# CREATING SANCTUARY IN THE SCHOOL

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*Abstract*

Children are only able to learn within a context of safety and security. But for many children today, neither their homes nor their schools are safe places for living, much less learning. This situation shows no indication of reversing itself in the foreseeable future. Educators then, must face what becomes an intolerable burden - how to educate children who are disturbed, distracted, hyperaroused and whose behavior often interferes with their own learning and the learning of others. For the last decade, the author of this paper has been involved in the creation of safe environments which promote healing for adult survivors of childhood trauma. The purpose of this paper is to describe the process of "Creating Sanctuary", by exploring the possibilities of applying some of the same ideas that have been of such benefit to adult patients, to the creation of a "sanctuary" environment within the classroom, and of creating schools that can become safe places - sanctuaries - for the children and for the adults that work there. "Creating Sanctuary " will describe the basis for the actual process of providing a safe and healing environment for children who need to recover from the effects of trauma, and for less traumatized children as well. Basic assumptions, values, goals and the process that must be shared by all members of the system will be described.

## *CREATING SANCTUARY*

The material discussed in this paper is based on knowledge derived from establishing and working in the context of *The Sanctuary™,* an inpatient therapeutic milieu unit designed to treat adults who have been traumatized as children.[1] Sometimes the trauma is physical abuse, or sexual abuse, but for other patients, it is an early medical or surgical experience, loss of a parent, witnessing violence , or serious accidents. Whatever the initial cause, our patients suffer from a variety of conditions that have at least one thing in common, they originate in and have a resonating effect with disrupted childhood development. Our adult patients have become time travelers of a sort, allowing us the ability to view, albeit "through a glass darkly", the evolution of their disorders, and simultaneously, the evolution of many problems for our species.

Our understanding of the prevalence of trauma as a causative factor in the etiology of many kinds of psychiatric and social disorders has necessitated some important shifts in practice and perspective for us as psychiatric practitioners. Our first goal was to reduce "sanctuary trauma", the experience of expecting a protective environment and finding only more pain (Silver, 1986). In service of this goal, we had to think deeply about the entire concept of safety, not just physical safety, but psychological, social, and moral safety as well. As a consequence, we found that we had to review and change many of our basic and previously unquestioned assumptions about human nature, our value system, the goals of our treatment, and the processes by which we dealt with our patients and each other. We have come to believe that these shifts in perspective, here called "Creating Sanctuary", are relevant for all institutions within which human beings must live, learn, and function, not just psychiatric institutions. This paper is a beginning attempt to promote cross-disciplinary fertilization and integration. Attempts at connecting material across the chasm of different

disciplines is always risky because of differences in language, experience, and focus, so I beg indulgence if there are glaring gaps in my knowledge of the educational system. Nonetheless, fragmentation is the hallmark of trauma and a case could be made that we all exist within a fragmented, "trauma-organized" social system . Our social situation has become so dire that we must risk some leaps across this chasm of our differences and find better ways of making sense of the enormous problems that confront all of us. My purpose in writing this paper is to invite a mutually enriching dialogue in service of creating environments that are more life-affirming for children and the adults who love them. Creating Sanctuary is a process. It is the path, not the destination. Creating Sanctuary is a group experience of forming a safe space of containment and the group is either creating it, destroying it, or failing to protect it at any given moment in time. Everyone is responsible for their contribution to the creation of this safety and it takes everyone's participation for a net of safety to be sustained. Describing a process is always more difficult than describing a thing, but I hope that this paper take some beginning steps in that direction.

## *BASIC ASSUMPTIONS AND ATTITUDES*

### *Normality & Health: Trauma-Organized Systems*

Creating Sanctuary mounts a substantial challenge to some of our basic paradigms about human nature, in fact many of these basic assumptions are completely reversed, or at least turned sideways (Bloom, 1995). The first basic assumptions that we had to challenge in our work with psychiatric patients were our definitions of "normality" and "health". As we thought about the subject, it became clear that these two ideas are not necessarily equivalent. In fact, as we learned more about the profoundly negative impact of traumatic experience on generation after generation within a family, we realized that many of our social systems, including the family, are "trauma-organized" (Bentovim, 1992). By this we mean that the repeated experience of trauma becomes one of the central organizing experiences in the individual, in the family, and in larger social groups. Our development as a species as been so profoundly influenced by the intergenerational strain of trauma that we really have no clear idea of what health looks like, how it feels to be in a healthy system, or what the processes are that go into maintaining a healthy system. Our postulate is that social organization around trauma is more the norm than health. As a result, we are always "feeling in the dark", exploring uncharted territory when we try to design and implement alternative environments. These attempts are complicated by, and frequently sabotaged by, the backwards, regressive pull of trauma-organized habits which are extremely difficult to overcome. One of the central tragedies of human existence is our powerful and unconscious compulsion to repeat the past. If our past has been a happy one, then we will tend to repeat the patterns of relationships and habits that bring more happiness. If our past has been guided by misfortune, then our future will tend to lead towards more misfortune. This means that we *all* play an important role in determining whether our systems support trauma-organized normative behavior or healthy behavior. It is a choice that we each make every day through our interactions with each other.

### *From Sickness & Badness to Injury*

A corollary of the confusion between normality and health are our basic beliefs about *deviance.* Deviance is defined as "departure from the accepted norm". Two examples of deviance are "sickness" and "badness". When people are "sick", we generally excuse them from responsibility until they are well, but likewise, the sick role sets them aside from other

prerogatives belonging to the well person. When people are "bad", we hold them totally responsible and feel justified in punishing them.[2] The trauma model complicates this neat division dramatically by stating that much of what we call sickness and badness is a direct or indirect result of "injury", often injury inflicted in childhood at the hands of a caretaker. The children respond as best they can with life-saving coping skills. Tragically, these same coping skills, when used for too long or when they are no longer necessary, end up being diagnosed as psychiatric symptoms, largely because they have had such a negative impact on normal development. The reactions to trauma are based on biological changes in the mind and body over which children have no control. It is only logical that children will do anything to reestablish self-control, even if the choices that they make lead to further complicating problems. Sickness and badness locate the focus of the problem within the individual. In the case of sickness, it's not really their fault but it is their problem, their personal defect. In the case of badness, it is their fault and they will have to fix it themselves. In contrast, injury places the sickness or badness in an interpersonal context. In the case of childhood trauma, the injuries that children sustain are a direct result of a failure of the social group, one of whose fundamental purposes is to protect its young. The tragedy of childhood trauma is that it compels its own reenactment. History repeats itself in myriad ways, and without help, traumatized children are often destined to endure lives filled with tragedy. This "traumatic reenactment" is outside of the individual's conscious control but can be redirected through the intervention of other people so that the past does not automatically repeat itself.[3]

We all know something about comforting injured people. We have all been injured ourselves at some point in time, and it is relatively easy to draw on our own remembered needs at the time of injury and to use those memories for guidance in how to deal with the injured other. It is far more difficult for us to identify with "sickness" or "badness. The damaged child's sense of self is identified as helpless and powerless over this overwhelming sense of sickness or badness. Before they even begin their journey, they are stripped of hope that they can be anything other than sick or bad, because the assumption is that they were born that way, it is in their genes, it is who they *are*. The injury model says that "an abnormal reaction to an abnormal situation is normal behavior".[4] This implies that these were normal children before they were injured and *then* they became "sick" or "bad" - they were not born that way. It also implies that they can be normal children again. It restores hope and courage to be told "It's not your fault". The experiences that a child has with school personnel can be vital in this regard. The school can further the damage already done by damaged - and damaging - parents. Or alternatively, the school can provide another option for the child, a choice, another hope-sustaining way of viewing themselves and other people. The children we call resilient, the ones who survive and transcend traumatic home environments are the children who are provided with choices that they are able to use advantageously.[5] From what we can see from our clinical populations, luck, good fortune, or grace have far more to do with the options a child is presented with then anything the child can control.

