

CREATING SANCTUARY IN RESIDENTIAL TREATMENT FOR YOUTH: FROM THE “WELL-ORDERED ASYLUM” TO A “LIVING-LEARNING ENVIRONMENT”

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This paper addresses the need for a coherent conceptual therapeutic approach to guide work with disturbed children and adolescents in residential treatment centers. The paper identifies changes in the population currently in care; examines the two dominant approaches that historically have shaped the standard treatment models used by most residential centers; and discusses four longstanding debates that have complicated the development of a consistent therapeutic approach for residential programs. It concludes with a description of The Sanctuary[®] Model. Integrating a variety of treatment approaches, this trauma-based systems approach to care was first used with adult inpatients traumatized as children. It is now being introduced by a major social agency into three of its residential centers to provide a systematic treatment model for use in their schools, living units, and treatment sessions.

KEY WORDS: residential treatment; trauma; children and adolescents; history; Sanctuary Model.

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The Jewish Board of Family and Children's Service (JBFCS), a large mental health agency in New York City serving all New Yorkers regardless of race or religion, has a long history of providing residential treatment to troubled youth dating back to the start of the twentieth century. Like other residential providers around the country, our center faces both increased demands for service and shrinking resources. Service demands are exceptionally high given the ever-increasing number of severely disturbed children—disproportionately, the poor, immigrants, and children of color. Many of them suffer the consequences of trauma. Meanwhile, the overall residential treatment system faces mounting costs, overworked staff, funding shortfalls, and pressures to reduce length of stay (1). On still another front, most residential programs find themselves searching for a coherent therapeutic model best suited to meet the needs of their troubled residents.

This paper addresses the need not only for a coherent conceptual therapeutic approach for residential treatment centers, but *also* one that can consistently guide work with youth in all the residential program components: the living units, the school, and the treatment sessions. To this end, the paper (a) briefly identifies changes in the population currently in care; (b) examines two dominant treatment approaches that historically have shaped the standard treatment models used by many residential centers; and (c) discusses four longstanding debates that have complicated the development of a consistent therapeutic approach for residential programs. It concludes with a description of The Sanctuary Model[®] introduced by JBFCS at three of its residential centers in order to provide a systematic treatment model based on the integration of a variety of treatment approaches. JBFCS has adapted The Sanctuary Model, first used with adult in-patients traumatized as children, for work with the traumatized youth in its residential centers (2).

MORE TRAUMATIZED KIDS

JBFCS operates three residential treatment centers on a single large campus in Westchester County, New York, thirty miles from the agency's headquarters in mid-Manhattan. Together the three centers—Linden Hill, Goldsmith Center for Adolescent Treatment, and Hawthorne Cedar Knolls School—serve 230 severely disturbed children and adolescents. A 1999 analysis of 166 youth residing in these three programs found that 71.7 % were male, and 28.3 % were female. Eighty-one percent of the residents were 13 to 20 years of age compared to 19 percent who were 6 to 12 years old. The overwhelming

majority were youth of color: 42.2% African American, 30.7% Latino, 22.3% Caucasian, and 4.8% other. A review of the agency's records also found that over 70 percent of the residents had suffered abuse and neglect. The youngsters had also been exposed to high rates of chronic violence in their communities of origin (3).

Researchers at other centers have also found high rates of abuse among youth in care. A 1991 study reported that 56% of youths referred for residential treatment came from abusive families; still another center noted that 60% had some history of abuse and a "sharp increase in the number who have been sexually abused" (4,5). These figures tend to be understated given that physical and sexual exposures are typically underreported. The clinical implications of these exceedingly high rates of traumatic exposure are now well documented. They produce extensive comorbidity including higher rates of suicide, depression, substance abuse, cognitive problems, and compromised interpersonal relationships (6,7). In addition, traumatized youngsters are more volatile and experience unpredictable eruptions of aggressive behavior. This "abuse reactivity" leaves residential staff feeling off-balance either leading them to distance themselves from the residents or call for stricter controls (4,8,9).

In sum, the overrepresentation of increasingly poor, minority, and immigrant youngsters with trauma backgrounds combined with staff responses to their behavior have severely tested the standard treatment models used by most residential centers around the nation and suggests the need for new types of intervention (4,9).

THE IMPACT OF TWO DOMINANT TREATMENT APPROACHES

Since World War II, treatment of youth in most residential centers has been guided by psychoanalytic, behavioral or learning theory. However, in the formative years two psychoanalytic approaches—intensive individual treatment and milieu therapy—dominated the field and shaped the evolving standard model.

