Creating Sanctuary for Children

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

Keynote Address
Annual Meeting
American Association of Children's Residential Centers
Pasadena, CA
October 20, 2005

Introduction

Autobiography in Five Short Chapters
by Portia Nelson

I walk down the street.
  There is a deep whole in the
  sidewalk.
  I fall in.
  I am lost….. I a helpless.
  It isn't my fault.
  It takes forever to find a way out.
I walk down the same street.
  There is a deep hole in the sidewalk.
  I pretend I don't see it.
  I fall in again.
  I can't believe I am in the same place
  But it isn't my fault.
  It still take a long time to get out.
I walk down the same street.
  There is a deep hole in the sidewalk.
  I see it is there.
  I still fall in …. It's a habit.
  My eyes are open
  I know where I am
  It is my fault.
  I get out immediately.
I walk down the same street.
  There is a deep hole in the sidewalk
  I walk around it.
I walk down a different street.

Years ago, the poet and actress, Portia Nelson wrote a poem that beautifully sums up the process of recovery for adults, children and families. She called it "An Autobiography in Five Short Chapters (Nelson 1994). In her poem, Nelson verbally demonstrates the helplessness and bewilderment associated with the "holes in the sidewalk" that life brings as well as the adaptations we make that result in habits that make it difficult for us to change. Healing, she implies is a learning process in which we must recognize that we did not intentionally bring upon ourselves the painful experiences we sustain, but that once we have fallen, something compels us to "walk down the same street" and for quite some time, we still do not recognize that now we are willing the behavior we are repeating. Only when we have learned that we are trapped in our own habits can we begin to take responsibility for our lives by first walking around the "hole", and then walking down an entirely new "street". This is the way people recover from terrible events – never all at once, and never without stumbling.

The challenge for all of us who wish to help children recover from terrible events is this: How can we promote relationships and whole environments that help children move through the steps that Ms. Nelson has outlined – as rapidly as is possible?

This becomes an extremely pressing question when we fully take on board what is at stake. The situation is urgent – childhood presents windows of opportunity because children are still so actively

developing. Most brain development occurs after birth so that children's experiences play a very large role in determining what kind of people they are going to be, how their brain gets "wired", how they learn to manage their emotional states.

The ACEs Study

As a result of over twenty years of research, we know that traumatic experiences can result in a host of chronic and often life-long physical, emotional, occupational, and social problems. The Adverse Childhood Experiences Study (ACEs) is the largest study of its kind to examine the health and social effects of adverse childhood experiences over the lifespan. The authors of the study asked over 18,000 adults in an HMO in California to categorize their experiences with childhood adversity. The categories included: physical or psychological abuse by parents, contact sexual abuse by anyone, severe physical or emotional neglect as well as living in a household as a child (eighteen years of age or younger) where there was anyone who was: mentally ill, a substance abuser, a victim of domestic violence, or imprisoned. The ACEs score then represented a simple addition of the number of categories of adverse experience. In this list it is important to recognize that exposure to criminal victimization, repetitive violence and community violence were *not* part of the study and therefore the results of the study are likely to have even broader implications for an urban population.

Only 48% of this white, over 50 years of age, middle-class and educated population had an ACEs score of zero. One in four admitted to at least one category of childhood adversity while one in 16 had an ACEs score of four. Sixty-six percent of the women reported at least one childhood experience involving abuse, violence or family strife. Because all the respondents were part of a health maintenance organization, the authors of the study also had access to their complete medical histories. They analyzed this data and found clear and direct relationships between the ACEs score and a wide variety of physical, emotional and social diseases and disabilities. People exposed as children to adverse experiences are at much greater risk for heart disease, chronic lung disease, liver disease, diabetes, obesity and hypertension. Adults with childhood adversity have increased teenage pregnancy rates, divorce rates, depression, suicide attempts, post-traumatic stress disorder, alcoholism, IV drug abuse and dependence, school failure, and unemployment. The higher the ACEs score the more likely people are to have fifty or more sexual intercourse partners, to have sexually transmitted diseases, and to be raped. With an ACEs score of 0, the majority of adults have few if any, risk factors for any of these problems. With an ACEs score of four or more, the majority of adults have multiple risk factors for these problems or the diseases themselves.

As a consequence, children, adolescents, and adults exposed to childhood adversity have a much higher probability of requiring the services of our expensive public systems including special education, child protection, mental health, health and criminal justice services. So profound were these findings that the authors concluded that the ACEs study has demonstrated that childhood adversity appears to determine the

likelihood of the ten most common causes of adult death in the United States [1]. (Felitti, Anda et al. 1998; Dube, Anda et al. 2002; Whitfield, Anda et al. 2003).

Why is exposure to interpersonal violence so problematic across the lifespan? The authors of the ACEs study have proposed an explanatory pyramid to serve as a conceptual framework for understanding the impact of adversity across the lifespan. Exposure to violence in childhood frequently disrupts normal neurodevelopment. These disruptions of critical developmental pathways can result in a wide variety of social, emotional, and cognitive impairments in childhood and throughout adolescence. In late childhood and adolescence, these impairments put children at risk for the adoption of a number of health-risk behaviors like drinking, drugs, smoking, and promiscuity. Over time, these behaviors – and the lifestyles that support the behaviors – lead to disease, disability, social problems and ultimately premature death. In the past these linkages have often been overlooked because they are diverse, complex, and occur over a very long time-line.

There is no longer any excuse for ignoring these connections. Exposure to childhood adversity is costing us the health of our nation and it is costing us economic well-being as well. But despite the fact that publications about this study have been coming out in the literature since 1998, there has been little media coverage of this ground-breaking work. Why is that? Why is it so difficult for the mental health professions and society-at-large to confront what is happening to children in so many American homes and communities? After all, based on the ACEs study and hundreds of other supportive investigations, there is something very, very wrong and it is insidious. The ACEs study combined with several decades of attachment research clearly demonstrate that there is a multigenerational aspect to traumatic experience that is largely unseen perhaps because it is so endemic, affecting individual families, social institutions, economic priorities, and ideological frameworks to such extent that it is invisible, defined as "normal" – holes in the sidewalk that we collectively keep falling into, not walking around. A species that destroys its own children destroys its future and cannot survive.

