurred in the patients when they were offered a different and coherent cognitive framework to understand their lives and their problems – a trauma-informed approach. The way we came to represent this change as it was reflected in us was a shift in fundamental question from "what's wrong with you?" to "what happened to you?" [33]. In making this shift, the shame of being a social deviant that is associated with virtually every other psychiatric diagnosis, was alleviated and removing that barrier enabled our patients to more willingly experience compassion for themselves and others while simultaneously increasing their capacity to assume more responsibility for their own recovery. As we began to see them differently – not as "sick or bad" people radically different from ourselves, but as injured human beings who had actually survived and coped with torturous experiences – our role expectations of them and of ourselves shifted radically as well. Together we learned what it means to truly "create Sanctuary".

In retrospect, we came to realize that we had made what Thomas Kuhn has called a "paradigm shift", a transformative change in the basic mental models upon which we understand and grapple with the nature of reality. This shift allowed us to see our patients as courageous survivors who had gone astray, who had learned to adjust to adversity and who were going to need to learn how to readjust to healthier conditions. We came to see ourselves less as healers or fixers and more as educators and mentors.

We began to see the mark of trauma everywhere, in ourselves, our systems, and the world around us and came to recognize the true "parallel process" nature of reality as patients reenacted their experiences with us, we reenacted with each other, and history kept being repeated in the world around us. In a multitude of dramatic ways, our patients demonstrated to us that the personal is indeed political, that there were social, economic, and political contexts within which their injuries had occurred, raising awesome issues of personal and ethical responsibility and accountability. The underlying premise of trauma theory is *interconnectedness*: of mind and body; self and other; the personal and the political; the biological with the psychological with the social with the spiritual.

As research began flooding in, supported by our own experience and observation, it also became evident that most behavior disorders are related to a past history of trauma, that a substantial proportion of physical illness is likewise related, and that most of the clients in virtually every other social service system have a similar history. The ACEs study has simply provided an evidence base for what we observed clinically for decades.

The statistics on the number of people exposed to overwhelmingly traumatic experiences, taken together, mean that there is resident in the population at any point in time, a large pool of traumatized people as well as friends, relatives and colleagues who have been affected by them. People who have survived traumatic experiences are not just in psychiatric hospitals, prisons, or homeless shelters. They are doctors, nurses and lawyers, judges, child protection workers and teachers, mechanics, police officers and truck drivers. They serve in the military and they serve in the Peace Corps. They run businesses and lead governments. As a consequence, it became obvious that one-to-one psychotherapy would never be able to reverse this situation AND that most of the pathology we all have to address was at some point in time PREVENTABLE.

Why is it that despite the fact that most people are exposed to serious childhood adversity followed by various forms of adult victimization experiences, the professional community has only recently even begun to address the need for "trauma-informed systems"? What is the resistance to learning about and adequately treating traumatized people really about? There are many reasons for this resistance, some of which have deep historical, social, and economic roots, others that are related to current circumstances and cultural climate. Upon interviewing a number of health and mental health providers who have significantly altered their approaches to care by incorporating knowledge about the impact of trauma into their basic practice, I heard many responses consistent with my own experience, some of which are listed in Table 5. When you read this list, you may recognize issues relevant to your own experience, but the journey of development is different for every

individual. It may be useful to review the list in Table 5 and ask yourself the questions, "What will I have to change about myself or my practice in order to adequately address victims of interpersonal violence?" and "What are likely to be the personal, professional, organizational, and social barriers I must surmount in order to make trauma-informed change?"

