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TOWARD THE EVOLUTION OF SANE SOCIETIES

SANDRA BLOOM

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Creating Sanctuary

Toward the Evolution of Sane Societies

Sandra L. Bloom, M.D.

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This book is dedicated to the staff and patients
of 2 Main South, 2 West, and *The Sanctuary*

and

to Roy Stern, M.D.,
teacher and friend.

Contents

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And finally with profound respect, I give my thanks to our patients, who have taught us so much over these years, most especially to "Dawn."

Introduction

DAWN

It seemed to me imperative that there be somewhere, somehow established a sane asylum, however inadequate temporarily, and accordingly it was the aim of my associates and myself voluntarily to commit ourselves wholeheartedly to the opportunity afforded by such an experimental social set-up.
-Trigant Burrow, 1937, *The Biology of Human Conflict:*

An Anatomy of Behavior Individual and Social
This is our major problem in social psychiatry: to learn how to keep these United States from becoming in long periods of peace a conglomeration of disunited states of mind and heart.
Lawrence Kubie, M.D., 1943, *Psychiatry and the War*

In the field of mental health, most attention has been given to psychotherapy; some to mental hygiene, but very little as yet to the design of a whole culture which will foster healthy personalities.
Maxwell Jones, 1953, *The Therapeutic Community*

For most of us, life runs like an invisible thread through time, each day connected to the next, indistinguishable from the one before, changes blending into more or less smooth transitions. But then along come days or moments that stand out as markers, abrupt rifts in the otherwise seamless fabric of day-to-day life. I am going to describe to you one of those rifts in my life, one of those events that prompted a voice in my head to whisper, “You will never be the same again.”

In 1985 my life was going reasonably well. I was running a psychiatric practice and a hospital psychiatric unit that was a success. I was doing well financially, had a lovely home in the country, drove only fifteen minutes to work in the morning, was a member of a small community. I was completely insulated from professional politics and had even less interest in national or global politics. Like so many Americans, I blocked out the unpleasant realities of my fellow countrymen, the alarming reports about the escalating national debt, the growing fear of some impending doom that seemed to lie beneath the Reaganomic hypomania. After all, I had no idea what the underlying causes were for all these problems, and I had no idea what to do about any of them. I did my part to be a good person, a good psychiatrist, and a good boss. What else could anyone expect of me?

I had first met Dawn in 1980, when she was only eighteen. She was a college student on a Philadelphia campus. She had falsely accused a man of raping her, and when confronted with the obvious evidence of his innocence, she broke down emotionally. Her mother, whom I had known from a previous job, asked me to see her, and I agreed.

Dawn, as I will call her, was a beautiful young woman. Bright, funny, warm, and engaging, she was the ideal patient. Her "false memory" initially appeared to be a fluke, an anomaly in an otherwise unremarkable life. As we probed, however, it became apparent that Dawn had always had trouble with the men in her life. Her teen-age relationships were more chaotic than the average, and she seemed predisposed to become involved with men who manipulated, seduced, and exploited her. She had sexual problems, gaps in her memory which she took as a matter of course and inexplicable bouts of depression alternating with anxiety that would come and go for no apparent reason. Her self-esteem was relatively poor, and despite her obvious abilities she felt worthless. Sometimes she had difficulties giving an accurate account to me of her experiences, particularly if these involved men. Her father had been an abusive, sick, and troubled man who had died a few years before. He had beaten and humiliated her mother and her brother, but Dawn denied that she had ever had much difficulty with him.

Her recall of the events that had precipitated her visits to me were hazy at best, and she avoided much discussion about it, managing to steer me off course quite successfully on any number of occasions. In those days I was much more likely to just go where the patient directed, not choosing to probe troubled spots on my own initiative-good therapy was supposed to be "non-directive." I saw her regularly, and then more sporadically, for two or three years, helping to guide her through the crises of young adulthood. She graduated college and moved to Boston with her mother, but she stayed in touch with me. Eventually, she started

therapy again, this time with a very competent feminist therapist, because of the recurrence of anxiety, depression, and difficulties with relationships. Still, I was surprised one day in 1985, when I received a panicked call from her mother. Dawn was using drugs for the first time in her life and had become suicidal. She desperately needed hospitalization to keep her safe, and her mother asked if I would admit her to our psychiatric unit. I spoke to her therapist, who agreed with this plan, and I advised her mother to bring Dawn back to Philadelphia immediately.