In the inpatient milieu, this shift in perspective necessitated a change in every person in our system. Everyone - nurses, doctors, support personnel, families, and patients - had to begin to base their understanding and practice on an injury-based model. Only by grasping this underlying premise were *we* able to summon up the necessary compassionate regard to overcome the victim's self-blame, overwhelming shame, and sense of utter hopelessness. The individual hurt person could only move towards change if she or he believed that such change was possible and we were the only ones who could convey that sense of hope. For schools, this means that the entire school must go through a similar shift in assumptions about human nature, about children and their parents, that is very basic. As

we discovered before we began our system soul-search, we thought we had always been compassionate. Only when we put those assumptions to the test against our most difficult cases were we really able to see our missteps. Importantly, before we understood how childhood trauma impacts on the mind and body of the individual, we could explain bizarre, disruptive, and alienating behavior in no other way than to blame the victim. Trauma theory gave us an entirely different way of understanding human behavior that allowed us to relate more easily to the suffering person, regardless of their behavior. Admittedly, this is far easier to do for children who are labeled "sick" then for those labeled "bad". Sick children are generally called sick because their suffering effects them far more than it does anyone else. Bad children are labeled bad because they torment other people more than they appear to be tormented themselves. It is much easier to feel compassion when the other person is hurting him or herself, rather than when they are hurting us. But both sick *and* bad children have been hurt by others. Their different styles of adjustment may have more to do with the gender they happen to be and their individual reaction to helplessness, than it does with basic sickness or badness.

***Responsibility - Ours & Theirs***

The shift to an injury model, however, in *no* way implies an abdication of responsibility. Since developing ideas about Creating Sanctuary, we have put increasing pressure on our patients to assume responsibility for their own lives and their own behavior. One of our primary working assumptions is that neither authority nor insanity is an excuse for violence, whether that violence is directed towards the self or others. What this change in process *does* insist on, however is a sharing of responsibility. We now recognize that our response is as important in determining the outcome of any course of action as the action itself. Children must still be held responsible for their behavior and the consequences of it. But our responses to their failure can be altered. Punishment is used only to the extent that it serves the purpose of providing the child with an alternative learning experience that does not automatically reenact the previous traumatic experience. The purpose of punishment in this model is not revenge, or using the child as a social example to others. Our responses are designed to teach a lesson that the child needs to learn - responses that provide a corrective emotional experience. Punishment must never be violent or traumatic because if it is, we simply deepen the problem instead of correcting it.[6] Any situation that places the child's body in a state of hyperarousal and overwhelming emotion increases the likelihood of a traumatic response. Children who have responded to injury by engaging in "bad" behavior are reenacting their traumatic relationships with caregivers. For them, their behavior is what is expected and is normative at an unconscious level, even if they consciously know that they are behaving wrongly and would like to change. Often, being "bad" has been the only escape from unendurable helplessness, the only way they could exert any control in their environment. In their abnormal environments, their behavior was *adaptive.* Therefore, if we want them to stop it, we have to convince them that it is no longer adaptive but maladaptive. If these children are put in other situations in which they are not safe, they will inevitably revert to this "adaptive" behavior as a learned response to the danger. To change, they need to find out that they can be in safe situations that they cannot control through violence, in which they have to deal with other people, and in the process discover that nothing horrible happens. The key in strategizing how to handle "bad" kids is figuring out how *not* to do what they are cueing us to do. These children are quite comfortable with rejection, abuse, harsh discipline, unrealistic expectations, hostility, and pain. This is normal for them; it is predictable and in this predictability they feel some tenuous form of safety. The invite rejection; they set up

situations in which it is extremely difficult for us to resist treating them in kind. They are *not* comfortable with firm but fair limits, realistic and clear expectations, kindness, understanding, respect and compassion. They will see this behavior as suspicious, threatening, unpredictable and terribly frightening until they have tested it repeatedly to see if the safety holds. Only after this testing period will they feel safe enough to make the internal adjustments necessary to redefine the external world as different from their parental homes. Containing this amount of conflict and negative feelings puts a strain on any system. And a system can only handle so much. The well-intentioned goal of a full inclusion policy that attempts to integrate seriously injured children back into normal classrooms can be disastrous for the injured child, the teacher, the school, and the other children in the class if the entire school community has not been properly trained in how to manage the inevitability of traumatic reenactment.

The challenge with the "sick" children is somewhat different. Because these children often pose more problems for themselves than others, their pain is easier to overlook, particularly when the background "noise" of the "bad" children is so demanding of attention. If they are not just ignored, these children tend to evoke much more sympathy and compassion from school personnel. But what they need in addition to kindness are expectations and hope - particularly the expectation that they do not need to stay sick, that they have a choice, but that they must overcome their own handicap of helplessness and help themselves, often by reaching out to others. These children are often involved in an endless search for a replacement parent that they will never find. Like animals shocked in their cages, these children have learned to be helpless. As a consequence they are easily revictimized. They tend to form relationships that are based on "trauma-bonding", relationships that replicate the disturbed or insecure attachments with primary caretakers. To heal, they must be able to create and sustain a safe bond with other people who then must encourage them to reparent themselves, to take charge of their own lives, to take any steps they can in overcoming passive helplessness. The symptoms of these children must be understood as a message to us that we need to understand and respond to compassionately, without allowing that message to excuse the child from assuming normal responsibilities. It is vital that we help these children to develop an identity that is not based on illness and weakness but which is instead built on their unique individual strengths and survival skills.

### *Knowledge is Power*

During the years before we developed an understanding about trauma, we paid relatively little attention to the importance of educating our patients about psychiatric concepts. In fact, the jargon associated with psychiatry was so inaccessible and the concepts so mystifying, that frequently, we would have had difficulty teaching what we did not really understand ourselves. When we began understanding the effects of trauma, many more things began to make sense. We found that the more we conveyed this understanding to our patients, the easier the work became because they were able to collaborate in their own care much more effectively. As they did so, they became much less dependent on us, more able to help themselves and each other because they shared a common language, a common experience, and understanding grounded in that experience. Until they had a way of understanding what was happening to them, they remained in a state of helpless panic, mired in the self-doubt and despair that inevitably accompanies a diagnosis of mental illness. One of the basic assumptions about the educational system is that the job of the school is to educate children. But generally, this education is confined to the traditional three R's. The trauma model clearly illustrates why limiting education in this way is hopeless. Traumatized, overstimulated children cannot learn their schoolwork in the

hyperaroused state which inevitably accompanies and follows trauma. They cannot calm themselves down and tend to overreact to even minor stimuli. Traumatized children are prone to "flashbacks" during which they spontaneously relive the traumatic experience or fragments of it, as strange physical sensations or pain, and overwhelming feelings of terror or sadness. Often these flashbacks take the form of behavioral reenactments, as when the sexually abused child is sexually provocative with other children. These experiences are easily triggered by cues in the environment like words, sounds, smells, colors, or feelings that are similar to the situation surrounding the original traumatic experience. These intrusive experiences reinforce children's sense of helplessness and estrangement from others (James, 1992; Van Der Kolk, 1987). People who are traumatized need to gain a sense of personal control. If they cannot find a way to do this in positive ways, then they will turn to destructive forms of personal empowerment. For children, this decision is largely determined by the choices available to them.

The normal process of educating children cannot proceed until a sense of physical and psychological safety is established in the school. Previously, this sense of safety has been taken for granted as a given. Now that many schools need metal detectors to ascertain which students are carrying guns, physical safety is no longer just assumed.[7] Some schools are beginning to consider the importance of other kinds of safety as well - psychological, social, and moral safety. As we now know, a sense of safety is vital to the learning process. To feel safe, traumatized children must understand something about what has happened to them, and to prevent secondary traumatization, the other children must understand the situation as well. This requires a different kind of learning, more like that of school systems involved in "cooperative learning" in which the members of the group learn to help each other[8]. We know from our adult patients that for many of them, the school played a critical role in determining their life outcome. In reviewing their lives, many patients focus on the important role played by a teacher as the one person who took the time to understand them and to care about and encourage their efforts. Many traumatized children find a solace, comfort, and way to overcome helplessness through their academic efforts. In the past, however, this healing response on the part of a teacher or school administrator has been based on luck and kindness, not necessarily as a planned strategy seen as part of the school mission. Sadly, our patients have also provided us with many opportunities to see how the schools have failed to serve this purpose in the past, how the school became just another part of the social system that failed to protect them as children.