Table 5 A Sample of Answers to the Question: *What Changes Did You Experience in Coming To Terms with the Reality of Interpersonal Violence?*
• I had to change my mental model of how the world works.
• I had to identify with the helplessness of the victim instead of the power of the perpetrator.
• I had to take more time than I usually have to interview, listen, and treat people.
• I had to come to terms with the reality of how unjust the world really is.
• I had to learn to wrestle with my conscience when conflicts arose about trauma survivors needing help vs. taking care of myself – as in when someone runs out of money for treatment.
• I had to empathize with people who do awful things and who sometimes behave terribly towards you.
• I had to deeply listen to horrible stories of abuse and deal with the feelings and images those stories evoked.
• I was no longer able to sustain the notion that there is a clear line of differentiation between good and evil.
• I could no longer believe that the past is the past, or that history doesn't matter.
• I could no longer believe that it is all about biology or genes.
• I had to rethink the whole issue of right and wrong, and a justice system based on getting retribution.
• I had to learn to speak out for the rights of survivors when my colleagues disagreed
• I had to accept that I made a lot of mistakes with people in the past.
• I had to remember things I didn't want to remember about things that

happened to me.
• I had to accept that I don't have the power I thought I had.
• I had to deal with the reality that the personal is political and I cannot get away from the political implications of your work.
• I had to accept that sometimes people decide to go on doing things that are wrong and that it is their choice to make.
• I had to give up the notion that DSM-IV diagnoses matter very much.
• I had to be willing to make people uncomfortable and feel pain in order to heal.
• I had to come face-to-face with the most profound ugliness and perversity
• I had to recognize that troubled parents who hurt their kids were usually troubled kids themselves
• I had to confront and overcome the fixed belief that talking about trauma is like opening up Pandora's box – asking for trouble without getting any positive benefit.
• I had to confront people in authority when I thought they were being wrong-headed or unfair and risk getting myself into trouble.
• I had to deal with everyone else's pessimism about change – even if that is the business they are in.
• I had to deal with how depressing it is that people do these things to other people, especially to children.
• I had to accept that the mind alters the body and the body alters the mind in ways we are only beginning to understand.
• I had to get used to the fact that they may never thank-you for the help you give.
• I had to become an alien, as the victim is an alien, and learn to exist outside the bounds of normal and even celebrated professional existence.
• I had to give up my notions that therapy can be very quick or that it has to be very long and be willing to focus on recovery – whatever it takes.
• I had to learn to keep my mouth shut at parties and at dinner with people who are not trauma specialists because the stories you tell freak out regular people.
• I realized that I am possibly quite capable of killing another person.
• I realized that I am possibly quite capable of being killed by another person.

• I had to change my ideas about what therapy is and isn't.
• I had to change my notions about how much control I have.
• I had to realize that in helping people I am only the driving instructor not the driver – and I have little or no control over the wheel.
• I had to be more willing to take risks and know that no one will protect me if things turn out badly.
• I like things to be straightforward and simple and nothing about trauma seems simple.

Organizational Complex PTSD: Stress as A Barrier to Systemic Change

Beyond the personal, there are larger, systemic barriers to making trauma-informed change. All of our medical, mental health, and social service systems today are experiencing significant stress caused by everything from "managed care", to deinstitutionalization, malpractice suits, government regulations, decreased funding, reductionist urges to only use "evidence-based practices, and even to pressures to become "trauma-informed".

Table 6

THE PARALLEL PROCESS NATURE OF ORGANIZATIONAL STRESS

Organizational Dynamic	Trauma-based Parallel Process
Social service systems today are experiencing significant stress.	CHRONIC STRESSORS: HOSTILE ENVIRONMENT
In many helping organizations, neither the staff nor the administrators feel particularly safe with their clients or even with each other.	LACK OF BASIC SAFETY
Atmospheres of recurrent or constant crisis severely constrain the ability of staff to: constructively confront problems, engage in complex problem-solving,	LOSS OF EMOTIONAL MANAGEMENT

