

The Sanctuary Model builds respectful culture in schools and treatment organizations so that troubled children—and those who work with them—are not subject to victimization. The therapeutic community addresses the needs of traumatized youth through a psychoeducational model called S.E.L.F. which deals with the challenges of Safety, Emotional management, Loss, and Future.

The Sanctuary Model of Trauma-Informed Organizational Change

Sandra L. Bloom and Sarah Yanosy Sreedhar

The Sanctuary Model® is a trauma-informed method for creating or changing an organizational culture. Although the model is based on trauma theory, its tenets have application in working with children and adults across a wide diagnostic spectrum. Originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children, the Sanctuary Model is an evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic therapeutic community in which staff and clients are empowered as key decision-makers to build a socially responsive, emotionally intelligent community that fosters growth and change (Bloom, 1997; Rivard, 2004; Rivard et al., 2003; Rivard et al., 2004; Rivard et al., 2005). The Sanctuary Model has been effective with children and adults across a range of human service organizations, including residential treatment centers, public and private schools, domestic violence shelters, and drug and alcohol treatment centers.

The Sanctuary Model is not a specific intervention but a full system approach focused on helping injured clients recover from the damaging effects of interpersonal trauma. 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 (Farragher & Yanosy, 2005).

The aim of the Sanctuary Model is to guide an organization in the development of a culture with seven dominant characteristics all of which serve goals that simultaneously create a sound treatment environment while counteracting the impact of chronic and unrelenting stress:

Culture of Nonviolence—building and modeling safety skills and a commitment to higher goals

Culture of Emotional Intelligence—teaching and modeling emotional management skills and the integration of thoughts and feelings

Culture of Social Learning—building and modeling cognitive skills in an environment that promotes conflict resolution and transformation

Culture of Shared Governance—creating and modeling civic skills of self-control, self-discipline, and administration of healthy authority

Culture of Open Communication—overcoming barriers to healthy communication, reducing acting-out, enhancing self-protective and self-correcting skills, teaching healthy boundaries

Culture of Social Responsibility—rebuilding social connection skills, establishing healthy attachment relationships

Culture of Growth and Change—working through loss and restoring hope, meaning, and purpose

Organizations committed to working with troubled individuals all face enormous stresses. Unfavorable financial, regulatory, social, and political environments can adversely impact organizational functioning and, under these circumstances, it is relatively easy to lose sight of the mission, goals, and values that should guide the work. Over time, stressed systems can become reactive, change-resistant, hierarchical, coercive, and punitive. Traumatized organizations may begin to exhibit symptoms of collective trauma similar to those of their clients, creating a “trauma-organized culture.”

Through the implementation steps of the Sanctuary Model, staff members engage in prolonged dialogue that serves to bring to the surface the major strengths, vulnerabilities, and conflicts within the organization. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never overtly surfaced before. As agencies across the country are beginning to use Sanctuary, the Institute has constructed a network to allow these sites to share their experiences and innovations with each other. In this way, agencies can count on long-term support as well as a process to ensure fidelity to the model among all of the agencies practicing Sanctuary.

Organizations in this community of practice, known as the Sanctuary Network, are reporting significant changes in their treatment environments as well as in outcomes for the children and families they serve. Some notable improvements have been documented in the following areas: reduction of physical restraint and aggression, improved staff morale, lower staff turnover, fewer injuries to staff and clients, improved collaboration, and improved clinical outcomes for children.

Changing the Question with Children and Families

The adoption of the Sanctuary Model at the Andrus Children's Center marked a significant shift in the culture of the organization as well as in the outcomes for many of the children served there. The Andrus Children's Center is a multi-service agency in Westchester, New York. The Andrus Campus Community and Mental Health Divisions reach 2500 children and families every year with a broad spectrum of preventive and restorative services for families and their children from birth through adolescence. One striking example was that of a mother and son who were treated at the 90 Day Andrus Diagnostic Center program. This family had been separated by a child-protective intervention and a foster care placement. Eventually, diagnostic evaluation was completed at the Andrus Children's Center. Initial reports from referring providers showed that the mother suffered from a personality disorder; her child was diagnosed with oppositional defiant disorder. In using the tenets of the Sanctuary Model, and specifically asking about trauma in the parents', child's, and family system's history, a very different picture emerged.

