

CITATION: Bloom, S. L. (2005) Introduction to Special Section- Creating Sanctuary for Kids: Helping Children to Heal From Violence. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations* 26(1): 57-63.

## ***Introduction to Special Section***

# **Creating Sanctuary for Kids: Helping Children to Heal From Violence**

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Editor

Throughout the last two centuries the care of children who have fallen on hard times has passed through a number of phases in the United States. Many of the debates related to these phases persist in influencing the present care of children within residential treatment centers in the United States (Abramovitz and Bloom 2003). In the early part of the nineteenth century it was considered a social responsibility to remove children from the evil moral influences in their homes and communities and to place them in reformatories and orphanages that stressed precision, regularity, and obedience to authority that was strictly enforced through the use of physical punishment (Rothman 1990). By the late 1800's, individual biological explanations of bad behavior dominated the approach to children in institutional settings and care centered on containment and protection from the community (Brace 1872). At the beginning of the 20<sup>th</sup> century, when larger social problems like poor childrearing and poverty entered social discourse, environmental theories dominated the explanations of why children ended up having behavioral problems. From around 1915-1960, individual psychoanalytic explanations powerfully influenced the growth and development of psychoanalytically oriented intensive individual treatment within residential settings as well as treatment programs and special schools guided by therapeutic community principles (Bettelheim and Sanders; Aichorn 1939; Redl and Wineman 1952; Bridgeland 1971; Kennard 1998). The social turmoil of the 1960's and 70's lent credibility once again to explanations that focused on negative social influences, poverty, poor education, poor parenting, racism and discrimination. But from the 1970's through today, treatment in many places has once again shifted to attempts to control maladapted children through behavioral and biochemical controls.

According to the MECA Study (Methodology for Epidemiology of Mental Disorders in Children and Adolescents) almost 21 percent of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment (Shaffer, Fisher et al. 1996). The impairment in about 8% of these children will be so severe that they will be sent residential treatment programs that account for nearly one-fourth of the national outlay on child mental health (Burns 1998). The types of

treatment these children receive vary widely and include psychoanalytic, psychoeducational, behavioral management, group therapies, medication management, and peer-cultural. Settings range from structured ones, resembling psychiatric hospitals, to those that are more like group homes or halfway houses. While formerly for long-term treatment (e.g., a year or more), RTCs under managed care are now serving more seriously disturbed youth for as briefly as 1 month for intensive evaluation and stabilization.

Residential care has long been a subject of concern related to: criteria for admission; inconsistency of community-based treatment established in the 1980s; the costliness of such services; the risks of treatment, including failure to learn behavior needed in the community; the possibility of trauma associated with the separation from the family; difficulty reentering the family or even abandonment by the family; victimization by staff; and learning of antisocial or bizarre behavior from intensive exposure to other disturbed children (Wells 1991; Loeber and Farrington 1998). Nevertheless, millions of children spend some part of their childhood in residential care and these children tend to be those who have the fewest family and community resources and the greatest exposure to violence (Rivard 2000; Rivard, Bloom et al. 2003; Rivard 2004).

Persistent debates that originate in the history of childcare continue today in residential programs, although few recognize the connection between past and present. Should children be protected from family influences that are considered to be the toxic reason why the children have been placed in the first place? Are the causes of children's problems biological/genetic or psychological/social? Is the child's behavior problem secondary to a "simple" lack of discipline or a lack of proper education? Are the children disturbed or delinquent? Is a corrective environment sufficient or do these children need specialized forms of treatment and if so, what are those forms? Is it most important to focus on correcting behavior or should the child and the staff understand the underlying causes for that behavior? Is a permissive or punitive response to children better? How much should children be taught to obey authority and how much should they learn to participate in democratic processes? How controlling should treatment environments be and how does external control develop into self-control? Is it important to formulate treatment approaches that are based on the child's history or does the history actually matter in changing behavior? Should a treatment staff be directing their efforts toward social control or toward the child's personal growth? What actually defines treatment success?

