Psychiatric Quarterly, Vol. 74, No. 2, Summer 2003 (© 2003)

Special Section
Sanctuary® Principles and Practice in Clinical Settings

INTRODUCTION

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Guest Editors

The five papers in this collection of articles represent a collaborative effort to bring the wisdom of social psychiatry and its concern with context and meaning back into a more central position in the ongoing conversation about what it takes to bring about real change. For several decades, the knowledge about what it means to be part of a therapeutic milieu has been marginalized. The words "therapeutic milieu" are still batted around, usually on treatment plans, but an increasingly smaller number of people actually know what a rigorous and demanding practice it is to create and maintain a truly "therapeutic" milieu. Many of the concepts referred to in these articles are not new. The tenets of good milieu management stretch back more than a century, even back to the Moral Treatment first practiced in the 18th century. Systems theory gave birth to the community psychiatry movement of the 1960's. The notion of nonviolence, even if not practiced, has been around for a very long time. What is new is the burgeoning knowledge we have gained in the last twenty-five years about the frequency of exposure to violence and the impact of trauma on children, adolescents, and adults.

The Sanctuary® Model pulls old and new together into a coherent conceptual framework that strikes a chord of deep resonance in staff and clients, children and adults. The articles in this issue speak to that chord, and are the product of three groups working interdependently. Bloom and Bills are at Community Works® in Philadelphia, and are part of the team who created the model. Abramovitz and Madsen are leaders in the Jewish Board of Family and Children's Services' Center for Trauma Program Innovation, implementing the Sanctuary model in clinical settings. Rivard's evaluation of the Sanctuary model comes

0033-2720/03/0600-0115/0

from Columbia University. In the first article, Abramovitz and Bloom provide an historical perspective on the unintentional fragmentation of care in residential treatment settings for children and address the ways in which the Sanctuary Model is helping to provide a coherent framework for integrating different approaches aimed at helping traumatized children to heal. In the second article, Rivard and colleagues describe a study underway at the same residential treatment setting to examine the implementation and outcome of the Sanctuary Model.

The authors of the third article, Madsen, Blitz, McCorkle and Panzer turn attention to the details of implementing the Sanctuary Model in a domestic violence shelter that must contend with the aftereffects of violence on women and children. The fourth article is coauthored with Bloom and the leaders of five other collaborative projects. They describe what it is like to serve as change agents all having in common a commitment to developing nonviolent, trauma-based community contexts for successful treatment. The final article by Bills describes the ways in which a general psychiatric practitioner can utilize the Sanctuary concepts in everyday practice.

Common themes emerge from these diverse experiences. First is the recognition that responding adequately to the needs of trauma survivors and promoting their recovery is extremely complex and difficult work. Engaging with high levels of physical and psychological suffering for many hours a day takes a toll and without a clear conceptual framework to make sense out of what one is thinking, feeling, and doing there is a tendency to blame the victims and inadvertently reenact a traumatic past. As emerges from these papers, much of the work of the Sanctuary Model is directed not at the clients, but at the staff who serve them and the systems within which treatment is embedded.

Victims of violence share in common wounding experiences with the abusive use of power. As a result, the uses and misuses of power and control will provide a central organizing framework for many of the symptoms that bring people into contact with the mental health system. Throughout these papers runs a second common thread, that of the need for any therapeutic system to maintain a running discourse around the issue of power, what it means and how it is used for good or for ill.

Knowledge is power and a third common thread in the Sanctuary Model is the implicit necessity for establishing a shared language and a shared meaning system that cognitively, behaviorally, emotionally, intuitively, morally, and spiritually makes sense. From the perspective of Sanctuary, the search for knowledge is unending. The goal, as one of the founders of the therapeutic community, Maxwell Jones said, is to always be creating a living-learning environment for patients and for staff.

Learning can only occur within a context of safety, and what "safety" really means is the fourth common thread in these papers. The achievement of safety is always an interaction between the individual and the environment. It is not enough to prohibit unsafe behavior. The environment must simultaneously support the creation of safety. To create safe environments, human beings have to confront complexity and the constancy of change. No individual mind is sufficient to the task. Only when we learn how to truly collaborate, as the standard, not the exceptional practice, can we adequately manage complexity and the changing nature of life. It is easy to forget these days that *change* is what therapy is supposed to be about. Not stability, but change. Creative and healthy change in a small inpatient unit requires the same qualities as it does in an entire nation: a set of shared values, a flattened hierarchy, shared decision making, a commitment to conflict resolution, balanced power, diversity, tolerance, kindness and mutual respect. Another name for all that is democracy.

ACKNOWLEDGMENTS

Dr. Panzer's work is supported in part by the Saul Z. and Amy S. Cohen Family Foundation and the National Institute of Mental Health (MH62896).