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Dr. Sandra Bloom - On Creating Sanctuary
BODY WORK DAY - OCTOBER 10TH - See Details Inside!
CREATING SANCTUARY
With Dr. Sandra Bloom

A Special Interview By Christine Rock

Dr. Sandra Bloom is the Executive Director of the Sanctuary at Friends Hospital in Philadelphia and President of the Alliance for Creative Development. She is President of the International Society for Traumatic Stress Studies and President of Philadelphia Physicians for Social Responsibility. Her latest book, Creating Sanctuary: Toward the Evolution of Sane Societies, offers a bold synthesis of the latest research on Post-Traumatic Stress Disorder found in a great portion of the American population.

N.V. Why do you believe that we are a trauma-based society here in America?
S.B. The reason I use those terms is because we know from large studies that three-quarters of people in the United States are going to experience a traumatic event in their lifetime and a significant proportion of them will go on to developing trauma-related syndromes which may be mental, physical or both. The actual rate of post-traumatic stress disorder (PTSD) may vary depending on the kind of trauma a person experienced. For example, the rate of PTSD from car accidents may be 12% where the rate of PTSD in victims of rape is more like 60-80%. Even when we look at the most conservative numbers a substantial portion of the population is suffering from the long-term consequences from traumatic events. We really did not begin to understand any of this until the men returned from Vietnam. About the same time we started getting the results from research on holocaust survivors and the women's movement turned the focus on domestic violence and childhood sexual abuse. My knowledge that has accumulated over the last twelve years has shown how devastating unresolved trauma can influence the life of a person and many generations of a society. There is a hidden force that is consuming much of value in our society.

N.V. What is Sanctuary Trauma?
S.B. Sanctuary Trauma is a concept first used by a psychologist named Steven Silver who was at the Coatesville Veterans Hospital here in Pennsylvania. He describes sanctuary trauma as what happens when someone is exposed to overwhelming stress or violence and expects to come back into a safe place, a safe haven and instead what they experience is more trauma. He was referring to the Vietnam veterans who came back from the war where they had gone through hellish circumstances. They had a right to expect that when they returned they would be cherished for the contribution they made and if for nothing else for risking their lives. Instead many of them were shunned, denied benefits, told they were crazy or baby killers and responded to with overall negativity. I related this to so many people I had seen who had experiences in psychiatric hospitals where they expected to receive help and comfort and instead they found circumstances that were quite the opposite. I found this to be sanctuary trauma too. This led us to asking ourselves "what is creating sanctuary all about?"

N.V. You mention in your book that many of the concepts for creating sanctuary were based on what is termed "moral treatment." Could you expand on that?
S.B. In the late 18th century in York, England there was a community of Quakers where a 19 year-old girl was sent to an asylum because of her disturbed behavior. There were no mental
hospitals back then and the mentally ill were often mixed with criminals and were confined from society and even put on display sometimes for the amusement of others. Within a couple of days of her stay she died mysteriously. The Quaker community members were deeply influenced by this and they established a hospital called the York Retreat, which is really the first site of moral treatment. The basic principle of moral treatment is if we take people who have become mentally or emotionally ill and put them with other people in a beautiful, healthy environment and give them opportunities to pray and to spend time alone and to socialize with others and to do constructive work, they would heal. Moral treatment was the kind, compassionate care given to someone who was having any kind of emotional problem. Friends Hospital here in Philadelphia was the first site of moral treatment in the United States and this idea spread throughout the country for about a quarter of a century. Then in an uncanny parallel with what has happened in this century it fell into disfavor. This was not because it was ineffective because indeed it was quite effective. What happened was that very rapidly the systems were overwhelmed. Moral treatment was designed to be administered to small groups of people with a high ratio of helpers to people who needed help. Very quickly these hospitals became a place for communities to send all of the people they did not want anymore. The rate of cure went down and state legislatures did not want to pay for the intensity of treatment required by moral treatment. This is how we ended up with the huge state hospital systems that we began dismantling in the 1970's.

N.V. Did the same moral treatment degradation occur in England?

S.B. Not to my knowledge. I visited the York Retreat last year and they are still going strong. They are considering creating a sanctuary unit like ours.

N.V. Other than the trauma-theory is there another therapeutic model that you use in creating sanctuary?