and involve all levels of staff in decision making processes.	
Communication networks tend to break down under stress and as this occurs, service delivery becomes increasingly fragmented, and organizational memory is lost.	DISSOCIATION, FRAGMENTATION, AMNESIA
When communication networks break down so too do the feedback loops that are necessary for consistent and timely error correction.	SYSTEMATIC ERROR
As decision-making becomes increasingly non-participatory and problem solving more reactive an increasing number of short-sighted policy decisions are made that appear to compound existing problems.	LOSS OF DEMOCRATIC PROCESSES and PARTICAPATORY MANAGEMENT, LOSS OF COMPLEXITY, IMPAIRED COGNITION
Unresolved interpersonal conflicts increase and are not resolved.	IMPOVERISHED RELATIONSHIPS
As the situation feels increasingly out of control, organizational leaders become more controlling, instituting ever more punitive measures in an attempt to forestall chaos.	NCREASED AUTHORITARIANISM, LOSS OF CRITICAL JUDGMENT, SILENCING OF DISSENT, INCREASED CONFORMITY
As the organization becomes more hierarchical there is a progressive and simultaneous isolation of leaders, loss of critical judgment, and a “dumbing down” of staff.	DISEMPOWERMENT, HELPLESSNESS

Staff respond to the perceived punitive measures instituted by leaders by acting-out and passive-aggressive behaviors.	INCREASED AGGRESSION
Loss of key staff and leaders due to downsizing. Standards of care deteriorate and quality assurance standards are lowered in an attempt to deny or hide this deterioration.	UNRESOLVED GRIEF
Over time, leaders and staff lose sight of the essential purpose of their work together and derive less and less satisfaction and meaning from the work.	LOSS OF MEANING
When this spiral is occurring, staff feel increasingly angry, demoralized, “burned out”, helpless and hopeless about the people they are working to serve.	DEMORALIZATION
Ultimately, if this destructive sequence is not arrested, the organization begins to look and act in uncannily similar ways to the traumatized clients it is supposed to be helping.	SELF-DESTRUCTIVE BEHAVIOR, FORE-SHORTENED FUTURE, LOSS OF CREATIVE PROBLEM-SOLVING

As a result, this sense of tension is felt throughout many organizations so that neither the staff nor the administrators feeling particularly safe with their clients or each other. Many helping environments are characterized by states of constant crisis that severely constrain the ability of staff to constructively confront problems, involve all levels of staff in decision making, engage in complex goal setting and problem solving, or in some cases even talk to each other. Team meetings, informal conversations, formal discussions, shared decision making are known to be important components of healthy work environments but without the time to truly collaborate, an organization loses the capacity to manage the emotions evoked by the stress of the work.

Under the stress of time pressures and increased demands, communication networks tend to break down both within and between organizations and as this occurs, service delivery becomes increasingly fragmented. Normally, it is through the steady flow of information and feedback that we are able to do timely and appropriate error-correction so that when the communication network begins to breakdown, so too does the normal error correction methods, increasing the likelihood of escalating levels of systematic error.

As fewer people actually participate in decision making and problem solving, decisions are likely to be more short-sighted and ineffective, or worse yet, may compound existing problems. The loss of more democratic processes within the organization results in the systemic loss of the ability to resolve complex problems complexly and the result is gross oversimplification of everything from staff policies to treatment decisions.

In such an environment, conflicts escalate everywhere, but without time and resources, conflicts cannot be resolved and therefore trust and interpersonal relationships deteriorate. As this situation is evolving, it does so insidiously. Nonetheless, as time goes on, the situation feels increasingly out of control and organizational leaders respond by becoming more controlling, instituting ever more punitive measures in an attempt to forestall what appears to be impending chaos. This results in organizational climates that promote authoritarian behavior which serves to reinforce existing hierarchies and create new ones. As this occurs, there is a progressive isolation of leaders, a dumbing-down of staff, and a loss of critical judgment throughout the organization. Everyone knows that something is happening that is all wrong, but no one feels able to halt the descent that is occurring. Helplessness begins to permeate the system so that staff members become helpless in the face of traumatized children, adults and families who then feel helpless to help themselves or each other, administrators helplessly perceive that their best efforts are ineffective.

