



***Living Sanctuary:
Creating Trauma-Informed
Systems That Promote Recovery***


Sandra L. Bloom, M.D.
www.sanctuaryweb.com



**The Relationship of Adverse
Childhood Experiences to Adult
Health Status**


A collaborative effort of Kaiser Permanente and
The Centers for Disease Control

Vincent J. Felitti, M.D.
Robert F. Anda, M.D.



**The Adverse Childhood Experiences (ACE)
Study**

- The largest study of its kind ever done to examine the health and social effects of adverse childhood experiences over the lifespan (over 17,000 participants)
- The majority of participants were 50 or older (66%), were white (75%) and had attended college (75%).
- 54% female; 46% male



Categories of Adverse Childhood Experiences

Abuse, by Category	
Emotional (by parents)	11%
Physical (by parents)	28%
Sexual (anyone)	21%
Emotional neglect	15%
Physical neglect	10%



Categories of Adverse Childhood Experiences

Household Dysfunction, by Category	
Substance Abuse	27%
Mental Illness	19%
Parental separation/divorce	23%
Mother Treated Violently	13%
Imprisoned Household Member	5%



Adverse Childhood Experiences Score

ACE Score	Women	Men	Total
0	34.5	38	36.1
1	24.5	27.9	26.0
2	15.5	16.4	15.9
3	10.3	8.6	9.5
4 or more	15.2	9.2	12.5

Almost 2/3 reported at least one ACE
More than one in five reported three or more ACEs



ACEs Study

- One in four was exposed to two categories of abusive experience,
- One in 16 to four categories.
- Sixty-six percent of the women reported at least one childhood experience involving abuse, violence or family strife.



Adverse Childhood Experiences Rarely Occur in Isolation...

They come in groups.

Given an exposure to one category, there is 80% likelihood of exposure to another.

As the number of ACE increases the number of co-occurring or "co-morbid" conditions increases.



ACEs Study

Strong, graded relationship between ACEs Score and....

- alcoholism and alcohol abuse
- chronic obstructive pulmonary disease (COPD)
- depression
- fetal death
- health-related quality of life
- illicit drug use
- ischemic heart disease (IHD)
- liver disease
- risk for intimate partner violence
- multiple sexual partners
- sexually transmitted diseases (STDs)
- smoking
- suicide attempts
- unintended pregnancies



ACEs and Risk of Revictimization

ACE Score	Intimate Partner Violence	Being Rape
0	1.0	1.0
1	1.9	2.0
2	2.1	2.8
3	2.7	4.2
4	4.5	5.3
5 or more	5.1	8.9



ACEs & Interpersonal Violence

- The results suggest that as the number of violent experiences increases:
 - the risks of victimization among women
 - and the risks of perpetration by men

increase by about 60% to 70%.

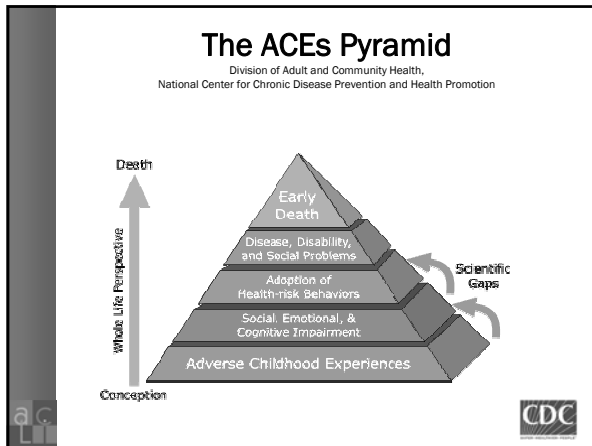


The Adverse Childhood Experiences (ACE) Study

Summary of Findings:

- Adverse Childhood Experiences (ACEs) are very common
- ACEs are strong predictors of later health risks and disease
- This combination makes ACEs the leading determinant of the health and social well-being of our nation
- **Adverse Childhood Experiences determine the likelihood of the ten most common causes of death in the United States.**





Impact of Multigenerational Trauma

- Something is very wrong
- Insidious effects of long-term exposure to acute and chronic stress on:
 - Individual families
 - Social institutions
 - Economic priorities
 - Ideologies
- A species that destroys its children and therefore forecloses on its future cannot survive.