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[1] For more information about the ACEs study and a complete list of publications visit www.acestudy.org or http://www.cdc.gov/nccdphp/ace/index.htm

But why is it so difficult to understand what it is like when life is lived in a war zone? In part it is difficult because many of us are in denial about things that have happened in our own lives. But in part it is difficult because what happens to people after exposure to trauma – particularly interpersonal violence – seems to defy common sense. After all, it is common sense that people avoid things that scare them, that we avoid pain, that if someone hurts you then you should stay away from that person. It is just common sense that we can tell who can be trusted and who cannot, based on our previous experience with them. It is common sense that people generally learn from their experience, that parents love their children, and that you don't hurt people that you love. And it is just common sense that if something really terrible happens to you, you most definitely will remember it. But despite what we view as common sense, traumatized people frequently put themselves in situations of danger; they often hurt themselves intentionally; they frequently get into and stay in relationships with people who hurt them; they do not seem to learn from experience; they frequently hurt the people they love the most and have been hurt by people who were supposed to care for them. And they sometimes do not remember the worse experiences of their lives.

This defiance of common sense is part of what makes the understanding of traumatic experience in the lives of our clients so difficult. To truly grasp the enormity of the problem, we must change our mental models of how we understand the world and how we understand human pathology. To change mental models means shaking the earth beneath our feet. Picture an iceberg. Think about reality as that iceberg. Most of what we pay attention to is the stuff above the water – the what, where, when, who of daily events, the newspaper headline attitude toward life that is all most of us have the time to pay attention to. If we are so inclined – as therapists for example – then we look a bit below the surface at the patterns and trends that are determining reality. Only rarely does anyone probe the depths of systemic structures - like racism, gender, economic ideology, religious beliefs – that are supporting those patterns and above that, the daily events. And almost never does anyone actually shake the down-deep foundations of thought – the mental models upon which all the rest stands (Senge, Kleiner et al. 1994). But trauma theory does challenge our existing mental models we use to explain human misbehavior in all its form.

Right now, there are three existing explanations for behavioral pathology: 1) people are sick; 2) people are bad; 3) people are both sick and bad. These three explanations in one form or another have been with us for a very long time. In our era, if someone is diagnosed as sick they are likely to be shunted off to the mental health system. If they are decided to be bad, they are shuffled over to the criminal justice system. And if they are both sick and bad, they are likely to go back and forth like a human ping-pong ball because no one really wants to deal with them. These notions of "sickness" and "badness" are mental models that are the foundations for several key social institutions. Trauma theory challenges these mental model ideas by saying that the problems that we see are not the result of "sickness" or "badness" but instead are about *injury*. And there are almost an infinite number of ways human beings can be hurt. A child can be injured genetically, developmentally, physically, emotionally, cognitively,

psychologically, socially, morally, and in any combination of one, more or all of these ways over the lifespan. Let's look at how that happens.

Impact of Recurrent Threat

The problems presented by most children who enter care are a result of exposure to recurrent threat. Their problems are complex and do not lend themselves to simple solutions. Exposure to repetitive violence changes the way the brain works. Children become hypersensitive to threat, so even small stresses produce large and inappropriate responses; the extremist thinking of the acute stress response has become chronic and that combined with their constant attention to even the smallest threat interferes with cognitive development. Aggression and poor impulse control, arguably normal parts of the acute stress response becomes the typical response to a variety of situations, precipitating school, learning, and relational problems. Their inability to manage affect interferes with cognitive development, producing even further difficulties in all those domains. Their affect level tends to be too high for the usual childhood self-soothing techniques to be effective, so this increases the likelihood that the child will turn to some other method of managing distressing emotions: violence, drugs, alcohol, cutting, bingeing, purging, sex, risk-taking or some other problematic behavior. Their responses to abnormal stress and to even the normal stresses of childhood either help them to achieve mastery – or not. If aggressive responses have helped them to feel less helpless, more in control, and achieve a better sense of master, then aggression is likely to become chronic.

Dissociative defenses that may have been life-saving at the time of the traumatic events may become chronically utilized, even under less stressful conditions so that other, more positive forms of stress management are not learned. If they begin having flashbacks along the way, then the intrusive symptoms are likely to create more stress, increase helplessness, and encourage the use of even more dissociation. A child for whom this picture has developed is likely to develop a negative sense of identity, trust, and place in the world. But human beings are adaptive, so children will adapt to adversity by changing their definitions of "normal" – and human beings resist changing anything that has come to feel "normal. One of many important consequences of this adaptation is an increased likelihood that the child will end up reenacting the trauma and in doing so, will be revictimized or may turn to victimizing others.

Under these circumstances, moral intelligence is difficult to develop and the child's sense of meaning, purpose, view of self and others will be powerfully influenced by his or her exposure to violence and the support systems' failure to protect him from harm. Exposure to chronic childhood adversity is like to produce profoundly disrupted attachment relationships that bode ill for future attachments. Children who have been exposed to the abusive use of authority are likely to have difficulty learning how to appropriately use their own personal authority with themselves and with others. Lacking appropriate affect management they are not likely to learn good conflict resolution skills or be able to grieve for the multiple losses they are likely to experience. They may become addicted to stress and therefore resist efforts to help them calm down or learn to self-soothe. All of this– if left untreated – is too frequently associated with continued deterioration, alienation, a foreshortened sense of future, and an inability to imagine any

better alternatives. When these children become parents, they are likely to have difficulty parenting. And the longer this goes on, the more normal it all may feel, and therefore the greater the resistance to change.