S.B. This other therapeutic model is what I see to be the next step of moral treatment and it came directly out of WWII. It began in England and then again came over here. Many psychiatrists were recruited to treat men at the front or back from the front or at home because there was such a high incidence of psychological problems secondary to combat. What they found was if they provided the soldiers with rest, the opportunity to talk and share with other soldiers about their experiences that this could get them back to the battlefield or at least help them recover. One of these psychiatrists was Maxwell Jones who worked with these group approaches to the treatment of mental illness. Maxwell focused on the idea of social learning and creating what he called the "living, learning environment." He saw this as an environment where everybody would live and simultaneously learn. Everybody in the community included not just the patients it included all of the staff such as the cook, the receptionist, the security guard, and the nurses and doctors. There were tenets of the community, people were expected to be responsible for themselves, for each other, and there was to be a maximum amount of freedom without license. As long as someone could handle himself or herself responsibly then their freedom could not be impaired. People were expected to be tolerant, to be willing to look at the underlying meanings, and to be

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committed to resolving conflicts. The hierarchy was radically changed and flattened from having the doctors at the top of the pyramid and everyone else tumbling underneath. It was designed to be a community with team treatment and the doctor was to be an essential part of the treatment team that would help people. I see myself as carrying on his legacy because he wrote and spoke a lot about this practice and its possible applications in schools, prisons and all of the institutions in society.

N.V. Did he use any other novel treatment forms?
S.B. He was the first person that I know of who would use drama in the therapeutic setting. People could be there six to nine months for long-term treatment. They would come in and be expected to write, produce, and direct their own drama based on their life and the problems they were wrestling with. He found that to be incredibly therapeutic, which it is. He used art and a lot of the things that later in the 1960's and 1970's was what the therapeutic community was all about.

N.V. What was the outcome of this?
S.B. Well once again we see the pattern of degradation when the institutionalization occurred and everyone was dropped out of the state hospitals without adequate services being provided in the community. The general hospitals began to get flooded with the kind of people they could not handle in an open way. The other problem with the therapeutic community was that it is a soft science. All of us who participated in this movement knew that it worked but it was very hard to study. It was hard to say anything except people have a right to freedom, and people should be allowed to talk, and the staff should be compassionate and it is really helpful to have a social support. All of that sounded mushy up against what was coming up as the new paradigm which was this is all biological and all we have to do is to treat it with drugs. The therapeutic community succumbed to these new forms.

N.V. How does your Sanctuary program differ from the therapeutic community model?
S.B. I think if there is something unique about the work done by myself and my team is that we combined the principles of the therapeutic community with a much harder science of trauma-based approach. We know a lot more now about why social support is so important and why compassion is so important and why we have to pay attention to people’s emotional system. The therapeutic community today is really about integration, taking any technique that works and using it. Techniques such as psychopharmacology, individual psychotherapy, group therapy, family intervention, psychodrama and art therapy.

N.V. What is a synopsis of the Sanctuary program?
S.B. We endeavor to create an ongoing therapeutic milieu, which I believe is the other important aspect of our work besides trauma theory. One of the cornerstones of the Sanctuary program is personal freedom and personal responsibility. This idea came out of the 1970’s when laws were passed in most states that said “people who are suffering from an emotional disorder have a right to be treated in an environment that restricts their freedom in the least possible way to maintain their safety.”

N.V. I understand that much of the Sanctuary program is providing education.
S.B. We educate people about all that we know about trauma and recovery. We give them as much information that we can in the time available which is now down to an average stay of nine days. This helps to give them a different cognitive framework and the best way to express this is we normalize for them what has been extreme pathology. They come in believing they are crazy, wacko, psycho and that they don’t belong in any way with “normal” people. We focus our care on a different question and assumption from the “what is wrong with you?” which is the traditional expressed or non-expressed question for anyone who goes to see a mental health professional. We shifted that question to “what happened to you?”