The Impact of Recurrent Threat

- Alters the way the brain works:
 - Hypersensitivity to even minor threat
 - Extremist thinking
 - Respond to many things as threat to life - aggression and impulse control
- Attention to threat while ignoring less threatening, but important information

The Impact of Recurrent Threat

- Interferes with normal emotional development
- Emotional states too intense to handle:
 - substance abuse,
 - violence,
 - self-mutilation,
 - risk taking
 - Impaired parenting – intergenerational transmission
- Reinforced by helplessness and evolves into control issues
- Interference with cognitive skill building
- Addiction to trauma



The Impact of Recurrent Threat

- Dissociation \longleftrightarrow distortion of the meaning of personal and interpersonal events
- Difficulties expressing emotions in words
- Interference with normal memory processing – too little, too much – haunted by the past
- Adaptation to adversity – change in definitions of “normal” and resistance to change
- Traumatic Reenactment - Revictimization



The Impact of Recurrent Threat

- Disrupted attachment
- Failures of trust
- Failures of development relationship skills
- Lack of self-esteem: Interference with development health identity
- Difficulties resolving conflicts
- Difficulties working through losses
- Trauma-bonding



The Impact of Recurrent Threat

- Problems with authority figures & internal authority
- Disrupted moral emotions – inability to consistently differentiate “right and wrong”
- Misguided sense of justice
- Absence of meaning, purpose, connection
- Demoralization, loss of hope
- Foreshortened sense of future



Complex Problems & Complex Solutions

- Do what we can to prevent further damage to brain and body (i.e. trauma history, appropriate psychopharmacology, stress management, medical care)
- Engage client in self-recovery (i.e. psychoeducation, bibliotherapy, movie therapy)
- Teach new cognitive & affect management skills (i.e.CBT, DBT, creative therapies, psychodynamic therapies)
- Treat the addictive symptoms (trauma-informed SA rx)
- Specific trauma resolution techniques (i.e.EMDR, bodywork, trauma art)
- Corrective emotional and relational experiences (i.e. therapeutic community, group therapy, family therapy)
 - Rebuild trust
 - Teach conflict resolution
 - Do grief work
 - Redefine social justice
 - Restore hope



Barriers to Recovery

- Clients may have had multiple disrupted attachments (in our research with children in residential, an average of six previous placements)
- Clients are likely to have experienced child maltreatment – abuse and/or neglect (in our research 70% documented – also remember ACEs study)
- Clients are unlikely to make the connection between any of these symptoms and previous experiences
- Clients are unlikely to want to talk about their previous bad experiences
- Clients are likely not to remember the worst parts of the experiences



Barriers to Recovery

- Clients will want to stay emotionally numb rather than feel the pain of the previous experiences
- Clients are likely to feel protective toward violence that occurred in the family
- The violence may still be going on – their families do not want to talk about it
- We don't want to talk about – or listen to - trauma either
- Mental health systems & social service systems & educational systems have not incorporated knowledge about trauma
- Our helping systems are fragmented, do not share assumptions, language, goals, vision.



Organizational Barriers to Recovery from Trauma



Outlining the Problem

- Problems in human service system have been accumulating and compounding insidiously for decades.
- Clients present at the doors of human service programs seeking remedy for their problems but they often leave with few solutions and sometimes with even more difficulties than they brought with them.
- Staff in many treatment programs suffer physical and psychological injuries at alarming rates, become demoralized and hostile
- Meanwhile, their counteraggressive responses to the aggression in their clients create punitive environments.