PSYCHOANALYTICALLY-ORIENTED INTENSIVE INDIVIDUAL TREATMENT

August Aichorn, was one of the first to use classical psychoanalytic drive theory in his educational work with institutionalized delinquent

youth. His 1935 book, *Wayward Youth* exerted a strong influence on the subsequent treatment practices developed for residential treatment centers (10). After World War II European psychoanalysts working at the Menninger Clinic in Topeka, The Langley Porter clinic in San Francisco, and Hawthorne Cedar-Knolls in Westchester County, N.Y. began to apply psychoanalytic approaches to some or all aspects of institutional care, including intensive individual therapy. Borrowing from outpatient settings these programs typically “superimposed” long-term psychoanalytically-oriented treatment on the residential environment “with little or no modification” (4). The leaders considered individual psychoanalytically oriented therapy definitive but downplayed both the patient’s daily routine and the impact of the group setting on the child’s progress. While focusing on new treatment methods, these innovators did little to change the setting except to make it more humane and protective (11). The belief that the institution’s primary role was to prevent deterioration between therapeutic sessions led Fritz Redl to identify this approach as keeping patients in “cold storage” (11). Nonetheless, the introduction of long-term individual psychoanalytically-oriented treatment into residential settings contributed to the transformation of these “institutions” into modern, specialized long-term residential centers (12).

THERAPEUTIC COMMUNITY/MILIEU THERAPY

Residential centers that created therapeutic communities and milieu therapy also applied psychoanalysis, but they used the principles to mediate the relationship between the individual and the institutional environment. At the turn of the century educators in residential school programs called Junior Republics, applied psychoanalytic principles to their work with troubled youth. Seeking the benefits of democratic participation, they combined psychoanalytic ideas with activities that encouraged “inmates” to assume leadership roles (13). The focus on the mediating role of the institutional environment continued into the 1920’s and 1930’s. A.S. Neill, the founder of Summerhill in England, for example, created an environment of total freedom and introduced the self-government meeting. Currently, interest in the impact of the institution on residents is known as “Planned Environment Therapy” (12).

Between World War I and World War II, British and American psychiatrists working in inpatient hospital wards developed new conceptual notions of the therapeutic community, milieu therapy, and

environmental therapy (9,14,15). However, the major innovations in children's residential centers occurred after World War II, led by Redl and Wineman's work with groups at Pioneer House in Detroit and by Bettelheim's milieu work at the Orthogenic School in Chicago. Working with delinquent youngsters suffering severe ego function disturbances, Redl and Wineman developed "techniques for [the] management of group process (including the elaboration of the concept of the "life-space interview") and [for] understanding the effects of the group upon the individual" (9). Working with severely psychotic and autistic children with fragmented and underdeveloped egos, Bettelheim introduced the notion of a total environment. He believed that "the young, for their own good, must be removed for considerable periods of time into a very special institution, supposedly designed to meet their needs: schools" (11, p. 218). In such places every detail would correspond to psychoanalytic thinking about child development and child psychotherapy. Unlike the early educators, however, Bettelheim did not expect the children he worked with to become active participants in their own recovery. But he did oppose authoritarian structures insisting that "there would be no hierarchies—everybody would be equally important, and that common psychological understanding of the children's needs, would form the basis of the institution's integration." (11, p. 221) Bettelheim called the new environment a "milieu" defined as a "medium, environment, [and] surrounding" because the term captured the idea of an enveloping matrix in which one lived.

Strongly influenced by the work of the early psychoanalysts and the milieu therapists, residential centers around the nation eventually adopted three prominent approaches: psychoanalytically informed individual therapy, group therapy, and milieu therapy. However, along the way several new problems arose making it more difficult for residential centers to link these theories to their daily practice (9). First, limited attention was paid to the interaction among these three methods or their impact on the wider residential program. Second, due to the lack of formal manuals and training programs, it was difficult to accurately implement and replicate the original ideas. Third, the psychoanalytic emphasis on the separation of individual clinical treatment from the center's other program components (e.g. group living and educational programs) led to a fragmentation of services that still plagues residential centers to this day. Finally, theoretical coherence suffered as both residential centers and individual staff within them favored different theoretical perspectives, some basing their treatment on drive theory, others on ego psychology or a combined and often confusing mishmash of many different theoretical concepts.