In our first efforts at Creating Sanctuary, we broadened our assumptions about our role as educators to include it as a fundamental part of good health care. Likewise, progressive schools are broadening the role of education to include emotional literacy as important a subject matter as reading, writing, or arithmetic.[9] Few people kill because they cannot read, write, or do sums, but they do perpetrate against others within a context of emotional illiteracy. If we cannot teach children how to get along with other people and feel better about themselves, the other educational skills are almost irrelevant. We can argue forever about whether this education should be done by the family. The point is that it is *not* happening and our children today are less socialized to live in a civilized world than they have been in centuries. If children are able to learn, able to get along with others, and are not self- or other-destructive, then we can assume that they are getting what they need from their families. If they are having difficulty learning, are unable to get along with others, are self-destructive or destructive towards others, then they are not getting what they need at home and it is the responsibility of the larger community to make sure that they do get their essential needs met in some alternative way. They are *our* children; we will *all* reap the benefits or the deficits of their future behavior. This is a major shift in perspective, a deliberate move away from viewing children as the individual property of their parents and

towards a community-based understanding of parenting as a mutual responsibility. If parents are going to have children, then they must be held accountable by their community for the safety and well-being of their children; likewise the community has a responsibility to parents to provide the social conditions that makes good parenting possible and to supply whatever education is necessary to improve parenting skills.

### *Interconnectedness & the Necessity for Group Process*

Another basic assumption is that of interconnectedness. Quantum physicists have been engaged in constructing a model of the universe that shows that all matter is interconnected and interdependent.[10] We already know something about these ideas from ecological studies, even if we have not yet put them into practice. The trauma model demonstrates the awesome interconnectedness of past-present-future. People who are traumatized often become frozen in the past, unable to develop further until they are able to take the nonverbal images and feelings associated with trauma and put them into words that can be understood and shared. Only then can the traumatized person begin to live once more in the present and plan for the future. The trauma model also establishes some very concrete connections between trauma, health, illness, and criminal behavior, between mind and body, between self and others. We now know that the physiological problems associated with repeated trauma affect the immune system, predispose to substance abuse and other addictions, and are not easily controlled by the victim.[11] Despite this growing recognition of fundamental interconnectivity, our problem-solving paradigm is still individual and competitive, based on a world that is drawn into constant clashing dualities rather than connection. In any discussion, we inevitably look for who is right and who is wrong; who wins and who loses when what reality demands is not either-or but both-and problem-solving. This model assumes that we are all interconnected and that success is defined by integrating opposites into a functioning whole, not the dominance of one part of a duality and the submission of the other.

The ideas about interconnectedness also focus on what happens when a group of people, working together and interacting with each, come together to form a system. This system takes on a life of its own that is greater than the sum of the individuals within it. Tentative efforts to understand the way systems work can be drawn from our understanding of individual psychology. The process of Creating Sanctuary is an attempt to work with the entire group, as a group, using a model different from the model of individual psychology, but drawing on that model for information. We assume that the group, like the individual, has both conscious and unconscious levels of function and expression. This model has been best articulated thus far in the psychiatric literature of the 1950's, 60's, and early 70's that refers to the practice of the therapeutic community model of treatment.[12]If we are to make further progress in schools, in communities, in any aspect of human functioning, then we must become more skilled at functioning as a whole group in which each individual joins his or her identity towards the conscious goals of group process, thus forming "group consciousness". If this is to happen, then learning how to do this must begin in childhood and is best learned first at home within a democratically focused family and at school, within classrooms which teach and practice democratic principles.

### *BASIC GOALS*

Out of these shared assumptions, attitudes and values springs a set of goals towards which we must all work if Creating Sanctuary is to be successful. The overarching goal is to create an environment within which children and adults can maximize their potential for

learning and growth with as little exposure to trauma as possible. This goal can only be achieved by the ongoing participation of everyone in the system. Our goal in therapy is to help people achieve a state of health, having transformed and transcended their own traumatic experience. Simultaneously, our goal is to perform that service in a context that enhances our own growth and reduces the potential for harm to us. The goal for the school must remain the education of children, but that goal needs to be widened to include a definition of education that reflects the real needs of children today. The family is evolving into some other form that we cannot discern yet. While this is happening, the school must engage more actively in this evolution by assuming the functions that are not being fulfilled at present. It is not a matter of what is right or wrong, this is just about dealing with reality for the sake of the children. The goals of the school must also encompass the health of the teachers, administrators, school boards, and other school personnel. In a family, if the parents are not healthy, they cannot provide a healthy environment for their children. Likewise, if the system that encompasses the school is behaving in a dysfunctional way, the members of the system cannot provide a healthy environment for learning.

Maximizing human potential depends on ever-increasing integration of function. Individual human function is compromised by fragmentation. In severely traumatized patients, we often see a high level of specialization of function directly parallel to impaired function in the same person. As a result, it is not uncommon to see someone who holds an executive position in a company who continues to function at the level of a five-year old in interpersonal relationships, or a patient who can accomplish death-defying feats under traumatic circumstances who is incapable of going to the store alone or sit quietly enjoying a movie. These represent problems with integration. Our society and all our social systems function in a similar way. We have an unending supply of experts and specialists but there is little integration between different levels of expertise and different specialties. The right hand doesn't know what the left hand is doing. Our goal, therefore, in any transaction or decision is to achieve the next higher level of integration instead of being trapped into false dichotomies. The more we are traumatized, the more fundamentally fragmented we are, with each trauma causing yet another split in our personality functioning. Traumatic memories remain "trapped" in a nonverbal domain in the form of images, feelings and sensations, unavailable to verbal thought, but repeatedly acted-out through behavior that is often destructive to self or others.[13] Our goal, therefore is integration, the union of opposites, regardless of whether this is in the individual psyche or within entire social systems. This integration requires making the unconscious, nonverbal experiences conscious and putting them into words that can be shared with other people, rather than reenacting them through destructive behavior.

## *PROCESS*

### *Questioning Basic Assumptions*

So far we have covered a bit about the "What", the "Why" and the "Who" of Creating Sanctuary, now what about the "How"? Creating Sanctuary is a process, always happening in the present, not fixed and static. Its central focus is growth and development and therefore, to the extent it becomes inflexible and unmoving, it will turn into a rigid institution and the source of creative change will be lost. This being the case, the process will be largely formed by the people who are involved in it, not some external authority, and every system will have a different "personality" just like individuals do. If the basic assumptions and values are in place, then the actual process can be variable, can change over time, and must be flexible enough to grow itself as needs change. For us, the process of

Creating Sanctuary began with a thorough evaluation and exposure of our own underlying and often unflattering basic assumptions. We could not really make changes in our behavior until we became committed to changing those assumptions. We suspect that if these basic assumptions and values have not been altered, than the process of Creating Sanctuary is doomed to failure, in fact it is probably impossible to engage in such a process without changing one's basic paradigm structure. This may be why so many of our previous anti-violence, anti-drug, and similar programs have failed to be as effective as we had hoped. Any process that seeks to change a system, must begin its work at the level of basic assumptions. If, as a culture, we have not based our interventions on the assumption that the protection of children from harm is an overriding social responsibility, then we will not commit ourselves to the investment of time, energy, and money necessary to guarantee that such protection actually occurs. Attempting to modify a system without altering these assumptions is like building a structure without a sound foundation - it is destined to collapse and when it does, may do more harm than the original structure it was built to replace.