As the administration becomes more punitive, the staff respond by developing a wide array of acting-out and passive-aggressive behaviors as well as escalating levels of punitive behavior directed at the children, adults, and families. Under funding pressures, downsizing frequently results in the loss of key staff members, leaders, affiliations, and programs and as a result everyone left behind experiences multiple losses, while the organization as a whole loses much of its organizational memory. As standards of care deteriorate and quality assurance standards are lowered, everyone becomes increasingly saddened, frustrated, angry about the loss of former standards of care and their individual and shared ability to be productive and useful.

Over time, leaders and staff lose sight of the essential purpose of their work together and derive less satisfaction from it. Many of the best people find this intolerable and they leave so that the amount of individual dysfunction becomes concentrated in the people who remain. When an organization is in

this downward spiral, the staff feel increasingly angry, demoralized, burned out, helpless and hopeless – but failing to see the almost insurmountable barriers to recovery that the system has erected, the hopelessness is projected onto the children, adults, and families who are seen as being radically different from previous generations and far less reachable. Ultimately, if this destructive sequence is not arrested, the organization can begin to look and act in uncannily similar ways to the traumatized people it is supposed to be helping. The result of this process is what I have come to characterize as *Organizational Complex PTSD* [34].

S.E.L.F. - A Simple, Nonlinear Framework

With such great complexity confronting us where do we begin? How can we help individual trauma survivors recover when our systemic problems stand in the way? "S.E.L.F." is a simple, nonlinear conceptual framework for managing great complexity. As part of the Sanctuary Model [32, 33, 35], S.E.L.F. provides a cognitive behavioral therapeutic approach for facilitating client movement through the four critical stages of recovery: *Safety* (attaining safety in self, relationships, and environment); *Emotions* (identifying levels of affect and modulating emotion in response to memories, persons, events); *Loss* (feeling grief and dealing with personal losses, resistance to change), and *Future* (trying out new roles, ways of relating and behaving as a "survivor" to ensure personal safety and help others). These four constructs reflect the recurring themes that trauma survivors present regardless of the specific nature of the insults or traumas that they have experienced.

These elements are consistent with other staged models of trauma treatment and recovery, although S.E.L.F. does not proceed in sequential stages but instead works as a simultaneous phased implementation tool of the Sanctuary Model [18, 36, 37]. It is more like a compass that can be used as a guide while moving through the difficult recovery process. By using S.E.L.F. children, adults and helpers are able to embrace a shared, non-technical and non-pejorative language that allows them all to see the larger recovery process in perspective. The accessible language demystifies what sometimes is seen as confusing and even insulting clinical or psychological terminology that often confounds people, while still focusing on the aspects of problematic adjustment that pose the greatest difficulties for any treatment environment. S.E.L.F. also offers staff members and the organization as a whole, a conceptual framework for thinking about and working through organizational problems that interfere with the vital work we have before us.

Much of the initial focus in any treatment setting must be on Safety and Emotions. In S.E.L.F. the definition of *Safety* encompasses four domains: physical, psychological, social, and moral – See Figure 2 [32]. The development of a safety plan embraces problems as diverse as self-mutilation, running away, aggression, chronic suicidality, interpersonal abusive behavior, racial slurs,

rumor-mongering, failing to follow medical directions, and inadequate self care. Most of the problem behaviors and overwhelming emotions that present difficulties for children, adults, clinicians and behavioral health settings reflect problems with appropriate management of distressing *Emotions* and many modalities of intervention can help people develop better emotional management skills. *Loss* can be clinically recognized as a failure to make progress, continued acting-out, reenactment behavior, chronic depressive symptoms, sudden regression, and unresolved bereavement. We found that it was far more productive to talk about "grief" instead of "depression". The concept of grief has sociocultural and time-limited pathways for resolution that are explicit in every culture and that can be brought to bear even upon losses that are highly symbolized or that originate far in the past [19]. *Future* represents the goal – 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 and requires the assumption of personal and social responsibility, appropriate risk-taking, education, and progressive change in self image, behavior and interpersonal relationships. Support groups based on S.E.L.F. can be conducted in almost any setting and offer a meaningful psychoeducation framework for survivors to begin the process of recovery[4]