LONG STANDING DEBATES

Any current attempt to define standard residential treatment must recognize that debates about the definition of the problem, preferred therapeutic approaches, organizational practices, and the overall goal of treatment have existed since the 1830s when children were first placed in orphanages and Houses of Refuge. Since then, a dominant view typically emerged in various historic periods, but only lasted until the same controversy resurfaced in subsequent decades. While the “winning story” prevailed, it exerted an enormous influence on nearly all aspects of institutional practice from administrative structures to the front-line services.

PROBLEM DEFINITION

One persistent debate concerns the etiology of the troubles that bring children and youth into residential care. Do they reflect individual behavior or flawed social conditions? Are the youth’s problems due their own recalcitrance, “bad” parenting, or the deprivations of poverty? These debates over the causes of individual and social problems persist to this day, but the favored answer continues to change.

Prior to the 1800’s religious explanations of individual and social problems prevailed. Many Americans viewed the individual as inherently evil and contaminated by original sin. Society did not blame individuals for their plight, seeing poverty and other problems as predetermined and a function of God’s will. With the advent of the industrial revolution, this religious understanding gave way to moralistic explanations. They attributed the behavior of troubled children to child rearing by morally unfit (lazy, immoral, etc) parents who were a bad influence and/or who did not teach their charges how to resist the corrupting temptations of urban life. Around the same time, the United States began to develop institutions for orphans, delinquents, criminals, the mentally ill and other groups in the population. Between 1830 and 1875, seeking to protect children from the “perils of want and the contamination of evil example,” the early reformers favored “snatch[ing] them from the contagion of vice” and placing them in reformatories and orphanages (the latter housed children with living as well as deceased parents)—the forerunner of the residential treatment centers (16, p. 210).

By the end of the 19th century, the rise of Social Darwinism and the Eugenics Movement combined with massive immigration served

to intensify explanations of problems as centered in the individual, rather than looking to religious or societal explanations. Adding the notion of biological defect to existing moral “diagnoses,” social problems of all kinds were attributed to low intelligence (then referred to as feeble-mindedness). As these “individual explanations” reached a crescendo, troubled children, especially the poor and foreign born, were deemed wild, bad, potentially criminal, and labeled as “the dangerous classes” (17).

In the early 20th century, during a turbulent period of social reform, the biological explanations of individual and social problems associated with Social Darwinism and Eugenics gave way to a new emphasis on social conditions, as well as new psychological understandings. Many social reformers in the Progressive Era (1896–1914) accepted that poverty contributed to individual and social problems, and they set about devising new remedies. While individual explanations persisted, instead of labeling youth with low-intelligence, educators and psychologists diagnosed troubled youth as having character disorders such as a “psychopathic” or “sociopathic” personality. Influenced by the new mental hygiene movement, they argued that these conditions could be recognized, treated, and possibly prevented. Troubled youth had not “learned to deal with frustration, deprivation, and external authority.” Since the cause of the child’s disturbed behavior remained linked to the home, prevention focused on parent education about child rearing practices in schools and communities and included calls for more discipline, strict toilet training, and regular feeding schedules (18, p. 66–68).

After World War I, under the growing influence of psychoanalysis, attention shifted to internal psychological conflicts as the cause of individual and social problems. Instead of child rearing, poverty or other external forces, the dominant psychoanalytic view now stressed the individual’s internal perception of their objective environment and the idea that conflict existed between the individual’s desires and the demands of reality (19). As noted above, after World War II, the major residential treatment centers organized their work according to the principles of psychoanalysis.

Community and social psychiatry emerged in the 1960s and posed a serious challenge to the dominance of psychoanalysis. In this period of massive social change, exclusive reliance on psychological explanations of individual and social problems gave way to serious consideration of the harsh realities of poverty, unemployment, poor education, race and sex discrimination and other external conditions that might interfere with full functioning. In the 1970’s, the insights of social psychiatry were pushed aside in the hope of finding biological and genetic

causes for individual problems. In the 1980's, the recognition of Post Traumatic Stress Disorder (PTSD) and the trauma paradigm shifted the psychological explanation of many problems from internal neurosis to psychological injury resulting from exposure to overwhelming life events, such as physical abuse and community violence. The trauma paradigm incorporated both internal and external forces taking into account both individual psychology and the conditions under which people lived. While the psychoanalytic explanation implied that something was wrong with the individual, the trauma model highlighted what had happened to them as individuals embedded within a complex social matrix.

