

CITATION: McCorkle, D. and Peacock, C. (2005) Trauma and the isms – A herd of elephants in the room: A Training Vignette. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations* 26(1): 127-133.

TRAUMA AND THE ISMS-A HERD OF ELEPHANTS IN THE ROOM: A TRAINING VIGNETTE

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Abstract

This article explores some of the challenges of training childcare staff of a residential treatment setting in the Sanctuary Model when issues of racism and classism arise. We refer to these as “elephants in the room” – significant obstructions to delivering service that were being denied and ignored and that did not therefore play a significant role in organizing interventions. We explore the ways in which we used the Sanctuary principles to make it possible to engage in meaningful staff discussion about these difficult topics.

Creating Sanctuary® refers to the shared experience of creating and maintaining safety within any social environment (Bloom 1997; Bloom and Reichert 1998). The writers were both involved in implementing the Sanctuary Model in a large residential facility for children and adolescents operated by the Jewish Board of Family and Children's Services of New York. In New York State, Residential Treatment refers to a system that provides care for children referred by the juvenile justice, child welfare,

and/or mental health care systems. Children usually enter residential treatment after a series of unsuccessful placements in lower levels of care, such as foster and group homes. Some children enter residential treatment from inpatient psychiatric units, after which they require a continuous high level of supervision, support and treatment.

Providers of residential services for children routinely focus on issues of safety within the treatment environment. But notions of safety usually revolve around the physical safety of the children who are entrusted to care in residential treatment. Safety for the staff and safety in the context of creating safe community are rarely considered as an important part of the treatment environment (Abramovitz and Bloom 2003). When we began training childcare staff in the Sanctuary Model, the notion that safety for the children could be achieved without paying attention to building a safe community for everyone was one of several “elephants in the room” – significant obstructions to delivering service that were being denied and ignored and that did not therefore play a significant role in organizing interventions. The lack of safe community was greatly exacerbated by the past history of exposure to violence to which the children in the treatment setting had been exposed. From previous studies on the treatment population it was recognized that a large per cent age of youth in the residential treatment facility had behavioral and psychiatric symptoms related to their exposure to violence, trauma and adversity (Guterman and Cameron 1999). The demographics of the children who had been placed in this facility are remarkable for the overwhelming proportion of children of color and their previous history of out-of-home placements and psychiatric hospitalizations (Rivard, Bloom et al. 2003; Rivard 2004) .

Children in residential treatment are often referred by the juvenile justice system. Children of color disproportionately receive harsher consequences for similar crimes by juvenile court judges (Snyder & Sickmund, 1999). The National Mental Health Association reports that although African-American youth are only fifteen percent of the United States population, they are thirty-two percent of delinquency referrals to juvenile court, forty-six percent of juveniles committed to secure institutions, and fifty-two percent of juveniles transferred to adult criminal court. Youth of color who become involved in the juvenile justice system are often in need of intensive mental health services, although they are less likely to receive such support as a result of their delinquent status. Youth of color are also more likely to receive out-of-home placement over probation than their White peers (Snyder & Sickmund, 1999). One such form of out-of-home placement is residential treatment.

Residential treatment of children is under constant stress from under funding, quotas, and strained relationships between staff and administration and staff and youth. At their best, residential treatment programs provide a therapeutic milieu for a large number of traumatized children. At their worst, children simply reenact what has happened to them in their home environments, a situation that results in “trapping them in a seemingly endless feedback loop of destructive repetition that is conveyed from one generation to another via disruptions in attachment relationships” (Bloom and Reichert 1998) p. 168). Organizational systems can become “trauma organized”, shaped by the children’s reenactment of their traumatic experiences more frequently than the treatment setting is able to reshape the children along more constructive lines. Too many critical incidents and “traumatic enactments” push staff into adapting to adversity by avoiding meaningful engagement with the children or by becoming punitive with them. In this

kind of an environment, pressures are exerted on leaders to just DO something and line staff become increasingly passive followers. As this happens, the benefits of team treatment and the power of diversity are lost. Organizational dynamics may inadvertently recreate the differences in power and the routine abuses of power that are so typical of the racist environments that many of these children have already experience. “The Sanctuary Model® represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive, more democratic context within which healing from psychological and social traumatic experience can be addressed. . Participatory democratic processes, characterized by diversity along every dimension, are essential to culture change and to facing painful realities that organizations would sooner deny – the “elephants in the room”.