The further utility of S.E.L.F. is that it can simultaneously be employed in a parallel process manner to deal with problems that arise within the treatment setting between staff and clients, among members of staff, and between staff and administration. Applied to such issues as staff splitting, inadequate communication, poor morale, rule infraction, absenteeism, administrative withdrawal and helplessness, and misguided leadership, S.E.L.F. can also assist a stressed organization conceptualize its own present dilemma and move into a better future through a course of complex decision making and conflict resolution [38]. S.E.L.F. has now been demonstrated to be of great value within many different treatment settings: inpatient [38-41]; outpatient [42]; parenting programs [43], children's residential programs [38, 44, 45]; domestic violence shelters [46]; and substance abuse facilities [38, 47]. Research funded by the National Institutes of Mental Health [48] has also supported the use of S.E.L.F. as part of the implementation of The Sanctuary Model within a residential setting for children [49-51].

Using S.E.L.F. in Health Care Settings

For general health care providers, victims of interpersonal violence present a number of challenges: they frequently have a variety of comorbid conditions; they do not necessarily respond to standard medical treatment and many may

[4] For more information about a S.E.L.F. group curriculum visit www.sanctuaryweb.com

be considered “problem” or “resistant” patients. Often, their medical complaints are mysterious, inconclusive, vague, and diverse without meeting criteria for a definitive diagnosis and yet their suffering is very apparent. It has been estimated that up to 75% of all visits to primary care providers involve the presentation of psychosocial problems through physical complaints [52]. Sometimes, though their pain is quite real, its origins are to be found in the body memories and flashbacks that are typical responses to past trauma, but unrecognized as such by the patient. In short, it is the patients who have been exposed to chronic and recurrent trauma who are likely to pose the most significant challenges to virtually any medical practice. As one of my colleagues has noted, *“when care providers see someone in a clinic or an office with difficult and/or confusing constellations of complaints, they should consider the possibility of the PTSD diagnosis* [53].

A thorough medical history should include exploration of past traumatic experiences as routinely as we ask questions about family medical history and past surgical experiences.

Table 7 ROUTINE TRAUMA QUESTIONS IN PRIMARY CARE SETTING
1. As a child or adolescent did you live in a household where there was anyone who abused drugs or alcohol?
2. As a child or adolescent did you live in a household where there was anyone who was mentally ill or who tried to commit suicide?
3. As a child or adolescent did you live in a household where there was anyone who was imprisoned?
4. As a child or adolescent did you live in a household where there was anyone who assaulted anyone else in the household?
5. As a child or adolescent did you live with a foster family?
6. What is the worst thing that has ever happened to you?
7. What is the worst thing that has ever happened to someone in your family?
8. Have you ever been the victim of a crime?
9. Have you ever been in a natural or manmade disaster?
10. Have you ever been in an accident serious enough so that you were medically examined?
11. Have you ever had excessive fear concerning medical procedures or

surgery?
12. Have you ever served in the armed forces? If yes, were you involved in combat?
13. Did you suffer any form of severe physical or emotional neglect as a child?
14. Have you experienced psychological /verbal abuse as a child or as an adult?
15. Have you ever been physically assaulted as a child or as an adult?
16. Have you ever been sexually molested or assaulted as a child or as an adult?
17. Have you ever witnessed someone else being seriously injured or killed?
18. At any point during this (these) experience (s) did you think you were in danger of serious personal harm or of losing your life?
19. Have you ever sexually or physically assaulted someone else?
20. Have you been a civilian victim of war or witnessed any kind of atrocity?

How can a health care provider use S.E.L.F.? Health care providers tend to be practical and problem-oriented so that the S.E.L.F. framework can provide a handy, goal-oriented organizing framework for complex post-traumatic problems. Let's use a case as an example and develop a S.E.L.F. treatment plan for her.