N.V. That distinction is powerful.
S.B. Yes, it is what the Sanctuary is all about. If somebody says "you are depressed because you have a genetic biochemical abnormality that is not going to get better and all you can do is adjust to it" well I believe that is a dead-end.
N.V. It sounds like a life sentence of doom.
S.B. It does not mean there are not genetic components or that it is not possibly a biological illness or that people can not respond to medications. All of those things can be true.
N.V. What is another key component of your Sanctuary program?
S.B. The most important thing for the people that we treat is that we teach them that they must recognize the violence in their lives and to completely give it up. The other thing our patients get to experience is what it is like to live in a community where the rules are different. For example it is an environment where one is expected to talk about how they feel. People can express themselves emotionally and nobody is going to be laughed at or ridiculed. It is an experience for many people where they can really feel safe for maybe the first time.
N.V. When I attended a discussion the you led two years ago you mentioned the importance of the staff team members modeling the same level of honesty that you teach the clients.
S.B. One of the most corrosive aspects of human systems is hypocrisy. It is like a poison, a toxic to any kind of a system whether it is family or a whole nation. The patients have a right to expect us to be rigorous in creating this kind of safety for ourselves, for each other and for the community as a whole. You cannot have different rules for different people and expect that the system will work.
N.V. I remember from that discussion where you described that if there was any deceit or hypocrisy in the behaviors of the staff members the patients would immediately sense this and would somehow mirror this back.
S.B. Yes and this is a fascinating phenomenon that not many people know about although it has been rigorously described since the 1950's. It happens in any group. I think the best thing to do is to give you an example. We had our Sanctuary unit previously at another hospital. We knew for several months that we were going to have to leave that hospital and go to the Friends Hospital because of the changes in the healthcare environment and we knew we had to find a safer place. It meant that we were not going to be able to take our nursing staff along with us because of the setbacks and Friends had a compliment of nursing staff. This was a major loss for us. These were people that we had come to really work closely with. We were all one like part of the same family. The move was scheduled for July and in the spring before this was to occur we had not really faced this and we were still in denial about what was coming. We had not really discussed it. Everybody knew about the change and the feelings had not surfaced. There was cognitive information but the feelings had not been addressed at all. There was another program in Great Britain and they wanted to start a unit like ours and they sent one of their nurses to visit and to stay on our unit for two weeks. She was a very experienced, savvy nurse who had worked for many years in the therapeutic community. We were doing rounds where we meet regularly to discuss what is going on in the community and with each individual person. We were all complaining and moaning about how terrible the community was and how nobody was doing their fair-share of the work and how the patients were focusing on everybody else's problems and not their own. We were complaining how group process was going so slow and people were being nasty and horrible and couldn't we just discharge these people and get new people in? This was kind of the tone at that time. The visiting nurse asked us if the major upcoming change we were facing could be playing any role in what was going on. Now we are people who were doing this work for decades and we looked at each other and said this was a concept we never heard before. The magnitude of denial ever among the most sophisticated people is really shocking, including us. So for the first time we began...
to really talk about what was coming and how hard this was going to be to have to leave our staff behind. We expressed our feelings about how unfair the conditions were that were making us do this when we had such a good program and it was going so well. By the next week when we did our rounds we had the same population of patients and everybody said we had the best community we’ve had in years. People said that everybody was working and all the patients were hard at it and it was tremendous and what an incredible turn-around. The patients did not change and nothing changed about our circumstances. What we did is surface a conflict that was eroding our capacity to function smoothly as a group. That changed the overall milieu. The patients had no idea of what the problem was and still at a deeper level, at a level of group unconscious they were responding in a confused and confusing way to that unexpressed conflict.

N.V. Can this happen in other social situations?
S.B. This phenomenon happens in families all of the time where there is conflict between the parents and the kids start acting out. Look to the parents and look for the conflict that may be not resolvable or it is no big deal but it is hidden. That is the stuff that causes problems. Just let the conflict exist out in the open so it stops causing problems.

N.V. It is amazing how that shifts consciousness and yet it does.
S.B. It is amazing and it goes on in groups all of the time. It is the missing factor that groups do not see in the workplace in the churches and in the schools.

N.V. Do you have a model of treatment?
S.B. We use a stage model of treatment that we call S.A.G.E. which stands for safety, affect management, affect being another word for emotions, grieving and emancipation. We assess where people are in those stages of recovery for example, are they at the level where they are still using drugs or are they still sexually promiscuous, or are they still cutting themselves? If they are then most of the focus of their treatment will be on safety. We help them to understand what they need to do to get those behaviors to stop so that they can be safe with themselves. Other people come in with enormous problems managing the affect that arises as a result of beginning to do this work.

N.V. And lots of times they don’t even understand what is happening.
S.B. Yes, they are terrified that they are losing their minds or that they are crazy. They are experiencing feelings that they never felt before.