The debate about individual verses social causes of problems has not disappeared. Without realizing it, the discussions by staff working in today's residential treatment centers continue to echo past controversies. Is the child's problem biological/genetic, or psychological? Is the child's behavior problem secondary to a "simple" lack of discipline or a lack of proper education? Are the children in need of residential treatment disturbed or delinquent? With productivity pressures leaving little time for discussion, individual practitioners, residential center staff, and entire professions often reach personal independent conclusions on these matters. The differing assumptions they use contribute to the problematic absence of a coherent treatment model for the residential center system.

MULTIPLE THERAPEUTIC APPROACHES

Echoes of history can also be heard in current debates about the preferred therapeutic approach for work with troubled youth in residential treatment centers. The 19th century orphanages and houses of refuge as well as the subsequent training schools and reformatories utilized a limited number of program components: work, education, and rehabilitation. Neither the need to integrate these three components nor conflicting theoretical assumptions complicated their work as it does in today's centers.

Problems with service integration and conceptual clarity arose as psychological thinking took hold and as clinical treatment slowly spread from psychoanalytically-oriented programs to more mainstream institutions that housed many youth from poor and working class communities. At the same time, in order to meet the increasingly complex needs of youngsters in care, the residential treatment centers added additional components such as, clinical treatment, medical care,

recreational activities, occupational therapy, etc. to existing school, and group living components. This programmatic expansion further complicated the picture as the various program components utilized more than one therapeutic approach to achieve their ends. More than seventeen such approaches—including individual treatment, group therapy, milieu therapy/therapeutic community—have been found operative in most residential treatment centers around the country. Within any of these approaches, one can find many variations (20).

Most residential treatment centers try to cobble these approaches together in order to have a coherent treatment model. But the effort often does not succeed. According to Wells “few centers can now provide a substantive (much less a theory-based) written accounts of their program” and they still lack criteria “that rationally link diagnosis, etiology, prognosis, and (sic) criteria for specific forms of residential treatment.” The lack of such a model is not inconsequential for residential treatment centers. First, it has stymied researchers, clinicians and administrators (4,20). Second, the resulting fragmentation of services generates both practical and theoretical dilemmas.

On the practical front, the work with youth is highly fragmented, since the treatment approaches provided in the various program components remain isolated from each other. Thus, individual or group treatment received by the youth in a clinical session is disconnected from the work in the residential center’s living unit and both are isolated from the management approaches used in the school. This fragmentation fuels persistent debates as to where the “real” work gets done.

On the theoretical front, the proliferation of therapeutic approaches complicates residential work. For example, at one and the same center, staff may be conducting individual therapy based on classical psychoanalytic, ego psychology, object relations or cognitive behavioral theory as well as using reality-based techniques and medication (9).

Complications arise because each of these approaches is based on theories that contain different underlying assumptions. For example, many individual approaches follow the medical model, which assumes that “sick” youth have an internal, mental disease and should be passive recipients of expert treatment. In contrast, the group, milieu, and therapeutic community approaches adhere to a model which assumes that the resident’s problems stem from the interaction between the individual and the environment and that the youth themselves are capable of active, responsible participation.

Because each of these theories have different foci and dictate varied practices, staff at residential centers risk working at cross purposes and

sending mixed signals to the youngsters. Time pressures leave them little or no time to identify and sort out the implications of these conflicts for their work. In addition, the presence of multiple therapeutic approaches fuels persistent debates about which intervention is the most "curative." These complicated realities, have led two experienced practitioners to conclude that today's residential treatment centers must "find an integrative approach" (9, p. 137).

ORGANIZATIONAL PRACTICES

The organizational practices best suited to meet the needs of troubled and potentially out-of-control youth also remain a source of contention. But this was not always the case. The early institutions, which regarded obedience as the cornerstone of an orderly society, developed organizational practices to insure order and discipline. While using family metaphors to describe their determination to see that the institution followed "the order and decorum of a well-regulated Christian family," the organization of both orphanages and reformatories typically mirrored a top-down, military structure" (16, p. 234–5). The staff of these "well-ordered asylums" stressed precision, regularity and obedience to authority with specialized punishment for infractions. While both orphanages and reformatories enforced these measures, the reformatories were especially notorious for their coercive approaches, which included solitary confinement, enforced silence, and severe corporal punishment (16).

The issue of order and discipline continues to this day—embedded in current questions such as: should residences have an authoritarian top-down approach corresponding to the military or the hospital or should they have a Summerhill-type (see above) egalitarian organization with flattened hierarchies? The debate over hierarchical structures often erupts in struggles over decision-making authority between clinical leadership and the front-line, nonprofessional milieu staff. The clinical staff view the milieu staff as a vital part of the treatment team, but the latter often feel powerless to influence pivotal treatment decisions, especially those dealing with setting limits on aggressive behavior. The clinical staff believes that the front-line workers prefer punitive and coercive methods (that hark back to the early House of Refuge). The milieu staff believes the professional's preferences based on "modern" dynamic understanding are too permissive.

