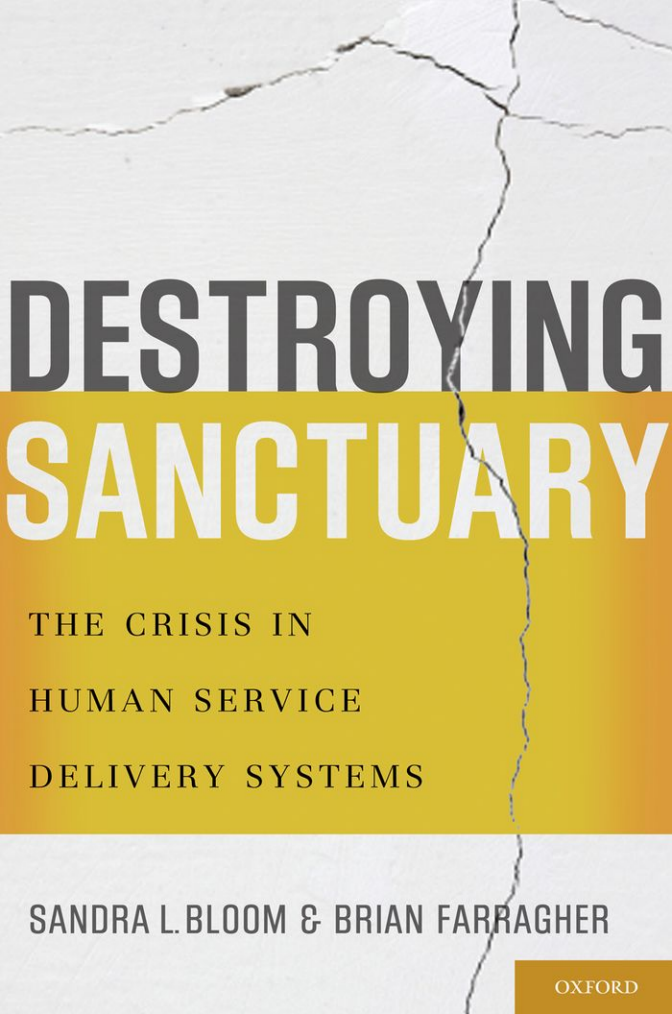
DESTROYING
SANCTUARY
THE CRISIS IN
HUMAN SERVICE
DELIVERY SYSTEMS
SANDRA L. BLOOM & BRIAN FARRAGHER
OXFORD

DESTROYING SANCTUARY

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Destroying Sanctuary

The Crisis in Human Service Delivery Systems

Sandra L. Bloom, MD
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This book is dedicated to the administrators, managers, direct and indirect care staff in our healthcare, mental health, and social services who, every day, are willing to take on the emotional labor of doing whatever they can do to relieve the suffering of those in their care.

The world is a daycare center and we are each given some toys to play with.

Roy Stern, M.D.

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Preface

Looking back over the last 40 years, I can truthfully say that I know a great deal about the stresses and strains of starting, working in, managing, closing, then starting again and again and again, mental health programs. I began this work in the 1960s as a psychiatric department secretary and then a mental health technician. From the 1970s through 2001, I went to medical school, trained as a psychiatrist, ran five renditions of our inpatient psychiatric treatment program, managed an outpatient practice, maintained a large inpatient and outpatient private psychotherapy practice, chaired a department, owned a business, supervised professional and nonprofessional staff, and became a novice researcher. In this most recent decade I have become a writer, a teacher, and a consultant to almost every kind of social service delivery program for children, adolescents, and adults.

This book is a direct outcome of that varied experience and my passionate regard for the people who do the kind of work we do, trying as best we can, for as long as we can, to relieve the suffering of others. I know how difficult it is to provide social service work, and I know how frequently our services fail to measure up to the standards of critics or of ourselves. In 1997, my first book, *Creating Sanctuary: Toward the Evolution of Sane Societies*, was published. It described the intellectual and emotional journey of a team of mental health providers, colleagues, and friends, who happened upon the knowledge that most of the people they were treating as inpatients, and as outpatients, had been exposed to significant adversity usually beginning in childhood [1]. That adversity had changed them, had played a determining role in their cognitive, emotional, behavioral, social, and moral problems. As we wrestled with this new information, their exposure to adversity and all that went along with it changed us as well. We experienced a shift in our paradigm for viewing ourselves, other people, and the world around us. In the Introduction to that book, I said that my worldview had "*changed almost entirely as a result of what I have learned about what happens to human beings who are exposed to overwhelming stress*" (p. 13). That shift was best captured by one of my colleagues, Joe Foderaro, when he noted that we seemed to have changed the foundational question asked of troubled people, "*What's wrong with you?*" to the very different question, "*What happened to you?*" (p. 476) [2].

When I wrote that book I knew that our core values were radically diverging from the evolving values of the overarching U.S. health care system because what has become known as managed care was shifting the emphasis from what

we considered quality care to profitable care. As this happened, patients stopped being the customer. Instead the customer became the largely for-profit managed care companies that became the middle managers between the service delivery programs and the insurance companies. Under these conditions, psychiatric beds were eliminated and the competition for filling the beds became more intense. The result was that specialty programs were no longer encouraged, and although we continued to be a profitable venture for the hospitals where we were located, it became possible to fill the hospital beds without having to hire specialists. I also think that the work we were doing, creating what has since been termed a "trauma-informed culture" was too disturbing, too challenging of existing mental models at a time of overwhelming adjustment and change for the systems we worked within. Thus, the program I described in that first book, moved to a new hospital in 1996, moved again in 1999 and divided into two separate programs, and we ultimately decided to close the program in 2001 rather than face the degradation and humiliation of slow and strangulating program demise.

Toward the end of that first book, I described work that still had to be done, as I saw it at that time. I noted that our program was struggling to survive under increasingly dismal conditions for the delivery of human services. I described a status quo of cutbacks in spending on programs and personnel in mental health, an almost exclusive focus on biological treatments, and significant decreases in the ability to provide psychotherapy and social therapy. As an organizational leader, I had also discovered that the greatest source of stress to leaders does not usually derive from internal problems—at least not at first—but from dealing with the world outside. "*We learned that the health of our system would always be limited by the health of the systems within which we were embedded*" (p. 182) [1] .

At that time, my main motivation for writing the book was memorializing an experience that I believed was drawing to a close. I believed that our work meant little if it remained the product of a unique group of personalities working in a specific place during a specific time. For me, writing that book was the beginning of a grieving process, a letting go of what had been the purpose of my life up to that point: treating adults as a psychiatrist on an inpatient unit and following many of those same people in long-term psychotherapy. But it was also a message in a bottle that I launched out into the ocean of information and hoped that someone, someday would pick up, read, and use.

To my surprise, the ocean of information was not as vast or impersonal as I had imagined. People did begin to respond to the message I had launched into the world even before the World Wide Web was much of a force. By that time, I had been winding down my clinical psychiatric practice and had begun consulting to and training a wide variety of mental health and other mental health, social service, and health care programs in what it means to help

very traumatized people. I had the opportunity to interact with people working in inpatient and outpatient mental health programs for children and adults, domestic violence shelters, homeless shelters, emergency rooms, medical schools, health clinics, home visitation programs, HIV programs, child protection services, substance abuse facilities, and others. In traveling all around the country and internationally, I began to see the universal nature of the system problems that I had personally experienced in moving our program five times in 10 years.

Gradually I came to recognize that organizations are alive, and that as individuals, we can become very closely identified with the organizations that we join. I watched an organization come alive and learned what it meant to feed it, nurture it, revel in its successes, and suffer heartache when it failed. I learned what it is like to spring to the defense of a program when it is attacked, and to lose your own personal certainty and safety in the face of organizational demands. I discovered what it is like to face up to and face down a wide variety of leadership experiences that test one's inner strengths, fortitude, self-awareness, emotional intelligence, and beliefs. I witnessed the conflict over divided loyalties when sometimes people defended their organization instead of protecting the people in their care. And I had come to understand what it is like to mourn a system when it dies.