What can happen when children, adolescents and adults who have suffered similar experiences of adversity come together to form groups, like gangs, organizations, nations – and of course, families? All human groups respond in typical ways to threat, but for people who have already been exposed to a lifetime of violent behavior, current threats are likely to cause groups responses that are even more exaggerated than would be considered normal – group hyperarousal. Leaders may become bullying and willing to direct aggression at others, projecting anxiety onto any available external enemy, leading to a chronic state of conflict. The attendant increase in authoritarianism leads to a loss of critical judgment skills and an increase in the use of aggression directed at whoever or whatever is designated as the external enemy. Extremist thinking may become chronic and develop into a group norm. Attention to repetitive threat may lead to the exclusion of other possible group goals. In order to protect group unity, the group is likely to silence dissent through deception or force, increasing intragroup violence. Such a group is likely to lose transparency and become more secretive over time. Social norms develop that support the status quo which continues to reinforce the conditions of chronic threat. In the meantime, democratic processes that are more able to respond to complex demands, are eroded and corruption increases. The groups loses a sense of shared purpose and vision and becomes increasingly fragmented, conflicts are not resolved. New and complex problems cannot be adequately addressed and change continues to be resisted.

As I have been describing these troubling symptoms have you been thinking about the children and families you have treated over the years? As clinicians it is understandable that we would want to select out just one or a few of these problems because the complex needs are so overwhelming. Just a simple listing from the problems I have outlined can be overwhelming. No wonder you feel so tired at the end of the day. Helping children to change their life trajectory after years of developmental insults is complex and demanding work.

What does that work entail? All of our helping systems have to recognize and be able to respond to chronic hyperarousal. We must accurately assess the degree of threat that the child or family poses to us, personally and professionally because violent acting-out is always a real potential. At the same time, we must minimize the threatening conditions that surround the child and instead, buffer them with a sense of surrounding safety. Safety, however, turns out to be a complex subject itself. Adequate safety planning must include teaching the child how to become physically, psychologically, socially, and morally safe. We have to help the child's body in any way we can, particularly to minimize physiological hyperarousal. But no one can be with the child all the time, so the child has to be taught how to self-soothe. Children who dissociate need to learn how to keep themselves grounded in order to stop dissociating as a habitual behavior. As we know from the ACEs study, chronic stress is likely to be already taking a toll on the child's body so we must attend to physical health, illness, and fitness.

But all that is just the beginning. We have to find methods to improve cognitive skills, treat whatever addictive or compulsive behaviors have arisen, teach affect management skills and encourage the use of words, rather than behavior, to express feelings. We have to teach the child conflict resolution skills, alter their attitudes toward

authority, address and redirect reenactment behavior. Many traumatized children require specific trauma resolution techniques to stop flashbacks and dissociation. When the time is right, these children need help in working through the grieving process and learning how to let go and say goodbye to the only past they have known. This must happen in the context of learning how to make and sustain healthier relationships with adults and with peers. And I would argue that none of this is possible without the child being pulled toward a better, alternative future that can only happen if the adults around him or her have inspired hope and encouraged the transformation of pain into a survivor mission.

Barriers to Recovery

And there are a number of barriers to recovery, even under the best of circumstances. Children in care are likely to have had multiple disruptions in attachment relationships and they are likely to have experienced some form of child maltreatment – in our residential sample that was documented in 70% of the cases in the study (Rivard, Bloom et al. 2003; Rivard 2004; Rivard, McCorkle et al. 2004; Rivard, Bloom et al. 2005). The children usually do not make a connection between their symptoms and previous experience and they are unlikely to want to talk about these experiences, even if they have the words for such painful feelings. Many cannot even remember the worst parts of the experiences and they would prefer to stay emotionally numb rather than feel the pain that is attached to those traumatic memories. They are likely to remain loyal to their families, even when the family is the source of the trauma, and in many cases, unbeknownst to those who are trying to help, the violence or dysfunction in the family is still going to – and no one wants to talk about it.

But there are other barriers too – as mental health and social service providers, we haven't wanted to talk about the traumatic lives that so many of the children in care actually experience. Certainly most mental health systems have not thus far incorporated knowledge about trauma, nor have other social service systems or school systems. In fact, our helping systems themselves are often fragmented, lacking a common set of basic assumptions, a shared language, clear goals, and a positive vision of the outcomes for the children and families. Then there is the issue of "recovery" – what is it? How should it be defined? Is it a reasonable goal for damaged children? What conflicts exist between a "recovery" model of care and a "traditional" model of care?

The current situation in residential care poignantly illustrates this dilemma. Most residential treatment programs for children cobble together any combination of more than seventeen treatment approaches including individual, group, family, and what gets termed "milieu" treatment (Wells 1991). Every approach is based on certain assumptions – i.e. psychodynamic, cognitive-behavioral, behavioral, family-systems – and in some cases the basic assumptions that then inform staff behavior are in conflict with each other. In some settings there is no meaningfully active theoretical basis at all and line staff tend to do whatever makes sense to them, and this is often similar to what they experienced in their own families – for good or for ill. Any treatment approach that hopes to provide a wide variety of approaches must also have a complex, integrating and synthesizing system and an intensive, sophisticated and constant supervisory and training system.

What frequently happens in the actual lived experience of a residential treatment center however, is that a mishmash of training approaches are all diluted without the costly and time-consuming integrating function occurring. As a result, staff often work at cross-purposes and are inadequately trained to do the work expected of them. As one investigator has pointed out, there is a "lack of manuals, formal training programs for specific programmatic approaches and few centers can 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 and Whittington 1993).

For the most part, the children's past history of trauma does not get directly addressed at all. An example of this is explored in one study of a large residential treatment program which found that therapists reported a substantially low level of knowledge about the exposure to community violence that their clients had experienced (Guterman and Cameron 1999). Instead it is quite usual for a therapist or treatment team to get caught in a child's reenactment of their previous social experience and in doing so the child's traumatic history is reinforced, not treated, by their present residential experience. In part this is due to ignorance – the study of trauma is relatively new and the study of traumatized children is even newer. The National Child Traumatic Stress Network – the federally funded initiative to try to more adequately research treatment methods for children – is only four years old. In part it is due to tremendous resistance in the mental health field specifically, and in society in general to dealing with the vital issue of childhood adversity. As Brian Farragher, COO of a Andrus Children's Center has put it, *"These children have always been with us…It's just that they have shaped us a lot more than we have shaped them"* (Farragher 2004). In part it is due to the enormous stresses that have seized hold of the mental health and health care delivery systems in the last few decades and that are now chronic.

