Chapter 2

Encountering Trauma, Countertrauma, and Countering Trauma

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Introduction

Avoidance is a primary strategy for dealing with the aftereffects of trauma. Avoiding memories. Avoiding reminders. Avoiding the unintegrated fragments from the past. It wasn't really until I noticed my marked avoidance about working on this chapter that I truly tuned in to my own, long-term countertrauma. My reaction surprised me. Every time I went to begin this chapter, my thoughts remained completely jumbled until something distracted me and I turned to some other project. I have observed the workings of my mind over time and I deal with the past largely by moving on to something pulling me into the future. Good events, bad events fade away, like landscape on a fast-moving train and unless pain or joy have riveted them as memory markers, I am just done with it—illustrating, perhaps, the adaptive uses of dissociation.

The Sanctuary Model is my intellectual "child" and self-care has always been a fundamental component of the model. Nonetheless, it has taken this chapter to compel me to look with a degree of steadfastness at the multiple ways I have been affected by my childhood, training as a psychiatrist, learning about trauma, becoming a trauma therapist, and then changing direction and walking down another path. Richard Gartner has written, "By engaging deeply with the traumatic material, the analyst grows psychologically and spiritually, reciprocally giving to the traumatized patient and gaining, in return, a new understanding of how human beings can survive and triumph over extraordinarily harrowing events." (Gartner, 2014, p. 623, and Chapter 1 this volume). I too have engaged deeply with the traumatic material. I have felt honored by the work that I could do to help

people heal and awed by their ability to survive as well as their commitment to life and healing, even in the face of repetitive rejection and what was often appalling bad treatment.

Around 1990, I was sitting with my team, reviewing our patients' progress, when one of my colleagues gave voice to the paradigm shift that had happened to us as clinicians when he described the change in our fundamental presenting question to our patients from "What's wrong with you?" to "What happened to you?", a phrase that has now become a national slogan (Bloom, 1994). After decades of immersion in the traumatic material that Dr. Gartner refers to, I too went through another paradigm shift for myself when my prevailing and finally life-determining question became, "*Why must these things happen to people in the first place?*" My journey has been one of astonishment, excitement, outrage, betrayal, disgust, and a stubborn insistence on seeing previously unseen patterns while finding hope, laughter, and truth in the face of all of it. In the movie, *Grand Canyon,* Danny Glover's character declares to some thugs he is persuading not to beat a guy whose car has broken down, "You know, it doesn't have to be this way". That phrase could be my epitaph.

The emphasis on our personal experience puts this chapter somewhere within the context of a public confessional, if I am to be honest with the reader and with myself. One of the challenges is to honestly represent the past as well as the present, and inevitably it will be a past that has been worked over by the massaging of information, knowledge, and emotions that occurs over the years. Traumatic memories can remain completely frozen in time, but in thinking about ideas of vicarious trauma, compassion fatigue, and countertrauma it is less about traumatic, fragmenting moments and more about deeper soulful changes that are a result of empathic contact with other people's traumatic memories and how to make sense out of those changes over time.

I decided to use this chapter as a way of making sense, of trying to see patterns I have not seen before, or seen only dimly. The three books I have written about my work follow a pattern—creating, destroying and restoring Sanctuary (Bloom, 1997, 2013; Bloom & Farragher, 2010, 2013). Similarly, this chapter will trace a related pattern as encountering trauma, countertrauma, and countering trauma. Given the theme of this book, I need to focus on my experience with trauma but also try to highlight the factors that promoted my resilience in the face of what I have witnessed.