Mary is a 30-year old diabetic woman whose diabetes has been controlled by oral medication. Today she presents to her family physician because her diabetes is out of control. She has not been following the prescribed diet, has recently gained a great deal of weight and if the situation does not improve she will have to go on insulin. She has repeatedly been in abusive relationships and is now working on extricating herself from yet another one. She has two children who she loves, but who seriously test her patience when she is not feeling well. She has few friends. Her mother and sister try to help her out, but she rejects their help, believing that with both of them there are always "strings" attached. She works at an unsatisfying secretarial job and wants to go to nursing school and fulfill a childhood dream but has been unable to mobilize her resources to do so. At work, she gets into many stressful conflicts with boss and with peers, largely because she is intolerant of and inpatient with people and then she comes home and treats herself by eating. Mary tends to swallow her feelings and doesn't speak truthfully about what she feels. She often feels like hurting other people when she is angry and it is then that she is likely to take out her feelings on her children and sometimes hurts herself by secretly cutting. She doesn't feel like she really understands her own feeling and often

does things and says things on impulse that she doesn't feel she can control. Mary has had many significant losses in her life that she has never really worked through and she has a childhood history of physical and sexual abuse at the hands of her alcoholic father who is now deceased. As a child, Mary repeatedly witnessed her mother and sister being beaten by her father. Her mother was hospitalized several times for depression when Mary was very young.

A initial S.E.L.F. treatment plan for Mary might look like this[5]:

SAFETY	
GOALS	**OBJECTIVES**
Physical	Follow guidelines for treatment of diabetes
	Recognize unsafe impulses and use support when impulse to binge occurs
	Understand and follow good nutrition guidelines
	Get blood work done on schedule
	Understand and properly use diabetes medications
	Speak up about any side effects or concerns about medications
	Weigh myself weekly and follow weight loss diet
	Take steps to avoid continuing abusive relationship
	Exercise actively to remain strong and healthy and lose weight
Psychological	Avoid or get out of playing a victim role with other people
	Avoid or get out of playing a perpetrator role with other people
	Work on building trusting relationships with family members
Social	Recognize impulses to provoke conflict and ask for help

[5] Thanks to Gus Haracopos and the rest of the treatment team at Andrus Children's Center

	Develop better task schedule with my children to avoid arguments
	Tolerate differences that I see as negative
	Reach out to others for support
	Role model safe and respectful behavior toward all
Moral	Be honest with self
	Be honest with other people
	Speak up when I feel unsafe or threatened
	Pursue nonviolence in relations with others
EMOTION MANAGEMENT	
	OBJECTIVES
	Start to notice internal feelings and responses to situations
	Express internal states using language
	Express feelings in ways that other people feel safe and respected
	Look for link between body language, facial expression & emotion in self and others
	Name what feelings might have influenced argumentative behavior after that behavior is over
	Name what feelings might have influenced self-destructive behavior after that behavior is over
	Use time away to interrupt and think about outbursts and difficult situations
	Give myself a safe space
	Assert myself to express how I feel before I blow up
	Seek help from family members or friends to stay on track and stay OK

	Use relaxation techniques
	Write a journal entry or other
	Express feelings in artistic, creative ways
	Exercise
	Use strategies to stay on task even when upset
	Use strategies to help make better decisions even when upset
	Use positive self-talk instead of falling into negative patterns
LOSS	
	OBJECTIVES
	Tolerate discussion about painful realities
	Use emotion management coping skills to bear the feelings instead of eating
	Learn the facts about this loss and how it can affect people in general
	Learn how the losses I have experienced still affect me
	Write about what it's like to live with this loss
	Use creative expression about what it's like to live with this loss
	Learn about how other people have come to terms with a similar loss in their lives
	Write about what it's like for me to come to terms with these losses
FUTURE	
	OBJECTIVES
	Identify career paths and goals in nursing
	Identify potential role models or mentor in nursing
	Make plan for returning to school
	Learn about saving money and start to do so

	Work with family to plan and follow routines for family life
	Improve relationships with the children & adults in my family
	Take more responsibility for household chores and tasks
	Follow health practices and recommendations
	Understand and follow good nutrition guidelines
	Exercise actively to remain strong and healthy
	Reach out and build friendships in my community
	Join diabetes support group