***Reorienting the System***

The first step in changing the paradigm is education. Ultimately, education of children into the new model will be an on-going part of the process. Initially, it is most important to educate the adults in the system - everyone from the janitors and cafeteria workers, to the bus drivers, the teachers, the administrators, the support personnel, the school board members, and as many representative members of the parents' groups as possible. This may be the only time when outside specialists and trainers need to be consulted to help facilitate the beginning stages of this reorientation in perspective. An outsider is often useful so that everyone in the system can participate in the initial formation of the new process without having to be in an externalized and hierarchical role. If there are long-standing unresolved conflicts within the system, if may be useful to utilize outside facilitators for a longer period until the group has established a more safe and secure identity and process itself. If the adults in the system can learn to provide a safe containment system for overwhelming feelings, the children will respond dramatically. People cannot be expected to make fundamental shifts unless there is some good reason to do so. The goal of this educational change is to deliberately shift attitudes, to move the fundamental question that we pose when we confront a troubled or troubling person from "What's wrong with you?" to "What's happened to you?", and "How can we help?".[14] The first question, whether expressed as question or just as attitude, makes an immediately prejudicial judgment about the worthiness of the person in reference to the questioner. With this question, we start off any interview already established as an adversary. The person then must prove that there is not anything *wrong* with him, or suffer the humiliation of admitting that there is. The alternative questions extend a hand of compassion, possibility, and opportunity. Relieving the person from the burden of shame leaves open the possibility for the realistic self-appraisal of responsibility and request for assistance. The place to begin this change in approach is with us. When we made this shift in perspective and practice on the inpatient unit, it was not the patients who changed; *we* changed. We changed the way we dealt with our patients, but we first changed the way we dealt with each other. When we were able to make the environment safer, less fragmented, and more emotionally responsive to *our* needs, the environment automatically became more health-promoting for our patients. This principle probably applies to every system, similar to the well-known family therapy precept that if we are able to help resolve the parental conflicts, the children's problems often evaporate.

With the trauma model we now have a way of explaining troubling behavior that is grounded in the body, in science, and in meaning[15]. This information is teachable, makes sense, is relatively jargon free, and is immediately accessible. Armed with this knowledge, many other things fall into place. Fear and rigidity often spring from ignorance. Knowledge brings relief from that fear and compassion as well. We are presently caught in a blaming paradigm that leads nowhere. Finding a scapegoat for a problem does not solve the problem, and yet many of our problem-solving efforts lead nowhere except on a futile search for someone who is at fault. We then become preoccupied with punishing the offender and make no further advance to get to the level of causality that determined why that particular offender made the choices he or she did. This being the case, the behavior is quite likely to be repeated, and if the root causes are not eliminated, it is likely that more individuals will continue to make the same poor choices. When we stopped "blaming the victim" by labeling patients "manipulative", "attention-seeking", "demanding", "needy", "borderlines", and all the other pejorative terms we resorted to out of our own sense of frustration, we embarked on a much more thorough search for "why?" Why is this person harming herself? Why is he so hostile? What purpose do these symptoms serve that could have been adaptive under other circumstances? What do these behaviors tell us about the tragedies of their lives? Once we began asking *those* questions, the nature of the therapeutic relationship changed, our approaches changed, the patients felt more able to trust us and to risk change, and we felt better about ourselves. In the school setting, as in the clinical setting, these questions must also be extended to the troubled parents of the children. The effects of trauma are multigenerational, and demonstrating compassionate concern for the parents can be instrumental in helping the parents help their children, as good teachers have always known.

The danger in looking for causes, however, is clear. Once we begin to look at the reasons *why* people behave badly, we begin to see how clearly we are all interconnected, trapped within a web of interdependent, multigenerational, and overwhelming social problems like poverty, racism, sexism, unemployment, and many more.[16] Once a problem becomes a social problem, and not just the problem of an individual perpetrator, then we are all engaged, we must all participate in solving the problems. And the fact is, we simply do not yet know how to effectively work together to do that. Faced with this anxiety, we go back to finding someone to blame, and the problems do not get fixed, but instead, worsen. This is exactly the way our individual patients behave and it is the way an entire group behaves as well. This situation will not change until we change our underlying assumptions about our own responsibility to each other. We still all feel the backwards pull towards blaming behavior that is always lurking in our behavioral repertoire. Changing the way we view ourselves and other people is hard work - it feels like we are constantly stretching ourselves, pulling ourselves onward, and sometimes, like rubber bands we spring backwards to old behavior and have to stretch ourselves out once again. Only the understanding encouragement of each other prevents that regressive pull backwards from being permanent.

Facing up to the truth of what really happens to children in our society is extremely disturbing. Because this material is so anxiety-provoking and requires such a shift in our way of doing things, there will be some members of any audience who cannot be persuaded. For some, this material is simply too threatening. If your whole life has been built around a core set of beliefs about the basic nature of yourself and other people and someone suddenly tells you that you have been misguided for all these years, this may not come as welcome news. Those of us who have gone down this road already can testify to how overwhelming and confusing these insights are initially. At first, the experienced individual burden is too much to bear. Everyone goes through a period of disequilibrium before

settling down to a new vision. The people who are already closest to that vision, who have caught previous glimpses of it through their own experience, will feel quite frustrated by the more resistant people in any group. Once we begin to understand that this kind of resistance rises more frequently from fear than cruelty, it is a little easier to exercise patience with each other. Those who are least afraid can assume the responsibility for leading the group towards change, which also includes the responsibility to find a way to integrate *all* points of view into a cohesive whole - and *that* is not easy.

### *Gathering Consensus & Leadership*

If things are bad enough, or if the group is excited enough, a moment will come when enough interest, excitement, and even hope has been generated, that it is time to begin the process of achieving agreement on the level of basic principles and goals. The "how" of reaching the goals can be negotiated constantly, but failure to agree on the basic paradigm will stymie all attempts at change. If agreement at this fundamental level cannot be reached by the entire school, then a pilot program of these ideas can be tried instead. If the pilot is successful, the teachers and students will be so obviously better off that the less progressive members of the system will be more likely to want to be part of the positive action. If a pilot study is undertaken, however, the administration must give the pilot full support and protection from negative forces in the environment. The mandate for change must come from school leadership and must be backed up by them, regardless of where this change leads, as long as it is in the best interest of the children. Protection of the less powerful in the system is always an essential and indispensable responsibility of leadership. Too often, leaders devote their loyalty and obedience to those above them in a hierarchy while neglecting to recognize that their core responsibility is to those *beneath* them in that hierarchy. This underprotectiveness is a disaster in families and it is a disaster in other systems as well. If a pilot program cannot be adequately protected it is probably better to not do it at all then to set the pilot up for a sabotage effort from within or from without. If the negative forces are too powerful, it is better to wait for a better time while working on the neutralization of such overwhelming negativity and resistance to change. Administrators, school board members, and teachers play a vital role in providing models of good authority for the entire school community. Good authority figures are able to exercise consistent and rational problem-solving and conflict resolution, are openly communicative and direct, practice fair play, are flexible enough to change with changing circumstances, openly demonstrate emotional warmth, compassion, and self-control, are highly relational and connected to others, and consistently and predictably practice what they preach. Bad authority, which is typical of many abusive homes, is associated with violence, coercion, abusive power, unpredictability, manipulation, secrecy, inconsistency, rigidity, and emotional distance and disconnection.(Pitt-Aikens & Ellis, 1989).

### *Creating a Vision*

If agreement on these basic principles can be reached, then it is time for the adults to openly create a vision with each other about the kind of school they want to work in, how they want to feel, how they want to be treated and treat each other. This requires a relatively high level of trust among the participants in this process and the school leadership may have to lead the way in this regard.

The best rules are often the simplest, and Robert Fulghum's rules from kindergarten remain the best (Fulgham, 1989): "Share everything, play fair, don't hit people, put things back where you found them, clean up your own mess, don't take things that aren't yours,

say you're sorry when you hurt somebody, when you go out into the world, watch out for traffic, hold hands, and stick together". If you think this is silly, just imagine working in a setting in which *everyone* obeyed these rules and you probably won't think it's so silly. Since we are used to functioning only within hierarchical, and often power-abusing systems, leadership often elicits more fear than loving respect. Fear is a barrier to any kind of constructive change. If the process is to continue, these barriers to group process must be overcome. We are only now beginning to understand how important emotional stability is in determining the outcome of any decisions. Emotions allow us to experience a sense of value in our lives and connect us to other people. People who feel nothing are far more of a danger to human survival than people who feel too much. It is clear, however, that good decision-making requires modulation of our internal emotional states and for that, we must depend on each other.[17] Interactions with other human beings play a large role in determining how our bodies learn to modulate our emotions and are vital determinants in the worthiness of our decision-making process and the overall health of any system[18].

