

CITATION: Farragher, B. and Yanosy, S. (2005) Creating a trauma-sensitive culture in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations* 26(1): 97-113

Creating a Trauma-Sensitive Culture in Residential Treatment

Brian Farragher, LCSW
Executive Vice President
Chief Operating Officer
Andrus Children's Center
1156 N. Broadway
Yonkers, NY 10701
914-965-3700
bfarragher@jdam.org

Sarah Yanosy, LCSW
Clinical Coordinator
Diagnostic Unit
Andrus Children's Center
1156 N. Broadway
Yonkers, NY 10701
914-965-3700
syanosy@jdam.org

Abstract

In this paper, the Chief Operating Officer and one of the social workers at the Andrus Children's Center offer a first hand account of turning their center into a trauma-informed program for over 150 children. They describe the impact of traumatic experience on the children in care and on the organizations that serve them and then tell the story of how their staff is using the Sanctuary Model to bring about real and significant changes in the children, the staff, and the organization as a whole.

Introduction

This paper is intended to recount the experience of the Andrus Children's Center as it struggled to become a trauma-informed and trauma-sensitive treatment program. Andrus is located on a 110 acre campus just north of New York City. We serve 73 children in our Residential Programs and another 80 children in our Day Treatment Program. All of the children in care have serious emotional problems that have adversely impacted their functioning at home, in school and in the community. Approximately 60 – 70% of these children have been exposed to some kind of trauma, with the children in the Residential Programs being much more likely to have traumatic exposure.

A great deal has been written about the issue of childhood trauma over the last ten years. The research findings on the impact of trauma on the developing brain of children have yielded some exciting new ideas about the nature of mental illness and behavioral disorders. Although it is still in the early days, many of the theories about how trauma impacts children rings very true for those of us who have spent our professional lives working with abused, neglected and injured children.

This research has prompted us to begin to explore how we could apply some of this new science to our 75 year old treatment center. We knew bad things had happened to many of our children, and the research helped us to understand what impact these terrible events had on the children with whom we had been working. But, like so many other treatment centers, we had little if any idea what we could do to intervene.

Through a combination of good fortune and dumb luck we became acquainted with Dr. Sandra Bloom. We had sent our Residential Director to a conference on safety with the expectation that he would learn a few things about fire safety, evacuation procedures, suicide assessment, restraint reduction and all the other things we usually focus on when we think about safety. What he returned with was a handful of power point slides entitled "Creating Sanctuary ®." (Bloom 1997) These slides suggested a trauma-sensitive environment could be created by focusing on safety, emotion management, loss and future. It was not what we were looking for but just what we needed.

Within a couple of weeks we contacted Dr. Bloom (we like to call her Sandy, and she prefers that as well) and had her come in for a chat. About 8 weeks later we had signed on for a two year consultation, and three and a half years later we are still at it, trying to figure out how we can best respond to the needs of injured kids.

This paper is not intended to be a serious academic pursuit. What we hope to do here is to share some of our experiences - the lessons we have learned, the discoveries we have made and the questions we have raised as we have tried to reshape our campus programs and create the kind of trauma-focused and trauma-sensitive environment we envisioned in the Spring of 2001. It is fitting that our entire experience thus far has mirrored how we began. We sent our Residential Director off to learn about safety, and he came back with a new treatment model that certainly would enhance safety, but promised much more. We embraced this new model to provide better treatment for traumatized children, and it has certainly done that. But has also reshaped our entire program and has made Andrus a better community for all its members. So the first important lesson for us is that when you start to change things, it is hard to predict what you will learn or where you will end up.

The case studies used to illustrate specific issues are composites of several different children, incidents and circumstances. Many of the details, names, history, cottage, ages, gender and incidents have been blended and changed significantly to protect confidentiality.

Framing the Problem

It is our assumption that readers have had at least some orientation to trauma theory and the impact trauma has on children. What might be less common knowledge, however, is the impact trauma has on every level of the organization and why organizations that fail to grapple with this issue do so at their own peril.

Trauma's Impact on Children:

Children who have witnessed or have been victims of interpersonal violence, community violence, have been neglected or suffered terrible losses often present with a wide range of emotional and behavioral problems. They can have difficulty forming relationships, and can be hypervigilant and reactive. They often perceive the actions of others as threatening, unfair or malevolent. They can become quite rigid and respond to situations and people they view as threatening with the same self-defeating responses over and over again. They often resist the efforts of caregivers to help them develop new ways of coping. They appear hell bent on creating or stirring up crises wherever they go. They frequently feel wildly out of control and hopeless and helpless to do anything about these feelings. These children can appear disconnected, cold, uncaring and unfeeling.