When Mary returns for her follow-up visits, the practitioner can then refer back to the treatment plan with Mary and in doing so, Mary becomes more educated about the impact of trauma and the steps necessary to recover. Gradually she comes to understand how her unsafe behavior is tied to difficulty dealing with distressing emotions, which itself is tied to a history of many losses and exposure to violent abuse, all of which interferes with the achievement of possible and pleasurable future goals that she has for herself. Because S.E.L.F. focuses on change and not just on Safety, on many domains of the patient's life and not just her presenting symptoms, it becomes far more likely that change will actually occur and that the underlying causes for resistance to change can be surfaced and addressed. Over the course of her visits, the practitioner can give Mary reading material, suggest videos for her to watch, promote the use of support groups, and urge her to engage in creative expression, all of which in and of themselves, provide Mary with opportunities to invest in therapeutic change.

Does this mean that Mary will not have to see a mental health provider? Perhaps. Or maybe, as Mary takes a more task-oriented approach to problems that have previously felt overwhelming and impossible to resolve, she will become far more amenable to deeper therapeutic work. The tasks, goals and objectives in the S.E.L.F. treatment plan break down the complex idea of recovery into more manageable "bites". When Mary feels less helpless and overwhelmed she is more likely to begin to chip away at her problems and health care providers can use S.E.L.F. on a regular basis to help guide Mary toward success. And guaranteeing that Mary has some success is critical. Exposure to repetitive trauma robs people of the sense that they can master their own reality and instead they feel helpless, even when there are steps they can take to do better. If the health care setting supplements regular medical visits with the opportunity and encouragement for Mary to join a S.E.L.F. Psychoed Group as well, then progress is likely to be more rapid since Mary will

be urged on in her efforts by group support and will benefit from the group learning experience.

The Sanctuary Model: Transforming Our Organizational Cultures

What do you suppose happens when a victim of interpersonal violence encounters a helping system of care that appears desperately in need of help itself? When health care providers are stressed, angry, fearful, and demoralized it is difficult for them not to convey their emotional states to their most sensitive patients. Ultimately, despite the gadgetry and technological advances of modern medicine, healing is delivered by other human beings and anything that interferes with the well-being of the staff in any setting is bound to interfere with the delivery of vital healing services.

For many of our settings, to become holistic and trauma-informed means to undergo transformation. Transformation means "A change in an organism which alters its general character and mode of life". Children, adults, families and organizations represent nonlinear systems – they are alive. They are capable of growth, change – and yes, transformation, but we cannot imagine that applying linear models will help them grow. The solutions to our problems – individual, therapeutic, and social – are possible but only if we learn to tolerate and manage complexity. We must stop pretending that human bodies, human beings and human systems are machines and recognize their inherent ability to change IF we create climates that promote growth and change, that encourage the *emergence* of innovative and complex solutions to complex problems.

The Sanctuary Model ® represents a comprehensive trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. The Sanctuary Model was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children. The Model has since been adapted by residential treatment settings for children, domestic violence shelters, homeless shelters, group homes, outpatient settings, substance abuse programs, parenting support programs and has been used in other settings as a method of organizational change. The Sanctuary Model is not an intervention but a full system approach focused on helping injured children, adults, and families recover from the damaging effects of interpersonal violence. Because it is a full system approach, effective implementation of the Sanctuary Model requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process.

The aims of the Sanctuary Model are to guide an organization in the development of a culture with seven dominant characteristics all of which serve goals related to a sound treatment environment and a healthy

workplace: a commitment to nonviolence serves to orient a program around the need to develop and role model safety skills; a commitment to emotional intelligence emphasizes the importance of teaching and role modeling emotional management skills; a commitment to social learning is directed at building and modeling good thinking and problem-solving skills; a commitment to democracy ensures an environment of civic participation that models the civic skills of self-control, self-discipline, and the administration of healthy authority; a commitment to open communication encourages everyone in the environment to overcome existing barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills and model the skills involved in creating and maintaining healthy boundaries; a commitment to social responsibility requires the learning or rebuilding of social connection skills and the establishment of healthy attachment relationships; a commitment to growth and change guarantees that the environment as a whole and every individual within it will focus on the restoration of hope, meaning, and purpose [6].