Ideally, the process of creating a shared vision would be initiated by a representative team composed of key members of the school community including members of the school board, administration, faculty, support personnel, parents, and students as well, particularly in the case of the secondary schools. This team could begin the process of creating policies and procedures that reflect the imminent change in focus and direction for the school - a school constitution, or bill of rights and responsibilities, or whatever metaphor works best to convey a declaration of independence from past negative habits and the beginning of something different. Once the adults have engaged themselves in such a process it becomes far easier to teach the children how to do it. The problem with including children in this stage of the process in the beginning, is that this limits the necessary conflictual interactions of the adults that must be worked through if change is to occur. If there has been relatively little participation from the students, these documents pertain only to the adults in the system, although they can serve as the basis for similar overall documents for the entire school.. If the adults can figure out how to change themselves, they can serve as models for the children. If the adults do not "walk the walk and talk the talk", the system will not change. If this part can be accomplished successfully, the rest is much easier. The process of creating a vision can then be engaged in by the children as a whole and within each individual classroom so that the shared values and goals permeate the entire system.

***System Maintenance***

"System maintenance" or even "system therapy" is vital if any real change is to occur. Maintaining the system is accomplished through meetings, both formally scheduled and impromptu meetings that people have with each other in any smoothly functioning organization. It is *not* wasted time. Minor conflicts or misunderstandings become major battles largely because of a lack of immediate conflict resolution. As in the body, a tiny splinter if left to fester, can turn into a life-threatening infection that necessitates amputation. Unfortunately, in most systems, this maintenance function is the first thing to go when budgets are tightened and responsibilities are increased. This is a major cause of system malfunction. The adults are role models for the children. If the adults can create a system for themselves that is responsive to *their* needs it is likely to be a much safer container within which children can safely learn and grow. It has been recognized for a long time, that in a therapeutic milieu, whenever the staff is having a conflict, particularly a simmering, unvocalized, submerged conflict, the patients will act-out the conflict. They know without really knowing, that the staff members are troubled in exactly the way children recognize and respond to conflicts between their parents. As long as there is an on-

going and reliable method of conflict resolution at the level of the staff, the patients will feel safe and able to focus on their own goals, rather than becoming enmeshed in the mire of staff conflicts. Therefore, resolving staff conflicts at all levels, is an essential factor in maintaining the health of any system. Conflicts are inevitable and will never be eliminated. What is important is that there be a process which regularly surfaces and addresses those conflicts, thus taking away their hidden power to cause rifts or ruptures in the integrity of the system. Resolving such conflicts is, of course, time-consuming. Unfortunately, in most systems, little attention is paid to this vital role of system maintenance and helps to explain why the functioning of so many systems is impaired. Although we have some recognition that we need to regularly fuel a car, change the oil, check and replace the brakes, rotate the tires, and adjust its functioning in a myriad of different ways, we do not seem to recognize that human systems need maintenance as well. Human systems are maintained through human communication. It is through the formal and informal networks of communication, both verbal and nonverbal, that we are regularly fueled and checked for problems. Without sufficient time for meetings, conferences, case reviews, or conflict-resolution sessions, our systems breakdown as surely as a poorly maintained automobile.

***Traumatic Reenactment, Mutual Support, and Self-Help***

One of the revelations that occurred to us as we came to change our way of doing things was the realization of how much we needed help from each other as a normal part of the therapeutic process. Traumatic reenactment is the compulsive and unconscious need to repeat a traumatic experience by recreating the past through relationships in the present (Van der Kolk, 1989). The forces of traumatic reenactment are powerful and even the most insightful member of the community is at times vulnerable to their destructive effects. In order to be effective with injured children, it is necessary to get involved enough to understand what is wrong so that we can help then find a way out of their dilemma, but to be safe, we must have colleagues around us who can rescue *us* if we become overinvolved and lose perspective on what our role is supposed to be. In this way, faculty members need to assume a caring and compassionate co-supervisory relationship with each other. Like therapists, sometimes teachers can become overinvolved, feeling that they have to save a certain child. This can result in a boundary trespass that is dangerous for the teacher and the child. Sometimes a teacher becomes so infuriated by the behavior of a certain child, that the conflict in their relationship comes to dominate the entire class. Everyone is vulnerable to the peculiarities of specific children, usually the most troubled and problematic kids, and teachers must be able to assist, support, and help each other safely through these difficult relationships. It is inevitable that in dealing this closely with children, many of whom are quite troubled, all kinds of conflict within the helping professional will be elicited. Our only safety net is the support of each other.

If the school leadership is committed to change, and have some idea of the changes they wish to implement, they can begin the process of actually doing it. But this takes time and a commitment of resources for training, and even more important then training - time for system maintenance. An era of specialization has left most of us feeling helpless, often in vital areas of our lives. From our experience in changing our psychiatric unit, we learned that the process of change does not necessarily require “experts”. When we began making these changes in our system, there was no one to turn to for help. No one else knew more than we did - or if they did, we could not find them. So we had to do it ourselves - we had to start with us. This is an essential message to the schools, to the teachers, and to the children. We already have the resources we need to figure out how to solve the problems but we cannot access those resources without talking to one another. We have become far too

dependent on looking outward for solutions that lie within and among ourselves and far too attached to an established body of knowledge that says what we should and should not do. If we are going to stop the trend towards violence and fragmentation in our systems, we are going to have to break the established rules, since clearly, they are not working. The trick is to find ways to break the rules that do more good than harm. We found that effective change only came about when we relied less on individual decision-making, which was often flawed and inadequate, and more on group process decision-making so that we could balance and moderate each others' extremes. If this can be accomplished, the faculty and administrators can feel more hopeful, interested, and safe with each other. Then it is time to move on to the children. We noticed with our patients that when we began to see them not as passive sick people or helpless victims, but as human beings with a potential for recovery and empowerment, they began seeing themselves differently and they began behaving differently. This was a formative lesson for us. Much of how we behave towards ourselves and each other depends on expectations. The best teachers are often those who have high expectations for their students but who are also willing to help teach the children how to reach those expectations. We realized that we had always set our expectations far too low for our patients and they obliged us by living down to those same expectations. When we began to believe that people really *could* change, that they really *could* get better, they started improving in some dramatic ways. Even many of the most damaged patients, the ones who had spent years in state hospitals, who cut themselves, burned themselves, made frequent suicide attempts - the ones we had previously given up as hopeless - began to gradually improve. It was a humbling experience to see that we were not nearly as important as we thought we were. In fact, what our patients often needed us to do was get out of their way and allow them to grow without putting up unnecessary obstacles to their growth. What they needed from us, more than anything, was education which provided them with some tools, encouragement which gave them hope, and a physically, psychologically, and socially safe space. In this safe space, they could learn, suffer through their own memories, talk to each other, re-experience the pain, exercise their creativity in the service of healing, learn to laugh and play again, and grow.

***The Classroom as Community***

Ideally, each classroom would be run as a therapeutic community, a safe place within which the children could experience emotional modulation on a constant basis. When we began teaching our patients the same material that we had learned ourselves about the effects of traumatic experience, their perspective and process began to shift in a parallel fashion to our own. If children understand more about what they are going through, how their own minds and bodies are effected by the violence around them, they will become more empowered to make different decisions, particularly if such decisions are reinforced and modeled by the adults around them. If hyperaroused, distressed children can depend on a network of relationships within which they can talk about their pain, learn new skills, and trust other people, the likelihood will be greatly increased that they will be far better able to learn and do less acting-out in the classroom. In a group setting, this support does not have to be the sole burden of the teacher, as it is in a traditional hierarchical system, but can instead be the expectation that is placed upon the entire group of children to be mutually supportive and concerned about each other. This same shift in attitude and emphasis can have just as much of a positive effect on the nontraumatized children, as they learn to deal more fairly and compassionately with those around them. At present, the attitude of "I am my brother's keeper", is not a value to which children have any consistent exposure and yet it is the only attitude that can get us out of the deteriorating spiral of

alienation within which our culture is presently gripped. If we cannot do anything to change the homes these children live in, then we must expand their options. Let us provide them with an alternative reality. After all, they spend a considerable amount of their waking hours in school for at least nine months out of every year. We have no idea how rehabilitative those hours could be if our priorities were structured differently, without jeopardizing educational requirements. The most devastating aspect of trauma in childhood is the hopelessness it often breeds. Even if we cannot adequately protect many of these children, if we can protect the source of their hope, we will have done a great deal. Children know that childhood is limited, that someday they will be able to run their own lives. Our responsibility is to provide them with an alternative to traumatic reenactment.