In the late 1990s, I had the opportunity to start a relationship with the Jewish Board of Children and Family Services (JBFCS) in New York to implement what we had started and I had written about—The Sanctuary® Model—in children's residential services. We obtained a grant from the National Institute of Mental Health to study the process of implementation, and this resulted in some significant positive changes that have led the Sanctuary Model to become an "evidence-supported" practice.

In 2000 I began consulting with the Julia Dyckman Andrus Memorial Center, or as it is more familiarly known, Andrus Children's Center. It was there that I met Brian Farragher and started a collaboration that has led to the development of the Sanctuary Institute, an outcome I never imagined in 1997 when the book about our experiences was published. Now I know what it looks like as organizations gradually, painfully, and sometimes traumatically transform themselves into something they were not born to be and as leaders within these organizations find themselves as excited, invigorated, and exhausted as any new mother. As of this writing, over 100 programs—residential and acute care mental health facilities for children and adults, substance abuse programs for adolescents and adults, homeless shelters, an urban child welfare program, an academic program, private hospitals and state hospitals, an insurance company, domestic violence shelters, and juvenile justice facilities, from coast to coast, across the Atlantic and the Pacific—have been through our Sanctuary Institute training and have become part of the Sanctuary Network.

This growing network of interconnected programs is setting new standards for what it truly means to have "trauma-informed" care for a wide variety of children and adults who have experienced repetitive exposure to adversity and trauma. Hundreds of administrators and thousands of clinicians and front-line workers are endeavoring to discover the keys to expanding democratic workplace practices, improving the quality of care, achieving better outcomes for the clients and better workplace environments for themselves, and transforming their systems to meet the needs of the twenty-first century.

I would like to express my gratitude to the Board of Trustees, the staff, and the administrators at Andrus Children's Center, and most of all to Nancy Ment, Brian Farragher, Sarah Yanosy, Lorelei Vargas and the entire faculty of the Sanctuary Institute for their unswavering support and commitment. None of us envisioned over ten years ago, that the Sanctuary Institute would be the good news of the beginning of this century. I am also very grateful to all of the state agencies, funding organizations, administrators, and staff members who are participating in the Sanctuary Network. They struggle with the issues we describe in these chapters, every day, often foregoing their own needs and desires to help the children and adults in their care. I also would like to thank Maggie Bennington-Davis and Tim Murphy as well as Kathy Wellbank and Cynthia Figueroa, and Judy Dogin who by their efforts helped me to believe that teaching this work to other programs was indeed possible.

In addition to my work with the Sanctuary Institute, I serve on the faculty of the Drexel University School of Public Health and am Co-Director with Dr. John Rich and Dr. Ted Corbin, of the Center for Nonviolence and Social Justice. Along with Linda Rich, Ann Wilson, Dionne Delgado, and our other staff members, we have the opportunity to explore what it means to view violence as a public health problem instead of simply an individual problem and put into practice some ideas about prevention. I am grateful to Dean Marla Gold, Dr. Arthur Evans, Director of Behavioral Health for the City of Philadelphia, and to Joe Pyle and the Scattergood Foundation for their continuing support of our work.

My mentor, who taught me all about how goofy systems can be a very long time ago, Dr. Roy Stern, says he doesn't remember saying what I wrote down as the epigraph of the book, but that may speak to how much we are both misremembering as we age—I know he said it! But I haven't misremembered the love and support from my parents, Dorothy and Charles Treen, and am grateful that I have been lucky enough to share most of my Dad's 95 years with him.

Whatever wisdom resides within these pages has been cultivated through interaction with many people over the years but most importantly, Joe Foderaro, RuthAnn Ryan, Beverly Haas, Lyndra Bills, Liz Kuh, Carol Tracy and. I am grateful for their continued laughter, friendship and support.

This book is about what happens to human service programs under the impact of unrelenting stress and multiple losses. At the urging of my colleague, Dr. Lyndra Bills, who has been "along for the ride" with me for the last 17 years, we have titled it *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* because that is what has been happening for the last several decades. The important places of refuge—of sanctuary—for the most injured among us are in great jeopardy and are being destroyed. Never perfect places of safety in the first place, many mental health systems, health care systems, and social service programs of every size, shape, and variety are collapsing under over 30 years of system fragmentation even while public costs have escalated dramatically.

This book is the first of two volumes. In it we describe the problems we are facing and some causes for those problems. The next volume, *Restoring Sanctuary: A New Operating System for Trauma-Informed Organizations*, will describe what we have learned about the elements necessary for creating safe and healing organizational cultures in the world we live in today. Taken together, *Creating Sanctuary, Destroying Sanctuary,* and *Restoring Sanctuary* represent the cycle of life, at least mine so far. Throughout these past 40 years, although the rate of change in almost everything has become increasingly rapid, there is one thing that has not changed at all about the human race and that is the need for Sanctuary.

Sandra L. Bloom, MD

By 2000 the staff and administration at Andrus Children's Center had been intensively working on reducing the amount of restraints of children in our residential facility and exploring the outer dimensions of what it means to have a "trauma-informed system" for several years. When we at Andrus met Dr. Bloom and her team, we recognized our shared strengths and weaknesses and how we could complement each other. As a pioneer in applying a psychobiological understanding of traumatic experience to adults who had been abused as children, Dr. Sandy Bloom already had 20 years of experience in specially designed inpatient and outpatient treatment programs to treat psychological trauma and had consulted in a wide variety of other settings. I had extensive experience in the residential treatment of children and in management and had just become Chief Operating Officer at Andrus and had been the Campus Director at Andrus for approximately 6 years.

After many discussions, our Sanctuary process actually took off in the summer of 2001, so very early in the process we were confronted with the attacks of September 11th. The Andrus Children's Center is located in Yonkers, New York, just north of Manhattan so some people in the first Core Team lost close friends and family members. My brother Tom, is a New York City Firefighter as were many of the people I grew up with in Rockaway Beach. All of us were stunned and shocked by the images we saw nightly on the television,

and we all had our sense of safety and security shaken in a major way. However, these events provided us with a powerful experiential learning opportunity about the nature of trauma and the impact it had on each of us. We talked about how it was hard to concentrate, to sleep, how irritable some of us were. These events were imprinted on our minds, and many of us will never look at a clear blue sky in the same way or hear a plane flying over head without thinking about that day. It became easier to imagine what life might be like for children who have had daily experiences of shock, betrayal, loss, or devastation. These events changed how we looked at the world, how we looked at each other, and how we looked at the kids.

Our collaboration has led to the development of the Sanctuary Institute, a training program for organizations who have the dedication and commitment (and some would say, the sheer madness) to engage in system change during difficult times. This book represents a snapshot of what we have learned to this point about the stresses and strains of trying our best to create healing environments for very injured children, adolescents, and their families.

Our hope in writing this book and in creating the Sanctuary Institute and the Sanctuary Network is that we can create a critical mass of people who can and will begin to push back. Let's face it: we know what is happening and why things are going in this wrong direction. It's not just about good and evil—it is about understanding how people and systems react under stress and being able to use this knowledge to think about how we can get better results in spite of the fact that we are under a great deal of pressure, stress, and strain ourselves. For most of the programs and systems we work with, this process is not like moving a sailboat, it's like moving the largest ship in the world and it takes time, practice, and getting a lot of people onboard. But if we can do it, we know other people can, too.

Meanwhile, I want to thank Nancy Ment, our C.E.O for being my partner in this venture all along the way and all of the people at Andrus: the staff, the management, the Board, and the kids and their families, who have taught me and inspired me for a very long time. Most of all I want to thank my very patient wife, Ann, and my kids, Brian and Katie, for their love and support. Without them, nothing works for me.