Outlining the Problem

- Administrators become variously
 - perplexed,
 - overwhelmed,
 - ineffective,
 - authoritarian, or
 - avoidant
- as they struggle to satisfy the demands of their superiors, to control their subordinates, and to protect their clients, leaders become more punitive while..
- Subordinates become passive-aggressive, helpless, or overtly aggressive



Outlining the Problem

- When professional staff, nonprofessionally-trained staff, families, clients gather together in an attempt to formulate an approach to complex problems:
 - they are not on the same page,
 - they share no common theoretical framework that informs problem-solving,
 - Without a shared way of understanding the problem, what passes as treatment is often little more than labeling, the prescription of medication, and behavioral "management".
- When troubled clients fail to respond to these measures, they are labeled again, given more diagnoses, termed "resistant to treatment", stubborn, "borderline", just plain bad.



Outlining the Problem

- For "old-timers", the system appears to have lost knowledge it had previously gained and utilized
- The loss is keenly felt, but a sense of helplessness about the situation – and the clients – often prevails.
- Newcomers to the systems assume that there is nothing to be done except what they are told to do



Outcomes

- Mishmash of training approaches diluted all without integrating
- Staff (and clients) may work at cross-purposes – if they are grounded in any theory at all.
- Many clinicians and programs keep doing the same things that clearly do not work, if the “work” is that of recovery.
- Emphasis on “evidence-based” practices may avoid addressing systemic issues
- Burnout, frustration, cynicism
- Attempts to “fix” things frequently appear to make things worse



“the 20th century gave birth to a new species – the global corporation... a life form that can grow, evolve, and learn”.

Peter Senge, et al.,
Presence:

Human Purpose and the Field of the Future



The simplest way of understanding emergence is that it occurs whenever the whole is greater than – or smarter than – the sum of the parts. It is about understanding how collective properties arise from the properties of parts and the relationship between them.

Johnson, S., *Emergence*. 2001,
New York: Ballantine Books.



Organizations, like individuals, are living, complex, adaptive systems and that being alive, they are vulnerable to stress, particularly chronic and repetitive stress.

Organizations, like individuals, can be traumatized and the result of traumatic experience can be as devastating for organizations as it is for individuals.



The individual child or adult has become a “trauma-organized” system.....

In a parallel process manner, so too have our systems....



Parallel Process

When two or more systems – whether these consist of individuals, groups, or organizations – have significant relationships with one another, they tend to develop similar affects, cognition, and behaviors, which are defined as parallel processes

K. K. Smith, V.M. Simmons, and T.B. Thames,
The Journal of Applied Behavioral Science, 1989. 25(1): p. 11-29.



Parallel Process

Complex interactions between traumatized clients, stressed staff, pressured organizations, and a social and economic environment still in denial.

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



Dysfunctional Systems

- Declining organization (Merry and Brown, 1987)
- Neurotic organization (de Vries and Miller, 1984)
- Snakepit organization (Schwartz, 1990)
- Addictive organization (Schaefer, 1988)
- High fear organization (Ryan & Oestreich, 1998)

**SANCTUARY MODEL:
KNOWLEDGE ABOUT CHRONIC COMPLEX
TRAUMATIC STRESS APPLIED TO
ORGANIZATIONS.**



Organizational Stress as Barrier to Change

- Social service, health care, and mental health systems today are experiencing significant stress.

– CHRONIC STRESSORS: HOSTILE ENVIRONMENT



Chronic Stressors

- Changes in health care financing
- Decreases in training opportunities, funding
- Fewer staff, high staff turnover
- Less trained, professionally developed staff
- Mental health dollars shifted to corrections or out of system entirely
- Severely disturbed, disruptive, aggressive children & adults adapted to violent norms
- State budget cuts
- Trauma-informed knowledge has not necessarily impacted on treatment.
- Massive ethical conflicts – managed care



Organizational Stress as Barrier to Change

- In many helping organizations, neither the staff nor the administrators feel particularly safe with their clients or even with each other.
- This lack of safety may present as a lack of physical safety, as abusive behavior on the part of managers and/or staff, and a pervasive mistrust of the organization.
- Additionally, there is no safety from without as typified by a constant fear of funding cuts, loss of workforce, and compromised services leading to public and legal accusations and lawsuits. A perceived lack of safety erodes trust which is the basis for positive social relationships.

