Addiction and Trauma:

The Sanctuary Model of Trauma-Informed Organizational Change

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

This article sets out to accomplish several purposes. The first part of the paper will address the strong research-based connections between exposure to various forms of childhood adversity and the later use of various problematic substances and behaviors as a method for coping with that adversity. The second part of the article will attempt a description of what it means to have a culture that is truly "trauma-informed". The third part of the paper will describe the Sanctuary Model, a trauma-informed organizational approach and the research that informs it, The final part of the paper will address the orienting tool in the Sanctuary Model that we call "S.E.L.F." and how we use it as a framework to get children and adult clients, and staff all on the same page which is critical to having a trauma-informed culture.

Childhood Adversity and the Problems that Follow: The ACEs Study

The ACEs (ACE stands for Adverse Childhood Experiences) Study is a major retrospective study of 17,337 adult health maintenance organization members (54% female; mean age, 57 years) who attended a primary care clinic in San Diego, California within a 3-year period (1995-1997) and completed a survey about childhood abuse and household dysfunction, substance use, suicide attempts (including age at first attempt), and multiple other health-related issues. The ACE's study provides a documented link between childhood exposure to violence, psychiatric disorders, physical disorders, and substance abuse.

The researchers asked people to place themselves into eight categories of adverse childhood experiences by answering the following questions: Before the age of eighteen: Were you physically or psychologically abused by a parent?; Did anyone, sexually abuse you?; Was anyone in your household violent against your mother?; Was anyone in the household mentally ill or abuse drugs and/or alcohol?; Was there anyone in the household who was imprisoned?; Were your parents divorced or separated? The number of categories (not the numbers of occurrences) of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease.

The number of categories – not events – that the person admitted to then became their ACEs Score which essentially represents their "trauma dose" as children. Only a third of this middle-class, largely Caucasian and well-educated

population had an ACEs score of “0”. Two-thirds of the population admitted to an ACE score of “1” while one in four people were exposed to two categories of ACEs and onein 16 for four categories of ACEs. The authors also noted that ACES tend to be grouped together so given one ACE, there is an 80% chance of having exposure to another.

ACEs and Substance Use and Abuse

After adjusting for age, sex, race, and education, each category of childhood adverse experience showed an increased risk for smoking behavior, and these risks were comparable for each category of adverse childhood experiences. Compared with those reporting no adverse childhood experiences, persons reporting 5 or more categories had substantially higher risks of early initiation of smoking, of ever smoking, of current smoking, and of heavy smoking. Each relationship between smoking behavior and the number of adverse childhood experiences was strong and graded. For any given number of adverse childhood experiences, recent problems with depressed affect were more common among smokers than among nonsmokers [1].

Similarly, the risk of alcoholism and depression in adulthood increases as the number of reported adverse experiences increases regardless of parental alcohol abuse. It was clear from the study that children in alcoholic households are more likely to have adverse experiences. Depression among adult children of alcoholics appears to be largely, if not solely, due to the greater likelihood of having had adverse childhood experiences in a home with alcohol-abusing parents [2]. Compared to persons who grew up with no parental alcohol abuse, the likelihood of each category of ACE was approximately 2 to 13 times higher if the mother, father, or both parents had abused alcohol. For example, the likelihood of having a battered mother was increased 13-fold for men who grew up with both parents who abused alcohol. For almost every ACE, those who grew up with both an alcohol-abusing mother and father had the highest likelihood of ACEs. The authors of the study concluded that exposure to parental alcohol abuse is highly associated with experiencing adverse childhood experiences [3].

Likewise, the ACE score had a strong graded relationship to the risk of drug initiation from early adolescence into adulthood and to problems with drug use, drug addiction, and IV drug abuse. The persistent graded relationship between the ACE score and initiation of drug use for people born as early as 1900 suggests that the effects of adverse childhood experiences transcend social changes such as increased availability of drugs, social attitudes toward drugs, and recent massive expenditures and public information campaigns to prevent drug use. The authors point out that ACEs seem to account for one-half to two-third of serious problems with drug use [4].