It is easy for caregivers to see these children as bad, mean, sick or crazy in response to their troubling behavior. What is often missed, especially under stress, is that injured children repeatedly reenact yesterday's traumatic experiences with today's caregivers. It is easy for staff who are inadequately trained, often overworked and thoroughly stressed to get pulled into these reenactments. When we allow ourselves to be pulled into this recurring play, and we successfully act out our assigned role, we risk re-traumatizing the children we have pledged to help.

Case Example:

Latisha was an 10 year old African American little girl. She had been in multiple foster home placements, and each one failed because of her aggressive acting out and her foster parents' difficulties with managing her behavior. She was originally placed in foster care on an abuse and neglect petition. Her mother, who had problems with substance abuse, left her unsupervised while she went to purchase drugs.

Latisha ended up in Residential Treatment after three failed foster home placements. She was very angry, extremely reactive and unable to soothe herself. She also had some cognitive limitations. It was also apparent she was likely a very traumatized little girl.

Several months into her treatment, a disturbing pattern began to develop. Four or five nights a week, milieu staff were reporting that

Latisha was becoming very agitated at bed time. She would bang her furniture around her room, make a lot of noise, bother the other children and generally not respond to any staff direction. Staff would intervene and try to redirect her. They would instruct her not to move her furniture because it was very noisy and disruptive and prompt her to go to bed. When Latisha would resist these directives, things would escalate. Troubled children and tired staff are a bad combination. On most evenings this behavior would escalate to the point where Latisha would attack the staff and the staff would physically restrain Latisha. This pattern persisted for approximately two weeks (hopefully today we would respond more quickly), at which time leadership called a meeting to discuss what was going on. The team met and the following pieces of information were shared:

Latisha was creating a disturbance each night by moving her furniture around at bed time and making a lot of noise. What the milieu staff described, however, was that Latisha was not just banging her furniture around, but was actually moving her dresser up against her bed. They indicated it looked like a makeshift barricade.

Latisha's Social Worker, chimed in that about 3-4 weeks ago Latisha had confided in the worker that when Latisha was living in her mother's house, her mother's boyfriend would sometimes come into her room, tie her to her bed and rape her.

Here we have a little girl who has a history of being terribly abused at bedtime. She is scared and anxious and tries to manage these emotions by building a barricade in her room each night. The staff are not attuned to the trauma history and view this behavior as disruptive and try to stop it. The child resists and ends up in a conflict with staff. The situation escalates to the point that the staff restrain her and straddle her on the floor of her bedroom. When confronted with the reality that we were engaging in a reenactment with this child and that nightly our "treatment" program was retraumatizing this little girl, we were horrified.

Children who have been hurt like Latisha are trapped in the past and repeatedly replay their conflict and struggles in the present. All too often the response they receive from those of us charged with helping them to recover is a recapitulation of past experiences and past trauma.

What we have found in our work thus far is that this compulsion to reenact the past on the part of children in care places extreme pressures on caregivers and on the system. If we are aware of what is happening, we stand a chance of responding appropriately. If, however staff do not understand this dynamic, which is often the case, we are in big trouble. Even the most well-intentioned staff are at risk of re-injuring the children they are supposed to protect.

Trauma's Impact on Staff:

As we learn more about trauma we are also learning more about vicarious trauma (Bell, 2003; Pearlman 1995; Way, 2004). Working with traumatized children can take its toll on the most seasoned clinician. Most of what is written about vicarious trauma focuses on clinicians, generally clinicians in an outpatient setting who specialize in trauma. One would assume that folks who specialize in trauma work would have at least some sense of what the potential hazards are of working with this population and would take steps to bolster themselves against the potential adverse effects of the work.

Now think about residential care. These settings are staffed by inexperienced, marginally trained, low paid childcare staff. They work long hours because they need to supplement their low incomes with overtime, or constant staff turnover leaves them no choice. Typically, the children served in residential centers have significant trauma histories. Clinicians who do trauma work are typically advised to balance their caseloads so they do not have a disproportionate number of clients who are trauma victims. Such clients are very taxing, you know. They are encouraged to seek training, supervision and take great pains to monitor their self-care. By comparison, residential staff have no choice regarding how many traumatized children they work with. They typically work eight, ten, twelve, sixteen hours days with large groups of very challenging and traumatized children. Given that they are relatively low paid, self care activities like a gym membership, a massage, or a nice vacation are generally not realistic options. Ultimately, staff in residential centers are exceedingly vulnerable to the effects of vicarious trauma given the intensity and duration of their day to day exposure to so many injured children.