– BASIC SAFETY & BASIC TRUST



Organizational Stress as Barrier to Change

- After law enforcement, persons employed in the mental health sector have the highest rates of all occupations of being victimized while at work or on duty.
- Professional (social worker/psychiatrist) and custodial care providers in the mental health care field were at rates *more than 3 times* those in the medical field.

Bureau of Justice, 2001, Bureau of Statistics, U. S. Department of Justice.:
Washington, D.C.



Organizational Stress as Barrier to Change

- Atmospheres of recurrent or constant crisis severely constrain the ability of staff to:
 - constructively confront problems,
 - engage in complex problem-solving, and
 - involve all levels of staff in decision making processes –
 - or even talk to each other
- Atmospheres of chronic crisis and fear contribute to poor service delivery
 - LOSS OF EMOTIONAL MANAGEMENT
 - IMPAIRED COGNITION



Organizational Stress as Barrier to Change

- Communication networks tend to break down under stress and as this occurs:
 - organizational learning is negatively impacted,
 - organizational memory is lost,
 - organizational amnesia affects function,
 - service delivery becomes increasingly fragmented.
- DISSOCIATION, FRAGMENTATION
- ORGANIZATIONAL AMNESIA



Organizational Amnesia In MH System

- Traumatic organizational experiences may produce amnesia
 - Suicides
 - Homicides
 - Other patient or staff deaths
 - Lawsuits
 - Loss of funding
 - Patient or staff injuries
 - Sexual abuse
 - Media attacks



Organizational Stress as Barrier to Change

- When organizational amnesia and multiple breakdowns in the communication networks occur so too do the feedback loops that are necessary for consistent and timely error correction. This is particularly noticeable when a crisis occurs.

- MISCOMMUNICATION
- SYSTEMATIC ERROR



Communication Under Stress

- Perceptions narrow
- Contextual information is lost
- Increase in vertical communication structures
- Excessive use of one-way communication, top-down
- Feedback loops erode as a result
- Regression to previous learned behaviors
- Complex team behaviors decrease
- Groupthink
- Simple, punitive, sometimes draconian measures that do not address the real problems.



Organizational Stress as Barrier to Change

- As communication breaks down, errors compound and the situation feels increasingly out of control, organizational leaders become more controlling and authoritarian, instituting ever more punitive measures in an attempt to forestall what they perceive as impending chaos.

- INCREASED AUTHORITARIANISM



Crisis & Authoritarianism

- Centralization of control is significantly increased
- Leaders tighten reins,
- Power becomes concentrated at the top, and
- Participatory decision making is minimized



Organizational Stress as Barrier to Change

- 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.
- Dissent is silenced leading to simplification of decisions and lowered morale.
- Organizational democratic processes are eroded and accompanying this loss is an escalating inability to deal with complexity.

- IMPAIRED COGNITION
- SILENCING OF DISSENT
- LOSS OF COMPLEXITY



Decision Making Under Stress

- Attention narrows, focus on threat, cognitive rigidity
- Decisional conflict occurs - hesitation, vacillation, uncertainty, psychological distress
- Results in premature closure - failure to generate all possible alternatives and possible consequences.



Silencing Dissent

- Rarely welcomed in the workplace
- Organizational silence (Morrison & Milliken, 2000)
- Interviews - employees 22 organizations, 70% afraid to speak up about issues or problems at work
- "Undiscussables"? Decision making, procedures, managerial incompetence, pay inequity, organizational inefficiencies, poor organizational performance (Ryan and Oestereich, 1998)
- Under stress seen as threat to unified action and will be suppressed.



Organizational Stress as Barrier to Change

- Unresolved interpersonal, intradepartmental and interdepartmental conflicts increase and are not resolved.
- Interorganizational conflicts are likely to increase.
- The organizational conflict culture becomes rigid and inflexible; hierarchies become more fixed with one conflict management style dominating the rest.