Trauma-Organized Systems and Parallel Processes

It is quite clear that interpersonal violence, particularly in childhood, has very deep-rooted organizing effects on individual ways of relating and being in the world. The individual child has become a "trauma-organized" system and through the way the child relates, the actions that he or she takes, the way he or she is in the world, past abusive events are re-enacted and reinforced (Bentovim 1992). In a parallel process way, our systems also are oriented around the unresolved impact of repetitive stress. Organizations, like individuals, can be traumatized and the result of traumatic experience can be as devastating for organizations as it is for individuals. In fact, I have come to believe that there are complex interactions that occur between traumatized clients, stressed staff, pressured organizations, and social and economic environments that resist positive, trauma-informed change and that instead produce trauma-organized systems. As a result our helping systems frequently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to treat. Let me explain a little more about what I mean.

Chronic Stressors In a Hostile Environment

Not unlike the conditions that many of the children in care have lived with throughout their lives, all of our social service systems today are experiencing significant stress. Since every part of the social service system is in some way dependent on every other part, negative changes in one component of the system reverberates throughout the entire system. Significant changes in health care financing have ravished the mental health care in a variety of ways. There are fewer beds, reduced services, and overloaded professionals. There are fewer training opportunities and less funding for training, fewer staff in care settings, and the staff that are present are often less trained and less professionally developed. There are more regulations, more paperwork and fewer resources to guarantee compliance. The children entering care are extremely aggressive and have often experienced multiple displacements and disrupted attachment schemas before they even enter residential care. Meanwhile, trauma-informed notions of treatment have barely begun to enter the treatment environment, even though the majority of children who come into residential settings have traumatic experiences in their background.

So clear is the dire nature of the overall mental health situation that the National Association of Psychiatric Health Systems has declared that "*The overall infrastructure is under stress, and access to all levels of behavioral health care is affected*"(National Association of Psychiatric Health Systems 2003); the Bazelon Center for Mental Health Law has pointed out that "*the mental health service system in the United States is in crisis, incapable of meeting the needs of hundreds of thousands of people desperately seeking help*"(Bazelon Center for Mental Health Law 2001); and Bush's New Freedom Commission has stated that: "*What seems clear from the national data is that the supply of most types of beds for short-term inpatient psychiatric care has declined with the most severe drop occurring in publicly operated services. This decrease most affects those individuals who have the greatest level of impairment—adults with serious mental illnesses and children with serious emotional disturbance*" (President's New Freedom Commission on Mental Health 2003).

Erosion of Basic Safety and Security

As a result, this sense of tension is felt throughout organizations so that neither the staff nor the administrators feeling particularly safe with their clients or each other. The lack of safety – physical safety – is an important component of daily work for many people who work in mental health. In fact, after law enforcement, persons employed in the mental health sector have the highest rates of all occupations of being victimized while at work or on duty. Professional (social worker/psychiatrist) and custodial care providers in the mental health care field were victimized at rates *more than 3 times* those in the medical field (Bureau of Justice 2001).

Workplaces that are experienced as fundamentally unsafe – physically and emotionally - are experienced collectively as well as individually. When a large number of people collectively experience fear, difficult-to-resolve and even dangerous strategic dilemmas arise that contain within them the potential for violence (Bostock 2002). The tendency of a staff to escalate coercive control measures in psychiatric settings is likely to occur whenever they fear for their own safety, the safety of their colleagues, and when

they do not trust the organizational structures and norms to contain potential or real violence.

Repetitive Crises and Loss of Emotional Management

Many helping environments are characterized by states of constant crisis. Chronic fear states in the individual often have a decidedly negative impact on the quality of cognitive processes, decision making abilities, and emotional management. The impaired thought processes tend to escalate rather than reduce, existing problem so that crisis tends to pile upon crisis without the individual recognizing the patterns of repetition that have seized his or her life decisions.

Organizations respond to crisis in similar and observable ways and significant problems arise when the crisis state is prolonged or repetitive, problems not dissimilar to those we witness in individuals under chronic stress. Organizations can become chronically hyperaroused, functioning in crisis mode, unable to process one difficult experience before another crisis has emerged. The chronic nature of a stressed atmosphere tends to produce a generalized increased level of tension, irritability, short-tempers and even abusive behavior – all signs of impairment in the ability to appropriately manage emotional states. The urgency to act in order to relieve this tension compromises decision making because managers and line staff are unable to weigh and balance multiple options, arrive at compromises, and consider long-term consequences of actions under stress. Decision-making in such organizations tends to deteriorate with increased numbers of poor and impulsive decisions, compromised problem-solving mechanisms, and overly rigid and dichotomous thinking and behavior.

When a crisis hits, most managers want to do the right thing. But one of the things that makes a crisis a crisis is that no one really knows what to do for certain, yet everyone expects the organizational leaders to know what to do. When everyone is under stress, the ability to think complexly will be relatively compromised -an intrinsic part of the stress response itself. Stress increases a person's vigilance towards gathering information, but it can also overly simplify and perceptively distort what is seen and heard. Negative cues are usually magnified and positive cues are diminished or ignored altogether. Furthermore, the stress of an event is determined by the amount and degrees of change involved, not whether this change is good or bad (Appelbaum, Gandell et al. 2000).

All of this severely constrains the ability of staff to constructively confront problems, involve all levels of staff in decision making, engage in complex goal setting and problem solving, or in some cases even talk to each other. Team meetings, information conversations, formal dialogue, shared decision making are known to be important components of healthy work environments but without the time to truly collaborate, an organization loses the capacity to manage the emotions evoked by the stress of the work.

Fragmentation, Dissociation and Organizational Amnesia

Organizations must constantly be learning in order to adapt to changing circumstances. Groups of people learn through experience and via the sharing of information. Under the stress of time pressures and increased demands, communication networks tend to break down both within and between organizations and as this occurs organizational learning slows down or ceases entirely. Memory loss occurs when

information ceases to be shared and when there is little time to draw upon past experience and relate it to present circumstances. As this occurs, service delivery becomes increasingly fragmented and parts of the organization lose touch with other vital parts.