But what rarely appears in the popular press as a significant causative factor in the evolution of substance abuse disorders is the intimate connection between alcohol and drug use and post-traumatic stress disorder. War trauma has been associated with very high rates of substance abuse with 60%-80% having concurrent diagnoses of alcohol abuse or drug abuse or dependency. Vietnam veterans with higher levels of war zone stress were more likely to exhibit chemical abuse or dependency than those with lower levels of stress, indicating that the neurobiological alterations associated with PTSD may make affected individuals more susceptible to substance abuse [5]. Battered women are 15 times more likely to abuse alcohol[6]. Briere reported that 27% of adult sexual

abuse victims had a history of alcohol abuse and 21% a history of drug abuse, while Herman found that 35% of female incest victims abused drugs and alcohol. The numbers rose to 80% in a group of female incest survivors who had been inpatients [7]. Substance problems have been shown to increase over time in several studies of disaster victims [8]. Of a sample of 2300 police officers, 23% reported drinking problems and another 10% said they abused other drugs [9]. In a metanalysis of the sequelae of civilian trauma, victims of noncombat trauma were significantly more likely to have a number of psychiatric disorders including substance abuse [10].

It is the impact of childhood abuse and neglect that is the most disturbing and may have a great deal to do with the rising incidence of substance abuse among the adolescent population. Approximately 50%-60% of women and 20% of men in chemical dependency recovery programs report having been victims of childhood sexual abuse. Approximately 69% of women and 80% of men in such programs report being victims of childhood physical abuse [11]. Estimates of the rate of PTSD among substance abusers varies between 12% and 34%, while for female substance abusers, the co-occurrence rate is 2-3 times as high [12]. In a study of 50 patients in an inpatient chemical withdrawal unit and 50 patients assessed for an outpatient chemical dependency program, 39% had a dissociative disorder and 43 reported childhood abuse [13]. In another study of 265 men being treated in an inpatient substance abuse unit, 41.5% had a score of 15 or more on the Dissociative Experiences Scale, a common accompaniment of childhood trauma [14]. Yandow estimates that as many as 75% of women in treatment for alcoholism have a history of sexual abuse [15]. A history of childhood rape doubled the number of alcohol abuse symptoms that women experienced in adulthood and there was a significant relationship between pathways connecting childhood rape to PTSD symptoms and PTSD symptoms to alcohol use [16]. In a large HMO survey, people who had survived four or more categories of adverse childhood experiences had a 4-12 times increased risk for alcoholism and drug abuse [17].

In one study that looked at the clinical characteristics of women with PTSD and substance dependence, the dual-diagnosis women consistently had a more severe clinical profile, including worse life conditions, both as children and as adults; greater criminal behavior; a higher number of lifetime suicide attempts; a greater number having a sibling with a drug problem, and fewer outpatient psychiatric treatments [18]. In a study looking at the long-term effects of parental substance abuse and a history of childhood abuse in a population of adult children of substance abusers, 62% reported a substance abuse history now while another 24% admitted to a previous substance abuse history. Of this population, 79% believed they had been emotionally abused, 43% physically abused, 41% sexually abused and 51% neglected while 28% met criteria for PTSD in the past and another 21% were presently diagnosed as having PTSD [19].

And it is not just previously traumatized adults who are at risk. In a recent large national probability sample looking at risk factors for adolescent substance abuse and dependence, adolescents who had been physically assaulted, who had been sexually assaulted, who had witnessed violence, or who had family members with alcohol or drug use problems had an increased risk for current substance abuse/dependence and the presence of PTSD independently increased risk for marijuana and hard drug abuse/dependence [20] (Kilpatrick et al, 2000). In a longitudinal study of the connection between maltreatment

and drug use, children who are maltreated are at on-third higher risk for using drugs as teenagers [21]. Another group of researchers asked teenagers to self-report their abuse and sexual molestation experiences as well as their substance abuse experience. The abused children tended to begin using drugs and alcohol at a younger age and tended to be heavier consumers of drugs and alcohol, even by eighth grade [22].