We believe most residential treatment centers look like and operate like we did three years ago. Staff working on units with the children are generally inadequately trained. They have little understanding of the impact exposure to trauma has on the children they work with, let alone understanding how these children impact them as caregivers. Given their relatively low status in the institution, they are seldom folded into the assessment process or decision making. They work crazy hours and get little support. They get cursed at, threatened, spit at, hit and abused. They have little understanding about why the children act the way they do. They are terrified of losing control over the group and often engage in coercive practices to maintain control. Supervision is limited, and when it is offered, it is often delivered by supervisory staff who also have limited knowledge about trauma and are nearly as rattled as the direct care staff are.

Earlier we discussed the risk of vicarious trauma when working with traumatized children. But after weeks, months or years of working under these conditions, direct care staff are not vicariously traumatized, they are just plain traumatized. They can become increasingly less hopeful, more rigid and less creative, they lose empathy, become overly controlling, coercive and sometimes abusive.

Another contributing factor in this already toxic stew is that many staff bring with them their own history of loss and trauma, which may make them even more vulnerable. A fairly informal survey of our milieu staff conducted approximately 12 months ago revealed that over 75% had suffered some significant traumatic event in their life time such as the loss of a parent or another close family member or exposure to violence such as being the victim of assault, physical abuse, sexual abuse, verbal abuse or other adverse situations.

Although anger is the emotion we talk a lot about in training, fear is an all too common emotion for our staff at work. Many staff come to work afraid: afraid of getting hurt, afraid of losing control of the group, afraid of losing control of themselves. Working this way day after day has its impact, and staff can easily begin to look and act like the children they are supposed to be helping.

Without adequate knowledge, supports or breathing room, these staff can become vulnerable very quickly and all too willingly play into the children's reenactments. They can become coercive and punitive with children who are aggressive and impatient or dismissive and neglectful with demanding children. At best such responses serve to affirm children's negative worldview and at worst further injure and traumatize them.

Case Example:

Carl was a young milieu therapist. He joined the staff right out of college and was assigned to our young boys' cottage. He was bright, reliable and thoughtful. He formed solid relationships with the children and was considered a rising star by agency leadership. After several months in the residential program, he transferred to a milieu position in the education program and was placed in a classroom with a group of children who all had a significant history of trauma.

At first Carl adapted well to his new assignment. He continued to impress his co-workers and agency leadership and took on increasingly complex and challenging tasks. After several months Carl's performance began to deteriorate. He began coming to work late in the mornings, and incidents of absenteeism began to mount. When questioned about this issue Carl indicated he was having car trouble and was battling a sinus infection.

Within several weeks Carl's co-workers were raising concerns about his mood and temperament. Carl was asking for frequent breaks, failing to complete assignments and becoming increasingly short tempered with co-workers and far more punitive in his response to children's difficult behaviors.

When questioned about his deteriorating performance Carl dismissed the concerns and would blame the apparent difficulties on the lack of structure in the classroom, inadequate staffing and ineffective disciplinary practices. It was apparent Carl was struggling, but no one knew quite how to help him.

One day Carl was serving lunch to the children when two of the students began to bicker and argue. Carl asked them to quiet down, but they ignored his request. Carl raised his voice, but still there was no response. Suddenly Carl turned and threw a plate of food against the dining room wall while shouting a litany of expletives. He stormed out of the cottage leaving everyone stunned.

Carl was suspended from his position and referred to the agency's EAP program. He remained on disability for several months and eventually resigned, obviously still shaken by his experiences.

Although Carl is an extreme case, many staff who work with these difficult children for extended periods are prone to mistreating and potentially re-injuring these children. Facilities need to pay closer attention to these issues if they honestly expect to help children recover from the injuries that brought them into care. Although efforts were made to reach out to Carl, those efforts were too little too late. It was clear we underestimated the toll this work takes on caregivers like Carl.

Trauma's Impact on the Agency:

Residential centers provide 24-hour care, 365 days a year to traumatized children. These settings are very intense, highly volatile, often unpredictable and exceedingly complex environments. Things can go very wrong, very fast. At the same time the high cost of residential care makes these centers a constant target for funding cuts and cost control efforts. Many are located in communities that are less than thrilled about having such troublesome neighbors.