Encountering Trauma

> It seems eminently reasonable to view the concept of the trauma itself as a potential opportunity for growth; we must seek to determine appropriate procedures as a function of the interaction between the subject, significant others in his social world, and socially skilled professional workers during the period of stress.
>
> (Dr. Maxwell Jones 1968, p. 86 *Beyond the Therapeutic Community: Social Learning and Social Psychiatry*)

My early learning was in the context of a loving home with me at the center as a longed-for and beloved only child. Until adolescence, my parents respected my intellect, encouraged my own decision-making abilities, and were fair to me, even as a young child. I was intelligent and curious, able to mix with adults from early on and gently expected to manage my emotions. My experience of justice, therefore, was experiential, positive, and practical. There were no harsh punishments. When I was very young, my parents left the city where they had lived their whole lives in order to give me the life they had never had. They both had to work hard to pay the bills and keep our home, but I never felt deprived of parental involvement or abandoned. They taught me about hard work and discipline by example. "If you are going to do a job, do it right".

I grew up in a safe, small suburban community and knew nothing about violence. I attended school from nursery school to high school graduation with the same group of children and had good friends. I was active in my community and felt valued and protected, although there was no obvious danger to be protected from. My parents volunteered in the community and conveyed the importance of service. My mother was raised as a Quaker, my father as a Protestant, but he was more skeptical about organized religion. Only my mother cared about religion, and she took me to a Lutheran church where the minister delivered interesting sermons and was inspiring to young people. My parents' key teaching was, "You have to be able to look yourself in the mirror at the end of the day". My childhood taught me that safe and loving homes, embedded within safe, service-oriented communities where people took care of each other, was not a utopian dream but a reality. I did have sanctuary growing up and I know for a fact that things do not have to be the way they are for millions of children today.

There were bumps of course. When I was around six or seven, my dog was killed by a heedless driver while I was out Christmas caroling with my scout troop on the night before Christmas Eve. And, born with visual problems, I had three surgeries on my eyes as well as surgeries for acute appendicitis and a tonsillectomy, all before I was ten. But my parents were protective, kind, and compassionate throughout these experiences so they were not traumatic. My central nervous system was well-buffered by the empathy I received, and since I was a "good child" my medical caregivers were also very good to me. The groundwork was being laid, however, for my future career because I was already calming my parents' empathic distress on these occasions over what was happening to me.

I know most trauma therapists, at least those of us who had been at it for quite some time by the mid-1990s, had our own experience of trauma sometime in our pasts. In adolescence, my development and separation triggered something in my mother that I will never know about in detail, but she became emotionally abusive and my bewildered father withdrew from the battle between us. My emotional development was derailed. As I understand it now, a dramatic rift in my life occurred, a sense of emotional abandonment that affected me and my parents but that was unseen by anyone else. It was this that left me prepared to believe the traumatic stories I was to hear later and to understand that even relatively small disruptions can produce major effects if they occur during the long course of our development. And that families have intergenerational unspoken secrets, while the repetitive patterns of our lives reveal those secrets, even when the details are lost to time.

In adolescence, working in hospitals became my refuge, a pattern that would compound over the years. When I was fifteen I began volunteering in an inner-city hospital and considered myself very lucky when the volunteer director chose to put me in the emergency room. I knew I wanted to go into medicine and the emergency room was the place to be. Over the course of the next two years, I was to have my first encounter with trauma, mostly of the physical sort. I held someone's head still while the surgical resident sewed up his head wound after a fight. I saw the horror of a child brought in after being deliberately submerged in boiling water. I saw my first dead body, touching the man's arm and feeling the unique coldness of death and wondering at the loss of the spiritual force we call life.

But still, I did not experience all this as traumatic myself. I was not intimidated. I loved being there. I felt compassion for suffering people. I wanted to be at the hospital, not at the swimming pool enjoying summers and holidays with my friends. I wanted to avoid being home while also feeling useful. The camaraderie shared with others, the sense of doing sacred work, and of not being scared by it, all helped compensate for the loss I had experienced in my family as a result of the disruptive experiences of adolescence. And my parents approved of it at a time when it was difficult to get their approval for just being myself. Surrounded by caring and supportive adults, even in the frenetic place that was a city emergency room, I could open myself up to the powerful learning experiences I was having without being emotionally overwhelmed.