Brian Farragher, LCSW, MBA

Prologue: October 1996

Background

The narrative below is taken from material written by the management team of an adult inpatient, acute care mental health program in October 1996. The original Sanctuary® program, specializing in treating adults who had exposed to severe adversity as children in an acute care psychiatric setting, lasted for 10 years following the previous decade of development. This narrative was written at almost the precise halfway point in the life of that program. We had already treated several thousand trauma survivors and would treat several thousand more before we closed. I (Sandy) was in the middle of writing a book about the profound experiences that my colleagues and I had encountered along this journey of becoming "trauma-informed" and that book would be published the next year under the title, *Creating Sanctuary: Toward the Evolution of Sane Societies* [1].

All of our patients had very complex problems, co-occurring disorders, and comorbid physical conditions. They suffered from depression, various shades of psychosis, dissociative disorders, phobias, panic states, and other forms of anxiety. Their personalities had been skewed by the developmental impact of childhood adversity in a wide variety of ways. Many of them had experienced adult trauma as well as childhood adversity—everything from severe gunshot injuries, to domestic violence, to sexual assault, and even one truck driver who had the misfortune to be driving through Oklahoma City in 1995 at the time of the bombing. We treated people who were well-educated middle-class professionals, and we treated people who had grown up in extreme poverty who had very little education at all. We treated people with criminal histories, and we treated Philadelphia policemen who had been severely injured on the job and had posttraumatic stress disorder. We saw Vietnam veterans, Holocaust survivors, one alleged contract killer in his twilight years, and one madam of a "house of ill repute."

At the time when this report was made, we had just been forced to move the program from a for-profit hospital in the suburbs of Philadelphia, to a more urban, nonprofit hospital. Three members of this team, however, had been together for 16 years at this point, doing inpatient work that had evolved into The Sanctuary. The Sanctuary program itself would survive for 5 more years and would need to move again in 1999, split into two separate programs, and finally close in 2001. The situation we had left was ideal, during a very good era

for the development of innovative services in private mental health settings. This account reflects our difficulties in adjusting to a new, and less welcoming, environment, in a not-for-profit hospital that was struggling to survive in an ever-more "managed" environment. On this particular day, the management team for *The Sanctuary* met from noon to five o'clock on Friday, October 25, 1996 to discuss the current situation on the unit and make recommendations for change. In attendance were all three Sanctuary psychiatrists, the Director of Social Work, the Clinical Coordinator, three creative therapists, two social workers, two primary therapists, the head nurse, and a social work student. The following is a summary of the retreat written immediately afterwards based on notes recording each person's comments. We believe these notes present a shared personal and collective background for this book.

Sanctuary Retreat, October 25, 1996

The most pervasive complaints voiced by everyone relate to problems with the pace of treatment and space constraints in our present physical setting. Last year we averaged 1.28 admissions a day. Since moving here the number of admissions has risen by 65%. At the same time the length of stay has decreased from an average length of stay of 14 days down to 9.8 days, a 30% drop that is predicted to continue to go lower [the length of stay did go down to 5 days].

The results of this dramatic and sudden increase in pace are manifold, dynamic, and interactive. We are accustomed to having frequent close communication between all members of the treatment team. We attribute much of our success to this level of communication, which has always provided a web of connection and support. Basically, we have always have had a "safety net" around our program that is invisible but very strong. It's really why we can contain people who are doing and saying dangerous things without locking anybody in, because that safety net keeps everyone safe. We stop dangerous things from happening before they happen because we know when something is wrong. It is unlikely that any patients will "fall through the cracks" and be ignored because every patient is connected to a number of people on the team and through those relationships connected to the entire team and the rest of the community—just like in a real web. Various members of the treatment team can get to know important aspects of each patient and then the information can be pooled in an efficient manner so that each patient's problems can be understood and explored in depth.

But our staffing pattern was designed to meet the treatment needs of a maximum of 22 patients, when our average occupancy was around 80%, meaning that periods of a full census would be interspersed with periods of a lower census. It's like having a weekend to do your laundry, change the sheets, clean the house, and go food shopping in the sense that during the down period the treatment team could catch up on all the things we don't get time to do when the myriad details of

running a good program—completing medical records, returning phone calls, program development, program evaluation, quality assurance, training, and supervision. These periods also provided an opportunity for the staff to emotionally refuel, reconnect with each other, debrief from the very high level of stress entailed in intensively treating victims of trauma, share new learning, and intellectually integrate the overall experience.

In our present situation we are operating 24 beds at 100%+ capacity (sometimes the administration puts extra beds in the hallway). In addition to this, whenever an empty bed becomes available the hospital is using our unit to board other patients who should not be—and don't want to be—on a specialty trauma program. Not only does this increase the demands on us because their nursing needs are no different than anyone else, but it creates unnecessary conflict on the unit because neither they nor their doctors have to follow our program rules and it interferes with the normal development of a sense of community. It would be like having a classroom of fifth graders and suddenly you just plop in some kids from another class who sit at unfilled desks but actually go somewhere else for all their classes. It's a situation that breeds trouble because they never have the chance to adopt the norms of the community. In addition, because of present admission policies in the managed care environment, the patients who are admitted tend to have a much higher level of acuity. The increased rate of turnover means that it is more difficult for a community to form and have the "older" patients help orient the "newer" patients, formerly a powerful socialization tool. The physicians for these patients, who don't know anything about how we approach treatment, are often working at cross purposes to the goals of the program, and that requires more team time as we debate what to do in trying to resolve what are actually deep philosophical issues about treatment, like when the physician on the case believes that the person's memories of abuse are just attempts at manipulation or when he has administered so many drugs that the patient cannot even think or worse, becomes disinhibited.

Since so much of our sense of safety is dependent on the maintenance of our social safety net which depends on communication among all team members, there is a constant state of stress and worry about the patients who do want to be there and come specifically for treatment at The Sanctuary. We all feel a pervasive sense of guilt and inadequacy over our ability to give the patients what they need in ever-shortening lengths of time. There is no recognition that we deal with extremely traumatized patients with very complex problems. Questions arise as to how decades of mistrust can be overcome in a week, how years of trauma bonding and traumatic reenactment behavior can be undone in 10 days time, how 5 days can provide enough time for even the most elemental development of a contract for safety in someone who is severely self-abusive. As the physicians and the hospital try desperately to survive as viable entities in what feels like an impossible and abusive system, punishment coming from some quarter seems to be increasingly common.

Such daily stresses raise important questions about meaning, purpose, priorities, and values that are unanswerable and often directly contradict our stated beliefs and values that are the core of our philosophical premises. Everyone is feeling increasingly helpless in the face of these changes that we have had no part in making and which undermine the recovery of our patients. Repeatedly questioning their own potential hypocrisy in preaching a philosophy of care and compassionate concern while being forced to practice in a seemingly cold-hearted and calculated fashion, the staff members are being confronted daily with complicated moral dilemmas that force them to choose only between evils, never the good.

In addition, since coming here we have lost our social workers to virtually all clinical involvement. Formerly, they were the bedrock of the program, providing the interconnecting "glue" for all aspects of the patients' care, including team meetings, regular meetings and groups with the patients, meetings with referral sources, and family therapy sessions. But at this facility the social workers have taken over the functions of case managers and quality assurance. At least 80% of their time is now consumed by inputting data into the computer, talking to insurance reviewers, spending vast amounts of time listening to "Musak" while on hold with these insurance companies, speaking to various other institutions, and supervising discharge plans. The institution is depending on these case managers to protect the hospital from what are becoming routine abuses of the managed care system. Any failure of protection is viewed as a personal failure of the social worker; the social worker gets blamed when patient days are refused so that the hospital will not get paid. These are jobs that the social workers are neither trained for nor ever wanted and are vastly different than the jobs they had come to love and for which they had developed a high level of skill. In a period of 3 months they have gone from being extremely capable, valued, connected, and fulfilled professionals to feeling like harried secretaries and isolated bureaucrats. Not only has this left the social workers unhappy and discouraged, but this has left a dramatic hole in our clinical programming and in our communication safety net because they just aren't available. This results in an increased workload on everyone else's part, less family contact, less communication with referral sources and with the patients.