Leaders in residential centers become extremely risk averse. In most cases they are operating in or near the financial margins, and one bad incident or unflattering newspaper expose' can push an already challenged system over the edge. The stress caused by troubled and sometimes scary children on one end and a threatening and hostile financial and political environment on the other generates consistently high levels of stress. Systems that are this stressed respond in much the same way as the traumatized children they treat. They become reactive, overly controlling, fragmented, rigid, hypervigilant and helpless. The treatment center often becomes less about treatment and recovery and more about control and coercion. The facility slowly becomes more concerned about self-preservation than about actually accomplishing its stated mission.

The organization functions in a constant state of crises. Communication breaks down, decision- making becomes top down in nature, people stop thinking through problems and teamwork disintegrates. Complex problems are met with formulaic solutions, which allow staff to feel like they are doing something even though no lasting results are realized. The system lives from crisis to crisis. Staff burn out and leave, and new staff pick up right where their predecessors left off. Although everyone has some vague idea of what the mission should be no one is really quite sure how what they are doing with this child, this cottage or this program is moving anyone toward that mission.

Trauma and stress are omnipresent in residential centers. In fact, trauma has been part of residential care from its very beginning. The earliest residential centers in this country were orphanages, which were charged with the care of children who were either abandoned by their parents or had lost their parents. Trauma is in the roots of our residential centers, it is in our bones. We believe that traumatized children have done more to shape these institutions than these institutions have done to shape these children. Injured, abused and neglected children are often angry, usually scary and always challenging. In many cases the interventions we have developed to "treat" these children are controlling and punitive and risk further traumatizing the children they are supposed to heal.

In Sanctuary, we believe we have found a model that allowed us to reclaim our treatment center and recommit to our mission of helping these children recover from their injuries. Recovery from injuries perpetrated in a social context must occur in a social

context. These centers, responsible for healing, must become therapeutic communities where recovering is more important than control and compassion and empathy drive out fear and coercion. The following is a brief account of some of the steps we took at Andrus to begin to move our Treatment Program in a new direction.

Developing Solutions: Creating Sanctuary: Putting the “T” back in RTC

The focus on containment rather than treatment in many RTCs does a great disservice to the staff, children and families. Breaking out of this status quo and creating a trauma-sensitive culture in the RTC can interrupt the cycles of reenactment that occur at every level of the organization. At Andrus, the Sanctuary Model was the vehicle for creating a trauma-sensitive culture and for building the protective factors necessary for the staff and the agency as a whole to do this very challenging work. A trauma sensitive culture is one in which all members feel physically, psychologically, socially, and morally safe; where members of the community manage their emotions appropriately; acknowledge and deal with loss and grief; and focus on creating a positive future. In the Sanctuary Model, this concept is expressed through the acronym SELF, which stands for safety, emotion management, loss and future. SELF is the foundation on which the new Andrus culture is being built.

Creating a trauma-sensitive culture involves a deep examination and transformation of agency dynamics and includes all community members, upper management, families, middle management, children, line staff as well as every department and function. We conceptualize this change as having five components: integration, understanding trauma, avoiding reenactment, fighting rigidity and embracing non-violence. Most importantly, creating this kind of culture is an on-going process, one that is never complete, never linear, but always evolving with lots of movement forward and a fair share of movement backward (although we think there is less of this than there used to be).

Integration:

Integration refers to the concept of creating a unified and healthy organization in which all members are active participants in decision-making and all accept responsibility for each other’s well-being and safety. At Andrus, the Sanctuary Model provided the forum for moving toward integration. With Dr. Bloom’s help, we created a multi-level, multi-disciplinary Core Team that met twice monthly with her for a year to discuss agency issues and to learn about how trauma affects not only individuals, but entire organizations. Through the Core Team, representatives from each department were able to take an honest look at their own departments’ strengths, shortcomings, styles of interactions and most importantly the assumptions which had been driving their current behaviors and functioning. Beginning with these individual or small group assumptions, the Core Team was able to build shared assumptions, beliefs and values that were common to the entire agency. These shared assumptions, beliefs and values would

serve to foster greater integration within the agency as a whole. Our new shared beliefs were:

1. We will ask clients not “what is wrong with you”, but “what has happened to you?”
2. We must work as a non-hierarchical group.
3. All people who work or live or come to school here must be safe
4. Our job is to help people put their feelings into words rather than act them out.
5. We must help people think as a group.
6. We must approach conflict resolution as a team.
7. We must create a living learning environment.
8. At Andrus, the milieu IS the treatment.