Systematic Error

Normally, it is through the steady flow of information and feedback that we are able to do timely and appropriate error-correction so that when the communication network begins to breakdown, so too does the normal error correction methods, increasingly the likelihood of escalating levels of systematic error. Miscommunication within systems can occur for a variety of reasons: channels may be inadequate for the volume of information that is entering them – they may be too few, too narrow, or too slow.

In mental health organizations, clinical communication networks have traditionally been defined by team meeting structures as well as the informal sharing of information that occurs between people in relatively confined spaces. As time pressures have increased, both informal and formal communication systems have been eroded with staff members in acute settings having little time at all to communicate the valuable informal information and team structures being limited to only the most vital information delivery. With little time or incentive to chart data about the context of the patient's life, the patient file may have relatively little value and be too narrow in form to be of much use. The time delay of information between various shifts or components of the system may increase the likelihood of miscommunication so that a day later, the staff is just beginning to respond to events that have occurred the day or days before. As communication has become more dependent on the technology of computers and email, technological difficulties may also interfere with the direct and immediate conveyance of important information.

Pathologies of information flow can happen when excessive or improper filtering of useful data of the inadequate filtering of useless or erroneous data occurs. For example, when the traumatic roots of mental disorders is ignored and forgotten, and when knowledge of milieu management is lost, then it is likely that information vital to the patients' recovery will be systematically filtered out of the flow of information and judged as irrelevant to the immediate concerns. The loss of psychodynamic and systems perspective means that far-ranging information about context and meaning will be eliminated from discussion and often replaced by or even swamped by erroneous or irrelevant information about details of behavior that do not necessarily lead anyone anywhere.

Increased Authoritarianism

As this situation is evolving, it does so insidiously. Fear-provoking circumstances within an organization are contagious. Within a group, emotional contagion occurs almost instantly and time-honored group responses are likely to emerge automatically (Hatfield, Cacioppo et al. 1994). Threatened groups tend to increase intra-group attachment bonds with each other, and are more likely to be drawn to leaders who appear confident, take control and are willing to tell other people what to do. As time goes on and the situation feels increasingly out of control, organizational leaders respond by

becoming more controlling, instituting ever more punitive measures in an attempt to forestall what appears to be impending chaos.

It is important to understand that under crisis conditions, strong authority behavior by leaders coupled with obedience to authority by followers may be life-saving. In a group confronted by new, unique and dangerous conditions, if someone in a position of authority - or someone with the confidence to assume authority - gives orders that may help us to survive, we are likely to automatically and obediently respond. Lipman-Blumen has studied the dynamics of leadership and has recognized that *"Crises can create circumstances that prompt some leaders, even in democratic societies, to move beyond merely strong leadership to unwarranted authoritarianism. In tumultuous times, toxic leaders' predilection for authoritarianism fits neatly with their anxious followers' heightened insecurity..... Set adrift in threatening and unfamiliar seas, most of us willingly surrender our freedom to any authoritarian captain"*(p.99-100) (Lipman-Blumen 2004).

Chronic crisis results in organizational climates that promote authoritarian behavior that serves to reinforce existing hierarchies and create new ones. Under stress, leaders are likely to feel less comfortable in delegating responsibility to others and in trusting their subordinates with tough assignments when there is a great deal at stake. Instead, they are likely to make more decisions for people and become central to more approvals; this in turn builds a more expensive hierarchy and bureaucracy (p.117) (Ryan and Oestreich 1998). Communication exchanges change and become more formalized and top-down. Command hierarchies becomes less flexible, power becomes more centralized, people below stop communicating openly and as a result, important information is lost from the system. "*It is the increased salience of formal structure that transforms open communication among equals into stylized communications between unequals. Communication dominated by hierarchy activates a different mindset regarding what is and is not communicated and different dynamics regarding who initiates on whom. In situations where there is a clear hierarchy, it is likely that attempts to create interaction among equals is more complex, less well learned, and dropped more quickly in favor of hierarchical communication when stress increases*", p. 138 (Weick 2001).

As this occurs, there is a progressive isolation of leaders, a dumbing-down of staff, and a loss of critical judgment throughout the organization. Everyone knows that something is happening that is all wrong, but no one feels able to halt the descent that is occurring. Helplessness begins to permeate the system so that staff members become helpless in the face of traumatized children, children feel helpless to help themselves or each other, administrators helplessly perceive that their best efforts are ineffective. Under the best of circumstances, democratically-inclined leaders struggle to reinstate participatory processes, often against the resistance of a demoralized staff. Under the worst of circumstances, people in positions of leadership who are already inclined towards authoritarian behavior may become "petty tyrants" who are arbitrary and self-aggrandizing, take pleasure in belittling and humiliating subordinates, discourage initiative and are harshly punitive (Ashforth 1994)

Losses of Participatory Democratic Processes, Learning, Complexity

As fewer people actually participate in decision making and problem solving, decisions are likely to be more short-sighted and ineffective, or worse yet, may compound existing problems. The loss of more democratic processes within the organization results in the systemic loss of the inability to resolve complex problems complexly and the result is gross oversimplification of everything from staff policies to treatment decisions. Authoritarian structures are notably slow to respond to changing conditions but meantime, the organizational climate, the system within which the organization is set, the children, the staff and the families are all changing, sometimes rapidly and the organization cannot keep apace with the rate of change and therefore falls behind.