Meanwhile, in college I had discovered that psychology and sociology, not biology or chemistry, were far more interesting to me. After two years of volunteering, I had to get paying jobs for college and began working in the psychiatry department in the same hospital, first as a secretary and later as a mental health technician. It was there that I first learned about insanity and exactly how much actual sanity often exists among those labeled as mentally ill. And it was there that I first understood the social and political context of mental health treatment. In 1969, Ullman wrote that, "the mentally ill person is seen as a member of an oppressed group, a group deprived of adequate social solutions to the problem of individual growth and development" (Gray, Duhl, & Rizzo, 1969, p.263). In those days, mental illness was viewed as a social construct and therefore the possibility was strong that social forms of intervention could significantly change the outcome for those labeled as "mentally ill."

But it was not at all clear to me exactly how what was happening at a social level produced some people who were mentally ill, some who were socially dysfunctional, and some who seemed to have few problems. These experiences left me determined to go to medical school. Much of that experience is shrouded by time but it was sufficiently positive for me to decide to enter psychiatry, a determination that was present from the time I first entered medical school. Throughout this time, I was learning my profession within the context of the same hospital that provided care for people trapped in dreadful poverty, beset by multigenerational racism as well as the emerging cocaine epidemic.

During my residency, I was under the tutelage of psychiatrists who had been influenced by the intellectual currents of social psychiatry, radical

psychiatry, and psychoanalytic thought that dominated our psychiatric department at the time. In the psychiatric department where I worked and trained, I watched while psychiatrists who were my teachers joined in civil rights and anti-war protests, wrote letters that allowed women to get what were then otherwise illegal abortions, and allowed men to avoid being sent to Vietnam. Some of these psychiatrists were in the forefront of practicing a different kind of psychiatry—therapy that involved the family, therapy that listened to the meaning behind the schizophrenic's unique language, group therapies of all sorts from psychodrama to Tavistock groups, therapy that was socially and politically engaged under the rubric of "community mental health."

They taught me to always question authority, to take into account everyone's point of view in order to understand a complex problem. Common sense, a relatively rare commodity, could be found in some people with little or no education and could be dishearteningly absent in those most highly educated. People needed to be viewed as complex adaptive, self-organizing systems who had the creative ability to change. By constantly challenging us as residents to push beyond our own fixed assumptions and beliefs, and by demonstrating the paradoxes of human existence as they presented in our patients, we learned about complexity by illuminating the absurdity of simplistic solutions. Even in the 1960's my mentor was challenging the growing dogmatism and the reductionist scientism that was already beginning to dominate psychiatry, recognizing psychiatric labels as only sketchy descriptions of an otherwise exceedingly complicated being. He and the people he assembled to work with him, people from different races, professional backgrounds, and socioeconomic classes, created a therapeutic milieu that was an open, compassionate, healing environment for anyone who sought treatment there. Although psychotic patients and people with addictions, then as now, were sometimes prone to violence, and people were frequently admitted because they were suicidal or self-harming, our inpatient unit had an open-door policy and he fervently defended our right as staff and the right of our patients not to live behind locked doors to which other people held the keys. As a result, I discovered that the social environment could powerfully influence a propensity toward violence and that maintaining clear and strong social norms discouraged most forms of acting-out behaviors.

After finishing my residency and working as a staff psychiatrist for two years, I was given the opportunity to create a new program in a community

hospital. By that time, I recognized that I needed to create my own program rather than serve in someone else's. In the turbulent and exciting time that was the 1960's and 1970's, change was in the air. Alongside the anxiety associated with seemingly chaotic and sometimes violent change, there was a surging of hope and vision that was captured in a number of ways that influenced members of my generation, hinting at positive visions of the future for the human race. I brought together a group of talented colleagues and we thought that we could create something entirely new, a system embedded within the mental health system, in which the past no longer would predict the future. Within the small and manageable situation of a psychiatric unit, we could experiment with smaller system change that could have implications for larger scale change. As Maxwell Jones, one of the founders of the democratic therapeutic community, had pointed out, "The psychiatric hospital can be seen as a microcosm of society outside, and its social structure and culture can be changed with relative ease, compared to the world outside" (Jones, 1968, p. xii).