This is compounded by the significant loss of the ability to obtain thorough psychological testing on any of our patients. We used to be able to include a deep assessment which often quickly surfaced critical problems such as underlying psychotic thinking, potential neurological dysfunction, and as yet unseen personality traits and vulnerabilities but insurers will no longer pay for psychological testing. As physicians, this is infuriating—it would be like not allowing radiologists to use their machines!

To make it even worse, we were not permitted to bring our trained nurses with us when we came here, so we have had to train the staff in the Sanctuary Model ourselves. This would be fine except for the fact that since arriving at this hospital

we have had difficulty establishing a stable nursing pool, so people keep showing up who do not know us, do not know our patients, and do not know our program. The nurses themselves have been very supportive and cooperative but need more training in our treatment model for them to be effective, and yet there is no time for such training to occur. Every second is accounted for, even "double-booked," making teaching a luxury that we cannot afford and yet cannot afford to do without, producing yet another cycle of helpless frustration. In addition, the constant, uncontrollable, threatening, and often irrational interface with insurance companies is sometimes simply unbearable. It seems like there is a crisis everyday and the level of stress is growing exponentially, but not from the patients. They just want some help overcoming their problems. But they are definitely negatively affected by our frustration and stress: it's contagious.

As a result of all this, there is never a moment's respite for the treatment team. What we call secondary traumatic stress is increasing on the part of the staff. Free-floating anxiety, chronic feelings of anger, fear, depression, guilt, and loss are admitted to by everyone, and people are feeling the pressure not just at work but at home with increased marital, relational, and parenting discord. There has also been an increase in physical symptoms and actual episodes of physical and emotional illness on the part of staff members. Since our staff members universally pride themselves on their commitment to the patients and see this commitment not just in professional, but in moral and even spiritual terms, they so far have refused to compromise on the quality of care.

Since time cannot be manufactured, the result is a serious infringement on personal time, which further contributes to burnout. It is not unusual for both physicians to be still present on the unit until 11 p.m. after beginning work early in the morning. At our previous unit, some of the pressure on the physicians was relieved by a call schedule that included our primary therapists who were nurses. Until we arrived, we were unaware that the bylaws at this hospital were quite different and that the primary therapists would not be permitted to do the admission evaluations they had been doing for years because of the completely unrealistic regulations of managed care. As a result, our physicians are frequently required to work 7 days a week on alternate weeks, since they must be available on Saturdays for admissions. They must be present, even though the primary therapist is present on the unit, since only a physician can sign the history forms, not because there is any immediate medical necessity.

There is simply no time for the preventative and restorative activities that help make this work possible without damaging health. Most importantly, perhaps, there is no time for the mutual debriefing that formerly was the primary defense against compassion fatigue. We are doing trauma work. We are engaging with several dozen people every day who have the most disturbing histories imaginable, all of them leave and new people come in within days, and the process starts again. It's heartbreaking because we know we can help people recover, but we need time,

space, and emotional energy to do that. As one staff member put it, "There is not even any time for tears."

Despite being overcrowded with people, there is a sense of complete alienation and disconnection from others, a sense of having no permanent sense of belonging and feelings of pervasive isolation and loneliness, all attributed to the extreme time constraints, multiple demands, and lack of control over external factors that bear directly on internal management. The staff is highly competent and yet the sheer volume of work is producing inefficiency and a general feeling of fear secondary to sensing that things are "falling through the cracks," that it is impossible to keep up, that disaster is always somehow imminent.

Rounds are held three times a week, but many times now we do not even know who the patients are if the Sanctuary doctors are not treating them, and other than the Sanctuary physicians, the attending doctors rarely come to the team meetings or participate in treatment. The time constraints mean that there is virtually no flexibility in the system. What each person does or doesn't do has an even larger impact on everyone else since the system is built to be tightly interconnected. When an unexpected medical problem arises, when the nurses are delayed in distributing medications, when patients arrive late from lunch, when the groups do not end immediately on time, then the entire schedule is disrupted, causing reverberating stress on every aspect of the system. Tempers shorten, frustration increases, stress soars, even from the slightest shift in timing, shifts that in real life and real time are inevitable.

Space is a chronic stressor. The unit we presently occupy is very poorly equipped for group functioning or for team treatment due to serious design flaws. One room was put together to provide for a staff room, but the number of phones ringing and beepers going off makes for a deafening level of inescapable noise. There is very little personal space and no place to gather in comfort or quiet. The nursing station is far away from the patient rooms. The main lounge that is used for group meetings is invariably oppressively hot. There is no boundary between the patient space and the nursing station, so confidentiality is constantly breached and there is no privacy in this critical area between staff and patients as a result of an extremely poor architectural design. Part of the unit is structured to be a locked intensive care unit, but when we are forced to utilize this space for this purpose, we are forced to further compromise our nursing staff since additional nursing staff are rarely, if ever, provided. We have always had unlocked doors and programmatically emphasize freedom from coercion as a basic treatment approach. But the hospital pressures us constantly to lock the doors of our program, which is in direct conflict with our professional and treatment philosophy and undermines the very goals of the program.

The fatigue is compounded by problems related to interfacing with a large, long-standing, stressed bureaucracy. Our treatment team is accustomed to a high degree of autonomous decision making, innovation, and problem solving that is

not encouraged in the present system. There is a feeling among the team, that our work is undervalued, our philosophical principles poorly understood, and our boundaries not respected. The demands of the bureaucracy often appear to defy rational common sense and good care, but they are insisted upon even if time for patient care is sacrificed. There is little sense of being in control while having a continuing strong sense of being responsible for all that goes on, a situation that breeds helpless rage. Admissions appear on the unit regularly without any screening from the management team—an experience that was formerly unheard of and is extremely detrimental to good unit management. Any innovation requires a seemingly endless series of meetings and levels of permission before it can be implemented. There is redundancy built into the system that results in needless paperwork and more wasted time when there is no time to be wasted. In our conversations, over and over again, the issue of lack of control arose about every area of care from who gets admitted to the unit to the temperature of the front lounge, to who gets to interrupt any meeting by paging, to staff physicians who repeatedly refuse to cooperate with community norms…

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Introduction: January 2010

Some months ago we were in a meeting in which a group of providers were talking about services to children in the child welfare system and the need to reduce or eliminate stays in residential treatment programs. It seemed that we were talking about the child welfare system as though it were a conveyor belt and its role was to deliver its kids, who sounded a lot like inventory, to the right place at the right time. The intention seemed to be to run the tightest ship in the shipping business. But what always seems to get lost in these conversations is that we are talking about *kids*—small people with flesh and blood, developing brains, and the potential to be almost anything, good or bad. Both of us were lucky; we had families, safe schools, stable neighborhoods, and an absence of violence in our lives. The kids we serve are coming to us after their fifth failed foster home placement, their sixth family, their sixth school, and their sixth community. They generally arrive with all of their worldly possessions in two or three large, black garbage bags. No family pictures, no trophies, no certificates of merit, and no real hope that things are going to be much better at this next placement. Many of them are children of color and their lives bear witness to the legacy of racism. The adults we serve have been beaten down by their experiences as children, often multigenerational experiences of poverty, abuse, neglect, discrimination, illness, and despair.