For the most part, answers to these questions have been determined largely by opinion, experience, and economic and political forces, not by research. As a result, most residential treatment programs for children cobble together any combination of more than seventeen treatment approaches including individual, group, family, and what comes to be called "milieu therapy" or in some cases, "therapeutic community" (Wells 1991). These approaches are usually not well-defined, even within much less across institutional settings. And complicating things further, every approach is based on differing theoretical assumptions about the nature of the problem and the nature of the children.

Trying to synthesize and integrate these various assumptions and approaches into a coherent, systematized, individualized and effective approach to each child requires more time, skill, and resources than most organizations can afford. The result is that there

are multiple theoretical assumptions informing treatment – or no theory at all. There is no common language across and between disciplines and therefore no common understanding. Staff splitting is common with one component of the staff – frequently the childcare workers insisting on more punitive measures to deal with misbehavior, while another component – frequently the clinicians – calling for more permissive approaches. Unfortunately, the actual outcome is frequently a mishmash of training approaches which then are each diluted and not integrated with each other. The staff often work at cross-purposes without even recognizing that their conflicts are due to conflicts in basic theoretical models and instead attributing the problems to the resistance of the children or personality conflicts among the staff. There are no manuals or formal training programs for specific programmatic approaches and as one observer has said, “*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.”* (Wells 1991).

These theory-based problems are compounded by changes in health care financing, decreases in training opportunities and funding for on-going training and supervision, downsizing of staff who tend to be less professionally developed from the outset, the presence of increasing aggressive and behaviorally disturbed and destructive children in every setting, state budgetary cuts, and a fragmented mental health and social service delivery system.

To avoid unfavorable outcomes, residential treatment programs need a coherent, integrated conceptual approach that does not reinvent the wheel but instead offers the flexibility to do whatever is in the best interest of the child. It must be a framework that can consistently guide treatment in the cottages where the children reside, in the schools that they attend, and in their formal therapy sessions. It must be a biopsychosocial framework that is simple enough for everyone to understand, puts everyone on the same page, does not sacrifice complexity or diversity, is universally applicable, and provides an organizing framework for what everyone already does well.

Such an organizing framework must also address what may turn out to be the most critical aspect of any approach that seeks to adequately treat children in residential settings: a “trauma-informed approach”. An approach to childcare that takes into account the impact of overwhelming stress on child development is particularly important since it has been established that a large proportion of a residential treatment population have a history of exposure to violence, abuse and neglect.

Recent research on childhood trauma is helping us understand how children’s exposure to overwhelming stress is transmuted over time into adult psychopathology. As evidence accumulates it becomes clear that the brain organizes itself in response to environmental pressures that may be far more potent than even genetic influences because the central nervous system is so vulnerable to stress (Garbarino 1999). For these children, what begins as an adaptive response to threat – a fear state – becomes instead a fear trait that they carry into adulthood (Perry, Pollard et al. 1995). Children who are exposed to violence show disturbing changes in basic neurological and physiological processes and it is postulated that these disturbances have profound developmental consequences. Bruce Perry and his colleagues have observed persistent hyperarousal and hyperactivity, changes in muscle tone, temperature regulation, startle response, and cardiovascular regulation as well as profound sleep disturbances, affect dysregulation,

specific and generalized anxiety, and behavioral impulsivity in children who have been traumatized (Schwarz and Perry 1994; Perry, Pollard et al. 1995). Over time, these growing children proceed down a number of different pathways in order to help themselves adapt to disordered physiological stability and emotional dysregulation. Some will become addicted to drugs and/or alcohol. Others will develop an eating disorder. For others, anxiety or depression will be the predominant presenting problem. Still others will have recurrent difficulties with relationships that will dominate the clinical picture, while others manifest their underlying unresolved conflicts via bodily illness and dysfunction that can affect virtually any organ system. As a result, by adulthood, the presenting picture can look amazingly diverse and consequently, the common traumatic origins of the pathological processes of development can easily be overlooked or ignored (Trickett and Putnam 1993).