So, in 1980 I led the transformation of a medical-surgical unit in a general hospital in the far suburbs of Philadelphia into a short-term, intensive, unlocked, psychiatric unit designed to be a therapeutic milieu. By 1983, my colleagues and I had a thriving outpatient practice as well. We were doing good work for the community and our patients without having to compromise our ethical and practice standards. We were consulting with the local schools, lecturing regularly at many different venues in the community about mental health issues, interacting with the local churches and other social service agencies. We were faced with few ethical compromises because there was adequate money in the system and we were working in a well-resourced suburban community. We could make a fair living for our services, not have to compromise on the level of care we delivered to our patients, and have enough to accept the losses that inevitably accompanied treating the indigent because of increasing cuts in Federal funding for the poor (Bloom, 1997, 2013).

And by 1983, I was running a health care company. In the beginning I knew nothing about things like health care benefits, profit-sharing plans, management contracts, and corporate legal arrangements but survival of our program depended on developing the business structures that could support it so I had to learn about all of this quickly to prevent our dependence on some other company or institution. I didn't enjoy doing any of these management functions. That is an understatement—I despised

it—but for the next fifteen years this arrangement adequately protected my program, my staff and myself from the increasing degradation of mental health care delivery in this country.

Around 1985, five years after the American Psychiatric Society embodied the results of prolonged exposure to combat trauma in the diagnosis of Post-Traumatic Stress Disorder, my colleagues and I began recognizing that we had been denying the impact of childhood abuse on many of our patients, even though, in many cases, we had that information available to us. Our patients did not suddenly begin telling us about their abuse as a result of influence from us, the media, or anyone else. They had been telling us all along; we had just been refusing to listen (Jacobson & Richardson, 1987). When we reviewed old charts of patients who had been readmitted to our unit we discovered that they often had given us information that only now began to make sense. We had a particularly interesting situation since, being in a relatively stable community with a stable practice, many of our patients were people we treated before and after we had begun to recognize maltreatment as a major causal factor for a wide array of psychopathology, and we were therefore empirically able to see our own "before and after" results. As we expressed a willingness to take this information more seriously and include it in our treatment recommendations, our patients began to respond rather dramatically to the change in us, in our willingness to see them as credible informants about their own histories, as suffering human beings who deserved our respect rather than our disdain.

What we learned was not from textbooks, was not anything we wanted to know about, was not conveyed easily or comfortably to us by our patients. I found a journal entry from that time that expresses what I was feeling:

> *Tuesday, August 12, 1986, 4AM*
> *I wonder if Sartre's nausea was a result of contact with the bleakness and cruelty of life. Dawn* [pseudonym] *remembered being orally raped by her father at four years of age tonight. She saw him take a sledgehammer to her dog's back while the blood spurted out. On his deathbed, he told her he hated her and told her where he kept the pictures he took of the rape. And now I want to throw up too. So this is what they mean by the loss of innocence. I told her that she had been touched by evil and that this had set her apart. I believe that. But*

it doesn't help me accept its reality. Life is so terrifying when denial is penetrated. How would any of us survive without our wonderful defenses?

The reality of child abuse was hard to digest, internally conflictual for us all, made us feel contaminated, de-skilled, angry, guilty, resentful, disgusted, frightened, and sad. Only our respect for these survivors of traumatic experience kept us able and willing to listen. As we began to recognize their courage instead of seeing only their failures, they inadvertently rewarded our "efforts" by improving, and like any other scientific discovery, we suspected that we were on to something quite important, something with major implications for the culture.