***Self-Governance***

The suggestion that grows out of this experience that is relevant for the schools is that we probably need to turn more power over to the children. In many good classrooms this is already happening. There are existing models in which the teacher is more of a facilitator for the group process, stepping down from the role of hierarchical lecturer. Just like our adult patients, students must actively participate in creating the environment that is most conducive to learning and growth for them. As adults, our job is to see to it that they have the structure within which they can help to create just such an environment in every classroom and in every school. Children are carrying guns to school because they do not feel safe. So how would they recreate a sense of safety within the school? This is the fundamental question that needs to be addressed in every class of children. Let them participate in the creation of their own rules, constitution, body of laws and let them help formulate the consequences of breaking those rules. The teachers must be freed from the overwhelming - and often ineffective - burden of hierarchical leadership. The teacher's job in this system would be to provide the structure, guidance, questioning, provocation, and final say that is necessary for such a consensus approach to work. The teacher must protect the minority from being overrun by the majority and must be the guardian of basic values like tolerance, patience, and compassion accompanied by firm limits and clear expectations. The teacher must hold all accountable for the creation and implementation of the system of rules.

Enforcement of the rules should also originate with a representative group of students to whom the rest of the student body will accord respect. In the therapeutic community model, this is known as the community government. This self-governance should begin in primary school and not wait until secondary school, when bad habits are already well-established. Traumatized children desperately need repeated experiences with self-management and self-control to overcome the passivity and helplessness that is a byproduct of abusive power. And all children need early training in democratic processes. Such a self-governing body, however, will then need to be guided by members of faculty and administration. The determinations of these representative bodies then must be implemented and cannot be overruled by outside intervention. The limits of power must be articulated as part of the process, but then when such a group exerts its rightful power, it must be able to do so. This requires the cooperation of the entire system including parents, school officials, courts, police, and any other governing bodies that impact on the schools. Over and over needs to be stated: Power = Responsibility; Rights = Responsibilities. If we expect children to turn into responsible adults, then they have to be treated as responsible children before they become adults. When they are not behaving responsibly, then they are best judged by their peers with adult oversight, guidance, and final say. There are already models for this. In Concord, Massachusetts, the public school community has worked for

years on creating a mission statement and has epitomized their position in the slogan "Rights, Responsibilities, and Respect".[19]

### *Conflict Resolution*

One of the most critical functions that we can learn - and teach to children - are those of conflict resolution. There are now available many programs in peer counseling and conflict resolution that are entirely consistent with and must be a part of Creating Sanctuary.[20] One of the principles of conflict resolution is that conflict should be resolved at the level at which it occurs. When a patient comes to a staff member complaining about another patient or a member of the staff, our first question is "Have you discussed this with the person you are complaining about?" Usually the answer is a surprised "no", at which point they are urged to go deal with the problem directly and report back with the results. Often both children and adults must be directly taught problem-solving skills through role-playing, imaginative rehearsal, and group-problem solving techniques. Using real-life interactions, children engaging in such a process are learning *how* to think, skills that will serve them well in all their future endeavors. Intervention occurs only if the problem is not getting resolved satisfactorily, but usually it is not necessary. People *do* have the capacity to resolve conflict, to compromise, to see the other person's point of view, but that capacity must be routinely exercised, encouraged, supported, and *expected*. One of the most useful techniques for resolving problems in our setting has been understanding the mechanics of traumatic reenactment and openly discussing this in a group setting. When someone is presenting a particularly difficult and troublesome behavior, it is useful if a group of concerned and involved people can be drawn together with the person to begin the process of understanding how the present behavior is a reenactment of past hurt. Understanding this dynamic opens up the possibilities for choice, for redirecting the behavior down an entirely different path. This exchange must not be punitive, but supportive and educational, designed to help the person who is trapped in a reenactment, not to shame them.

Dissent is healthy and must be permitted, but it must be channeled in such a way that it becomes a strength of the system, not a handicap that hurts other people. Dissent is the signal to the group that some fragment of the overall group consciousness requires a new level of integration. Opening up to the dissenting opinion often requires a shift on the part of everyone. It is the dissenting voice that keeps us thinking, keeps us moving, keeps us aware of our own slippage into the sea of hypocrisy which is always there under our feet. If the dissenting voice is listened to regularly and respected, it does not need to be strident or aggressive.

### *Artistic Performance and the Transformation of Trauma*

Healing from trauma requires the safety of predictable and stable relationships. Only within such a context can children begin to "tell their story". Until children can transform their traumatic experiences into a verbal and shared narrative, they will remain a haunting presence, interfering with the children's capacity to deal with the here-and-now. Writing, drawing, sculpting, dancing, acting are all ways that people transform their nonverbal experiences into a verbal narrative that can be shared with others. Children should be encouraged to engage in these forms of "self therapy" and the arts programs, because of this endeavor, should have much more authority, funding, and credibility. Our need to perform may be nature's antidote to the prolonged suffering of trauma, and should be heartily encouraged rather than minimized and marginalized. It is entirely possible that a healthy arts program in a school of traumatized children may be more important in

preparing those children to learn, than any other skills we can provide. Engagement in these forms of "therapy" are also highly educational and consistent with the goals of the school. And there are strong indications that the need to perform to engage in ritual transitions and interactions with each other, are an important part of normal human functioning for all of us. Rituals provide us with a way of understanding our world and sharing universal feelings with each other as long as they are meaningful. Children may vent their frustration on the playing field, they may learn a great deal about teamwork and fair play. But too often sports are used as teaching opportunities for aggression, malice, and competition, feeding the tendency of human beings to act violently towards any group that is not our own. Programs that encourage self-expression and cooperation must take priority given our present social crises. We must begin to produce children who are ready to create a cooperative, not a competitive world.

***Community Tolerance for Violence***

Special programs need to be created and funded to address the needs of children who could not fit into the system. This is particularly pertinent to the so-called "conduct-disordered" child who is usually a victim of serious trauma.[21] Every effort should be made to help this child heal within the environment, but ultimately, if the child's symptoms are so severe that they make it impossible for the classroom to function as a healthy system, then the needs of the many must take precedence. Each school, therefore must have provisions for the most disturbed children, especially because they are still young enough to be helped. Without such attention, they are quite likely to go on to become another casualty, prematurely dead or imprisoned. If therapeutic milieu concepts can be applied in the classroom, much of the acting-out behavior can be diminished through the powerful effect of group pressure. However, there will still be situations that are beyond the capacity of the group to manage, particularly when the behavioral problems are based on organic, not functional factors. The basic and inviolable position of Creating Sanctuary is the absolute refusal to tolerate violence. Therefore, when violence cannot be contained by the group, then the violent elements must be taken out of the group until such time as they can contract for safety. When this is the case, the school must have the power and resources to find alternative placements for the violent child instead of being forced to sacrifice the well-being and safety of the entire class. Other ways of handling disputes between the school and parents, disputes that frequently arise in these cases, must be found rather than resorting to the court system. The justice system is, by definition, an adversarial system, and therefore, its basic assumptions and method are directly counter to those of this model. The full inclusion policy, although well-intended, can only work if sufficient funding is provided for training of school personnel and the other children in the classroom, if the children already damaged are not to be further traumatized by repeated failure. Without such special provisions, the danger is that a functioning classroom or an entire school can rapidly turn into chaos, while the level of education reverts to the lowest level necessary to keep the disruptive children in check. A parallel situation occurred in the psychiatric milieu settings when the state hospital system was dismantled and psychiatric facilities had to suddenly cope with the most severely ill segments of the population and insufficient funding was allotted to alternative services in the community. The care in many settings deteriorated and became more restricted and limited in order to cope with the physical threats that some of these patients presented. Decisions such as these, although often cloaked in terms resembling "the best interests" of the child or the patient are often made under the pressure of lowering costs. The counter to this pressure is the absolute need for safety in any

situation in which human beings are to live and function. We must stand firm in our resolve to protect children and each other from harm.