Regardless of what we do or where we work, we all need to begin by accepting the plain and repeatedly studied truth that the vast majority of the people we work with have been psychologically and socially injured. To help them it is crucial that we fully understand the nature of those injuries and the impact those injuries have had on their lives. But in the past, it has been very easy not to ask these questions or to ignore the responses, or over time just to forget the story. It is easy to forget just how much who we are today is shaped by where we come from and what we have experienced. It is hard to listen to the stories of profound injury day in and day out, whether they are being told with words or actions, while at the same time it is relatively easy over time to become hardened and calloused by these stories filled with sadness, trauma, and loss.

Because we all have our own stories, their stories sometimes come far too close to our own pain. We have found that the reason why we do not explore these stories more is not because it is too hard for our clients but because it is too hard for us.

Sanctuary

A sanctuary is a place of refuge from danger, threat, injury, and fear. It has been recognized since ancient times—and scientific research has validated—that for physical and emotional healing to occur, people need such a protected space in order to allow time, healers, and the natural powers of recovery to work their magic. In reviewing large numbers of studies that have looked at therapeutic outcomes, largely in mental health settings, what the client brings into a help-seeking environment accounts for about 40% of the outcome. But the other 60% of influence is determined by what helpers do and don't do within helping environments: the ability of a helper to be empathic, warm, and nonjudgmental accounts for a whopping 30% of influence, offering hope for about 15%, and providing people with an explanation for their difficulties and a method for resolving those difficulties accounts for about another 15% of outcome [3]. So a place that is a sanctuary for people who need help is one where the staff members are warm, caring, hopeful, have a clear theory and method for change, and are willing to deal with the problems that the clients bring into their doors.

This book is titled *Destroying Sanctuary* because it describes the multitude of ways that organizations and systems originally designed to afford injured people a healing refuge have instead become factories of neglect and abuse. One of the thoughtful people who reviewed this book before publication did not like the title we gave because the person did not believe that mental health programs—or presumably any of our social services—had ever actually been sanctuaries. Although never close to perfect, both of us—and many of our colleagues—remember a time when it was possible to provide more of a shelter than it is now, a time when well-intentioned, well-trained, and committed practitioners in every area of social service delivery and health care were able to feel that their work was valued and important, that they had control over the quality of service they provided, and that it was possible to "do no harm." Both of us have worked in helping environments where staff members of all educational backgrounds were well educated in theory, were able to use that theory to inform what they did, were hopeful about the capacity of their clients to heal, and were themselves warm, communicative, responsible, disciplined, nonjudgmental, and caring.

But for the reasons described in the Prologue—and detailed in this book—many people who work in health care, mental health, and social services do not

feel that way today. Contradictory theories and methods abound with little time for integrating complex and conflicting ideas about human nature and human problems. Frustrated beyond measure, many who work in these settings have become inured to suffering, angry, punitive, avoidant, and despairing. Many function in their jobs day to day without really feeling much hope that their work is making a difference in anyone's life. They are challenged to create any sanctuary for their clients, and they do not feel they have any for themselves.

We do not believe that this outcome has ever been the intention of anyone managing or working in these systems. Rather, we believe it is the insidious result of an all-encompassing mental model and system of beliefs that promote a mechanistic view of care giving systems, the devaluation of those who choose to do emotional labor and who work with vulnerable populations of people in any and all of the social services, the dehumanization of anyone who cannot compete successfully in a cut-throat economic climate inappropriate for the delivery of quality human services, a culture that is more enamored of sex and violence than of love, and the universal impact of chronic stress and repetitive trauma that results. Our radical antidote to the moral deterioration that is the result of these insidious forces we call the Sanctuary Model. We will briefly describe what we mean by that at the end of this volume. A fuller description will be our next volume in which we explore *Restoring Sanctuary: A New Operating System for Trauma-Informed Organizations.*

"Aha" Experiences for Health and Human Services

One objective in writing this book is to offer our colleagues a different, expanded conceptual framework—a language, a way of thinking—about their clients, their organizations, their managers, and themselves. We hope that as you read this you have many "aha" moments that are at the heart of insight, epiphany, and creativity. Those moments occur when suddenly ideas come together, integrate and become a cohesive whole and you see into a problem in a way you never have before. Whether we are talking about individual trauma survivors or traumatized systems, these "aha" moments are the starting point for healing and recovery. They prepare us to move down entirely different pathways in our minds and in our actions and that means we stop ending up in exactly the places where we started and instead we begin to explore new possibilities.

We think this is vitally important for the simple reason that our care giving organizations are struggling and are suffering themselves. Over the last 30 years it has become increasingly difficult to deliver adequate services to the people most in need of them, and this has caused an untold amount of stress and moral distress that is felt at individual, organizational, and systemic levels. The end point of this disarray is that our services are, to a great extend, ineffective

and this book explains the complex reasons behind the multiple ways in which good intentions go wildly astray.

Just an explanatory note: for those who have not worked in human services, the way we sometimes interchangeably use various words to describe components of the human service system may be confusing. We are aiming this book at the entire health and human service sector, but we often interchangeably discuss health care, mental health care, and social services or refer to them generically as human service delivery systems. Most of the concrete examples we use are from adult and child mental health care service delivery simply because that is the arena where most of our work has occurred. However, we draw additionally on our experience working with child welfare agencies; homeless shelters; medical hospitals; psychiatric hospitals for children and for adults; domestic violence shelters and programs; children's hospitals; substance abuse facilities; HIV prevention programs; faith-based support programs; juvenile and adult criminal justice systems; inpatient and outpatient services, community-based services, and virtually every component of the human service delivery network.

It is not a coincidence that beginning in 1980, the federal department in charge of everything from care of the physically and mentally ill, to substance abuse treatment, to child welfare and homeless services, to the Centers for Disease Control and the Public Health Service came under the jurisdiction of the Department of Health and Human Services (HHS). This structure designates an understanding that all human services dedicated to the HHS motto of "improving the health, safety and well-being of America" are interrelated and interdependent. That is our position in this book—that the problems that currently beset health care service delivery are mirrored in mental health care service delivery, substance abuse treatment, child welfare, services for the homeless and the poor, domestic violence services, and any other services devoted to improving the well-being of American citizens. And that this vast, interconnected network, so vital to the public health of the nation, represents both national success and national failure.

Systems in Crisis: The Impact of Biological Reductionism

A friend and change agent herself, lawyer Carol Tracy, once shared a quote about system change from a former Provost of the University of Pennsylvania, now the President of the Carnegie Corporation, Dr. Vartan Gregorian. She paraphrased a remark he made about system change, that *"In order to change a system you have to be either a loving critic or a critical lover."* In this book we have taken that admonition to heart and applied it to the human service delivery system. Over the last three decades we have watched a disturbing series of events unfold within the social service network that for us constitutes largely

a disintegration of many components of this system. The result of this disintegration is what many officials now are calling "a crisis" in service delivery. Certainly widespread economic forces like managed care have been a major determining factor in creating this crisis, but predatory financial behavior can only occur in an environment that is already philosophically and morally weakened.

When we began working in the human services arena, we learned that there was an intimate relationship between the individual who showed dysfunctional behavior of some sort and the context within which the individual lived and breathed. This context extended in concentric, interactive, and permeable circles around the individual outward and included family, community, nation, and world. We were taught that to help someone, it was important to understand that person's unique position within those concentric circles and the multiplicity of interacting influences that could be determining his or her behavior. We learned that human beings are profoundly divided and that we all have a conscious *and* an unconscious life. We live partly in the light and partly in the shadows.