Being trauma-informed means being sensitive to the reality of traumatic experiences.

The first step in providing treatment to this very troubled family involved is asking the question "What happened to you?" Although the words may not have been as blunt, the message this family had heard from service providers involved in their prior treatment had been "what's wrong with you?" This simple change in wording shifted the implication of blame and shame to one of understanding and collaboration. Changing this question allowed a doorway to understanding this family's history and, more importantly, a doorway for this family to understand that what had happened to them was affecting their daily lives in the present.

With the "what happened to you?" groundwork laid, the treatment team was able to begin an exploration of this family's history, which included generations of abuse and neglect as well as separation and abandonment. With this information, the team was able to begin an education process that helped the mother begin to see that many of the behaviors that she was enacting with her son had their roots in the ways she had adapted to her own

childhood experiences. The team's work at this point was to teach her about the impact of early childhood adversity on later life functioning and health with the hope of disrupting the patterns she was reenacting in her family.

Childhood Adversity and the Problems that Follow

The Adverse Childhood Experiences (ACE) Study was an important public health study conducted in the 1990s. Funded through the Center for Disease Control and Kaiser Permanente, this study demonstrated the multitude of connections between exposure to childhood adversity and later physical, psychological, social, and employment problems (Anda et al., 1999; Anda et al., 2002; and Felitti et al., 1998).

The ACE Study is a major retrospective analysis of 17,337 adult health maintenance organization members (54% female; mean age, 57 years) who attended a primary care clinic in San Diego, California, within a 3-year period and completed a survey about various types of trauma (childhood abuse, household dysfunction, substance use, suicide attempts, etc.). A person's "trauma dose" was representative of that person's admission to the traumas of childhood. The number of categories (not the number of occurrences) of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Specifically, the researchers found that after adjusting for age, sex, race, and education, each category of childhood adverse experience showed an increased risk for smoking behavior, alcoholism, and depression. Likewise, the ACE score had a strong, graded relationship to the risk of drug initiation from early adolescence into adulthood and to problems with drug use, drug addiction, and IV drug abuse.

The first step in providing treatment...is asking the question "What happened to you?"

ACEs appear to be intimately related to other problems as well. The number of categories of adverse childhood exposure showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The categories of adverse childhood experiences were strongly

interrelated, and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life (Rivard et al., 2004). Additionally, adverse childhood experiences in any category increased the risk of attempted suicide two- to five-fold. From this study it is clear that a powerful graded relationship exists between adverse childhood experiences and risk of attempted suicide throughout the life span.

ACE researchers also looked at unintended pregnancy in their study population. Women who experienced four or more types of abuse during their childhood were 1.5 times more likely to have an unintended first pregnancy during adulthood than women who did not experience any abuse (Dietz et al., 1999). Researchers also found a strong graded relationship between ACEs and a self-reported history of sexually transmitted diseases among adults.

The ACE Study provides a documented link between childhood exposure to violence, psychiatric disorders, physical disorders, and substance abuse. The correlations between adverse childhood events, health-risk behaviors, and negative health outcomes for adults indicate that early intervention for children who have experienced trauma is critical to disrupting the trajectory injury which can lead to physical and emotional illness. Children whose internal and external support systems do not provide adequate protective resources from these adverse experiences may find themselves entrusted to the care of out-of-home treatment providers. In these settings, where behavioral manifestations of their injuries often identify these children as needing help, there is a special opportunity to change that trajectory by creating a trauma-informed culture in which these children receive care.

What is a "Trauma-informed Culture"?