A second continuing organizational practice debate with historical roots concerns the institution's permeability to parental and community

influence. Should the family be involved, tolerated, or ignored? The early institutions removed children from their homes on the grounds that the problems of their charges stemmed from unfit parenting. Believing that parental contact acted as a barrier to moral reform, the orphanages and reformatories regularly terminated parental rights and restricted visiting privileges. In 1950's, Bettelheim's Orthogenic School also limited parental contact, arguing that the children's psychotically fragmented personalities needed an uninterrupted total environment. Current residential programs do not exclude parents as they did in the 19th century asylums. Nor do they limit school or community visitation as the Orthogenic School once did (11). But many centers still tend to view parental involvement with both skepticism and caution—fearing that the “dysfunctional” behavior of families will undercut progress made in treatment. However, the current pressure to reduce lengths of stay is driving a reassessment of this negative stance and a move towards closer collaboration.

OVERALL GOAL OF CARE

The final historic debate that still resonates today concerns the overall goals of care. In the 19th century the goal of care shifted from “protecting the child from want” to protecting the society from the child—by means of confinement. During the twentieth century, the emphasis evolved from education of institutional residents to rehabilitation, to psychological treatment. Despite this movement during the 20th century, old ideas can still be heard. Deeper philosophical questions persist. One question focuses on protection versus confinement. Practitioners still ask: is the overall goal of care to keep the residents out of harm's way or to confine them in order to prevent them from harming wider society? Such questions suggest ongoing concerns about social instability caused by the breakdown of family authority and the decline of community life. A second long-standing debate centers on the goals of social control versus personal growth and development. Should institutions strive for obedience to authority through punishment or should they seek the personal empowerment of residents by using all aspects of the institution as a vehicle for therapeutic change? If the goal is change, then what would it entail?

In sum, the proceeding discussion contends that residential treatment centers will benefit from a new therapeutic model. Some of the forces that have created the need for this change derive from the changed population in residential treatment centers; the impact of

the two competing treatment approaches; and the persistence of long standing debates about problem definition, therapeutic approaches, organizational practices and the goal of institutional care. The Sanctuary Model described next provides a coherent conceptual paradigm, consistent methods, and integrated interventions for work throughout the total residential treatment environment.

THE SANCTUARY MODEL

The search for a residential treatment model to meet the challenge of service integration led JBFCs to the Sanctuary model. In contrast to conventional residential approaches, Sanctuary addresses trauma exposure as a central organizing life experience. By drawing on both trauma theory and principles of the therapeutic community, the model integrates work in the various program components found in most residential centers: living units, schools and treatment sessions.

Integrated Frameworks

The Sanctuary Model was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children (2,21,22). The model integrates four conceptual frameworks: Trauma Theory; Social Learning Theory; Nonviolence; and Complexity Theory. Accumulated over several recent decades Trauma Theory draws upon a large body of research about the profound biopsychosocial and existential impact of overwhelming stress on human development and function. Social learning theory emphasizes the active use of the entire environment as a therapeutic agent of change. It is best articulated by practitioners of therapeutic communities and milieus (2,12) Nonviolent practice makes attention to safety an active, attitudinal, and political aspect of social life and organization (23). Complexity theory provides a way to understand complex adaptive systems—individuals and entire organizations—and to utilize their innate capacity for change (24,25).

Redefined Assumptions

The Sanctuary Model provides a pathway for resolving and integrating, the above noted debates in residential treatment. It does so by redefining basic assumptions about the nature of the problem; the optimal environment and skills for effective treatment; the impact of losses on youth; and the need for a shared vision about treatment outcome.

The Sanctuary Model shifts the debate about the nature of the problem by changing the definition of institutionalized children from “bad” kids or “sick” kids (or both) to children who have sustained physical, psychological, social, and moral insults that lead to developmental *injuries*. These injuries to the body, mind, and soul often exacerbate each other, so that the optimal treatment environment must be directed at healing all of them simultaneously. This, in turn, requires an integrated use of individual, group, milieu, family, and medical approaches with an overarching, emphasis on safety. Attention to safety includes safety with the self, safety with others, and safety in the environment.