Throughout a period loosely running from the 1950s through the beginning of the 1990s, and frequently outside of state institutions, in private and nonprofit clinical settings, as long as the customer was the client, there was an incentive to find methods that would deliver effective therapeutic services to the client. Innovations in mental health treatment have always been behind, and in many ways the stepchild of, general medicine. The technology that has advanced medicine has done relatively little to help us understand the complicated workings of the human psyche. But during this period, clinicians began experimenting with innovative methods for achieving significant gains in a time frame less onerous than that of the lengthy, expensive, and time-consuming methodology of psychoanalysis, while not losing the profound insights derived from a psychodynamic understanding of human systems. Innovation, spurred by the new knowledge about combat trauma, disaster trauma, child abuse and domestic violence, blossomed in what is still a young field of endeavor compared to other branches of medicine—traumatic stress studies [4].

Then, beginning about 30 years ago as the political climate became increasingly punitive, authoritarian, and "conservative" (perhaps less properly termed conservative than radically right wing), and a variety of pressures began to change the face of human service delivery so that in many ways it is unrecognizable today as the same system that existed two or three decades ago. The growing interest in the biological and genetic causes of mental disorder began to exclusively dominate the psychiatric field—what we refer to here as "biological reductionism." Various influences served to fuel deinstitutionalization resulting in the loss of many institutional settings for study and research and the shifting of 24/7 care to short-term, intensely "medical model," pharmaceutically driven

psychiatric care. Innovation in many non-biological therapeutic methods within the mental health system virtually ceased when the customer ceased being the client and became instead the middle managers of insurance companies and the organizations they created or hired, a system known as "managed care."

System Degradation: Systems in Crisis

What we now find in health, mental health, and social service settings around the country is profoundly disturbing. In many different kinds of programs something is dreadfully wrong. The post-World War II spirit of extraordinary hope and belief in progress in all human affairs, even among the most disordered in our society, has given way to a passivity and pessimism. The belief in the "common good" and our individual responsibility to contribute to that common good has been eroded. The result is a cynicism and hopelessness about the clients our systems are supposed to serve. The clients haven't really changed very much, but the providers of care and entire systems of care have changed profoundly.

As a result, over the last few decades, serious problems within all of these systems have been accumulating and compounding insidiously. As historians have explored, the science of mind and body integration was in its infancy during the tumultuous 17th century when influential men like philosopher René Descartes turned over the body to physicians and the mind to the clergy and philosophers [5]. This remains the situation today, despite the fact that an enormous amount of mental health treatment is provided by primary care physicians and social services by religious organizations. Clients present at the doors of mental health and social service programs seeking remedy for their problems, but they often leave with few solutions and sometimes with even more difficulties than they brought with them. Staff in many treatment programs suffer physical and psychological injuries at alarming rates, become demoralized and hostile, and their counter-aggressive responses to the aggression in their clients create punitive environments. Leaders become variously perplexed, overwhelmed, ineffective, authoritarian, or avoidant as they struggle to satisfy the demands of their superiors, to control their subordinates, and to protect their clients. When professional staff and nonprofessionally trained staff gather together in an attempt to formulate an approach to complex problems, they are not on the same page because they lack a common theoretical framework that informs problem solving. Without a shared way of understanding the problem, what passes as treatment is little more than labeling, the prescription of medication, and behavioral "management." When troubled clients fail to respond to these measures, they are labeled again, given more diagnoses, and termed "resistant to treatment."

Meantime, the system grinds on, people go to work, and caregivers do the best they can. Caregivers frequently change jobs in search of a better place to work, while longtime workers become profoundly demoralized. Clients do not

get the benefit they could and should be receiving. Managed care companies, recognizing the disarray, seek simple solutions by funding only "evidence-based practices" that selectively endorse only forms of interventions that meet medical standards of proof of efficacy. As important as it is to be able to show that what we do is effective, the present emphasis on a very narrow range of evidence-based practices allows people to ignore the long-established fact that most forms of psychotherapeutic interventions are effective as long as several key factors are present, most importantly, safe relationships and hope. At the same time, few programs actually hold themselves accountable for results that are based on whether or not the client has improved. Instead, they are often accountable only to productivity demands, budgetary requirements, and the completion of paperwork.

As is always the case when individual financial gain supersedes social welfare, the public system has been the most profoundly affected by these changes. It is still possible for wealthy and some upper middle class patients to seek out therapeutic interventions from knowledgeable and systems-informed therapists. But even for them, if they must be hospitalized, they are unlikely to have anything resembling the kinds of therapeutic experiences offered in years past, although the disassembling of the state hospital systems has also virtually guaranteed that no one will experience any form of inpatient care for more than a few days.

As a society, we have done a terrible job of taking care of our children, and we seem to have no sense that our failure to care for our kids has really long legs. As a result of a series of decisions, many of which have been made because of increasing financial pressures, we may have lost a whole generation of children and families. Our justice system is exploding because we have not done a good job with these men and women from the very beginning. There is no sense of foresight that each dollar we cut out of education, children's mental health, child welfare, housing, Head Start, and other programs that support the vulnerable, young, and oppressed will likely cost us thousands of dollars down the road. Politically-based decisions are made with very short-term goals in mind but the problems that are left unaddressed have very long legs that reach far out into the future. Our failure to address our front end has left us crushed under the back-end results.

From what we have seen, it has become evident that there is no quick fix. We need an entirely different way of thinking about, planning, and addressing our current problems. We need new "mental models" and a multitude of "aha" moments.

New Mental Models

Mental models are deeply held assumptions. They are so deeply held and operating outside of our individual awareness that we don't even realize the

role these assumptions are playing in determining what we think, feel, and do. Our mental models are activated when we observe the exact same event as someone else but describe it—or experience it—in entirely different ways. As you read this book, we challenge you to think about your own mental models.

At least two different mental models, each of which has a number of component parts, presently exist in our organizational world. We describe these as *Organizations as Machines* vs. *Organizations as Living Beings.* These two categories are themselves misleading because, as you will see in our description, no person, organization, or society falls neatly into our idealized category; rather, each exists somewhere along a continuum. We believe that over the last few decades, the human service delivery system can be described more like a machine than as a living organism delivering complex services to living individuals and families.

Organization as Machine

The mental model that has dominated group life—and therefore individual existence—for the last several hundred years views organizations as machines that operate more or less like clocks with interchangeable parts, lacking feelings, able to perform their function without conflict—regular, predictable, ordered, and controlled [6]. In the model of system as machine, individuals are cogs in the organizational machine, functioning independently and competing with other individuals for survival. And each organization is itself a machine that is embedded within a larger mechanistic view of society that includes local, county, state, and federal component parts. Organizations can become dysfunctional and fixing them requires external expertise and some form of top-down social engineering.

Organization as Living Being

It was not until the 1940s that mechanistic thinking began to broadly change, and this overly simplistic view of how organizations work became much more complex. The hallmark of all living systems is interratedness and interdependence and an understanding of these characteristics became known as "general systems theory" [7]. A system can be defined as a set of interrelated elements that respond predictably and interact with each other consistently over time. As a result, change at any one point will eventually have an impact on the total system and its component parts [8]. Another characteristic of living systems is "emergence," which occurs when the whole is greater than the sum of the parts. For example, in your body, organs emerge from combinations of cells, and an organization's collective identity emerges out of the combined individual identities of everyone within the organization.

Living beings have both conscious and unconscious processes. For a living organism to be consciously aware, all the time, of everything that is going on to

sustain life would require brain power not available to individuals or organizations. So over time, and in the course of development, much activity that may have at one point been conscious, deliberate, and strategic, takes on a kind of life of its own, outside of conscious awareness. The longer an organization has been in operation the more likely it is that much of what occurs in the organizational culture is happening at the level of unconscious norms and basic assumptions, built on mental models that are completely out of view. Any challenges to these basic assumptions—which provide our individual and shared organizational minds with stability and security—are likely to give rise to anxiety and to "social defense mechanisms" that we will discuss in Chapter 4.