We began wrestling with this knowledge on our unit, questioning ourselves and our patients about what it means to be a trauma survivor. We read everything we could find about trauma and abuse, attended conferences, began connecting with other colleagues. We began teaching our patients everything we had been learning. When we began validating the horror and injustice of their experiences and in return offered a comprehensive cognitive framework within which they could understand and begin to restructure their symptoms, treatment became much more effective. Patients previously considered virtually hopeless began to show sustained improvement. Many of these people entered treatment with clear memories of their childhood physical, sexual, or emotional abuse. Others had fragments of memories but began having flashback experiences that were vivid and terrifying. Still others, with symptoms similar to the first two groups, remembered little until after they entered treatment.

For the first several years, we had few preconceptions about the nature of the entire recovery process. This was all new material to us. Little that we had been taught in our various training programs prepared us for what we were inadvertently uncovering. I felt an incredible release of energy as my own psyche and intellect began to integrate this new knowledge into my existing understanding of what makes people—and the world—tick. In the bodies and minds of our patients, it became clear to us that, given the complex biological, psychological, social, and existential impacts of trauma, no one therapeutic approach could possibly hope to respond to this complexity. The psychobiology of trauma, the emerging body of research and clinical wisdom about the multigenerational impact of traumatic experience and its effect on attachment behavior provided us with what we

came to believe was a secure and scientific underpinning for the practice of the therapeutic community as well as multigenerational family therapy. Science was providing a theoretical basis for understanding why such a variety of psychotherapeutic approaches—cognitive-behavioral, exposure, Gestalt, psychodramatic, art, movement—were important to address the complex presentations of trauma. Finally, I saw a door opening on the possibility for healing the extreme fragmentation that has plagued the mental health world for so many years.

In the short-term, cohesive, therapeutic environment that we provided for our patients, we could witness an ideal context for organizing and delivering a wide variety of therapeutic interventions while providing the support and constant supervision that we all needed to effectively do this work. At the same time this context could be designed to—in and of itself—counteract the multiple influences of traumatic experience. In its emphasis on creating a culture of belonging, safety, openness, participation, and empowerment, much of the fundamental damage done by exposure to chronic violence could be counteracted and, if not undone, then transformed (Haigh, 1999). We came to believe that a therapeutic milieu that is truly working is one in which we could create enough turbulence to edge people toward change, toward a critical turning point, while providing a safe enough container so that their choices were somewhat constrained, deterring a deterioration into chaos. In our therapeutic milieu we promoted that turbulence through the work of psychotherapy, through group process, through the everyday friction of social interaction and social learning, and through planned interventions. In a planned therapeutic environment, we contained the turbulence by having a clear value system and coherent practice, based on democratic principles that we all agreed to share as a way of life. We came to see ourselves less as healers or fixers and more as educators and mentors.

By 1991, we decided that we knew enough about the impact of trauma on our patients to establish a specialty unit that at that time we began calling "The Sanctuary®." Over the next ten years, we treated thousands of trauma survivors, most of them suffering from some variant of "complex PTSD" while their diagnoses reflected the entire spectrum of the DSM-IV. We watched "miracles" occur as men and women, many diagnosed as chronically mentally ill, became committed to the process of recovery and turned their lives around. These miracles were not the result of our expertise, since in the early years of understanding the issues around trauma

treatment we were in "beginner's mind"—learning as much from our patients as they were learning from us (Bloom, 1997, 2013).

Little had prepared me for embracing the devastating magnitude of traumatic experience in my culture. For me, the study of traumatic experience was also a political wakeup call. Here I was, comfortably ensconced in suburbia with a lucrative and successful practice and a healthy management contract to operate our program designed to compassionately respond to the needs of the "mentally ill." Having been immersed in the tenets of social psychiatry, we had never completely forgotten our roots, but the mores of the 80's did not lend themselves to philosophical speculation about the sources of oppression that laid the groundwork for our psychiatric care. When I began to recognize that the evolution of the psychiatric problems in the majority of our patients—and at the time these were mostly middle-class Caucasians—began with exposure to violence in childhood, frequently exacerbated by exposure to more violence as adults, it became impossible to ignore the social and political forces around me.