On the day that Dawn was admitted I remember experiencing profound shock and revelation, but I had no idea where this revelation would lead. I walked into the examining room expecting to see a depressed version of the young woman I knew. I expected that she would shamefully explain to me her recent misadventures and that together we would struggle to make some sense of it all. I expected that she would be embarrassed and hopeful that I would not be angry with her, a scenario we had run through many times in the past.

When I walked into the examining room the person I saw before me was Dawn-but not Dawn. This person was sitting cross-legged on the couch and greeted me not with the sob and plea for a hug that I had expected, but with a shy little mischievous grin, not entirely appropriate to the current situation. Most striking was her voice, which was tiny and childlike, and her physical mannerisms, which demonstrated the indescribable sense of movement one associates only with children. Had a camera been on, I could have received a special Emmy nomination for my overt composure, which bore no relationship to what I was feeling inside. I smiled back and simply asked “Who are you?” That is how striking the difference in the two was- I actually had the sense that I was with another person, different in a substantial way from the one I knew so well. She responded that she was “Little Dawn” and, when asked, gave the address and phone number of her family home when she was seven, a fact I later confirmed.

This was simply not possible. Oh, sure, I had read *The Three Faces of Eve* and I had seen *Sybil* - both representing the most well-known presentations of multiple personality disorder. But that was Hollywood. This was a small town in Pennsylvania. I was sure that I would never see a case of multiple personality disorder, and certainly not in someone I knew as well as I thought I knew Dawn.

Over the course of the next three weeks I learned a great deal. Dawn’s child “alter” already felt safe with me because unbeknownst to me, we had spoken many times in the past. As I thought back, I remembered that Dawn occasionally called me at a time of personal crisis, outside of our usual therapeutic hour. When she first got on the phone, her voice would sound childlike, but I always assumed that this was simply “regression” and that she was voluntarily adopting a little-girl voice because of some emotion she was

experiencing. Actually, that gives me far too much credit - I really never reflected on why she was doing it- she just was, and I was responding to her as a mother might to a little child. As she calmed down, her voice changed, she sounded more in control of herself, and that was the signal that we could end the conversation. I never asked her at our next meeting whether she remembered the content of the phone call - it never occurred to me that she didn't. I assumed continuity of consciousness because I really was not aware of any alternative.

My training experience had been a good one. As psychiatric residents in the late 1970s, we became very proficient at getting histories and learning about childhood experiences and family dynamics. Family therapy was gaining a great deal of credibility in those days, and we had come to recognize that the family system was the crucial context for understanding the patient. We knew that childhood and family experience had some kind of direct connection to adult dysfunction and yet we did not really understand.

No theoretical model was available to pull together the biological, the psychological, the social, and the philosophical/spiritual into one comprehensive framework. There were only fragments of knowledge - a piece here, a piece there. I knew about child abuse from my work in the emergency room and in pediatrics. But I never really thought about those abused children grown up. Incest was certainly known to exist, but was said to be exceedingly rare. I had heard about "dissociation" and "hysteria" but I associated them more with faking and attention seeking than with responding to overwhelming life events. I understood a little about the personal oppression of violent homes but made no larger connections to racial, sexual, or political oppression. I had heard of the repetition compulsion, but *why* people would continually repeat the past never really made sense to me even though I could daily see the evidence with my own eyes.