This eighth tenet of the Core Team, to acknowledge that the milieu is the treatment, was most helpful in cementing the other seven. Agency leadership took the stance that the milieu is the most powerful force in creating change in our clients, and every person, regardless of title or position, is part of that milieu. Working within this framework, all staff should feel empowered and responsible to make decisions effecting a child’s treatment. This clarification of the treatment philosophy not only allowed staff at every level of the hierarchy to participate in shaping the culture of the milieu, it demanded that they do so.

But in order to effectively participate, people had to communicate with each other. In order to communicate with each other, people had to have a shared language. One of the tasks of the Core Team was to train the staff in trauma theory and to teach them a common language – the language of trauma. Armed with the words to describe the behaviors they were seeing and a greater understanding of their own responses, staff were better able to communicate with each other and with the children. With everyone using the same words and concepts, it becomes easier to talk about problems and formulate solutions, rather than blame each other for bad outcomes or ignore them altogether. All members of the milieu are on a level playing field and all understand what we are trying to accomplish together.

The crux of this language is the SELF Model (Foderaro and Ryan 2000; Foderaro 2001). This simple way of understanding the needs of people who have been traumatized also organizes treatment goals. Part of employing this common language in the milieu is to teach the children to use it as well. Treatment plans, planning conferences, lifespace interviews and therapy sessions all construct dialogue using the language of SELF. Staff and children are explicit about which behaviors promote or hinder safety as well as when and how certain coping skills may allow children to manage their emotions in ways that will promote their own safety and well-being. The language also gives children and staff an opportunity to address loss and grief, a treatment issue that is often neglected in residential settings in favor of a focus on behavior. Finally, the SELF model encourages a focus on the future, and that in turn encourages the children to work toward change. It encourages an active process of imagining how things will be different and better once they have coped with their traumatic experiences, and pushes them to construct and work toward goals to create that future. The use of the SELF model applies not only to the children and families, but to the staff and the agency itself as a living, dynamic entity.

CASE EXAMPLE:

Ronald is a 12-year-old boy who came to Andrus over three years ago. He had a history of physical abuse and neglect while living with his mother who had both a history of mental illness and substance abuse.

Ronald would often fly into fits of rage when he was frustrated or disappointed. He would hit people, break things, threaten to hurt himself and at times make scary suicidal gestures like tying a rope around his neck or cutting himself with glass.

His treatment was complicated by his mother's constant lack of follow through and his resulting disappointment when she would break promises or fail to show up as planned. Ronald loved his mom and held on to the hope that she would eventually come through for him, even though she never had. Ronald desperately wanted to live in a regular family.

The work with Ronald had to be organized along all four dimensions of the SELF Model. Ronald was behaving in an unsafe manner because of his difficulties managing his emotions. If he was every going to effectively manage his emotions, however, he was going to need to mourn his mother's inability to meet his needs and come to grips with her shortcomings. He would also need to adjust his future goal somewhat: although he could still live in a regular family, it was not going to be his birth family. Not only was Ronald participating in doing this work, but all of the cottage staff, school staff and clinical staff knew about and reinforced these goals in their interactions with him.

After several years in care Ronald has done some great work. He has learned skills to better manage his feelings of anger and frustration and as a result he can keep himself and others safe. He has successfully mourned the loss of his mother and accepted her limitations and began visiting with a perspective foster family. Ronald was able to make this transition because of the gains he has made in managing his emotions and behaving safely. He was now ready to fulfill his dream of living with a regular family.

Understanding Trauma:

In order to effectively use the language and begin the work on safety, emotional management, loss and future with the children, the staff need to have a basic understanding of how traumatic experiences disrupt normal coping and functioning in individuals and systems: to teach staff to ask “what happened” rather than “ what is wrong with you?” As part of our training effort, we designed a six session training for direct care staff, including milieu therapists, social workers, teachers, as well as administrators, which covered basic psychobiology of trauma, reenactment, the language of SELF, and vicarious trauma. We also used the trainings as an opportunity for staff to assess the agency’s functioning in various areas. We talked about values and beliefs and how our own experiences can impact our work. We also focused on understanding that

working with traumatized children and families can be traumatizing to the staff. Talking to the staff about vicarious trauma and ways to use each other for support was a large part of the training.

Once the staff were versed in trauma and its impact, we began to teach the children. In each classroom, clinical staff and teachers began psycho-education groups to teach the children about trauma. Knowing that the parents held an enormously important role in their children's lives, and that they too would need to use the tools of SELF, we began to encourage the children to teach their families what they had learned. We used the forums of open-school night, family day, and graduation to allow the children opportunities to present what they had learned. Social workers incorporated the language into family therapy sessions, and taught families about trauma in that setting as well. This is an area that still needs work, but we have made some impressive gains.