If we look at the relationship between childhood victimization and the risk for alcohol and drug arrests as a young adult, the odds of being arrested for at least one such offense are 39% greater for maltreated children than for control subjects in a large study project [23]. This connection between childhood exposure to trauma and substance abuse is particularly important when we look at the urban population. In a study designed to measure young people's exposure to violence, the Project on Human Development in Chicago Neighborhoods is looking at the determinants of antisocial behavior, delinquency and crime, and substance abuse. They found that urban children are experiencing a wide range of violence exposure, from the 88% who said they had seen someone hit during their lifetime to the 3% who had been sexually assaulted in the past year. Between 23 and 30% of the children had witnessed a shooting or someone being killed or shot at, while 66% of them had heard live gunfire. Eight percent said that they had been shot at in the last year, 15% said they were attacked with a weapon and 31% said they had been hit. Fourteen percent had been sexually assaulted during his or her lifetime [24].

ACEs and Medical Problems

ACEs appear to be intimately related to other problems besides substance abuse. The number of categories of adverse childhood exposure showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life [17].

ACES and Mental Health Problems

Additionally, adverse childhood experiences in any category increased the risk of attempted suicide 2- to 5-fold. From this study it is clear that a powerful graded relationship exists between adverse childhood experiences and risk of attempted suicide throughout the life span. The authors of the study believe that alcoholism, depressed affect, and illicit drug use, which are strongly associated with such experiences, appear to partially mediate this relationship [25].

ACEs and Sexual Behavior

ACEs researchers also looked at unintended pregnancy in their study population. Women who experienced 4 or more types of abuse during their childhood were 1.5 times more likely to have an unintended first pregnancy during adulthood than women who did not experience any abuse [26].

Researchers also found a strong graded relationship between ACEs and a self-reported history of sexually transmitted diseases among adults. For both women and men, the prevalence of STDs (sexually transmitted diseases) was 5

times higher for those who had been exposed to 6 to 7 categories of ACEs during childhood than for those who were exposed to no categories of ACEs during childhood [27, 28]. Each category of adverse childhood experiences was associated with an increased risk of intercourse by age 15, with perceiving oneself as being at risk of AIDS and with having had 30 or more partners [28].

What is a "Trauma-informed Culture"?

The Adverse Childhood Experiences Study, in combination with many other studies connecting childhood experiences, adult exposure to violence, and negative outcomes indicate that the impact of traumatic experience must play a vital role in the development and implementation of all mental health, substance abuse, and social services. To create a truly trauma-informed treatment culture then requires trauma-specific treatment approaches that help psychologically injured people to heal. But these studies tell us that it is not just the clients in treatment programs who have been traumatized, but the staff members as well. So being trauma-informed means being sensitive to the reality of traumatic experience in the lives of most people – children, their parents, staff, administrators, state officials, police, courts, schools, and everyone else. It means being sensitive to the ways in which trauma has affected individuals, families, and entire groups (i.e. Native Americans, African-Americans; LGBT individuals). And it means becoming sensitive to the ways in which trauma impacts organizations and entire systems.

In fact, our growing knowledge about the short and long-term effects of chronic stress and repetitive trauma requires a shift in the way we view all human problematic behavior. We need to stop viewing people as either "sick" or "bad" – philosophical positions that inevitably lead to the problems associated with the mental health system or the criminal justice system - and instead begin viewing all of these problems as the result of injuries, some to the body, some to the mind, some to the ability to relate, some to the sense of right and wrong, and some to the Soul.