Countertrauma

> In our competitive and insecure world it is hard to find a group climate where there is a sense of security without fear of reprisal. To achieve such a group climate requires a social structure where the sanctions are positive and there is no threat from the abuse of authority.
>
> (Dr. Maxwell Jones 1968, p. 73 *Beyond the Therapeutic Community: Social Learning and Social Psychiatry*)

We were excited by the prospects of change that spread out before us, thrilled by the often seemingly miraculous responses of our patients. I became passionate about the importance of what we were learning and how everyone needed to know about it. But I was working ridiculous hours, cramming two work weeks into one and often working weekends, carrying a full caseload of outpatient therapy cases, treating patients on the unit—sometimes all of them—running the outpatient practice, serving as Medical Director for the psychiatric unit as well as Chair of the psychiatric department and Board Member of the first hospital and later Associate Medical Director of the next hospital. I had also begun giving lectures about trauma and consulting to other agencies. Self-care was impossible—and not even a word in my vocabulary. My friends and closest companions

were the people I worked with and we rarely talked about anything other than work, sometimes long into the night. It exhausted me psychologically and spiritually and thanks only to the strong genetic proclivities of my ancestors did I not burn out physically.

Three journal entries sum up the way I was feeling at the time and for a number of years to come:

January 18, 1988
That terrible lassitude should creep in soon—I give it a week. Then the world's sorrow crowds out my dwindling supply of good cheer. All day, week, month, yearlong—problem chases problem. So many that none get my full attention. Never can I really sit back and say, "Whew, job well done" because in trying to resolve one I am neglecting another. And of course, no one is satisfied with my performance. For each one I am doing more for the other. And meanwhile, my life ebbs away, with all my own loves and hopes and aspirations now crammed into a very few hours each day… I live my life every day feeling like the woman of a thousand faces, one to fit each situation, each new problem.

November 9, 1988
What a dreadful time to live in. I wonder if people have always felt that way.…Corruption is everywhere, even in my little hospital, there's little real concern for children—witness the daycare nightmare, more homeless walk the streets than any time since the Middle Ages thanks to Reagan's cuts to low income housing and the closing of the State mental hospitals, drug abuse and its sister crime is outrageous, I sleep with a gun and bullets beside my bed, no one really seems to give a damn about the environment, the news is filled with horror stories, education is in a complete mess, families are disintegrating or just emotionally killing their members. I see no indications of hope. Money has truly become God. I am badly infected too. But I am embarrassed and ashamed.

December 25, 1988
It is possible to have compassion burnout. One can only listen to unbearably tragic stories for so long before tiring, running, fleeing. The loss of innocence is the loss of a love affair with the present.

As my journal entries reflect, from the beginning of the journey with trauma, I had become increasingly heartsick. My job as an individual therapist, as the medical director for a psychiatric unit, and as the supervisor for several dozen other clinicians meant that over the course of two decades, I was compelled to bear witness to thousands—not hundreds, but thousands—of terrible stories. When it all began, we could not conceive that there could be so much evil in the world. Within a few years, we could not conceive of ever having not known there was so much evil in the world.

Psychoanalysts have long focused on the analyst's need to tolerate intense affect within the transference. Sooner or later, that affect would be negative affect—anger, rage, shame, sadness. More recently, Johnson and Lubin have pointed out how critical it is for the therapist to change the trauma schema, or as we have taught, to avoid getting trapped in other people's reenactment of their trauma scenario (Johson & Lubin, 2015). I discovered that I was very vulnerable to getting caught in these traps and thereby feeling sometimes like a victim, sometimes like a persecutor, sometimes as a collaborator with the perpetrator by playing along with the denial and resistance of the client, and all the while, trying to do the impossible by rescuing other people from something that had already occurred and that was now a part of the past. Before I understood the dynamics of trauma, I really had not understood these very common countertrauma presentations. It was liberating to have concepts and terms to describe this to myself and to share with my team members.