The elephants of racism, classicism, and white privilege surfaced early on in a senior management retreat that was held to introduce the Sanctuary Model®. The management retreat was mainly White male leaders with a minority of women and people of color. The trainers were White. The beginning phase of creating Sanctuary involves an expanded discussion of shared values and their implications for change. We organize our trainings around the importance of shared values. These values derive from the standards of therapeutic community as practiced in the original in-patient Sanctuary units (Bloom 1994; Bloom 1997; Bills and Bloom 1998; Courtois and Bloom 2000; Bloom, Bennington-Davis et al. 2003). Key values include: a communal atmosphere, group meetings, a belief in the therapeutic role of everyone, participatory democracy, shared authority and responsibility (Bloom 1997; Kennard 1998; Campling and Haigh 1999).

We began by presenting some shared assumptions. The first stated assumption was that a commitment to nonviolence is critical and includes a willingness to maintain four levels of safety: physical, psychological, social, and moral. At this, the group smiled and nodded. The second shared assumption focused on the necessity of flattening the hierarchy of authority and control so that more participation and inclusion could be promoted. Because in this center, leaders tend to be White and childcare workers, people of color, flattening a hierarchy directly and indirectly has enormous implications for systemic racial divides and prejudices. We emphasized that although it is important for leaders to give orders and staff to follow orders in an emergency it is important that the program shift back to a nonhierarchical, network model of power and control after the emergency is past. At this point the group began to look uneasy and the leaders were not smiling. The third assumption was that children in residential treatment are not sick or bad but hurt and injured. At this the group mumbled and it seemed not everyone could buy this assumption. One particular Haitian-American staff person had an unmistakable frown on his face. The trainer nervously mentioned that the implication of a flattened hierarchy was that open and honest discussion is welcomed. The gentleman declined an invitation to respond but indicated that he would test the waters of openness as the day progressed.

After lunch, the trainer again invited the group to express any annoyances or disagreements they might have with the shared assumption lists. The gentleman with the frown spoke up saying that he liked to represent different perspectives and was now willing to speak his mind. We knew we had done the right thing in putting this presentation on an authentic footing but my internal radar was unprepared to respond to

his comment. “This project sounds like several white people telling a whole lot of black people how to care for a whole lot of black children.” This courageous gentleman was addressing at least three elephants in the room - classism, racism and White privilege. Open communication had been minimal in the morning but as the afternoon progressed the communication became increasingly open. This gentleman became my colleague and became one of the most powerful trainers of the Sanctuary Model.

The violence of racism has been traumatizing to large groups of people and is often not addressed in institutional settings, even when racial divisions are clear and present. Because the racism is embedded in the system and not necessarily overtly expressed in any way, the presence of racism and other forms of discrimination are frequently denied, avoided, and ignored. But just as abused, neglected children have experienced a violation of a basic sense of justice, the impact of racial injustice must be addressed institutionally. “The chronic, institutional stresses of poverty and racism are examples of social forces that can be termed traumatogenic in that they breed interpersonal traumatic acts (Bloom and Reichert 1998) p. 37.

From that day on, we have continued to address racism and disempowerment in our institution. An example is that most of our clinical directors and supervisors are White and the vast majority of milieu workers who are with the children twenty-four hours and seven days a week are people of color (African American, African Caribbean, Dominican, Haitian and Puerto Rican). Prior to the introduction of Sanctuary and the subsequent flattening of hierarchy, the seating patterns in a treatment conference generally reflected race and class divisions with White, Middle Class staff seated at one end of the table and people of “other races “ and classes seated at the other end of the table. The White, Middle Class staff often participated actively and the people of “other races” were more passive and appeared tired and disenfranchised. Currently, we assess the success of a Sanctuary Treatment Conference by the amount of shared participation by all staff. The basis of social relationship is reciprocity and the basis of an effective therapeutic milieu is that everyone has an equal role.

There is an undeniable parallel between the lack of basic justice that abused and neglected children experience and the experience of racism and classism experienced by the children and many of that staff that is another form of basic injustice. These injustices have become institutionalized. At a recent Ground Rounds trauma case presentation, all staff were presenters not just the “privileged” staff with letters after their name. As a result of recruitment and retention of racially diverse staff, this presentation was racially diverse. Racial and class issues now have a better opportunity to be addressed. “If the milieu of the program is one of openness and sensitivity to differences, racially diverse students and faculty can create a healthy tension in the program that enhances racial awareness and sensitivity” (P. 29).