Knowing that we had too long overlooked traumatic experiences in favor of treating behaviors, we also revamped our assessment process. We now use several standardized trauma assessments, the Traumatic Events Screening Inventory (TESI; Ford and Rogers, 1997) and the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) to measure exposure to trauma and trauma symptoms. Asking about trauma and collecting information about a child's response to trauma creates a greater openness around trauma. It allows staff members to have some insight into a child's experience and anticipate triggers and responses for the children. The overall goal is to encourage children and the adults in their lives to tolerate facing their trauma, rather than to leave the unspeakable unspoken.

Avoiding Reenactment:

Perhaps the most influential part of the staff training in trauma was teaching about the traumatized person's tendency to reenact the trauma and to reenact traumatic relationships. When staff could see a child's provocative behavior or the staff's seemingly punitive or overly permissive response to that behavior as part of a reenactment, there was less blame, more understanding and more appropriate intervention. This understanding of traumatic reenactment allowed the staff to recognize when they were being pulled into a child's reenactment, and rather than responding to what may have previously been seen as a personal slight, staff were able to recognize these behaviors as a normal response to trauma that required specific and empathic intervention.

Conceptualizing acting out as reenactment behavior allowed the staff to depersonalize the negative behaviors of the children and use more planful and less reactive forms of interventions. But interrupting a pattern of reenactment requires a great deal of energy as well as reliance on one's coworkers. Part of the work that we did in the trainings was to help staff identify and break through their assumptions about each other and begin to build trusting, supportive relationships. We created an expectation of solid teamwork and mandated that cottage teams create times to meet with each other to plan and to address emerging problems.

Part of creating a trauma-sensitive culture is creating safe space for confrontation. During trainings, we talked about race and culture, and how some personal styles of interacting with children might be seen as inappropriate or re-traumatizing. We talked

about how certain staff were seen as heavy handed, and how co-workers feared confronting these methods out of fear of retribution. There was some resistance to creating openness and confrontation, but definitely some gains. One thing we learned was that the staff who were often criticized for being heavy handed were often “set up” on some level to behave this way by staff who too quickly abdicated responsibility. Creating this feeling of safety in confrontation continues to be a work in progress. For the most part, staff who work together every day have developed shared beliefs about how to provide behavioral support to the children in their care. They are able to intervene when they see a colleague begin to escalate or engage in a reenactment with a child. Staff are encouraged to use the “tapping out” technique to let a colleague know that he or she needs some time away from the child.

When a team sees itself as the treatment delivery system, it is less likely to rely on one or two individuals to do all of the hard work of intervening with children in crisis. When all members feel a strong sense of responsibility for their children’s and each other’s safety, they are more likely to step in when they see a staff member stepping outside of the boundaries of their shared values and beliefs. When stepping in is seen as a helpful form of teamwork, rather than a negative comment on another’s work, it advances the creation of a trauma-sensitive culture. Furthermore, when supervision is used to reinforce the use of tapping out and constructive crisis resolution is valued more than saving face with a child, it creates a safer environment for everyone with a reduced reliance on physical restraint.

Fighting Rigidity:

Another aspect of creating a trauma-sensitive culture is encouraging flexibility and creativity in the residential program. Often teams design their programs around what they feel are unwritten rules about how things must be done or around old beliefs and values. As described earlier, a damaging effect of trauma is rigidity and inability to see things from a new or different perspective. In a trauma-driven organization, responses are rote and reactive, and planning is minimal. In a trauma-sensitive culture, responses to problems are explored and evolve through a more democratic system of shared decision-making. Creativity is one of the best defenses against a stagnant and punitive system. A democratic environment creates space for creativity. Staff need to know that it is safe to try new things, as long as they stay within the shared values and beliefs of the organization. All team members should feel free to offer suggestions, rather than waiting for someone in a perceived position of power to hand down a solution or worse, blame for the problem. Often, in strict hierarchical systems, blame travels down the hierarchy, and responsibility is pushed up. By eliminating blame and focusing on the shared goal of problem solving, members of the community can find a wider range of voices from which solutions can emerge.

CASE EXAMPLE:

We will return to the case of Latisha discussed earlier. Once the team realized they were engaged in a reenactment with Latisha, they made the following creative (and very sweet) plan.