- IMPOVERISHED RELATIONSHIPS
- DISRUPTED ATTACHMENT



The Nature of Conflict

- Arises when two or more individuals view a situation from different frames of reference and demand mutually exclusive outcomes (Miller, 1985)
- Levels of conflict in teams include:
 - individual group members;
 - content of the issue;
 - interaction or psychosocial level;
 - method level;
 - external relations level (Glasl & Ballreich, 2006)



The Nature of Conflict

- Conflict evokes emotion – to be in conflict is to be in an emotionally charged situation.
- Successfully managing conflict demands emotional intelligence in individuals and in the group as a whole.
- Understanding and management of “collective disturbance”



Organizational Stress as Barrier to Change

- As the organization becomes more hierarchical and autocratic there is a progressive and simultaneous isolation of leaders and a “dumbing down” of staff, with an accompanying “learned helplessness” and loss of critical thinking skills.
- The organization and the individuals in it become highly risk-avoidant.
 - DISEMPOWERMENT
 - HELPLESSNESS
 - RISKY RISK AVOIDANCE



Learned Helplessness

- A debilitating cognitive state in which individuals often possess the skills and abilities necessary to perform their jobs, but exhibit suboptimal or poor performance because they attribute prior failures to causes which they cannot change, even though success may be possible in the current environment (Campbell & Martinko, 1998)
- In a controlling, non-participatory environment exercising top-down management, every subsequent lower level of employee is likely to become progressively disempowered. (McGrath, 1994)




Risky risk avoidance happens when mental health organizations become so risk avoidant that they inhibit therapeutic change and instead insist on trying to “control behavior”.

The only way we can control someone else’s behavior is to completely restrict their freedom and when we do that we also eliminate their capacity to make the choice to change

Organizational Stress as Barrier to Change

- Staff respond to the perceived punitive measures instituted by leaders and the escalation of conflict by acting-out and passive-aggressive behaviors. Rumors fly and nasty forms of gossip increase.

- INCREASED AGGRESSION



I Heard It Through The Grapevine
(Crampton, Hodge & Mishra, 1998)

- 70% of all organizational communication comes through this system of informal communication
- several national surveys found that employees used the grapevine as a communication source more than any other vehicle [300]
- communicates information far more rapidly than formal systems of communication.
- communicates information to employees before managers have even begun the process of activating the formal system of communication.

Poisoning the Grapevine

(Baker & Jones, 1996)

- Occurs when dysfunctional relational styles learned in the troubled family are brought into and played out in the workplace,
- When bosses engage in gossiping and backbiting in order to maintain control, power and security.
- Managers may gossip with subordinates about other employees or clients and play one employee off against another.
- The supervisor may make disparaging comments about one employee to another.
- All of this lends itself to the promotion of a toxic environment



Organizational Stress as Barrier to Change

- Staff, leaders, and programs depart. Neighboring systems close. Standards of care deteriorate and quality assurance standards are lowered in an attempt to deny or hide this deterioration.

- UNRESOLVED GRIEF



Organizational Grief

- Deaths by suicide or homicide
- Staff or client injuries
- Sudden firings or other departures of key personnel may be experienced as organizationally traumatic,
- The sudden death of a leader or otherwise influential employee.
- The effects of downsizing, mergers, hostile takeovers,
- Cuts in program funding,
- Changes in roles,
- Increased and burdensome demands of insurance companies
- Loss of reputation, status



Organizational Grief

(Carr, 2001)

- Losses to the organization are likely to be experienced individually as well as collectively.
- For the same reason, failures of the organization to live up to whatever internalized ideal the individual has for the way that organization should function, is likely to be experienced individually and collectively as:
 - a betrayal of trust
 - a loss of certainty and security
 - a disheartening collapse of meaning and purpose.
- "the relationship between employee and organization are: deep-seated; largely unconscious; intimately connected to the development of identity; and have emotional content" (p. 429)



Organizational Stress as Barrier to Change

- 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.
- When this is occurring, staff feel increasingly angry, demoralized, helpless and hopeless about the people they are working to serve: they become "burned out".