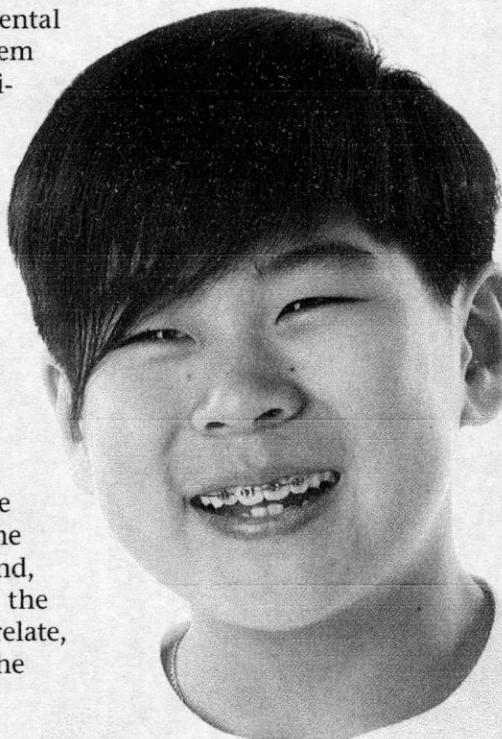
The family referred to earlier had been in many treatment settings and had migrated up the ladder of care to hospitalization for the mother and residential care for her child. Although the treatment providers who had offered services were skilled and knowledgeable, this family required the context of a trauma-informed culture in which to heal from their physical, psychological, and social injuries. What this family required was a team with sophisticated knowledge of trauma and an understanding of the overwhelming drive to reenact it. Armed with this knowledge and, most importantly, the ability to transfer that knowledge to the mother and child, the team was able to disrupt the pattern of animosity, hostility, and abuse between mother

and child as well as between family and treatment providers. The team's success hinged on the context for the relationship: the culture that they had created welcomed this family and demonstrated a different way to relate. It is this trauma-informed culture that provides the backdrop for specific interventions, but in many cases IS the treatment.

To create a truly trauma-informed treatment culture requires trauma-specific treatment approaches that help psychologically injured people to heal. But the ACE Study indicates that it is not just the clients in treatment programs who have been traumatized, but the staff members as well. Being trauma-informed means being sensitive to the reality of traumatic experiences in the lives of most people—children, their parents, staff, administrators, state officials, police, courts, schools, and everyone else. It means being sensitive to the ways in which trauma has affected individuals, families, and entire groups (i.e., Native Americans, African-Americans, and LGBT individuals). And it means becoming sensitive to the ways in which trauma impacts organizations and entire systems.

In fact, the growing knowledge about the short- and long-term effects of chronic stress and repetitive trauma requires a shift in the way all human problematic behavior is perceived. Professionals need to stop viewing people as either "sick" or "bad"—philosophical positions that inevitably lead to the problems associated

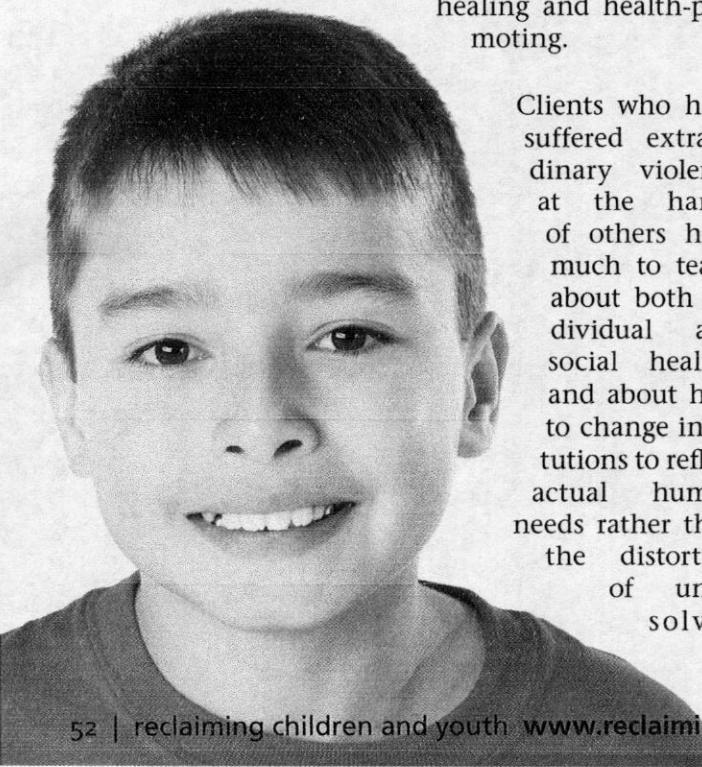
with the mental health system or the criminal justice system—and instead begin viewing all of these problems as the result of injuries, some to the body, some to the mind, some to the ability to relate, some to the sense of right and



wrong, and some to the soul. In understanding adversity as a universal human condition—recognizing that not only people who receive treatment but also those who provide treatment are vulnerable to the effects of trauma—society must move to looking at healing through a lens in which all members of a community are capable of intervening as helpers. This includes staff, children, families, and community resources, and requires that shared responsibility be recognized and encouraged among community members for themselves and for each other.