We rarely if ever asked people about their history of abuse assuming, perhaps, that any major traumatic experience would be volunteered willingly by the patient. We knew that repression existed, but believed that people repressed what they felt guilty about, all those putative sexual fantasies and longings for the parent of the opposite sex. The idea that people could be "forgetting" memories of actual experiences of rape, molestation, and physical abuse simply did not go across the screen of our minds. We were never told that these things *did not* happen. In fact, there was often clear evidence that they had. But the real traumatic events in our patients' lives were not emphasized. Instead we overlooked, denied, or minimized their importance. And the patients colluded with this denial because they were no more eager than we were to open up the Pandora's box of their own childhood experiences.

What I hope I am getting across to the reader is that the particular kind of blindness I had experienced was really a sort of figure-ground problem. If you

have ever puzzled over an optical illusion picture, you know what I mean. You only can see the old hag or the vase, and no matter how hard you try there just isn't anything else there. Suddenly your eyes blink and there is the beautiful young girl in a big hat or the two faces staring at each other. In retrospect, the facts of Dawn's case seem blatantly obvious. But back then, I had no way to understand the facts, no context within which they would make sense.

As I asked questions that demonstrated my willingness to hear, the child alter revealed a history of paternal incest, brutality, and emotional abuse about which I had been totally unaware, and yet which helped to make so much more sense out of the symptoms that had always plagued Dawn. It also helped to explain the earlier "false" memory. Her memory had not been as much false as it was distorted and displaced. She had superimposed a stranger's face on that of the true perpetrator, her father, because it was less shocking to her conscious mind. But the lie had led not to relief, but a worsening of symptoms. Dawn's mother confirmed, as best she could, the reality of Dawn's experience, and it was consistent with a pattern of abusive behavior that her father had imposed on other family members. I gently explained to the adult Dawn, who would be brought back "out" at the behest of the child, what the difficulty was and then received permission from both Dawns to make a videotape of the child alter.

I sat with Dawn while she watched this unknown part of her, in her body, the me-but-not-me, on the television screen communicating directly with her. This helped to substantially decrease her understandable anxiety about her sanity and within a few sessions they were communicating internally. I stayed with her while she re-experienced the rape. Re-experience is not quite the right word because the adult part of her experienced it for the first time with me. It was the child part that had taken care of the memories and feelings of that awful night. Putting together the missing pieces of her life helped Dawn enormously. She had spent most of her life being haunted by events she could not remember, and they had left their imprints on every relationship she had tried to have. Before she left the hospital, she had integrated into one identity. Out of the hospital, she began to show dramatic improvement in every aspect of her life as more memories returned. A decade later, she now leads a productive and worthwhile life as a teacher and mother, although depression, one of the common chronic symptoms of childhood trauma, continues to periodically dog her heels.

Dawn's diagnosis, though perhaps the best thing that had happened to her as an adult because it led to better treatment, marked in my own life a personal and professional crisis: I was a mess!! I thought I was a pretty good diagnostician. I thought I was very skilled at formulating an understanding of a person after I had gotten to know them. But now I felt as though I didn't know anything, or at least I was no longer sure what I did know and what I didn't. My assumptive

world had shifted and knocked me off my pins. After all, Dawn was someone I had thought I knew well. What other secrets were lying in the dark closets of memory for which we held no key? What was most humbling about the experience was the recognition that the information had not even been that well hidden. The problem was that I had no mental schema within which the information would make sense and therefore, I simply failed to see it. I had been taught to believe that multiple personality disorder was extremely rare, if it existed at all, and therefore it did not exist for me. I had been told that incest does not occur in nice families, and therefore Dawn could not have been an incest victim - after all, I knew and liked her mother. Caught in the middle of my own personal earthquake, I realized only later that I had experienced some of the first tremors of an intellectual quake that was going to shake the entire psychiatric profession, the aftershocks of which are still with us today. Once the lid is off the box, there is no putting the hobgoblins safely back in.