The Sanctuary Model:
A Trauma-Informed Organizational Approach

The Sanctuary Model ®, is a trauma-informed method for creating or changing an organizational culture. Although the model is based on trauma theory we have found its tenets have application in working with children and adults across a wide diagnostic spectrum. Originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children, the Sanctuary Model is an evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic therapeutic community in which staff and clients are empowered as key decision-makers to build a socially responsive, emotionally intelligent community that fosters growth and change [29-33]. The Sanctuary Model has been effective with children and adults across a range of human service organizations, including residential treatment centers, public and private schools, domestic violence shelters and drug and alcohol treatment centers.

The Sanctuary Model is not a specific intervention but a full system approach focused on helping injured clients recover from the damaging effects of interpersonal trauma. Because it is a full system approach, effective implementation of the Sanctuary Model requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process [34].

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

- **Culture of Nonviolence** – building and modeling safety skills and a commitment to higher goals
- **Culture of Emotional Intelligence** – teaching and modeling emotional management skills and the integration of thoughts and feelings
- **Culture of Social Learning** – building and modeling cognitive skills in an environment that promotes conflict resolution and transformation
- **Culture of Shared Governance –** creating and modeling civic skills of self-control, self-discipline, and administration of healthy authority
- **Culture of Open Communication –** overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries
- **Culture of Social Responsibility** – rebuilding social connection skills, establish healthy attachment relationships
- **Culture of Growth and Change** – working through loss, restoring hope, meaning, purpose

The results of creating a trauma-informed culture should be observable and measurable. The outcomes we should expect to see include: less violence of all kinds, better staff morale, lower staff turnover, fewer injuries to staff and client, a truly collaborative treatment environment, the reduction or elimination of coercive forms of intervention, and better client outcomes.

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

In the Sanctuary Institute[1], key organizational questions frame an intensive five day workshop that helps organizational leaders to reclaim a culture of hopefulness and innovation. The Institute is an intensive and transformational

[1] For more information see www.andruschildren.org or www.sanctuaryweb.com; contact Sarah Yanosy at 914-965-3700

process that requires deep commitment and participation from organizational leadership, but the rewards will be both powerful and measurable.

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

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

S.E.L.F. is the implementation tool that is a fundamental component of the Sanctuary Model, an acronym that stands for Safety, Emotional management, Loss, and Future. S.E.L.F. is a conceptual tool (originally called S.A.G.E.[35-37]) that guides assessment, treatment planning, individual and team discussion, and the psychoeducational group work. S.E.L.F. is not a staged treatment model, but rather a nonlinear method for addressing in simple words, very complex challenges.

The four concepts: Safety, Emotions, Loss, and Future (originally Safety, Affect management, Grieving, and Emancipation) represent the four fundamental domains of disruption that can occur in a person's life. Within these four domains, any problem can be categorized. Naming and categorization are the first steps in making a problem manageable. Victims of overwhelming life experiences have difficulty staying safe, find emotions difficult to manage, have suffered many losses and have difficulty envisioning a future. As a result, they are frequently in danger, lose emotional control or are so numb that they cannot access their emotions, have many signs of unresolved loss, and are stuck in time, haunted by the past and unable to move into a better future.

The S.E.L.F Psychoeducational Group [2] is designed to provide clients – and staff – with an easy-to-use and coherent cognitive framework that can create a change momentum. Because it is a model that is "round" not square - circular, not stepped - it provides a logical framework for movement. We think of S.E.L.F. as a compass through the land of recovery that can help guide individual treatment, staff decision, team treatment planning, and an entire institution. It is not constrained by gender, age, race, religion, or ethnicity because the domains of healing that S.E.L.F. represents are human universals, unbound to any time, place, or person. In our residential programs, children as young as four are comfortably using the S.E.L.F. language – and using it appropriately.