### *Critical Incident Debriefing*

Another important part of the process of Creating Sanctuary in the schools is to establish "critical incident debriefing" teams to help decrease the long-term effects of trauma when violent incidents occur within the school itself. Models for this kind of intervention are well-established in the field of disaster research (Mitchell, 1983) , in hospital psychiatry (Flannery, 1990), and even in other community settings such as those programs sponsored by the Victims of Violence program at Cambridge Hospital.[22] These teams could be trained by professionals and consist of rotating teams of students, faculty, parents, and concerned community members. A team would then be called in to help those immediately affected by any episode of violence to expedite the healing process of the individuals and of the system. Any violent episode destroys the sense of safety, at least temporarily, and active efforts must be made to restore it. These kinds of disruption are best dealt with openly and with the participation of the entire school community. When the whole community unites to seal the rupture that acts of violence inevitably create, the active process of Creating Sanctuary is engaged.

### *Parenting & The Next Generation*

Parents, other family members or concerned friends would be expected to be actively involved in the school community, and not just in elementary schools but in secondary schools as well. When parents refuse to become involved, this can be viewed as a high-risk situation and community outreach should be done to evaluate how the community can assist the parents to be better parents for their children. The more cross-communication there is between parents and faculty, the more likely it is that the child will have a network of support. The more the school structures these opportunities for communication and interface between the school community and the parents, the greater the likelihood that communication will be direct and mutually beneficial. Again, the formation of community groups comprised of concerned parents, faculty, and administrators to focus on specific problem-solving can be very helpful. Using group process to help manage particular problems in a non-punitive way is often extraordinarily effective when individual and more traditional methods fail.

There also must be special intensive programs for teenage parents to keep them in school, to help them to provide adequate nurturing for their children, and to offer intensive parenting education to help them become better parents. There are now available excellent model programs to help high-risk mothers develop skills through parent-mentoring programs.[23] This is a singular opportunity for us to intervene at the level of prevention. These mothers want the help and major changes can occur for relatively little cost. This is the fastest and cheapest way of stopping the intergenerational spread of trauma. Ideally, secondary schools would have day-care on-site so that the mothers could stay in school without neglecting their infants and the infants could have the benefit of high-quality care that the mothers could learn from as well. The day-care could be part of the entire educational experience of the school as both girls and boys learn parenting skills in practice, not in theory. Special programs would also need to be created to deal with the special problems of boys as the masculine culture changes from one based on the values of the warrior to those based on the values of the guardian, the diplomat, and the Man of Reason.

Ideally, the school would become the hub of the community, used after school hours and on weekends as community centers where children and their families can take classes, pursue recreational activities, formally and informally meet with each to socialize and form a network of communication and safety that could help reclaim the community for the people who live in it. Somehow, we have to get parenting classes out of the realm of remediation and into the realm of normal education that *everyone* needs. People get more assistance in learning how to run a computer or a dishwasher than they do in raising a child. Just to drive a car you need a license which requires more study than is ever mandatory to rear a child.. Additionally, there would have to be far more integration of services and personnel between the school and other community agencies including public health, mental health, juvenile justice, child welfare, and any other public or private institutions that have a stake in seeing to it that children are protected, educated, and nurtured towards becoming healthy citizens.

***CONCLUSION: THE SHIFT TO GROUP CONSCIOUSNESS***

In the language of the therapeutic community, the whole is always greater than the sum of the parts. The essence of establishing a therapeutic community lies in a thorough understanding and practice of this concept. In Western culture we are only familiar with two basic positions which are usually placed in opposition to each other - individual consciousness and mob rule. Individual consciousness is seen as always in danger of being submerged into the group unconscious, and in doing so, man becomes little more than a mindless beast moving with the herd. However, as we can all see, individually, we are limited in our capacity for empathy, for exercising good judgment, for creative problem-solving. Despite the urgency of many of our systemic and environmental problems, many caring and intelligent individuals are busy burying their heads in the sand, feeling overwhelmed by the situations that confront them and unable to deal with the attendant sense of helplessness.

There is an alternative to individual consciousness or a herd mentality, an alternative called “group consciousness”. For the last fifteen years, a group of us have been involved in repeated experiences with group consciousness. Just as a group can amplify negative attributes and feelings of its individual members, so too can a group amplify positive attributes and affects, if there is an agreed upon and practiced set of established values. The emergent qualities that arise out of such a process are as powerfully effective in creating positive change as mob rule is in perpetrating destruction. It has been startling - and humbling - to discover that the results of group consciousness far outshine our individual problem-solving skills and that these results are not attributable to the sum of the individual efforts but instead constitute an entity that surpasses that sum and seems to take on a life of its own. It is that entity we call “The Sanctuary”.

The best metaphors for Creating Sanctuary are found in the theater and the concert hall. In discussing what we are trying to accomplish, the stage metaphor is useful because we are trying to redirect the traumatic reenactment scenario. We want to provide environments within which the individual’s particular complex of trauma-organized and self-destructive habits can be understood and then redirected, much like a play director directs actors on the stage. Children who have been traumatized unconsciously do the same thing over and over. They give other people in their environment certain cues for behavior that will induce an outcome similar to the original trauma. [24] Then, when people around them act in the way they have been cued, the child is retraumatized. Children who have been profoundly rejected will evoke rejection in others. Children who have tried to defend themselves against threat with hostility, will evoke hostility from others. Children who have

been seduced will become involved in inappropriate sexual behavior. Our job is to participate in their personal drama enough to understand the lines and the expected outcome, but to then change the direction of the play, redirect the traumatic scenario so that the trauma is *not* repeated. If the members of each classroom and the members of the school community can begin to function in this way, the group itself can become the agent for change for the individuals. This can only occur within a context of safety and trust.

In describing the process and the outcome, we need to learn to function as an orchestra, sometimes performing a classical symphony, but more usually improvising jazz. Wonderful music requires many different kinds of instruments, with different ranges, different tones, and different levels of participation. But they all must be properly tuned and able to make the appropriate individual contribution to the whole. The best music happens when each individual musician is a virtuoso who integrates his or her unique creative gift with other gifted performers until the results of their efforts makes a melody and a harmony, a sound, that is far greater than that of each individual alone. When *that* happens in a system, when each individual donates his or her best contribution to the well-being of the whole, Creating Sanctuary is happening. When the individual performers are not playing their best, it is the mutual responsibility of the individual and the group to discover what change in conditions would improve their performance. Teachers and other adults who interact with hurt children have an enormous opportunity to effect major change. Traumatized children do not necessarily require psychiatrists; they require adults who can extend the vital relational skills that good parents provide and a system that provides the safety and security for these relationships to be sustained. With sufficient will and commitment, any school can create its own orchestral suite and by doing so, can play the music of healing.

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Notes

[1]For specific information about The Sanctuary™ see Bloom, S.L. (1994). The sanctuary model: Developing generic inpatient programs for the treatment of psychological trauma. In M.B. Williams & J.F. Sommer, Jr. (Eds.), Handbook of post-traumatic therapy, a practical guide to intervention, treatment, and research. New York: Greenwood Publishing; (1997) *Creating Sanctuary: Toward the Evolution of Sane Societies* or www.sanctuarysage.com.

[2]For an earlier formulation of the relationship between the "sick" and the "bad" and the experience with treating both groups in a therapeutic community setting see Whitely, S., Briggs, D., & Turner, M. (1972). Dealing with deviants. London: The Hogarth Press.

[3]For an excellent discussion of the biological basis of traumatic reenactment see Van der Kolk, B.A. (1989). The compulsion to repeat the trauma: reenactment, revictimization, and masochism. Psychiatric Clinics, 12, 389-411.

[4]This poignant observation was made by Dr. Victor Frankl, a psychiatrist and concentration camp survivor.

