

## Sanctuary, trauma and the community

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Sandy Bloom and her colleagues have provided us with a rich and thought provoking account of working with trauma and the traumatised, using a therapeutic community approach. I must own up to some degree of bias, since I visited the Sanctuary programme in Philadelphia when I was first working in a traumatic stress service and I have had the benefit (and pleasure) of spending time with Sandy Bloom, Jo Foderaro and Linda Bills in professional settings to discuss this important work. In this concluding piece, I want to think about what the strengths and weaknesses might be of the TC approach to trauma.

Perhaps one of the most immediate strengths of using the community approach is to address the feeling of isolation that is so often felt by victims of violence. One of the points that I thought perhaps needed to be emphasised more strongly is that there are many causes of traumatic stressor, and interpersonal violence is only one of them. However, interpersonal violence, both in adulthood and childhood is probably more common than the major transport disasters or other types of natural disasters that so often grab the headlines in relation to traumatic stress research. Of course the other area of research which generated perhaps more information about PTSD than other types of trauma was the study of war veterans. These are a group of people, mainly men, who were exposed to extremes of interpersonal violence both as victims and perpetrators. There is interesting evidence to suggest that the commission of violent victimisation as well as the experience of being a victim, is psychologically distressing and can give rise to post traumatic stress disorders. PTSD is only one of a number of disorders that people can develop after exposure to trauma, but the risk of developing PTSD is higher after exposure to interpersonal violence.

When considering interpersonal victimisation, it can also be important to consider whether the victimisation took place in adulthood or childhood and whether it took the form of a comparatively brief discrete episode or whether violence was a feature of an enduring relationship which continued over time. Violent victimisation which happens as discrete episodes in adulthood does give rise to PTSD and other disorders, but people often make a good response to different types of treatment and continue with their lives. In this regard most research has focused on individual cognitive behavioural interventions, or pharmacological interventions. What group based work there is relates more to voluntary groups or self help groups for survivors of violence.

Where interpersonal violence has continued over a long period of time and was an integral feature of a dependent relationship, then the psychological morbidity is more complicated. Judith Herman coined the term "complex post traumatic stress disorder" for the constellation of symptoms and experience that survivors of childhood violence demonstrated in adulthood. Several commentators have noted the similarity between the features of complex post traumatic stress disorder and many features of severe personality disorder, especially borderline personality disorder. Specifically, complex PTSD involved distortions of a sense of self, dysregulation of affect and arousal as well as unstable interpersonal relationships which are often formed in very intense ways. Dynamically we argue that these are individuals who have not been able to internalise a soothing or stable internal working model of themselves in relationship with others, which they could use when feeling needy or distressed. It is perhaps relevant here to quote the recent research which shows that therapeutic communities can be effective for people with mild to moderate personality disorder, many of whom might be better understood as suffering from complex PTSD. We might argue that the living learning experience provided by the community provides an opportunity for people to develop or modify internal working models of relating, using the community as a secure base people are more able to develop a sense of self agency.

Using a therapeutic community approach therefore can be especially valuable for those who feel isolated and disconnected by their experience of trauma. Fear, helplessness and the sense of being out of control often leaves survivors feeling that their experience is both unthinkable and unspeakable and that therefore, no one else can really understand. Although perhaps less well researched, there is a long tradition of group analytic treatments for traumatic experiences. Specifically in relation to therapeutic communities, it could be argued that the TC approach was primarily treatment of war traumas; an approach which emphasised that the traumatic experience had happened to men as a group, as members of a military community. It was perhaps only by understanding their role in that community that they could make sense of what had happened to them and move on.

Elsewhere, Sandy Bloom has written about the provision of Sanctuary for victims of violence as a political issue (Bloom 1997). She raises a question which may be disconcerting and uncomfortable for mental health care professional. To what extent could we, and should we, take up the question of violence as a political issue and refuse to engage with it as a question of individual morbidity and distress? In this sense, violence and interpersonal victimisation is everybody's problem; we experience it and respond to it as a community. In the forensic setting that I work in, we are conscious of the harm that had been done to the community as a whole when any of our patients harms another, both in the hospital and of course in relation to the offence that brought them to Broadmoor in the first place. The Special Hospital can sometimes come to represent a sub-community of people who have been excluded from the larger community because of their violence. When individual commit crimes, at least one of the many meanings for such complex