- DEMORALIZATION
- LOSS OF MEANING



Burnout

(Cordes & Dougherty, 1993)

1. *emotional exhaustion* - a lack of energy and a feeling that one's emotional resources are used up;
2. *depersonalization* (also known as cynicism) - marked by the treatment of clients as objects rather than people; detachment and callousness toward clients, cynicism toward clients, co-workers and the organization;
3. *diminished personal accomplishment* - tendency to evaluate oneself negatively.



Organizational Stress as Barrier to Change

- 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



Parallel Processes

Kids / Adults

- Feel unsafe
- Angry/aggressive
- Helpless
- Hopeless
- Overwhelmed
- Confused
- Depressed

Staff

- Feel unsafe
- Angry/aggressive
- Helpless
- Hopeless
- Overwhelmed
- Confused
- Demoralized



Parallel Process

Individual

- Chronic stress, hyperarousal, tension
- Increased reactivity, often to violence
- Anxiety projected externally
- Difficulty w/ new info
- Fixation on continuing threat
- Addiction to stress
- Intolerance for ambiguity
- Loss of complexity

Organizational

- Chronic crisis environment, tension
- Increased reactivity, often abusive
- Anxiety projected externally
- Difficulty with new info
- Fixation on continuing threat
- Addiction to stress
- Intolerance for ambiguity
- Loss of complexity



Parallel Process

Individual

- Controlling behavior
- Loss of freedom of choice
- Increasing oppression
- Dissociation, reenactment
- Impaired impulse control
- Emotional numbing
- Fragmentation
- Denial of problems, hypocrisy
- Survival under adversity
- Resistance to change

Organizational

- Controlling behavior
- Loss of democratic processes
- Increasing oppression
- Dissociation, reenactment
- Impaired impulse control
- Emotional numbing
- Fragmentation
- Denial of problems, hypocrisy
- Survival under adversity
- Resistance to change



Parallel Process

Individual

- Damaged/damaging relationships
- Difficulties/denial of loss
- Rampant revenge
- Punitive justice
- Demoralization, alienation, despair
- Stagnation, repetition

Organizational

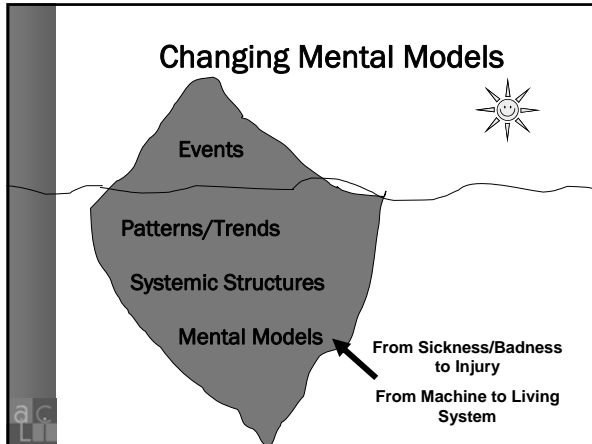
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Parallel Process of Recovery

The Sanctuary Model:
*The Mental Health and Social Service
Organization as a Living System*





Existing Explanations

- Sick – fix them – MH system
- Bad – punish them – Criminal justice system
- Sick & Bad – nowhere for them, bounce back and forth

Sickness Model vs. Injury Model

Sickness implies etiology within the sufferer	Injury model connects sufferer and environment
Sickness implies weakness, defect, hope for stabilization	Injury implies recovery, rehabilitation, even with possible handicap
Sickness implies passivity & experts	Injury requires active participant in recovery
Sickness denies personal and social accountability	Injury requires personal and social accountability



Changing the fundamental question

from

"What's wrong with you?"


to

"What's happened to you?"




"Creating Sanctuary" refers to the shared experience of creating and maintaining physical, psychological, social and moral safety within a social environment - any social environment - and thus reducing systemic violence.

CREATING A CONTEXT FOR CHANGE
Therapeutic Relationships
Hope
Road to Recovery



Implications of Organizational Stress

- Emphasize safety: the starting point of recovery
 - what it is: physical, psychological, social, moral safety
 - how to create it both individually and collectively
 - Bottom line: patients cannot be safe if the staff aren't safe



Implications of Organizational Stress

- Debrief crisis
 - develop systemic knowledge about evolution of violence
 - social immunity
- Can you be trusted? Question for staff and for patients
- Where does communication breakdown? Repair the network.