- *The staff arranged for an unused bunk bed to be moved into Latisha's room because it appeared she was comforted by feeling surrounded.*
- *They purchased a giant stuffed bear that she could keep in bed with her.*
- *The staff agreed they would no longer struggle with Latisha if she wanted to move her furniture. In fact, they would help her move the furniture and provide her more positive attention in the evenings at bed time.*

Latisha stopped moving her furniture after she got the bear and she was not restrained again at bedtime. The creative and democratic process which allowed the team to learn from each other and make suggestions to each other resulted in a viable, complex and creative solution.

This more democratic system of functioning, though healthier and imperative to a trauma-sensitive culture, can feel risky and unfamiliar to members of the community. It requires all members to take responsibility for the community, disallowing people to shift responsibility away from themselves. It also prevents people who are traditionally at the top of the hierarchy from making community-wide decisions in a vacuum, handing them down to the line workers to execute. For those who are used to unilaterally making decisions or policy, this can seem like a threat to their power. Working democratically can take more time, and in a crisis where quick decisions are required to ensure safety, we know we can fall back on the command and control style. It is no coincidence, however, that the times when we have a real crisis are fewer and farther between. We've recognized that a command and control style tends to make a command and control style necessary. Funny how that happens, isn't it?

Another way that an agency may become rigid is in how it defines treatment, and who it believes delivers it. In some programs, the people who are believed to be the primary deliverers of treatment are those with the advanced degrees. And often, in residential treatment, those people with the advanced degrees share this belief. The problem with the belief that only PhDs, MDs, or MSWs can deliver treatment - a belief that is also perpetuated by health care insurers and managed care companies - is that this belief discounts the importance of the milieu and the team as the primary service delivery vehicle. In a trauma-sensitive residential culture, all members of the team are providing treatment by influencing and creating the therapeutic milieu. That is not to discount the individual, group and family work that clinicians provide. In fact, clinicians at Andrus are seen as the treatment coordinators for each of their cases. Some of the other ways that we have fought rigidity in how we conceptualize therapy is through outside training and a focus on trauma-focused interventions, including new group and individual therapy models.

Embracing Non-Violence:

One of the most challenging aspects of dealing with children in residential care is the categorization of these children as violent. Often children who are not able to live in their homes have experienced violence at the hands of those who were supposed to care for and protect them. In many residential settings, this violence is unwittingly reenacted

over and over again by well-intentioned, but misinformed staff. We now understand Dr. Bloom's expression "Hurt people, hurt people." In a trauma-sensitive culture, the staff and children use their understanding of trauma and its impact to make conscious choices to avoid violence. One way to accomplish this is through safety planning. Having a formal meeting in which staff along with a child can document triggers to aggression, staff responses that might exacerbate aggression and staff responses that the child finds most helpful can lead to more appropriate interventions and a decrease in violent and aggressive behavior. The team, including the child, not only discusses what the staff should do to help a child avoid aggression, but the child also must have a plan of action, outlining steps he or she will take to avoid violence when triggered.

Embracing non-violence also means embracing shared power and decision making and reducing the abuse of power. One way to avoid abusive power is through open dialogue with members of the community at every level. Most importantly, it is imperative to recognize that unresolved feelings of discontent and anger can trickle down and be acted out by those at the lower levels of the hierarchy, sometimes staff and often the children. This concept, known as collective disturbance, is often a driving force in the aggression and violence we see in RTCs. Collective disturbances can manifest in excessive call outs, lack of communication between staff, confidentiality breaches, errors in technique, missed meetings, inability to make decisions, unwillingness to solve problems, and a sense that something bad is going to happen. These problems are common in most RTCs, but recognizing what drives them, a collective response of the staff and children to an unresolved, unspoken conflict, allows us to intervene.

Case Example:

In January of 2004 we saw an alarming trend in our RTC. Incidents of aggression on the part of children directed at staff began to skyrocket. Not only were the incidents more frequent, they were more violent and dangerous. Three staff people were injured in a matter of four weeks, with two of them missing extended periods of work. We typically have 10 or 15 incidents of aggression directed at staff each month and most are minor events like children pushing by staff people or impulsively lashing out at staff who are setting limits. In January the incidents of aggression directed at staff spiked to over three times the average with almost 50 incidents reported.