In a Sanctuary program all disciplines are trained together on the tenets of the model. The purpose of holding joint trainings is to allow for multiple perspectives. The variety of professionals in the training are able to learn from one another. In the first example, the milieu counselor’s opinion was heard by other employees, such as social workers and a psychiatrist. Perhaps these latter individuals were not aware of the racial implications that the milieu counselor raised. This is the beginning state of creating an environment which honors open and honest communication.

Leaders are included in the Sanctuary training. This is a direct enactment of the leveling of hierarchy assumption. As a result of training all levels and disciplines together, employees are aware from the beginning stages of implementation that leveling of hierarchy is an essential part of the Sanctuary model.

In a Sanctuary unit, staff and residents gather twice daily for community meetings. During these meetings there is time for discussing any community issues that staff or residents might want to raise. This opportunity creates a fair, democratic and equal opportunity system because the residents are active agents in the treatment for themselves and their peers. Community meetings also give residents the opportunity to formally express disapproval or praise about aspects of the program. Two basic examples are children voting on what kind of snack to have after school, and what time of day they are allowed “free time.” These decisions are not made solely by the adults in charge; the children are given a voice and are empowered by this aspect of the leveling of hierarchy.

In Sanctuary units, all staff have knowledge about the residents’ history, including any incidents of trauma exposure. This is to the benefit of the residents. For example, when a child is reenacting her trauma on the unit, unless the milieu counselor knows the history, she may not respond in the most appropriate and effective manner. Additionally, the milieu counselors are able to share how the trauma history is impacting the current behavior of the child. Ultimately, when everyone on the Team knows the history, they can work together more collaboratively to provide the best possible treatment.

In residential treatment, children spend the majority of their time outside of school with milieu counselors. Sanctuary honors all members of the team as therapeutic change agents. Treatment does not just happen in the social worker’s office, but in the cottage with all members of the community. Each child has a safety plan, which is an individualized list of self-chosen options to use when feeling upset or overwhelmed. The child receives assistance writing this plan with her social worker and primary milieu counselor, and is encouraged to call upon all safe adults in the Sanctuary environment for support. Children benefit when they can access safe and supportive people in their community. The leveling of hierarchy honors this process.

To not recognize and treat work stress is to ignore our core belief of providing emotional and social safety for residents and staff. These are collective problems that reflect another Sanctuary value that collective disturbances require collective responsibility. If there is an “incident” in one of our units, it is our practice to call the whole community together to address what we could have done and will do in the future to prevent collective disturbances of disrespect, physical aggression, personal property respect and sexual boundary issues.

Another outcome is training in supervision of staff that is strength based which validates the challenges and stressors of staff in balance with what should be. Just as therapy is about healing and connection, supervision must also be about validation and support in balance with what needs improvement. Maintaining our human connections is essential to lessening oppression.

Overall, we are committed to talking about the oppression of the “isms”. Martin Luther King Jr. reminds us that we are all entangled in a web of mutuality. We are committed to finding every opportunity to name racism, classicism, sexism, homophobia, and other forms of oppression without blaming but through exploring all of our identities.

“The degree to which therapists (all child care givers) understand themselves racially provides the foundation for taking the next difficult step of confronting the ways in which they may collude with a pro-racist ideology (p. 126). Pro-racist ideology is synonymous with White privilege and is defined as the “generalized belief that espouses and supports the superiority of Whites (P. 119). The more we are able to expose ourselves to how pro-racist ideology works, the more able we are to become racially sensitive. In supervising or advising residents, we often ask, “If you feel I am being racist, I hope you will let me know”. Only by challenging ourselves can we begin to challenge others. In a recent *Psychotherapy Networker* article, Dee Watts-Jones writes of the importance of addressing racist language in whatever form it appears : “This means continually being open to seeing the ways in which oppression hides in me and others, and to invite others to see as well, and to act” (p. 28)

In a *Family Networker* article, Kenneth V. Hardy has written an article about his own painful experience of “DWB (Driving While Black)” when he was brutalized by police officers. This ordeal challenged him to go beyond working with the problems of individuals and to take on the collective disturbances of larger social problems. “I don’t believe that relationships can thrive when pressed against a backdrop of oppression or voicelessness. Everything is connected: social prejudice and fractured relationships; psychology and ecology; domination and subjugation (p. 53).

It was impossible to talk about creating Sanctuary without addressing the isms of racism and classism. Strained relationships needed to be addressed by open and honest discussions of how power is differentiated. The risk taken by our colleague was the beginning of a democratic forum reflected in Martin Luther King Junior’s statement that “There comes a time when silence is betrayal.”

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