[5] There is an important and growing body of information about what goes into creating resilience. See Fogelman, E. (1994). Conscience & Courage. New York: Anchor Books; Higgins, G.O.(1994). Resilient Adults: Overcoming a Cruel Past. San Francisco: Jossey-Bass; Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In J. Rolf, A.S. Masten, D. Cicchetti, et al. (Eds.), Risk and protective factors in the development of psychopathology. New York: Cambridge University Press; Wolin, S.J.& Wolin, S. (1993). The Resilient Self. New York: Villard Books.

[6]Dr. Murray Straus has written an important book on the detrimental effects of corporal punishment entitled Beating the Devil Out of Them: Corporal Punishment in American Families. (1994). New York: Lexington Books. In it he asserts that "being physically attacked by a parent has been an almost universal part of the experience of American children" (p.22). See also Greven, P. (1990). Spare the Child: The Religious Roots of Punishment and the Psychological Impact of Physical Abuse.New York: Vintage Books.

[7]For specific information and ideas on physical methods for improving school safety, see Wheeler, E.D. & Baron, S.A. (1994). Violence in our schools, hospitals and public places: A prevention and management guide. Ventura, CA: Pathfinder Publishing of California.

[8]My thanks to Mrs. Anne Lewis of Corcord, Massachusetts for her advice and suggestions, including talking to me about the "cooperative learning model".

[9]Thanks to Dr. Susie Orbach for her ideas about "emotional literacy" the need to teach children competence in managing emotions and relationships with other people as vital to their normal growth and development.

[10]For further reading about this new view of the universe, see Darling, D. (1993). Equations of Eternity. New York: Hyperion. Davies, P. (1992); The mind of God: The scientific basis for a rational world. New York: Simon and Shuster; Ornstein, R. & Ehrlich, P. (1989). New world new mind: Moving toward conscious evolution. New York: Touchstone; Pelletier, K.R. (1985). Toward a science of consciousness. Berkeley, CA: Celestial Arts; Talbot, M. (1991). The holographic universe. New York: Harper Collins; Wilber, K. (Ed.). (1982). The holographic paradigm. Boulder, CO: New Science Library; Wolf, F.A. (1989). Taking the quantum leap: The new physics for non-scientists. New York: Harper and Row.

[11]There is an extensive body of information now available about the biological effects of trauma. See Davidson, J.R.T., & Foa, E.B. (1993). Posttraumatic stress disorder: DSM-IV and Beyond. Washington , DC: American Psychiatric Press; Friedman, M.J. (1990). Interrelationships between biological mechanisms and pharmacotherapy of posttraumatic stress disorder. In M.E. Wolf & A.D. Mosnaim (Eds.), Posttraumatic stress disorder: Etiology, phenomenology and treatment. Washington, D.C.: American Psychiatric Press; Van der Kolk, B.A., Greenberg, M., Boyd, H., Krystal, J. (1985). Inescapable shock, neurotransmitters, and addiction to trauma: Toward a psychobiology of post traumatic stress. Biological Psychiatry, 20, 314-325; Van der Kolk, B.A. (1989). The compulsion to repeat the trauma: reenactment, revictimization, and masochism. Psychiatric Clinics, 12, 389-411; Van der Kolk, B.A. & Saporta, J. (1993). Biological response to psychic trauma. In J.P. Wilson & B. Raphael, International handbook of traumatic stress syndromes. New York: Plenum Press; Van der Kolk, B.A. (1988). The trauma spectrum: the interaction of biological and social events in the genesis of the trauma response. Journal of Traumatic Stress, 1, 273-290; Van der Kolk, B.A. (1993). Biological considerations about emotions, trauma, memory, and the brain. In S.L. Ablon, D. Brown, E.J. Khantzian, & J.E. Mack (Eds.), Human feelings: Explorations in affect development and meaning. Hillsdale, NJ: The Analytic Press.

[12]For further reading about the therapeutic community see: Almond, R. (1974). The Healing Community: Dynamics of the Therapeutic Milieu. New York: Jason Aronson; Clark, D. (1975) Social Therapy in Psychiatry. New York: Jason Aronson; Hinshelwood, R.D. & Manning, N. (1979) Therapeutic Communities: Reflections and Progress. London: Routledge & Kegan Paul; Jones, M. (1953). Therapeutic Community: A New Treatment Method in Psychiatry. New York: Basic Books.; Kennard, D.(1983). An Introduction to Therapeutic Communities. London: Routledge & Kegan Paul; Wilmer, H.A. (1981). Defining and understanding the therapeutic community. Hospital and Community Psychiatry, 32, 95-99.

[13]The issue of memory, particularly as it relates to childhood experience, is presently being hotly contested throughout the country. Little attention thus far has been

paid to the abundance of evidence supporting major differences between normal and traumatic memory processing. For further reading see Van der Kolk, B.A. (1994a). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. Harvard Review of Psychiatry, 1 (6), 253-265; Whitfield, C.L.(1995). Memory and Abuse: Remembering and Healing the Effects of Trauma. Deerfield Beach, Florida: Health Communications, Inc.

[14]Thanks to Joseph Foderaro for this succinct way of explaining a profound interactional shift.

[15]For more reading about the "trauma model" see Bloom, S.L. & Reichert, M (Eds) (1995) "Bearing Witness", a monograph written for Physicians for Social Responsibility, 704 N. 23rd St., Philadelphia, PA, 19130. See also, DeZulueta, F., (1993) From Pain to Violence: The traumatic roots of destructiveness.

[16]For further thoughts on the social implications of trauma theory see Bloom, S.L.(1995) When good people do bad things: Meditations on the backlash. Journal of Psychohistory, 22.3.

[17]Important theoretical and experimental breakthroughs in the study of emotions are emerging. See Christianson, S. (Ed). (1992). The Handbook of Emotion and Memory: Research and Theory. Hillsdale, New Jersey: Lawrence Erlbaum Associates; Nathanson, D.L. (1992). Shame and pride: Affect, sex, and the birth of the self. New York: W.W. Norton; Ablon, S.L., Brown,D., Khantzian,E.J., & Mack, J.E. (Eds.), Human feelings: Explorations in affect development and meaning. Hillsdale, NJ: The Analytic Press.

[18]There is a growing body of information supporting the interaction between social support and actual changes in brain chemistry, particularly as human relationships impact on our endorphin system. For further reading see Van der Kolk, B.A., Greenberg, M., Boyd, H., Krystal, J. (1985). Inescapable shock, neurotransmitters, and addiction to trauma: Toward a psychobiology of post traumatic stress. Biological Psychiatry, 20, 314-325. Van der Kolk, B.A. (1993). Biological considerations about emotions, trauma, memory, and the brain. In S.L. Ablon, D. Brown, E.J. Khantzian, & J.E. Mack (Eds.), Human feelings: Explorations in affect development and meaning. Hillsdale, NJ: The Analytic Press.

[19]See note 8.

[20]A nonprofit group called the "Bucks County Peace Center", located in Langhorne, PA are actively engaged in consulting with schools to teach conflict-resolution skills to children, with some notable success. A useful classic text on the subject is Deutsch, M. (1973).The Resolution of Conflict: Constructive and Destructive Processes. New Haven: Yale University Press.

[21]For a discussion of the relationship between corporal punishment and later violent behavior, see Straus, M. (1994), Beating the Devil Out of Them: Corporal Punishment in American Families. New York: Lexington Books. For a discussion on the links between male role expectations and male violence see Miedzian, M. (1991). Boys Will Be Boys: Breaking the Link Between Masculinity and Male Violence. New York: Doubled. For suggestions on prevention, see McCord, J. & Tremblay, R.E. (1992). Preventing Antisocial Behavior: Interventions From Birth Through Adolescent. New York: Guilford Press.

[22] Contact Dr. Mary Harvey, Victims of Violence Program, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139.

[23] See Breakey, G. & Pratt, B. (1991). Healthy growth for Hawaii's "healthy start": Toward a systematic statewide approach to the prevention of child abuse and neglect. Bulletin of National Center for Clinical Infant Programs ,11, 16-22. Also refer to U.S. Advisory Board Report on Child Abuse and Neglect

[24]For examples of this, see Lenore Terr's (1990) book on the children who were involved in the Chowchilla kidnapping, Too Scared To Cry: Psychic Trauma in Childhood. New York: Harper & Row.

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