Naturally, I started wondering about what I was missing in my other patients. This experience had a similar impact on the other members of my treatment team. Our scientific curiosity was aroused. How many more stories were unheard? How many others among our patients had childhood histories of severe trauma, of overwhelming experiences that were more than a child could safely bear? Many patients, when asked, simply volunteered the information about abuse and other traumas in their backgrounds, and when we asked why they hadn't told us before they replied "You never asked!" Others responded that they had told us, and to our horror we reviewed some of their charts going back through the years, and, sure enough, they were right. We had obtained the history, carefully recorded it, and then behaved as if it had absolutely no bearing on their mental state. The information had played little if any role in our case formulations or treatment decisions. Other patients denied any history of abuse or trauma and talked about the ideal nature of their families of origin and their childhood experiences. They would then promptly fall apart with an exacerbation of symptoms, an increase in self-destructive behavior, and what we considered, at the time "acting out" and manipulation. This seemed an odd response to relatively straightforward questions, and we began wondering what that behavior meant. As we gently probed further, these patients would often tell us - no, show us - their memories of horrifying childhood experiences, often at the hands of someone who professed to love them.

This was awful. Oh, yes, from a scientific point of view it was fascinating. A mental iceberg we had never seen before, an entirely new intellectual landscape. There was some of the associated thrill of the explorer, I suppose, but that thrill was largely overwhelmed by the fear and horror of it all. *I did not want to know this information*. It scared me, as it did the rest of my team. How could

this be true? How could there be so much child abuse? What were we supposed to do with something we knew virtually nothing about - the effects of child abuse on adult behavior? Worst of all, it made us sick - sick at heart, sick in our souls, and sick to our stomachs. When you read accounts of people "remembering" childhood trauma, the implication is often that the patient sits quietly on some couch, gently whimpering perhaps, but calmly remembering events as if it were you remembering what you ate for breakfast yesterday. This is not what it is like. When people "remember" previous trauma, or abreact, as it is called in psycholingo, they relive it, or more often, as in Dawn's case, live it for the first time. It is terrible for them, extremely painful, embarrassing, and disgusting. But at least, deep inside, they know the secret they have been unwittingly carrying for a long time, and afterward they usually feel a kind of relief at the shedding of this burden.

The participant-observer is completely unprepared for what is coming and inevitably experiences some kind of secondary or "vicarious" traumatization at witnessing the horror and trauma of a past time intruding into the present. Trauma shatters assumptions (Janoff-Bulman 1992); it destroys the wall of safety and invulnerability that we use to shield ourselves from harsh realities, from recognizing our essential vulnerability. Witnessing trauma produces a similar effect on the bystander. Since that time I have not been puzzled by why the psychiatric profession has turned its back repeatedly on the reality of victimization (Herman 1992). It is too painful to bear. Blaming the victims for their problems and thereby allying oneself with the powerful perpetrator is far easier than emotionally containing the raw pain of innocent suffering and helplessness. Compassion for the victim leads to the need to take action to stop perpetration, and this means directly challenging the holders of power. It's a scary business.

We were unable to return to our former position of the three monkeys, "Hear no evil, see no evil, speak no evil." The smoking gun of child abuse lay all around us. We began to carefully explore what has been called "the black hole of trauma" (Pitman and Orr, 1990). Our body of knowledge grew as we academically and clinically surveyed this strange, terrifying, and yet strangely empowering landscape. Previously, psychiatry - and its primary focus, the human mind - had appeared to be a fragmented, often confusing and confused area of endeavor. So many of the reasons we had offered for why people do crazy things always seemed fragmented, circular, inconclusive, or just patently wrong. Implicitly, underlying many of our psychiatric notions and our psychiatric jargon was the concept of "original sin"- that somehow the patients were ultimately to blame for the troubles they got themselves into and if they would only do as they were told, they would get better. Biological psychiatry countered this implicit

judgmental attitude by attributing the cause of mental disturbance to impaired neurotransmitter function and genetic vulnerability, but in doing so it often veered in the direction of a dangerous and foolish reductionism, attempting to explain very complex problems with simplistic and unproven answers.