In this book, we make the case that instead of being seen as living systems, chronic and unrelenting stress has had and continues to have extremely detrimental effects on the overall functioning of the health and human services. Toxic stress—the strong, unrelieved activation of the body's stress management system—has destructive impacts on the social body just as it does the individual body. As a consequence of this toxic stress, individual workers within the organizations, as well as managers and leaders of organizations and of systems, are likely to become more primitive, inflexible, aggressive, authoritarian, and punitive and therefore unable to grapple with the level of complexity that characterizes every organization. *Destroying Sanctuary* describes the long-term, toxic effects of treating living systems as if they were emotionless machines. The next volume, *Restoring Sanctuary,* now in preparation will describe the ways in which living systems—families, groups, organizations, systems, and societies—can begin restoring themselves to health.

Thinking About Operating Systems: A Useful Metaphor

We believe these two categories—machines versus living beings—represent two very different ways of viewing ourselves, other people, our organizations, and the world around us. We will use an everyday analogy to mediate between the two conceptual frameworks: the computer.

Computers are machines, yet scientists are on the verge of integrating the components of these machines into human bodies and are using living systems as models to improve machines, a field known as *bionics*. Until recently *androids,* synthetic organisms designed to look and act like human beings, and *cyborgs*, beings that are partly organic and partly mechanical, have been relegated to the world of science fiction. But there is now global competition to produce robots that are increasingly like living beings, modeled on the way living systems work.

Hardware, Software, and Operating Systems

Computers and people have hardware and software. Hardware in a computer includes microchips, hard drives, input devices, and a "motherboard." People have

hardware that includes our DNA, genes, cells, and all of our organs, including our brains. But neither computers nor people really can do anything without software programming. There are basically two kinds of software: foundation software and application software.

In a computer, the foundation software is called an "operating system," a master program that controls a computer's basic functions and allows other programs to run on a computer *if* they are compatible with that operating system. Examples of operating systems include Microsoft Corporation's various versions of "Windows," Apple's Mac OS, and the –open source operating system Linux. All the things that a computer can do such as word processing, photography programs, and spreadsheets are all "application software." In order to function properly the application software must be compatible with the operating system.

Like people, computers can get "sick." A computer virus is a small piece of software that piggybacks onto real programs. Each time the program runs, the virus has a chance to spread and to wreak havoc on the entire computer. Computer viruses masquerade as other things and are transmitted through personal contact. They are hard to diagnosis, difficult to treat, malevolent, and contagious. They may lie dormant for years and then attack the system. As anyone knows whose life space has been violated by a computer virus, they represent a form of violence since they are created with the intention of doing harm to others. Now let's use these basic concepts and apply them to human beings.

The Human Operating System and the Virus That Disrupts It

Over the last few decades, research on the nature of attachment relationships has made clear that for human beings, healthy attachment is a fundamental requirement for physical, emotional, social, and moral development. We understand attachment as the basic "operating system" for individuals. Without an attachment relationship in early development, people cannot become fully human. As the grandfather of attachment studies, John Bowlby pointed out, we remain attached to others from cradle to grave.

During this same period there has also been the emergence of a different way of viewing the impact of traumatic experience and prolonged exposure to adversity, particularly in childhood. Trauma theory brings context back to human services without denying the importance of the biological discoveries of the last several decades; instead, it integrates those discoveries into a more comprehensive understanding of human beings.

Exposure to trauma, toxic stress, and severe adversity disrupts the human attachment system in a wide variety of ways. Such disruption can wreck havoc on the "applications" we use to adapt to the world, such as learning, emotional management, and memory. Trauma and sustained adversity do to the human operating system what a computer virus does to a computer. The problems

that result are complex and interrelated, which is why people with a history of exposure to trauma and adversity often are carrying around three, four, or five different diagnoses and are taking at least that many medications.

If people are to heal from sustained exposure to adversity and traumatic experience, then we need to shift the usual level of focus on treatment approaches or the "applications," to a deeper level. We need to figure out how to promote change in their "operating system," what we commonly call their "personality."

Over the last few decades the growth in knowledge of two interrelated fields of study—disrupted attachment and trauma—when combined, offer us a different paradigm for defining what we mean by "treatment". For people who have suffered complex exposure to trauma and adversity, deep, structural personality shifts have occurred—trauma-organized shifts in the individual's "operating system"[9]. People with these very complex disorders are the same people who populate our mental health, substance abuse, child welfare, and criminal justice systems. If they are to heal, they must experience a new trajectory of experience that shifts their personalities, changes their operating system, and changes their brains.

This change can begin when clinicians start exploring new possibilities and in doing so come to believe that significant alteration in deep structure is achievable. This internal shift may keep them from resorting to the more routine explanations that afford little hope of reasonably rapid alteration in personality structure. The second major change is in implementing the complex, holistic, integrated, trauma-informed, attachment-based, organizational approaches that are necessary for such alterations to occur and proving that they can. The third major change is in convincing policy makers that funding such intervention and treatment approaches is worth it and the earlier in a person's life that intervention occurs, the bigger "bang for the buck" the society will achieve. The secondary or collateral costs of failing to address these individual and family problems early in their development is socially and economically staggering and rather than minimizing treatment, we should be radically increasing effective approaches, including primary prevention efforts directed at young children and their families in an effort to forestall the inevitably greater need for increasingly expensive secondary and tertiary forms of prevention and intervention.

Organizational Culture: The Organizational Operating System

Like computers and people, organizations also have operating systems. The operating system for the organization is embedded within the organizational culture. Organizational culture arises spontaneously whenever groups of people come together for any length of time and focus on tasks long enough to create common traditions, rites, and history. It is binding in that it determines how people enter the organization, survive within it, and learn to solve problems.

As we will learn in future chapters, there are close and interactive relationships between individual identity and organizational identity. The organizational culture has both conscious and unconscious components and both elements get transmitted to new organizational members. Their ability to translate these elements—to read and respond to the "visible and the invisible group"—determines whether they are able to survive in the organization [8; 10].

We believe that the current operating system for the human service delivery system is outdated, mechanistic, and inappropriate to human health and well-being. This helps to explain why there are so many chronic clashes between our organizations and the living individuals who entirely comprise them. In order to adequately address the needs of the traumatized clients who fill the ranks of our trauma-organized human service delivery system, we need a new operating system—what is being referred to now as a "trauma-informed" operating system—for human service delivery organizations. Just as attachment is the basis of the individual operating system, social relationships are the basis of organizational functioning as well. We believe that in a parallel way, traumatic experience and adversity can profoundly disrupt the operating systems of organizations. We believe that the current mechanistic model of organizational functioning is a result of destructive and potentially lethal *parallel processes* secondary to chronic stress that have created a seriously flawed operating system for human service organizations and entire systems.

Organizational Stress, Parallel Process, and Trauma-Organized Systems

The issue of organizational stress turns out to be particularly salient for anyone involved in delivering human services. It is possible to imagine that car batteries, vacuum cleaner parts, and cushion covers could still be produced, even if everyone in each factory is under considerable stress. But there is no easy way to define the "product" that comes out of human service delivery organizations. People come to social service programs seeking "help" and when they get what they came for, that goal has been achieved through human relationships, not a factory production line.

Organizations, like individuals, can be traumatized, and the result of traumatic experience can be as devastating for organizations as it is for individuals. The outcome of a traumatic experience will be in part determined by the pre-traumatic level of organizational health and integrity. We believe that at this point, our social service network is functioning as a *trauma-organized system* still largely unaware of the multiple ways in which its adaptation to chronic stress has created a state of dysfunction that in some cases virtually prohibits the recovery of the individual clients who are the source of its underlying and original mission, and damages many of the people who work within it.