Implications of Organizational Stress

- Unearth the “skeletons in the closet” that are still playing a role in your organization?
- Review and process previous traumatic experiences that have never been organizationally resolved?
- Address bullying in your organization. Are people afraid to speak their mind?
- Do all the members of staff, clients, and key family members participate in decisions?



Implications of Organizational Stress

- Are there chronic sources of conflict that are never resolved? Review conflict management strategies and try out new ones.
- Is dissent welcome? Are there things that are simply undiscussable?
- How is staff morale?
- Do you see any counteraggression?
- Is your grapevine poisoned?
- Do you see signs of unresolved grief?
- Do you see parallel processes going on?



Creating Sanctuary

- Whole-systems approach – the house, not the rooms / furniture – organizational culture
- Required for people with very complex problems
- Focuses on creating reasonably healthy, total relational environment – parallel process of recovery.
- Focuses on healing, hope and the future, while providing means for recovering from ACEs
- Offers a coherent, shared, accessible rationale for understanding, recognizing, and addressing the problems.
- SELF

The Sanctuary Model

A template for system change – individual, family, organizations society.
Defining safety broadly: Physical, Psychological, Social and Moral

Creating a healthier culture by setting, monitoring and maintaining shared social norms and a shared, trauma-informed system of meaning.

Developing a Positive Normative Culture

- Organization identifies norms to be established
 - Sanctuary commitments
- Create mechanism to regularly familiarize all members with the norms
 - S.E.L.F.
- Manipulate member pressures to insure that high status in the organization is closely associated with conformity to positive pro-social norms.

Creating Sanctuary = Resolving Trauma
An Alternative Reality

- **Commitment to nonviolence**
– GOAL: Development of safety skills
- **Commitment to emotional intelligence**
– GOAL: Development of affect management skills
- **Commitment to social learning**
– GOAL: Development of cognitive skills
- **Commitment to open communication**
– GOAL: Development of trust, of flexible but firm boundaries




Creating Sanctuary = Resolving Trauma
An Alternative Reality

- **Commitment to social responsibility**
– GOAL: Development of relationship skills
- **Commitment to democracy**
– GOAL: Development of social/political skills
- **Commitment to growth and change**
– GOAL: Ability to cope positively with change



Sanctuary Toolkit

- Community meeting
- Psychoeducation curriculum
- Safety plans
- Red flag reviews
- Team meetings
- SELF treatment planning



S.E.L.F
A Map for the Journey.

- *Safety*: Physical, Psychological, Social, Moral
- *Emotions* – Handling feelings without becoming self/other destructive
- *Loss*: Getting over loss, preparing for change
- *Future*: Re-establishing the capacity for choice



S.E.L.F.

- A framework for recovery-for clinician and client
- Developed by a multidisciplinary group of clinicians
- Grew out of the need to manage complex clinical cases effectively and efficiently
- Assists in formulating and organizing complex clinical material into more manageable constructs
- Facilitates evaluation of the effectiveness of an intervention



Safety

- **Physical Safety**
 - Commitment to nonviolence
 - Shared mission, goals, objectives
 - Shared methods for reaching objectives
 - Staff and child safety plans
 - Early identification of abusive behavior
 - De-escalation techniques
 - Routine debriefing



Safety

• Psychological Safety

- Universal trauma assessment
- Trauma-informed training
- Respect for diversity – of all kinds, cultural competence
- Self-discipline, self-control, etc. as social norms
- Administration recognizes vulnerability to vicarious trauma and builds in preventative measures



Safety

• Social Safety

- Active participation of all involved parties – shared belief that everyone must have a voice
- Clear, strong, protected social norms
- Emphasis on integrity of community
- Participatory democracy as model



Safety

• Moral/Ethical

- Consistency between explicit and implicit values
- Walk the talk
- Staff model desirable behavior with children and each other
- Abusive use of power is confronted and resolved