The historic debate over authority vs. egalitarianism noted above arises when the erratic and aggressive behavior of troubled youth leads the staff of residential centers to conclude that the residents cannot be trusted to share responsibility for maintaining a safe environment. Therefore they impose top down rules rather than encouraging more equal participation. The debate gives way when we redefine the causes of unsafe behavior as due to the youth’s exposure to violence and other forms of trauma that lead to a loss of affect modulation. Once we view the youth as unable to appropriately manage their powerful emotional states, we can ask more meaningful questions about what “safety” really means for each individual and for the community as a whole. This new understanding also allows behavior modification and socioemotional reeducation regimens to maintain a sustained focus on the primary therapeutic task of teaching affect management skills.

Trauma survivors frequently experience overwhelming losses. Survivors with unresolved grief often resist the painful affect associated with grieving and this unresolved grief can arrest future growth and change. To assist recovery staff must recognize and respond to the combination of overwhelming negative feelings and resistance to change. Staff must also be able to engage in complex negotiations with clients, families, and each other around boundaries, traumatic reenactment behavior, dependency, and identification with the aggressor, and terror of change.

Healing requires a vision of restored health. What is the shared goal of treatment? What is the vision the client holds of “emancipation”—of freedom from being haunted by the past? All treatment debates and decisions must be informed by this vision of where everyone is headed. In service of this vision, debates about whose job is more important—therapist, educator, childcare worker—fall away in service of the larger goal of bringing about a healthy empowerment and enhanced social function of each individual child.

Key Elements of Model

The Sanctuary Model puts these fundamental attributes of healing into operation via a conceptual framework called "S.A.G.E.," an acronym that stands for Safety, Affect Management, Grieving, and Emancipation (26,27). This framework provides a simple, comprehensible, and comprehensive way for the clients, their families, and the staff to make sense of and respond constructively to very complex dilemmas. Important elements of the program are: building a patient-staff treatment partnership; flattening the organizational hierarchy; using a unifying, phase-specific trauma treatment approach-S.A.G.E. to integrate community and therapy education; promoting community building based on SAGE principles; and expecting patients and staff to share responsibility for maintaining a safe, nonviolent milieu. Integration of all of the above multiple systems, expands the notion of safety, provides concrete steps to enhance affect management and builds an interdisciplinary team process.

Defining, creating, and maintaining truly safe environments requires a rigorous practice that revolves around establishing nonviolence as a social norm, instead of passively accepting the inevitability of violence. To maintain a nonviolent environment, the shared focus shifts to enhancing "social immunity," the protective structures, beliefs, norms and methods that a group establishes or accepts that serve to prevent the emergence of violent conflict. These shifts require an ever-expanding capacity to deal with complex decision-making and conflict resolution. This level of complexity can only be adequately achieved when there is room for—and priority given—to integrating many different points of view into a cohesive whole. To do so requires an atmosphere of "social learning," defined by Jones as *"the little understood process of change which may result from the interpersonal interaction, when some conflict or crisis is analyzed in a group situation, using whatever psychodynamic skills are available. . . . Learning of this kind is complicated and painful: old learned patterns, adequate in previous situations, must be unlearned because they stand in the way of acquiring new and more adequate patterns of behavior"* (28). To his way of thinking and working, every social interaction or crisis presented a *"living-learning situation,"* which provided the grist for the therapeutic mill and the opportunity for changing and learning how to change. Such a living-learning environment can only flourish in an atmosphere that promotes democratic processes and consensus, while still being able to respond rapidly to any circumstances that threaten individual or community safety.

By drawing on both trauma theory and principles of the therapeutic community the Sanctuary[®] Model provides a coherent conceptual therapeutic approach to guide work with disturbed children and adolescents. It not only addresses the high levels of trauma exposure found in the changing population currently in care, it also integrates the work in the various program components found in most residential centers: living units, schools and treatment sessions. Sanctuary offers a strong contrast to the current standard model of treatment employed by a large number of mental health-oriented residential treatment centers.

CONCLUSION

This paper examined the historical evolution of the standard model of care in psycho-dynamically-oriented residential treatment centers. It revealed that two dominant approaches shaped their effort to develop a consistent therapeutic approach and that four longstanding debates have complicated the effort to arrive at more than a “unifying something” sufficient to meet the challenges they currently face (5). The Sanctuary Model put forward as an alternative approach is being systematically implemented by means of regular training for all participants, and creation of training materials, and psychoeducation and implementation manuals. Rigorous evaluation must also be part of the process in order to document potential beneficial effects. Thus, an initial report from a formal NIMH supported evaluation process underway for three years has just been published (29).

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