Just as the encroachment of trauma into the life of an individual client is an insidious process that turns the past into a nightmare, the present into

a repetitive cycle of reenactment, and the future into a terminal illness, the impact of chronic strain on an organization is insidious. As seemingly logical reactions to difficult situations pile upon each other, no one is able to truly perceive the fundamentally skewed and post-traumatic basic assumptions upon which that logic is built. As an earthquake can cause the foundations of a building to become unstable, even while the building still stands, apparently intact, so too does chronic repetitive stress or sudden traumatic stress destabilize the cognitive and affective foundations of shared meaning that is necessary for a group to function and stay whole.

Our emphasis on changing organizational operating systems so that they become trauma-informed systems is so important because we now recognize that most of the clients who require services in the human service delivery system are survivors of overwhelming life experiences and multiple kinds of adversity. Decades of clinical experience and previous research have demonstrated that creating a *trauma-informed culture* in and of itself could help staff and clients make better recoveries than has previously been possible. It also provides the necessary context for implementing *trauma-specific treatment* approaches.

A Word About Vocabulary

Now is a good point to clarify the terminology we use so frequently in the upcoming chapters. In this book we refer to "chronic stress," "toxic stress" "adversity," "trauma," "dissociation," "disrupted attachment," "acute stress disorder (ASD)," "posttraumatic stress disorder (PTSD)" and "complex PTSD" (also sometimes called "developmental trauma disorder"). But are these words interchangeable? No, they are not interchangeable, but they are related.

Stress as we use it in this book refers to the pressure that life exerts on us and to the way this pressure affects us. Thus, stress is both external and internal, and the effects of stress on our minds, bodies, and behavior can be positive or negative—or both [11]. The stress response is built in to our mammalian makeup and is a basic survival response, just like eating, sleeping, and reproducing are basic to survival. By chronic stress we refer to the fact that there are many situations in modern life that stimulate the physiological survival response, even when survival—in the moment—is not at stake. As mammals, our bodies and minds are adapted to experience a survival threat, respond with the stress response, take survival-based action, and then either recover or be killed. We are not designed to live with the chronic arousal of these basic survival responses.

Toxic stress is another word for chronic stress, generally applied to the prolonged experiences of exposure to adverse conditions that occur in childhood when the body's stress management resources are overused and overtaxed. It is

now well established that such experiences can be damaging to children's brains and bodies, rather like a toxic chemical [12].

Adversity can be defined as a state, condition, or instance of serious or continued difficulty or adverse fortune that implies that the person who experiences adversity is under conditions of chronic stress, but it is also true that individuals vary greatly in their response to adversity. Children often experience adverse experiences, sometimes for many years of their childhood, and as we will see later, there are indicators that this exposure can have very detrimental effects on the body, mind, and spirit. However, it is also true that the capacity to "bounce back" from adversity, also known as "resilience," may be a response to adverse childhood experiences. For many survivors, resilient strategies and maladaptive coping skills are interlaced and occur simultaneously.

A *traumatic event* has been defined in many ways, but our favorite definition is one that explains that a traumatic event is one that overwhelms the person's internal and external resources that enable him or her to cope with an external threat [13]. Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or human made disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Many people believe that there are also events like threats to one's safety or the safety of others, sexual harassment, and various manifestations of psychological abuse that can also be defined as traumatic.

Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease.

Dissociation is an automatic mental response that involves a failure to integrate or associate information and experience in the way our minds usually are able to do. Dissociation appears to be a central part of many traumatic experiences and is viewed by some as a "state"—a special type of consciousness that we all have access to under normal and traumatic conditions—and by others as a "trait," that is, a characteristic quality or property of an individual that may be heritable. There is still debate in the field about exactly what dissociation is and how important it is in understanding PTSD, but for now, a useful way of thinking about these differences is as "normal dissociation," meaning

dissociation that is not associated with maladaptive response, and "pathological dissociation" that is maladaptive [14–16].

After a traumatic event, most people experience "*acute stress*" and if they come to medical attention may be diagnosed with "*acute stress disorder*," which by definition must occur within 4 weeks of the traumatic event and be resolved within that 4-week period. Calling this a "disorder" may be a bit of a stretch, since so many people experience this after an overwhelming event, but not everyone.

According to *The Diagnostic and Statistical Manual* (*DSM-IV-TR*), published by the American Psychiatric Association and regarded as the standard for diagnoses, if acute stress-related symptoms persist for longer than a month, then a person is suffering from *post-traumatic stress disorder* or *PTSD*. If so, the person has experienced or witnessed a traumatic event, is suffering from intrusive reexperiences, such as nightmares and flashbacks, actively avoids encountering reminders of the traumatic event, and experiences symptoms of increased physiological arousal [17].

Because of the vital importance of attachment behavior for human survival, traumatic experience is associated with *disrupted attachment*—a disruption in the ability to trust and feel safe with other people. The experience of disrupted attachment can occur at any age, but it is well established that disrupted attachment in childhood is a major source of *toxic stress* and a wide variety of long-lasting negative consequences for the developing child and the adult he or she becomes [18–21].

Complex PTSD or *developmental trauma disorder* as of this writing are not yet officially considered diagnoses as defined by the American Psychiatric Association. Nonetheless, people working in this field believe it is necessary to understand the very complex changes in a person's body, mind, identity, personality, relationships with others, ability to differentiate right from wrong, and meaning-making that may be the result of exposure to toxic stress and disrupted attachment beginning in childhood, or to chronic, severe interpersonal violence that occurs at any age [22–25].

This book focuses on the crisis in the human service delivery system. The most difficult clients, with the greatest degree of complexity and who are the most challenging to all health and human service delivery environments, are those who have a history of exposure to adversity, toxic stress, and trauma. At the same time, the people who work in these organizations may have experienced traumatic events themselves and many will have experienced adversity as children. And the organization as a whole often has in its history some terrible events that have occurred. But for the most part, it is not the traumatic events themselves that cause the systematic dysfunction that we will describe in the upcoming chapters. It is instead caused by chronic stress that is the context within which many traumatic events occur and that is the result of the attempts

to address a traumatic event unsuccessfully. When we are talking about the conditions of the workers and the workplace in this book, and referring to whole organizations, an actual traumatic event is likely to be only one of the causes of the problems we describe here. It may have been the incident that triggered a response after years of tolerating toxic organizational environments.

Chapter Summaries

The goal of this book is a practical one: to provide the beginnings of a coherent framework for organizational staff and leaders to more effectively provide trauma-informed care for their clients by becoming *trauma-sensitive* themselves. This means becoming sensitive to the ways in which managers, staff, groups, and systems are impacted by individual and collective exposure to overwhelming stress. But most research about organizational dynamics and the process of change is not to be found in the mental health literature or in most health and social service training programs. For that, we must look to the worlds of business, management, organizational development, and communication, and little of this knowledge seems to have found its way into clinical or social service settings in the last few decades.

Our task has been to integrate a wide survey of existing knowledge of organizational dynamics with our understanding and experience in human service delivery environments. We hope that this expansion in knowledge will ultimately improve clinical outcomes, increase staff satisfaction and health, increase leadership competence, and enable human service delivery systems to develop an advanced technology for creating and sustaining healthier systems. We believe that a shift in mental models is a critical first step in enabling the mental health system and its "sister" social service systems to make a more effective contribution to the healing of traumatized children, adults, and families and therefore contribute in a positive way to the overall health of the nation.

The book is divided into 12 chapters. In *Chapter 1: Human Service Organizations: Dead or Alive?* we expand on the idea of organizations as living beings, not machines. Treating a living system as a machine may be useful in the short term but creates significant long-term, sometimes disastrous problems as we are seeing today throughout the human service field as each service sector decries the current, imminent, or future crisis in workforce development, in service delivery, in mission fulfillment, and in funding. Applying an economic mental model that applies to making "things" and believing the same principles will apply to delivering services to human beings can cause insurmountable obstacles to good care. We do not need to empathize with machines, but human beings require empathic regard in order to heal. To address these crises, we need to look at some basic mental model conflicts that exist between our economic