In the U.S., the Substance Abuse and Mental Health Services Administration (SAMHSA) has outlined the elements necessary to develop a trauma-informed system of care for vulnerable adults and this study also offers some guidance for what is necessary to develop trauma-informed systems for children (Blanch 2003). Their report focuses on four broad domains that must be addressed to create a system that is truly trauma-informed: Service System Integration that requires coordinating services at the level of agencies and broader service systems; Clinical Integration that requires coordination of services at the level of individual consumers; Specialized Services requiring the development of face-to-face therapeutic activities intended to help individual clients; and C/S/R Integration which necessitates the incorporation of consumer experiences and perspectives into intervention design, development and implementation.

The articles in this issue focus on a trauma-informed model of residential treatment for children, the Sanctuary Model, that was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children (Bloom 1994; Bloom 1997; Bloom 2000). The Model is being adapted by three residential treatment settings for children, all of which are a part of the National Child Traumatic Stress Network<sup>1</sup>. All three centers have recognized that a high proportion of their children are trauma survivors and that sending staff to learn various treatment techniques is not going to be enough to create a trauma-informed culture. The leaders of all three programs recognize that they need to create an organizational climate that can more effectively provide a cohesive context within which trauma in children can be addressed. The Sanctuary Model promotes Service System Integration and Clinical Integration as components that must be in place before Specialized Trauma Services can be implemented.

The first article, by the founder of the Sanctuary Model, Sandra Bloom, describes the parallel processes that occur between traumatized children and the staff that treat them and describes a whole-system approach to creating a system that can truly meet the needs of traumatized youngsters. Her paper describes an implementation process at the Andrus Children's Center (and now beginning at Parsons' Child and Family Center) that was facilitated by intensive training of a multidisciplinary Sanctuary Facilitation Team

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<sup>1</sup> Andrus Children's Center, 1156 N. Broadway, Yonkers, NY 10701 (914) 965-3700; JBFCS Westchester Division Director, 226 Linda Avenue, Hawthorne, NY 10532, (914)773-7501; Parson's Child and Family Center, Albany, NY.

(core team) representing every level of the organization, which then take on the responsibility of training the entire staff in the Sanctuary Model (Bloom, Bennington-Davis et al. 2003)

The second article by researcher, Jeanne Rivard and colleagues describes a research project at a large campus encompassing three residential settings operated by the Jewish Board of Family and Children's Services (JBFCFS) in New York. The research was in part supported by an NIMH grant investigating the implementation of the Sanctuary Model in that setting under the auspices of Columbia University, the Center for Trauma Program Innovation at JBFCFS and the Saul Z. Cohen Chair of JBFCFS (Rivard, Bloom et al. 2003). The implementation of Sanctuary in these three settings – Hawthorne–Cedar Knolls, Linden Hill School, and the Goldsmith Center – continues today and has expanded beyond the “experimental group” to include the “control group”, thus expanding Sanctuary to the entire campus as well as the on-site schools.

The third article by Brian Farragher, the Chief Operating Officer at Andrus Children's Center and Sarah Yanosy Sreedhar, the Clinical Coordinator of the Diagnostic Unit at Andrus Children's Center provides a first-hand account of how their organization is adapting the Sanctuary Model to the treatment of very disturbed children.

Drawing on their experience at the Jewish Board of Family and Children's Services facility in Hawthorne, New York, the fourth article by David McCorkle, M.S.W. and Caroline Peacock, M.S.W. describes some of the challenges and rewards of training childcare staff in a setting with difficult issues like racism and classism must be addressed but tend to be denied and avoided so that they become - as they colorfully describe them – the “elephants in the room”.

The fifth article by Andrus social worker Michael Thomas describes an interdisciplinary discussion of a difficult child in residential care, as a case study for practicing the kind of creative thinking that is characteristic of the Sanctuary Model.

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