N.V. It seems that it would be beneficial if community and family members could be more educated about this vital information so we can coach each other through our personal experiences with recovery.
S.B. I am glad you brought up the word coaching because we are really thinking that what we need to do is to get this program out of a hospital and the medical model that is no longer conducive to any kind of innovation on mind-body healing work. For us to get the Sanctuary into a program that is more like mentoring and coaching because that is what we are doing. We are coaching people on what they have to do to put the past behind them and to get on with their lives. The affect management stage is all about how to handle all of these overwhelming emotions and the most important thing is substituting relationships for the entire destructive behavior. The third stage of recovery is what we call grieving. If you have safety and you are managing your affect better at some point along the road to recovery you hit grief. It can often really surprise people because they believe they have worked so hard and started feeling so much better. They don’t understand why they now feel so bad. Whether it is a country or an individual, after a catastrophe you have to deal with survival first and only later can you take time to grieve what has been lost. It is the same thing for our patients and often they have an enormous amount of grief for all the lost opportunities, the lost time, the lost relationships and the loss of innocence. These losses are very difficult to explain to anybody else and this stage can be particularly difficult because for human beings grieving is a social-
cultural process. Every single culture has clearly defined steps that involve the social group in the grieving process. When someone is grieving something that is intangible or for something that was lost 30 or 40 years ago they don’t receive a lot of social approval for that, or social endorsement or support.

N.V. Many times people receive the opposite of support in the forms of condemnation and judgement.

S.B. Yes that makes it even harder. It is often the response of others that gets people stuck in this stage. They can stay in grief for years and years and be chronically depressed, go in and out of hospitals, try every single kind of drug, and even receive shock treatments because there is no pathway for them to resolve it. Grieving is not an individual process and people can’t do it all by themselves. The “E” stage represents emancipation and it is our way of saying that therapy is not life. Therapy is like school and you should go and re-learn relationships and re-learn all kinds of things. Your therapist should not be your only relationship that is important for you. Therapy should not go on forever. We should have other systems so that social learning and living environments can go on for a lifetime.

N.V. Are there any other aspects of the therapy relationship that fall short of emancipation?

S.B. Inherent in the therapy relationship is that it sets up an unequal hierarchical, always one-down position that we don’t think is consistent for healthy recovery. The emancipation stage is our way of saying ultimately you want to be free, you want to be free of the past, and you want to be free of labeling yourself as a patient. You move on with your life and you start giving back. You develop some kind of mission for yourself where you take the horrible things that have happened to you and you convert them to something that is good for you and for everybody else.

N.V. There is almost a metaphor in nature for the stages of S.A.G.E. With the spring season as the time for creating safety for what is to follow in the form of preparing the soil to support new growth for seedlings and young plants. Then the

summer is the time of expression with the flowers and vegetables coming into blooms and ripening. The fall and winter are the grieving time as the plants lose their leaves and fruits to focus their energies on going inward. Then comes the time of renewal and emancipation in the beginning of spring again.

S.B. That is beautiful! My team will like that a lot.

N.V. Do you have any recent situations that have presented themselves as opportunities to expand the practice of creating sanctuary outside of the medical model?

S.B. Our Attorney General for the state of Pennsylvania, Mike Fisher, read my book and he asked me to lead a task force on family violence. He created six social areas of focus: law enforcement/judiciary, neighborhood/non-profit groups, religious institutions, health care, schools/daycare, and businesses. We are going to have public hearings, discussions and make a series of recommendations.

N.V. I hope many of our readers decide to get involved and to be part of truly creating a new paradigm for social behavior in an effort like this with its potentially far-reaching effects. From reading your book and enjoying this interview with you I now understand you to be a kind of “paradigm midwife.”

S.B. Thank you, I like that very much.

Dr. Sandra Bloom will be speaking at Friends Hospital at on Oct. 6 about “Creating Sanctuary for Trauma Survivors” – (215) 831-7803.

Interviewers Notes:

I have been intrigued by Dr. Bloom’s work since I met her in 1996. A mutual friend of ours, Larry Menkes, invited her to speak at Pebble Hill Interfaith Community in Doylestown, Pa. She spoke about creating Sanctuary in a non-therapeutic community environment like Pebble Hill. I recall how she stressed the importance for any group to be very clear on their values and for each member to take personal responsibility for their behavior in reference to these community values. I resonated deeply with her insights and experiential knowledge because my life’s passion for Creating Harmony led me to many of the same realizations. I believe we are destined by the beauty of evolutionary design to co-create social forms that are based on love, compassion, honesty, cooperation, and shared leadership.