Impoverished Relationships and Disrupted Attachment

In such an environment, conflicts escalate everywhere, but without time and resources, conflicts cannot be resolved and therefore trust and interpersonal relationships deteriorate. The fundamental problem with creating atmospheres of threat and mistrust is that the more complex the work demands, the greater the necessity for collaboration and integration and therefore the more likely that a system of teamwork will evolve to address complexity. But for a team to function properly there must be a certain level of trust among team members who must all share in the establishment of satisfactory group norms. These are the norms that enable the group to: tolerate the normal amount of anxiety that exists among people working on a task; tolerate uncertainty long enough for creative problem solutions to emerge; promote balanced and integrated decision making so that all essential points of view are synthesized; contain and resolve the inevitable conflicts that arise between members of a group; and complete its tasks (Bloom 2004)

It has been clear to organizational development investigators that trust in the workplace is key to productivity and ultimate to the lifespan of the organization (de Geus 1997). In fact, in the business world, Fortune's "100 Best" companies to work for are more likely to have cultures in which trust flourishes, and have half the turnover rate (12.6% vs. 26%) and nearly twice the applications for employment of companies not on the list (Work & Family Newsbrief 1999). So powerful is the association between organizational trust and success that one organizational theorist, Jeffrey Pfeffer has noted that "*All work place practices and changes should be evaluated by a simple criterion: Do they convey and create trust, or do they signify distrust, and destroy trust and respect among people?"* (Levey 2005).

Disempowerment, Helplessness and Increased Aggression

As the administration becomes more authoritarian and punitive, the staff respond by developing a wide array of acting-out and passive-aggressive behaviors as well as escalating levels of punitive behavior directed at the children. Increased fear and authoritarian behavior combined with a breakdown in communication is likely to lead to an increase in workplace bullying and gives license to those employees who are already prone to engage in bullying behavior to continue and escalate their negative behavior towards others.

Bullying has been show to be associated with higher turnover, increased absenteeism, and decreased commitment and productivity. It has been reported to result

in lower levels of job satisfaction, psychosomatic symptoms, and physical illness as well (Salin 2003). Research has shown that workplace bullying is commonplace in many different organizations and professions including health care and mental health care settings. In one large survey, 8.6% of respondents experienced ongoing bullying and non-sexual harassment at work during the six months prior to the survey (Einarsen 1999).

Bullying behaviors may include social isolation or the silent treatment, rumors, attacking the victim's private life or attitudes, excessive criticism or monitoring of work, withholding information or depriving responsibility and verbal aggression. They may include changing work tasks or making them difficult to perform, personal attacks on the person's private life by ridicule, insults, gossip, being verbally humiliated in public, threats of violence (Einarsen 1999). The main difference between "normal" conflict and bullying is not necessarily what and how it is done, but rather the frequency and longevity of what is done.

Organizational factors are clearly important in the emergence, maintenance, prevention and response to bullying behavior. Thirty years ago Brodsy studied over a thousand cases of work harassment in the U.S. and concluded that for harassment to occur there must be elements in the organizational culture that permit or reward such behavior (Brodsky 1976). Bullying will only occur if the offender believes he has the overt or more usually covert support from superiors for his or her behavior. Organizational tolerance for or lack of sanctions against bullying serves to give implicit permission for the bullying to continue. Aggressive or predatory behavior that starts on a one-to-one level can end up splitting an organization into opposing camps. Conditions that serve as enabling structures and processes that make it possible for bullying to occur include power imbalance between the victim and perpetrator, low perceived costs of bullying from the point of view of the perpetrator, and dissatisfaction and frustration in the workplace.

Unresolved Grief & Demoralization

As standards of care deteriorate and quality assurance standards are lowered, everyone becomes increasingly saddened, frustrated, angry about the loss of former standards of care and their ability to be productive and useful. People and programs depart, while neighboring systems close. The loss of key staff further impairs organizational memory. Over time, leaders and staff lose sight of the essential purpose of their work together and derive little satisfaction from it. Many of the best people find this intolerable and they leave so that the amount of individual dysfunction becomes concentrated in the people who remain. The organization as a whole engages in behavior that is clearly self-destructive and detrimental to the organizational goals and values, but appears blind to this behavior.

When an organization is in this downward spiral, the staff feel increasingly angry, demoralized, burned out, helpless and hopeless – but failing to see the almost insurmountable barriers to recovery that the system has erected, the hopelessness is projected onto the children who are seen as being radically different than previous generations of children, and far less reachable. Ultimately, if this destructive sequence is not arrested, the organization can begin to look and act in uncannily similar ways to the

traumatized children it is supposed to be helping. The result of this process is what I have come to characterize as *Organizational Complex PTSD²*.

If You Want Deeply Rooted Change

Transforming this situation is what I think of when I hear words like "system transformation". Transformation means "A change in an organism which alters its general character and mode of life". In an organizational book aimed at teaching applications of chaos and complexity theory, author J. Goldstein pointed out that *"if you want deeply rooted change, you need to apply deeply rooted methods"*. It is vital that we understand and learn how to manipulate the forces that resist change in our systems just as therapeutic change is dependent upon redirecting individual resistance to change.

I am talking about the need to shift the very foundations of the way we think, what we feel, how we communicate, how we practice. The challenge for everyone in the mental health field is to consider how we unwittingly – and often in the name of science – erect barriers to recovery that prevent self-organization in the individual life of the children in our care and in our organizational lives as well. Our diagnostic categories shame children from the moment they enter care. Our rigid hierarchies prevent participation and innovation. From chaos theory we are learning that "an organization – even one as small as a child – will spontaneously know how to reorganize in the face of a challenge, if the obstacles hindering its capacity to self-organize are removed.

How do we create treatment cultures that promote and support positive change in the children, their families and ourselves? How do we maximize each other's strengths and minimize each other's weaknesses? How do we create workplace cultures that buffer us from the impact of repetitive stress so that we can be effective in helping children and families to recover? These tasks are too large to approach from an individual position. We have to make greater efforts to shape our organizational cultures to achieve more. Organizational culture matters because cultural elements determine strategy, goals, and modes of operating (Schein 1999).

Deliberately creating specific kinds of cultures requires attending more to norms than to rules. Rules are directives for conduct that are imposed by the institution and enforced by the staff through a system of penalties. For children raised in unhealthy environments, status may be achieved by breaking the rules, not following them. Children socialized in subcultures that place a high value on conning, challenging authority figures, aggression and disobedience are likely to use rule-based cultures as ways of proving that they can get around the rules, that they can successfully defy authority, that they can achieve power by breaking the rules. In such climates, the staff spend most of their time trying to enforce rules and applying sanctions.