**Psychoeducation
Safety**

- Fight/flight/freeze and the body
- Different kinds of safety
 - Physical
 - Psychological
 - Social
 - Moral
- Safety in Relationships
 - Boundaries
 - Trust
 - Bullying and the healthy uses of authority



Signs Of Impaired Emotions

- Feeling "out of control"
- Difficulty with aggression
- Overwhelming anxiety and panic
- Mood swings
- Flashbacks
- Dissociative episodes
- Paranoia
- Physical symptoms



**The Ways Clients Attempt To
Manage Emotions**

- Self -mutilation
- Suicidality
- Dissociation
- Substance Abuse
- Sexual addictions
- Violence
- Risk-taking
- Eating problems
- Somatizing



Addressing Emotions

- Identification of feelings: mad, sad glad, scared and ashamed
- Volume control of intensity
- Application of emotionally-variable response
- Differentiation of thoughts from feelings and behavior
- Identification and use of self-soothing skills
- Judicious and prescribed use of medication
- Constructive and creative use of emotional energy



Psychoeducation Emotional Management

- Managing emotions
 - Too much/too little emotion
 - Giving words for feelings
 - Self-soothing, stress management
 - Better problem solving
 - Addictions and managing emotions
- Dissociation
 - Disconnecting and reconnection
 - Keeping grounded
- Relationships & Emotional management
 - How hurt people hurt people
 - Resolving conflicts safely



Loss

- Without addressing the grief that accompanies loss, the traumatized person remains "trapped in their past, fluctuating between failures in maintaining safety and an inability to modulate affect"(Herman, 1992).
- *Unresolved grief always accompanies trauma*, and is the source of many underlying psychiatric symptoms.



Loss

- Chronic depression
- Death preoccupation
- Psychic numbing
- Anhedonia
- Haunted by the past



Addressing Loss

- Continue treatment approaches for SAFETY and EMOTIONS while addressing grief issues.
- Help client identify the loss issues to be focused on
- Establish an alliance or contract for working on loss including support systems
- Address the basic grief tasks: acceptance, pain, adjustment, reinvestment
- Help the client say "good-bye" to events of the past while still acknowledging that it is, and always will be part of their past



Psychoeducation Loss

- Grieving and letting go
 - Faces of loss
 - Breaking the cycle of reenactment and revictimization
- Stages of change
 - Without loss there can be no gain
 - Changing habits
- Giving up unhealthy relationships and creating healthy relationships



Future

- Successful management of SAFETY, EMOTIONS and LOSS fosters a sense of empowerment.
- Empowerment enables choice
- *Outcomes are no longer dictated by the traumatic past*
- Recovery process now able to continue with emphasis on creation of a future



Addressing Future

- The person should be referred to self-help groups and other group modalities to help increase social connectedness and functioning.
- The person should feel empowered to use supports and resources to address individual and social issues.
- The person uses resources to increase individuation, social responsibility and to create the future.



Psychoeducation Future

- Imagining and planning a better future – all the time
- Power and empowerment
- Be the change you want to see
- Preventing and responding to relapse
- Be part of the solution not part of the problem
- Having fun





Sanctuary Leadership Development Institute

- Five-day intensive training of leadership team
- Core team development
- 30-month consultation
- Peer-review Sanctuary certification process

Andrus Children's Center
Yonkers, NY
Brian Farragher, C.O.O.
914-965-3700
bfarragher@jdam.org





Sanctuary Network, 2006

- Andrus Children's Center, NY
- Hawthorne - Cedar Knolls, Linden Hill School, Goldsmith Center, Jewish Board of Children and Family Services, NY.
- Family & Children's Aid, CT
- Oklahoma Youth Center, OK
- Whitefields, OK
- Uta Halee Girls Village/Cooper Village, NB
- Vinita Alcohol and Drug Treatment Center, OK
- Pace School, Pittsburgh, PA
- Juconi Foundation, Puebla, Mexico & Guayaquil, Ecuador





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