I began to see the mark of trauma everywhere, in ourselves, our histories, our systems and the world around us, and came to recognize the true "parallel process" nature of reality as patients reenacted their experiences with us, we reenacted with each other, and history kept being repeated in the world around us. In a multitude of dramatic ways, our patients demonstrated to us that the personal is indeed political. A significant proportion of mental illness was clearly related to structural injustice and not just to sexism and racism but also to the even more fundamental structural injustice that exists between adults and children. This meant that most of the people we were treating for an untold amount of suffering had problems that were originally entirely PREVENTABLE.

That recognition produced a fault line in my psyche.

My own anger and righteous indignation became uncontainable as I experienced a sense of great and fundamental betrayal. I felt that the whole

point of my career choice had been usurped. I intended to be a doctor, to heal people who were sick. Their sicknesses were said to be of largely indeterminate cause and recovery was not even discussed as a meaningful possibility. Our job, my job, was to reduce symptoms, and in doing so, alleviate suffering. As a physician, I was assigned the responsibility for diagnosis, for treatment planning, for medication management. For the most problematic symptoms, medications were both necessary and inevitable, despite the many side effects that accompanied them. Neurotic symptoms were to be addressed with psychotherapy and sometimes medication. Personality disorders were said to be largely untreatable without intensive, long-term forms of treatment that were becoming increasingly unavailable, so it was advised that we not even try to treat them.

Not for the first time, I felt betrayed by all that I had been taught. As we learned more, we discovered that the knowledge we were discovering as if for the first time, had been there all along—at least much of it. Dr. Jennifer Freyd from the University of Oregon introduced the terms "betrayal trauma" and "betrayal trauma theory" in 1991 (Freyd, 1996). Betrayal Trauma Theory is a theory that predicts that the degree to which a negative event represents a betrayal by a trusted needed other will influence the way in which that event is processed and remembered. The betrayal represents a conflict between external reality and a necessary system of social dependence. As a psychiatrist, functioning within the health care system, I was socially dependent upon the existing acceptable paradigm and I was rapidly discovering that much of what we were taught and that we had taken for granted was essentially bullshit, sometimes entirely false and more often only a partial truth. More had been known—in the 1800's Pierre Janet had written an extensive body of work for exactly what trauma did to people, how it presented as various emotional problems, the role of dissociation, and what treatment had to be—but that knowledge had not been integrated, it had been completely dissociated (van der Hart, Brown, & van der Kolk, 1989). Freud too, as significant as his contributions were, had largely turned away from the meanings in the messages that he was getting from his patients (Herman, 1992).

But at the same time, we began to see that our ability to be a part of what could become a truly human revolution was being eroded away by enormous destructive changes in mental health care delivery that would rip away from us any pretense of having a Sanctuary for ourselves or our patients. Over the course of the twenty years of our program, we had

to reinvent ourselves four times in order to survive, first in 1991, again in 1996, then when our treatment team was split into two in 1999. We experienced these repetitive losses despite an excellent clinical reputation and providing a lucrative financial benefit to the hospitals where we were located. We discovered that although we were able to provide Sanctuary for our patients, there was no Sanctuary for us. We didn't treat patients as inferior beings who behaved like disobedient children, we did not lock our doors, we did not use seclusion and restraint, and our patients frequently got better, even without drugs. Whatever system we were in, we were always a counterculture. As these radical differences became more obvious in each hospital, we had to be extruded. We finally closed the program in 2001 just before the disaster of the World Trade Center bombing. It had become ethically impossible to continue to say we were doing what had become impossible to do—give our patients the tools they needed to recover. Our story was typical. Trauma programs grew and thrived in the 1990's and most had closed or were severely limited a decade later. It also became evident that, in our political beliefs as a result of this "awakening," we were moving in ways diametrically opposed to the mainstream political agenda (Bloom and Farragher, 2010).