TABLE 8 **CREATING SANCTUARY**	
Cultural Characteristic	*Trauma-informed Goal*
Culture of Nonviolence	• helping to build safety skills and a commitment to higher goals
Culture of Emotional Intelligence	• helping to teach emotional management skills
Culture of Social Learning	• helping to build cognitive skills
Culture of Democracy	• helping to create civic skills of self-control, self-discipline, and administration of healthy authority •
Culture of Open	• helping to overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy

[6] For more information on the Sanctuary Model of Organizational Change see www.sanctuaryweb.com and www.andruschildren.org

Communication	boundaries
Culture of Social Responsibility	• helping to rebuild social connection skills, establish healthy attachment relationships
Culture of Growth and Change	• helping to restore hope, meaning, purpose

The impact of changing an organization in this way should be measurable. We should be able to see the absence of violence and the presence of an environment that is physically, psychologically, socially and morally safe. This sense of safety should be reflected in a low level of critical incidents, low staff turnover, low staff and patient injuries, low patient complaints, better outcomes and better morale.

What Can You Do To Help?

As a health care provider, you can do a great deal to move the system to recognize and respond to child and adult victims of interpersonal violence by changing your practice in the ways described in this chapter and by challenging yourself to change as you want your patients to change. Interpersonal violence is not just a mental health problem or a health problem – it is the major public health problem of our times. As a health care provider AND a citizen, there are many tangible ways that you can contribute to systemic change:

- Legitimatize survivors: Support the mobilization of a survivor movement and integrate the voice of survivors into your clinical settings
- Disseminate notions of "therapy" outside of the one-to-one box and then introduce that "therapy" into domestic violence shelters, homeless shelters, schools, day care settings, health care settings, clinics, etc. Integrate mental health practices and procedures into your primary care setting and make sure these services are thoroughly trauma-informed
- Permeate the politics of your own settings and structures with the implications of trauma theory – walk the talk.
- Educate everyone who will listen – take any opening you can get – police, courts, schools, child protection agencies, parenting programs, domestic violence programs, victims services programs, district attorneys, family physicians, insurance companies, employers.

- Desegregate the discourse: Make clear connections between child abuse, family violence, criminal victimization, substance abuse, homelessness, poverty, prostitution, exploitation, physical illness, mental disorders and vast destruction of the environment.
- Penetrate academic settings: get this knowledge into training programs at every level – be willing to teach from personal experience.
- Populate the press: write letters to the editors, make friends with journalists, do op-ed articles, write a column, get some face time, learn how to do it properly.
- Legislate the issues: write letters, make visits, engage in discussions with political leaders, support candidates, learn how to lobby.
- Infiltrate funding streams – federal, state, county, foundation, private funders need to recognize the short-and long-term economic costs of failing to respond adequately to victims of violence

With education, patience and support survivors of unspeakable trauma do commit themselves to recovery, not because someone else frightens them into it. Certainly, fear may play a role in the urgency of their decision making, but ultimately the individual survivor makes transformative change because little by little he or she begins making different choices, fans the fires of hope, and begins to envision a different future than the one predicted by past behavior. There is in their process, guidance for all of us. We live in treacherous times and the future is perhaps less predictable than it has ever been in the history of humankind, while the rate of change is increasingly exponentially. We need to fan the fires of hope for each other. Together we must envision a different future than the solitary, deadly, and frightening future we see predicted in movies and hear forecast by our political leaders. In 1953, Maxwell Jones, one of the founders of the democratic therapeutic community wrote: *In the field of mental health, most attention has been given to psychotherapy; some to mental hygiene, but very little as yet, to the design of a whole culture which will foster healthy personalities.* This is the work that still needs to be done, this is the work of the next generations – to design and build a future that is worth surviving.

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