In contrast, although norms also deal with standards of conduct, they do so through the group pressure that is exerted on individual members. Violation of norms leads to a loss of status not a gain. It is behavior that a group expects of its members.

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² Parts of this paper are excerpted from Bloom, S. L. (2006) Organizational Stress as a Barrier to Trauma-Informed Change. To be published in the website of the National Association of State Mental Health Program Directors.

Creating and sustaining a normative culture requires a large up-front investment of time, energy and resources but in the long-term produces compound interest in the investment. To do so the desired culture must be explicit, consciously and deliberately planned to promote the objectives of the organization. It must be continually monitored both directly and indirectly, while any evidence of a weakening of the culture must produce an immediate, coordinated response by the entire organization. There must be a mechanism to regularly familiarize all members with the norms and it will probably be necessary to manipulate member pressures to insure that high status in the organization is closely associated with conformity to positive prosocial norms.

Creating Sanctuary – A Cultural Context for Change

The Sanctuary Model ® represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and socially derived forms of traumatic experience can be addressed. The Sanctuary Model 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 has since been adapted by residential treatment settings for children, domestic violence shelters, group homes, outpatient settings, substance abuse programs, parenting support programs and has been used in other settings as a method of organizational change.

Creating Sanctuary" refers to the shared experience of creating and maintaining physical, psychological, social and moral safety within a social environment - any social environment - and thus reducing systemic violence. The seven commitments of Sanctuary are tied directly to trauma-informed treatment goals.

CREATING SANCTUARY	
Commitment	*Trauma-informed Goal*
Commitment to Nonviolence	• helping to build safety skills and a commitment to higher goals
Commitment to Emotional Intelligence	• helping to teach emotional management skills
Commitment to Social Learning	• helping to build cognitive skills
Commitment to Democracy	• helping to create civic skills of self-control, self-discipline, and administration of healthy authority
Commitment to Open Communication	• helping to overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries
Commitment to Social Responsibility	• helping to rebuild social connection skills, establish healthy attachment relationships
Commitment to Growth and Change	• helping to restore hope, meaning, purpose

The philosophy of a therapeutic community is central to the Sanctuary Model (Bloom 1997; Norton and Bloom 2004). The Sanctuary Model challenges organizations to reexamine their basic assumptions concerning the extent to which social service

environments promote safety and nonviolence across physical, psychological, social, and moral domains. As such, the intervention is aimed both at strengthening the therapeutic community environment and at empowering people to influence their own lives and communities in positive ways. The core values of a therapeutic community are: the community itself is the most influential factor on treatment; clients are responsible for much of their own treatment; the operation and management of the community should be more democratic than authoritarian; and clients can facilitate each others' treatment (Kennard 1998; Haigh 1999).

The Sanctuary Model adds to these values an emphasis on creating a ''living-learning environment'' which is physically, psychologically, socially, and morally safe for both clients and staff. Establishing and maintaining a therapeutic community in the Sanctuary Model requires an active process of breaking down institutional, societal, professional, and communication barriers that isolate administrators, staff and clients. Simultaneously, the re-building process involves consciously learning new ways to relate as interdependent community members, creating and modeling healthy and supportive relationships between individuals, and developing an atmosphere of hope and non-violence.

In previous research, implementation of the Sanctuary Model has met with many challenges, primarily in changing the way staff conduct business as usual and in changing the organizational culture. In studying children's service systems, investigators found that organizational climates with greater job satisfaction, fairness, cooperation, and personalization, and lower levels of conflict were associated with both service quality and positive outcomes in children's psychosocial functioning (Glisson and Hemmelgarn 1998). We believe that these findings are relevant, not just to children's services but to services directed at all ages of people with complex behavioral and social problems.

Research on the implementation of the Sanctuary Model in a residential treatment setting has demonstrated some key findings that are relevant in planning a community collaboration (Rivard, Bloom et al. 2003; Rivard 2004; Rivard, McCorkle et al. 2004; Rivard, Bloom et al. 2005). Compared to a control group there were significant positive changes in the staff perception of themselves and the clients on the following measures: *Support*: how much clients help and support each other; how supportive staff is toward clients; *Spontaneity*: how much the program encourages the open expression of feelings by clients and staff; *Autonomy*: How self-sufficient and independent clients are in making their own decisions; *Personal Problem Orientation*: the extent to which clients seek to understand their feelings and personal problems; *Safety*: The extent to which staff feel they can challenge their peers and supervisors, they can express opinions in staff meetings, they will not be blamed for problems, and there are clear guidelines for dealing with clients who are aggressive.

Staff became aware that the extent and nature of their own communication was integral to the creation of a safe treatment setting. Similarly, a more psychologically and socially safe environment encouraged staff to openly share their ideas, opinions, frustrations, and mistakes. There was a general observation that the quality of team meetings and case conferences has improved with more active involvement and communication of all staff, and that these meetings provide a forum for practicing how to deal with program issues in non-hierarchical and more complex ways. Factors that promoted implementation included: staff training; use of a shared language and

conceptual framework; community meetings; building in sufficient time for discussing implementation and team building; keeping everyone motivated, capturing successes, promoting group cohesion, a psychoeducational framework for staff and clients, and strong leadership involvement. Factors which posed barriers to model implementation and consistency included: insufficient time to do the constant communication and teambuilding needed; conflicts in the ways in which different components of the program handled crises; lack of consistent and universal training; insufficient leadership involvement.

S.E.L.F.: An Organizing Framework

With such great complexity confronting us where do we begin? How can we help individual trauma survivors recover when our systemic problems stand in the way? "S.E.L.F." is a simple, nonlinear conceptual framework for managing great complexity. As part of the Sanctuary Model (Bloom 1994; Bloom 1997; Bloom 2000), S.E.L.F. provides a cognitive behavioral therapeutic approach for facilitating client movement through the four critical stages of recovery: *Safety* (attaining safety in self, relationships, and environment); *Emotions* (identifying levels of affect and modulating emotion in response to memories, persons, events); *Loss* (feeling grief and dealing with personal losses, resistance to change), and *Future* (trying out new roles, ways of relating and behaving as a "survivor" to ensure personal safety and help others). These four constructs reflect the recurring themes that trauma survivors present regardless of the specific nature of the insults or traumas that they have experienced.