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

The Sanctuary Model and the Democratic Therapeutic Community

The principles that guide the democratic therapeutic community— as distinguished from "concept therapeutic communities" so common in the United States for the treatment of substance abuse—are rooted in Moral Treatment of the 18th century and the fundamental ideals of the Enlightenment. Ultimately, in the Sanctuary Model the purpose of our shared assumptions, shared goals, shared practice and shared vision is to create what Maxwell Jones a half-century ago described as a "living-learning environment" within which healing, growth, and creative expression can occur [38]. This is as urgent a calling today as it was half a century ago. A wide range of settings including residential treatment settings for children or adults, acute care inpatient units, substance abuse programs, domestic violence shelters, homeless shelters, group homes, day hospitals, and intensive outpatient programs all have an opportunity to create environments that are intrinsically humane, as well as healing and health promoting.

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

References

1. Anda, R.F., et al., *Adverse childhood experiences and smoking during adolescence and adulthood.* Jama, 1999. **282**(17): p. 1652-8.
2. Anda, R.F., et al., *Adverse Childhood Experiences, Alcoholic Parents, and Later Risk of Alcoholism and Depression.* Psychiatric Services 53, 2002. **53**: p. 1001-1009.
3. Dube, S.R., et al., *Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction.* Child Abuse Negl, 2001. **25**(12): p. 1627-40.

4. Dube, S.R., et al., *Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study.* Pediatrics, 2003. **111**(3): p. 564 –572.
5. Friedman, M.J., *Interrelationships between biological mechanisms and pharmacotherapy of posttraumatic stress disorder. In ME Wolf & AD Mosnaim (Eds)..* in *Posttraumatic Stress Disorder: Etiology, Phenomenology and Treatment*, M.E. Wolf and A.D. Mosnaim, Editors. 1990, American Psychiatric Association: Washington, D.C.
6. Salasin, S. and R. Rich, *Mental health policy for victims of violence: The case against women.*, in *IInternational Handbook of Traumatic Stress Syndromes.*, J. Wilson and B. Raphael, Editors. 1993, Plenum Press: New York.
7. Green, A.H., *Child sexual abuse: immediate and long-term effects and intervention.* J Am Acad Child Adolesc Psychiatry, 1993. **32**(5): p. 890-902.
8. Grace, M.C., et al., *The Buffalo Creek disaster: a 14 year follow-up.*, in *International Handbook of Traumatic Stress Syndromes*, J.P. Wilson and B. Raphael, Editors. 1993, Plenum Press: New York.
9. Mitchell, J.T. and A. Dyregrov, *Traumatic stress in disaster workers and emergency personnel: prevention and intervention*, in *International Handbook of Traumatic Stress Syndromes*, J.P. Wilson and B. Raphael, Editors. 1993, Plenum Press: New York.
10. Brown, E.S., et al., *The psychiatric sequelae of civilian trauma.* Comprehensive Psychiatry, 2000. **41**(1): p. 19-23.
11. Matsakis, A., *Post-traumatic Stress Disorder: A Complete Treatment Guide.* 1994, Oakland, California: New Harbinger Publications.
12. Najavits, L.M., et al., *"Seeking safety": outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence.* J Trauma Stress, 1998. **11**(3): p. 437-56.
13. Ross, C.A., et al., *Dissociative comorbity in 100 chemically dependent patients.* Hosp Community Psychiatry, 1992. **43**(8): p. 840-2.
14. Dunn, G.E., et al., *Dissociative symptoms in a substance abuse population.* Am J Psychiatry, 1993. **150**(7): p. 1043-7.
15. Bollerud, K., *A model for the treatment of trauma-related syndromes among chemically dependent inpatient women.* J Subst Abuse Treat, 1990. **7**(2): p. 83-7.
16. Epstein, J.N., et al., *PTSD as a mediator between childhood rape and alcohol use in adult women.* Child Abuse Negl, 1998. **22**(3): p. 223-34.
17. Felitti, V.J., et al., *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.* Am J Prev Med, 1998. **14**(4): p. 245-58.
18. Najavits, L.M., R.D. Weiss, and S.S. Shaw, *A clinical profile of women with posttraumatic stress disorder and substance dependence.* Psychology of Addictive Behaviors, 1999. **13**(2): p. 98-104.
19. Weinstein, D.W., *Posttraumatic stress disorder, dissociation and substance abuse as long-term sequelae in a population of adult children of substance abusers*. 1998, New York University: New York.
20. Kilpatrick, D.G., et al., *Risk factors for adolescent substance abuse and dependence.* Journal of Consulting and Clinical Psychology, 2000. **68**(1): p. 19-30.