It was apparent to campus leadership that we were experiencing a collective disturbance. We believed this disturbance might have grown out of two factors. We had recently completed our year long staff training program on Sanctuary and we were also stepping up our efforts to reduce and eventually eliminate the use of physical restraint in managing behavioral issues. We were pressing the staff hard to be kinder and gentler with the children and challenging them to cease using coercive methods they believed were effective. Many staff were feeling vulnerable and although most were willing to make the changes we were looking for they felt we were taking away useful interventions and not providing them with anything new to replace what they lost. Staff people were angry, and in some cases scared, but they soldiered on. The feelings of anger, resentment and fear stayed below the surface, unspoken and unresolved, but staff were behaving

in a more ineffective and helpless fashion. It was clear they were looking to show us that our grand plans for organizational change were not all they were crack up to be.

Although this disturbance was taking shape for a several months, the tipping point came when one of the staff was attacked by a youngster for no apparent reason, seriously bruising her face and the area around her eye. For some inexplicable reason (actually it could be explained but it would take much too long) no one in campus leadership reached out to the injured staff person and checked on her condition.

She and her co-workers believed the children were more troubled, more aggressive and agency leadership cared less and less about the struggles the staff were facing. It was clear that things were going terribly wrong.

We decided to hold a lunch meeting and invite all the residential staff. We ordered a bunch of pizzas, and leadership opened the meeting by apologizing for our thoughtlessness and our passivity in the face of these very troubling times. Staff proceeded to vent about their frustrations and their struggles for the better part of the meeting. Affect was high but not inappropriate.

At the end of the meeting we discussed some possible solutions to the current problems and we agreed to act on some of the solutions.

Although we did act on several of the recommendations the residential staff made, the first change was not implemented until May. In February, the incidents of aggression directed at staff returned to their normal 15 and have remained at that level or lower since that point.

The problem was not immediately resolved but the underlying conflict was laid out and resolved to everyone's satisfaction

Understanding and intervening at the roots of violence, whether those are in the form of reenactments or collective disturbance is not the whole story. We must also use these safety breeches and incidents of violence as learning opportunities. Rather than becoming punitive with children or staff when they make poor choices, we have begun to use these incidents as learning and teaching tools. We try to “go to school” on every incident. One way we have done this is to create a Red Flag Review, a team meeting to understand and reformulate a plan, any time there is an incident of violence on campus. We have also created mandatory reviews every time a restraint is performed. The staff person must meet with his or her supervisor to discuss alternative or proactive responses for the future, and the team and the child meet to debrief the incident and revise the safety plan.

Summary

We know trauma has devastating effects on its young victims. We have also come to accept that working with trauma survivors can have an adverse impact on caregivers and treatment professionals. There is still little attention, however, paid to the impact trauma and stress have on the organizations that care for injured children.

We believe organizations like RTCs are very vulnerable because of the stress associated with caring for injured children in the context of a hostile social and political climate. Working with more and more troubled children with less and less resources can foster a sense of hopelessness and helplessness.

Although the effects of trauma and stress are devastating, the good news is that people can get better; they can recover, and they can thrive. We believe organizations too can get better, recover and thrive. The Sanctuary Model has provided us with a model not just to help children recover but a model for organizational recovery. We have reconnected with our mission and rediscovered what we value in this work, and we are feeling better and more successful every day.

References

Bell, H., Kulkarni, S., Dalton, L. 2003. Organizational prevention of vicarious trauma. *Families in society*, 84 (2): 463-470.

Bloom, S. (1997) *Creating sanctuary: Toward the evolution of sane societies*. New York: Roudlege.

Bloom, S. 1996. Every time history repeats itself the price goes up: The social reenactment of trauma. *Sexual addiction and compulsivity*, 3 (3): 161-194.

Bloom, S. L. (1997). Creating Sanctuary: Toward the Evolution of Sane Societies. New York, Routledge.

Foderaro, J. and R. Ryan (2000). "SAGE: Mapping the course of recovery." herapeutic Communities: The International Journal for Therapeutic and Supportive Organizations **21**(2, Special Issue): 93-104.

Foderaro, J. (2001). Creating a nonviolent environment: Keeping Sanctuary safe. In Violence: A Public Health Menace and a Public Health Approach. S. Bloom. London, Karnac Books: 57-82.

Pearlman, L. (1995). Self Care for Trauma Therapists: Ameliorating Vicarious Traumatization. Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators. B. Stamm. Lutherville, MD, Sidran Press: 51-64.

Ralph, I. (2001). Countertransference, enactment and sexual abuse. *Journal of Child psychotherapy*, 27 (4): 285-301.

Way, I., VanDeusen, K., Martin, G., Applegate, B., Jandee, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of interpersonal violence*, 19 (1):49-71.