These elements are consistent with other staged models of trauma treatment and recovery, although S.E.L.F. does not proceed in sequential stages but instead works as a simultaneous phased implementation tool of the Sanctuary Model (van der Kolk and van der Hart 1989; Van der Kolk, Brown et al. 1989; Herman 1992). S.E.L.F. helps staff to organize community meetings, staff meetings, treatment planning the psychoeducational curriculum, safety planning, and red flag reviews around one consistent framework. This apparently simple but actually complex quartet of ideas acts more like a compass that can be used as a guide while helping children to move through the difficult recovery process. By using S.E.L.F. children, adults and helpers are able to embrace a shared, non-technical and non-pejorative language that allows them all to see the larger recovery process in perspective. The accessible language demystifies what sometimes is seen as confusing and even insulting clinical or psychological terminology that often confounds people, while still focusing on the aspects of problematic adjustment that pose the greatest difficulties for any treatment environment. S.E.L.F. also offers staff members and the organization as a whole, a conceptual framework for thinking about and working through organizational problems that interfere with the vital work we have before us.

Much of the initial focus in any treatment setting must be on Safety and Emotions. In S.E.L.F. the definition of *Safety* encompasses four domains: physical, psychological, social, and moral.. The development of a safety plan embraces problems as diverse as self-mutilation, running away, aggression, chronic suicidality, interpersonal abusive behavior, racial slurs, rumor-mongering, failing to follow medical directions, and inadequate self care. Most of the problem behaviors and overwhelming emotions that present difficulties for children, adults, clinicians and behavioral health settings reflect

problems with appropriate management of distressing *Emotions* and many modalities of intervention can help children develop better emotional management skills.

Loss can be clinically recognized as a failure to make progress, continued acting-out, reenactment behavior, chronic depressive symptoms, sudden regression, and unresolved bereavement. We found that it was far more productive to talk about "grief" instead of "depression". The concept of grief has sociocultural and time-limited pathways for resolution that are explicit in every culture and that can be brought to bear even upon losses that are highly symbolized or that originate far in the past (Bloom 2002).

Future represents the goal – the hopeful vision of what the future can look like as a result of recovery and includes the willingness to engage in transformation that would lead beyond the "sick" role and requires the assumption of personal and social responsibility, appropriate risk-taking, education, and progressive change in self image, behavior and interpersonal relationships. Support groups based on S.E.L.F. can be conducted in almost any setting and offer a meaningful psychoeducation framework for survivors to begin the process of recovery[3]

The further utility of S.E.L.F. is that it can simultaneously be employed in a parallel process manner to deal with problems that arise within the treatment setting between staff and clients, among members of staff, and between staff and administration. Applied to such issues as staff splitting, inadequate communication, poor morale, rule infraction, absenteeism, administrative withdrawal and helplessness, and misguided leadership, S.E.L.F. can also assist a stressed organization conceptualize its own present dilemma and move into a better future through a course of complex decision making and conflict resolution (Bloom, Bennington-Davis et al. 2003).

Conclusion

The fundamental problem associated with traumatic experience is that victims keep repeating the same destructive intrapsychic and interpersonal behaviors without even recognizing the patterns of repetition and without the skills for managing the extremely distressing emotions associated with change. Traumatic events – and chronic stress – can produce a similar impact on organizations. Without intending to do so, without recognizing that it has happened, entire systems can become "trauma-organized" inadvertently organized around interactively repeating the patterns of repetition that are keeping the individuals they are serving – and their staff members – from learning, growing, and changing. And like individual trauma survivors, systems find it very thaw their frozen parts and reclaim movement.

Children, adults, and organizations represent nonlinear systems – they are alive. They are capable of growth, change – and yes, transformation, but we cannot imagine that applying linear models will help them grow. The solutions to our problems – individual, therapeutic, and social – are possible but only if we learn to tolerate and manage complexity. We must stop pretending that human beings and human systems are machines and recognize their inherent ability to change IF we create climates that promote growth and change, that encourage the *emergence* of innovative and complex solutions to complex problems.

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[3] For more information about a S.E.L.F. group curriculum visit www.sanctuaryweb.com

What I know about healing and recovery I learned from the thousands of trauma survivors we treated in our inpatient program. They taught us that they could not deal with their traumatic past unless they felt safe, that they needed a wide range of skills to draw upon to manage overwhelming and distressing emotions, that they needed the time, patience, and repetition that only a caring relationship can provide in order to work through their losses and say goodbye to the past. But they also taught us that the long and arduous journey of transformation could occur only if they could create a vision of where they wanted to go.

The same rules apply to system transformation – we must be safe with each other, we must draw upon – and integrate – the multiplicity of skills and wisdom that have been developed over the last century, we must recognize and work through our own resistance to change, and to begin that process we must share a vision of where we want to get. Leadership is key to the success of any transformation effort – and not just leadership at the top but leadership at every organizational level.

As a result of our experience in a number of residential treatment programs we have created a Sanctuary Leadership Development Institute (SLDI) at Andrus Children's Center in Yonkers, New York[4]. The institute is comprised of an intensive five-day workshop intended to help a team of organizational leaders create or reclaim a culture where innovation and creativity will thrive. The five-day workshop begins an intensive and transformational process that requires deep commitment and participation from organizational leadership but offers rewards that are both powerful and measurable. The goals are straightforward: to create a truly collaborative and healing environment; to work more effectively and therapeutically with fragile and traumatized children; to improve outcomes; to reduce coercive practices, to build cross-functional teams; to improve staff morale; to increase employee retention; and to reclaim the commitment upon which every child-focused organization was built. The change doesn't start with the children – the change must begin with us. Let's remember that, as Seymour Sarason pointed out, decades ago *"You cannot create the conditions which enable others to change unless those conditions exist for you"*.

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[4] For more information visit www.andruschildren.org

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