Just as confusing was the fact that mental *health* was never actually defined. What does a healthy person look like? How does he or she behave? It has become increasingly clear over the last forty years that the definition of health is profoundly influenced by cultural and social mores, but there are certain aspects of human health that are grounded in universal human needs. And if human health and ill health is so influenced by the social matrix within which we all function, then what about us? The participant role of the society and its representatives, in this case us, was never fully clarified and often simply ignored. Whenever a patient was unresponsive to our particular interventions we would deny or minimize our frustration or lack of accomplishment and call it resistance or manipulation, or some similar term whose purpose was to convince us that their lack of improvement was their fault, not ours.

As we studied the effects of psychological trauma, what began to emerge was the beginning hazy outlines of a field theory of human nature, a biopsychosocial philosophy within which all the fragmented pieces of knowledge about human biology, behavior and inner life could begin to form a cohesive whole. Through an understanding of how trauma affects the whole human being we were able to see the interconnected and mutually interacting web of biology, individual psychology, and social behavior, as well as philosophical, religious, and spiritual beliefs. Gradually, we awakened to the fact that our patients do not, by virtue of their psychiatric symptomatology, comprise a separate and discrete category of human experience. Rather, they march along the far end of a very long continuum of traumatic adaptation that chains us all together in our common - and often tragic - humanity.

As we deepened our understanding of the manifestations and effects of psychological trauma, we came to understand that the trauma itself does not determine outcome. Rather, the response of the individual's social group plays a critical role in determining who becomes a psychiatric casualty, who would pursue a life of criminal behavior, and who would be spared. Although as therapists we had previous contact with the ideas of family therapy and systems theory, we were still working from the premises of an individual model, in which problems are seen as being caused by the individual person or, at most, by "communication problems." In this view of the world, which characterizes such a fundamental aspect of Western philosophy, psychology, and politics, attachment behaviors are always slightly suspect, easily merging into the pathological and called neediness and dependency, regression or manipulation.

The entire experience with trauma provoked disturbing insights that have shaken us out of our complacency. The insight that humans have a predisposition to repeat traumatic experience has led to the eruption of a profound and disturbing fear: Our society appears to be in the grips of a post-traumatic deterioration that could also end in self-destruction, just as it does with patients who remain locked in the patterns of the past. We have become convinced that trauma is not an unusual or rare experience, but that it is, in fact normative. Just as a traumatic experience can become the central organizing principle in the life of an individual victim, so too is trauma a *central organizing principle of human thought, feeling, belief, and behavior* that has been virtually ignored in our understanding of human nature. Without this understanding we cannot hope to make the sweeping changes we need to make if we are to halt a universal post-traumatic deterioration.

This was yet another blow to our sense of secure knowledge. If other people are that critical in determining outcome, then we were bound to reexamine the basic assumptions that inform our therapeutic environment, the social sphere within which patients are plunged when they are at their most vulnerable. About this time, Dr. Steven Silver published a chapter about his experience in treating Vietnam War veterans in which he described "sanctuary trauma" as that which occurs when an individual who has suffered a severe stressor next encounters what was expected to be a supportive and protective environment and discovers only more trauma (Silver, 1986). We thought about the many patients who had come into psychiatric facilities expecting help, understanding, and comfort but found instead rigid rules, humiliating procedures, conflicting and often disempowering methods, and inconsistent, confusing, and judgmental explanatory systems. This led to a rethinking of the basic assumptions upon which we base treatment and a formulation of our treatment approach as "*The Sanctuary* Model of Inpatient Treatment (Bloom, 1994a, 1994b, 1994c).

A "sanctuary" is a place of refuge and protection. For our purposes the word connotes a place of temporary refuge, where some of the rules of our present everyday society are suspended to allow for a different kind of social experience. A concrete description of the place we call *The Sanctuary* is fairly easy. It is a discrete unit in a psychiatric hospital that can house twenty-four people with plenty of space for group meetings, private consultations, and various activities. The furnishings are attractive, the colors soft, warm, and inviting. There are pictures on the wall, some professionally done, some by people who have contributed a message of their own after their stay. The unit has televisions, a lounge space, a small kitchen. Ideally, people live in this environment for two to three weeks, although that rarely happens in these days of restricted care. Within the confines of these walls, a special program has been created to address the

needs of adults who were traumatized as children. They all suffer from a psychiatric or psychophysiological problem severe enough to compromise their level of function and necessitating hospitalization. This usually means that they pose enough threat to themselves or others that intensive treatment is vital[1].