Countering Trauma

> In the field of mental health, most attention has been given to psychotherapy, some to mental hygiene, but very little as yet, to the design of a whole culture which will foster healthy personalities.
>
> (Dr. Maxwell Jones 1953, p. vii *The Therapeutic Community: A New Treatment Method in Psychiatry*)

By this time, I had watched many survivors struggle with repetitive loss and with their own lack of ability to imagine anything about the future that was not a repetition of the past. By the early 1990's I knew that my life had to change. I knew I had something to write about and that I had to write my way out of the psychological and real traps I was finding myself caught in but I had no clear idea of my future, no plan. I did not start writing for professional audiences. I had no conceptual frame or ambition about making my way in psychiatry. I was seeing the connections between trauma and the events that were unfolding in the world and I began to write about what I was seeing. I began to see that trauma has

been a central organizing principle not just for individuals and families, but for whole cultures throughout history. I became active in several local and national organizations where I met like-minded people who shared my views.

With my background knowledge in sociology, social psychiatry, and the therapeutic community, I came to feel that my knowledge, experience, and inclinations would be better served by moving upstream into the systems within which our program was so unfortunately embedded. But, I had created an extensive maze of interconnected responsibilities. It took the next fifteen years of my life to disengage and to move on. I had no roadmap, I had no idea where I was going or what I was going to do, or even how I was going to make a living.

In 1998, I co-authored the first book that took a public health approach to the issue of violence and trauma, little knowing that a decade later I would be on the faculty of a school of public health (Bloom & Reichert, 1998). I agreed to serve on the Board of the International Society for Traumatic Stress Studies and was elected as President for the 1998 year. In 1999 I led a statewide task force on family violence for Pennsylvania state government. I began teaching about trauma theory and its implications to anyone who would listen and honed my abilities as a teacher, only to discover that I loved watching students of any sort, educational background, or experience absorb this new knowledge. I began writing about the Sanctuary Model, sending messages in a bottle out to the world about our discoveries. Just before we closed our program for adults, I wanted to find out if "creating Sanctuary" could be taught. I became involved in two long-term projects that enabled me to apply what we had learned about creating environments to treat traumatized adults to the residential care of children (Bloom & Farragher, 2013).

That work has thrived, has produced some positive research findings, and ten years ago led to the development of a training institute. As of this writing we have trained over 300 programs around the country and internationally in the Sanctuary Model and along the way have developed curricula, implementation and training manuals, an implementation method, a certification process, and a network of connected programs to create a community of learning.[1] What has emerged from experience with various therapeutic and social service settings is a plan, process, and method for creating trauma-informed, democratic, nonviolent cultures that are far better equipped to engage in the innovative treatment planning and

implementation, using collective moral imagination that is necessary to adequately respond to the extremely complex and deeply embedded injuries that children, adults, families and whole communities have sustained. In the process of all this, I have learned a great deal about all kinds of systems and how they interface with each other. I have written a trilogy of books and many chapters about systems dysfunction and system change (Bloom, 1997, 2013; Bloom & Farragher, 2010, 2013).[2]

I think that in the early years, many of us thought that scientific discovery alone would be enough to change systems. In reality, systems can change in a way that directly counters everything that science has to offer. Positive, trauma-informed change is going to require concerted, strategic social action and political engagement. The programs that are adopting the Sanctuary Model still represent countercultures within larger systems. The trauma field has provided the scientific underpinning for the human rights movement and somehow we have to bridge the gap between science and activism and offer our knowledge as an invaluable weapon in the war of ideas to those who can effectively use it. Given what I know now about the dynamics of trauma, we live in a culture organized around—and busily reenacting—the unresolved traumatic experiences of the past. For me there is no more important goal than trying to figure out how everything we have learned from trauma survivors across the last very violent century can influence the current of events that is driving all of us toward a future that is unsustainable, and instead move us collectively toward a future worth surviving. That will require a change in our emergent collective consciousness, guided by a morally inspired vision of possibility. After all, now is the human choice point. It doesn't have to be this way.

Notes

1 www.sanctuaryweb.com; www.thesanctuaryinstitute.org.
2 A full listing and most articles are available at www.sanctuaryweb.com.

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