The Sanctuary Model and the Democratic Therapeutic Community

The principles that guide the democratic therapeutic community—as distinguished from “concept therapeutic communities” so common in the United States for the treatment of substance abuse—are rooted in Moral Treatment of the 18th century and the fundamental ideals of the Enlightenment. Ultimately, in the Sanctuary Model, the purpose of shared assumptions, shared goals, shared practice, and shared vision is to create what Maxwell Jones described a half-century ago as a “living-learning environment” within which healing, growth, and creative expression can occur (Jones, 1968). This is as urgent a calling today as it was when it was first stated. A wide range of settings—including residential treatment settings for children or adults, acute care inpatient units, substance abuse programs, domestic violence shelters, homeless shelters, group homes, day hospitals, and intensive outpatient programs—can create environments that are intrinsically humane, as well as healing and health-promoting.



Clients who have suffered extraordinary violence at the hands of others have much to teach about both individual and social healing and about how to change institutions to reflect actual human needs rather than the distortion of unresolved

trauma. In an era of tightening budgets and bottom-line focus, methods to aid recovery from overwhelming experiences that are environmental and not solely dependent on expensive individual forms of treatment are even more critical than ever. This is especially true for those who are labeled with “personality disorders.” These clients frequently place great strains on the present components of the social service system because they demand time, attention, and investment of resources and because they require skillful interventions. However, once the underlying reasons for these disorders become visible—very frequently a past history of physical or sexual abuse and neglect—it becomes possible to pursue forms of treatment that can further personality change and growth so that people who have previously been a burden on an overly-taxed system can become contributing and productive citizens. The Sanctuary Model, grounded in the ideas of the democratic therapeutic community, is in many ways a subversive idea in that the goal of the therapeutic community is not to maintain an unhappy status quo but to create the “heat” that generates change. This change is generated largely through the democratically informed interactions between staff and clients and clients with each other.

S.E.L.F. as a Useful, Trauma-Informed Implementation Tool

S.E.L.F. is the implementation tool that is a fundamental component of the Sanctuary Model. An acronym that stands for Safety, Emotional management, Loss, and Future, S.E.L.F. is a conceptual tool (originally called S.A.G.E.) (Bills, 2003; Foderaro, 2001; and Foderaro & Ryan, 2000) that guides assessment, treatment planning, individual and team discussion, and psychoeducational group work. S.E.L.F. is not a staged treatment model but rather a nonlinear method for addressing in simple words very complex challenges.

The four concepts—Safety, Emotions, Loss, and Future (originally Safety, Affect management, Grieving, and Emancipation)—represent the four fundamental domains of disruption that can occur in a person’s life. Any problem can be categorized within these four domains. Naming and categorization are the first steps in making a problem manageable. Victims of overwhelming life experiences have difficulty staying safe, find emotions difficult to manage, have suffered many losses, and have difficulty envisioning a future. As a result, they are frequently in danger, lose emotional control (or are so numb that they cannot access their emotions),

have many signs of unresolved loss, and are stuck in time, haunted by the past and unable to move into a better future.

The S.E.L.F Psychoeducational Group¹ is designed to provide clients and staff with an easy-to-use and coherent cognitive framework that can create a change momentum. Because it is a model that is "round" not square—circular, not stepped—it provides a logical framework for movement. It is not constrained by gender, age, race, religion, or ethnicity because the domains of healing that S.E.L.F. represents are human universals, unbound to any time, place, or person. In the authors' residential programs, children as young as four are comfortably using the S.E.L.F. language—and using it appropriately. S.E.L.F. is a compass through the land of recovery that can help guide individual treatment, staff decision, team treatment planning, and an entire institution.

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¹ S.E.L.F.: A Trauma-Informed Psychoeducational Group Curriculum is available at www.sanctuaryweb.com

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