The Sanctuary is, of course, exactly what it says it is - a program to treat traumatized adults. But from another perspective a parallel agenda is visible. The truth is, we did not create *The Sanctuary* for the sole purpose of treating patients. We wanted to create a relatively sane environment for us as well, an environment that would satisfy some important needs of the people who work in and manage the program [2].

This book is the story of how a group of friends and clinicians came to a better understanding of some of the mysteries of life. People who consider themselves patients or victims of trauma may certainly find the information contained within these pages of benefit. But I am not as much interested in writing about how we taught our patients as I am in sharing what they taught us. These lessons have been personally and professionally transformative and if properly understood could contribute to transformative changes in the concentric series of social systems of which we all are a part.

In Chapter 1 and 2, I will focus on what traumatic experience does to the body, the mind, the relational network, and the ontology of the victim and those close to the victim. Learning about the effects of trauma is not as simple as learning a new body of information. Traumatic experience forces us to develop new categories, new ways of thinking about our past, our present, and our future. Trauma theory challenges, reinterprets, expands, and even demolishes many of our existing paradigmatic structures - the underlying rules and practices that give form and meaning to our lives. These rules are partly or wholly unconscious, undefined, simply accepted as the way things are. They define the way we perceive reality.

In the practice of psychiatry, nature and nurture have run as parallel and often warring etiologic positions. Just as today, other times in our past have witnessed efforts by biological reductionism and genetic determinism to drown out the voices of nurture, environment, and development (Kirshner and Johnston 1982). In Chapter 3 we hear again a few of those insistent voices arguing for the essentially social construction of human existence. One of the most important lessons we have learned is that honoring and learning from the past is the only way of guaranteeing safety in the present and ensuring that we have a future. It is profoundly true, as Santayana reminds us, *"Those who cannot remember the past are condemned to repeat it."* We cannot hope to integrate the biological, the psychological, the social, and the philosophical without learning from the wisdom of the past.

In Chapter 4 I pick up the threads of my story and recount how we were changed by - and changed - our small experimental society as a result of what we learned about trauma. We called the physical and psychological result of this change *The Sanctuary,* and in this section I will describe our experience of creating and maintaining a therapeutic milieu that is designed to address the needs of adults who were traumatized as children.

For years the inpatient setting has been considered a laboratory for social change [3]. But before we had an understanding of trauma it was difficult to generalize from the small microcosm of a psychiatric inpatient unit to the larger social sphere in any significantly relevant way. No commonly shared language could adequately express our insights. Psychiatric disorder was constituted of basic "otherness" that bore little if any causal relationship to the outside world.

Trauma theory has taught us that this perception is nonsense, that most psychiatric disorder is the culmination of "normal reactions to abnormal situations," situations largely created by the failure of our social systems to provide traumatized children with the protection and care to which they have a right. As this recognition grew, the implications became enormous. Our tiny inpatient community was a small system embedded in a series of concentric systems that failed us in the same way that we were failing our patients, and that they had been failed as children. In fact, the degree of health in those "parent" systems was a limiting ceiling on how healthy we could make our own, not at all unlike the situation in which children find themselves when confronted with impaired parents.

We realized clearly that without reverberating change in the hierarchy of systems, we would continually find ourselves fighting to maintain the safety and security of the unit, forced to mount psychic and corporate battles to protect the state of health we had achieved. This drain of energy, consequently, took its toll on the development of further progress. This has been an extremely useful lesson in graphically detailing the necessity of total system change and the difficulties involved in attempting to fix a part without fixing the whole. It was humbling to discover that our system and the systems around us are as *resistant* to change, *manipulative,* and *stubborn* as any of the psychiatric patients we were treating. This was another example of the dawning recognition that the wall we establish between *them* and *us* is an arbitrary one, born out of our need to distance ourselves from our own shortcomings rather than out of any sense of absolute reality.