21. Kelley, B.T., T.P. Thornberry, and C.A. Smith, *In the wake of childhood maltreatment*. 1997, Office of Juvenile Justice and Delinquency Prevention, U. S. Department of Justice: Washington, D.C.
22. Bensley, L.S., et al., *Self-reported abuse history and adolescent problem behaviors II: Alcohol and drug use.* . Journal of Adolescent Health, 1999. **24**(3): p. 173-180.
23. Ireland, T. and C.S. Widom, *Childhood victimization and risk for alcohol and drug arrests*, in *National Institute of Justice Research Preview, November, U. S. Department of Justice*. 1995.
24. Selner-O'Hagan, M.B., et al., *Assessing exposure to violence in urban youth.* J Child Psychol Psychiatry, 1998. **39**(2): p. 215-24.
25. Dube, S.R., et al., *Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study.* Jama, 2001. **286**(24): p. 3089-96.
26. Dietz, P.M., et al., *Unintended Pregnancy Among Adult Women Exposed to Abuse or Household Dysfunction During Their Childhood.* Journal of the American Medical Association, 1999. **282**: p. 1359-1364.
27. Hillis, S.D., et al., *Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study.* Pediatrics, 2000. **106**(1): p. E11.
28. Hillis, S.D., et al., *Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study.* Fam Plann Perspect, 2001. **33**(5): p. 206-11.
29. Bloom, S.L., *Creating Sanctuary: Toward the Evolution of Sane Societies*. 1997, New York: Routledge.
30. Rivard, J.C., et al., *Preliminary Results of A Study Examining the Implementation and Effects of a Trauma Recovery Framework for Youths in Residential Treatment.* Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 2005. **26**(1): p. 83-96.
31. Rivard, J.C., *Initial Findings of an Evaluation of a Trauma Recovery Framework in Residential Treatment.* Residential Group Care Quarterly, 2004. **5**(1): p. 3-5.
32. Rivard, J.C., et al., *Implementing a Trauma Recovery Framework for Youths in Residential Treatment.* Child and Adolescent Social Work Journal, 2004. **21**(5): p. 529-550.
33. Rivard, J.C., et al., *Assessing the Implementation and Effects of a Trauma-Focused Intervention for Youths in Residential Treatment.* Psychiatric Quarterly, 2003. **74**(2): p. 137-154.
34. Farragher, B. and S. Yanosy, *Creating a Trauma-Sensitive Culture in Residential Treatment.* Therapeutic Communities, 2005. **26**(1): p. 97-113.
35. Foderaro, J. and R. Ryan, *SAGE: Mapping the course of recovery.* herapeutic Communities: The International Journal for Therapeutic and Supportive Organizations, 2000. **21**(2, Special Issue): p. 93-104.
36. Foderaro, J., *Creating a nonviolent environment: Keeping Sanctuary safe*, in *In Violence: A Public Health Menace and a Public Health Approach*, S. Bloom, Editor. 2001, Karnac Books: London. p. 57-82.
37. Bills, L.J., *Using trauma theory and S.A.G.E. in outpatient psychiatric practice.* Psychiatric Quarterly, 2003. **74**(2): p. 191-203.
38. Jones, M., *Social Psychiatry in Practice*. 1968, Middlesex, England: Penguin.