I have come to believe that we have had a number of experiences with victims of trauma that may have a great deal of relevance for the social systems within which we all must function. In Chapter 5 I speculate about the potential for social reconnection. Everyone seems to recognize that we presently are in need of

change. Argument abounds, however, about what form that change should take. Powerful forces in our society are pushing for a movement backward in an attempt to undo the perceived damage that has been wrought by the profound changes of the last half century. Other forces are pushing us forward into a "new age," which is described either in dark forecasts of apocalyptic doom or idyllic utopianism. Community life has broken down dramatically, and we are only beginning to recognize how important to our daily survival is the web of connection that a community provides.

But there are relatively few voices talking about *how* we get from "here" to "there." Part of the problem may be that we do not yet have any kind of a clear vision about where "there" is. We do not spend a great deal of time envisioning a better future for ourselves and our children and even less time figuring out how to make that future a reality. Nor have we had available to us an understanding of how "complex adaptive systems" function. Only now is a model for systems change being developed (Holland 1995). We have, however, learned a great deal about the human elements within any system that create the most chaos and disorder. That is why I think I have something to share with you. I have been a part of a better system for the last fifteen years. It is not idyllic or utopian. It does not work flawlessly. But it is more responsive to human well-being than any other system I have ever encountered. As a result, we have learned a great deal about what is important to human beings - all human beings - and some important lessons about how human systems succeed and how they fail.

My world view has changed almost entirely as a result of what I have learned about what happens to human beings who are exposed to overwhelming stress. These changes have been alternately terrifying and exciting, frustrating and gratifying, infuriating and pleasurable. At times I seek out new knowledge, a new way of looking at the world. At other times, I regress, harking back to old and timeworn explanations for puzzling feelings and behaviors. This new way of viewing the world is far more personally demanding and draining than the old. In the last ten years, my life has totally and unexpectedly changed both personally and professionally. I now have bigger areas of clarity about things that were in a muddle before and this understanding has brought with it more compassion for myself, for other people, and for our sad, struggling world. But there is no longer any place to hide. I see what is meant by the saying "ignorance is bliss". Now that I know more about the ways of the world and how the pieces fit together, I cannot bear the silence that gives consent. Suffering demands a voice, a witness, and that means giving up the freedom to be a bystander. This book is a call for more company out here, on the edge, on the firing line, speaking out against tyranny in all its forms, including the tyranny of a dying and deadly vision.

We are on the threshold of a new millennium. Signs of social strain are manifest all around us. Our existing paradigmatic structures no longer adequately hold us. We appear to lack adequate methods to solve problems that are global, interconnected, ecological, and biopsychosocial. We lack an alternative vision for the future, and as the Bible says, without a vision a people perish. When Thomas Kuhn (1970) talked about a "paradigm shift" he noted that it is impossible for an old paradigm to be overturned until a new paradigm is born. I believe that our work with some of the most injured and socially alienated of human beings provides us all with important information about what we need to do to reconnect to each other and to the natural world that sustains us. These patients have provided us with some vital pieces of a new paradigm, the still hazy outlines of a new way of thinking, relating, and behaving, and a new way of defining reality. I have used the phrase "creating sanctuary" as a way of illustrating the verb-noun, process-object, every-changing organic nature of what *The Sanctuary* means. A sense of safety, wholeness, life, caring, and home is something each of us actively creates - or destroys - every moment of our lives. It is the ultimate choice of every human being, of every human community. It is my hope that the insights we have gained from our work with some of the most injured warriors in the battle of life can contribute to an interdisciplinary, interracial, transgendered, global conversation leading to a new, more humane and attainable vision for the centuries to come.