Chapter 3
Creating A Nonviolent Environment: Keeping Sanctuary Safe

Joseph F. Foderaro, L.C.S.W.
CommunityWorks
Philadelphia,
Pennsylvania, United States

INTRODUCTION

In 1986, Dr. Stephen Silver, in his work with Vietnam veterans, used the term "sanctuary trauma" to describe the impact that an inhospitable, unsafe, and disrespectful health care system had on the returning veterans of combat experiences (Silver, 1986). He maintained that to those who have been subjected to past traumas, a safe and sane environment was critical to the development and redeployment of constructive intrapsychic and social defences. Otherwise, patterns of maladaptation were bound to continue. But what constitutes a safe and sane environment and what methodology contributes to creating and maintaining such a milieu? The goal of this chapter is to provide a concrete example of a small psychiatric unit struggling to answer these questions with a view to providing suggestions of approach to any community searching for the means to end violence.

SANCTUARY – NOT JUST A PLACE

Since 1980, a team of clinicians has been striving to create an environment that would not create sanctuary trauma, but would instead provide a place within which safe healing from trauma could begin. The *Sanctuary*®, which presently is a twenty-four bed, short-term inpatient program hosted by Friends Hospital in Philadelphia, is dedicated to working with adult survivors of abuse, other traumatic experiences, and long-term and severe neglect. *Sanctuary* started off, and remains to this day, an experiment using the tools of social psychiatry toward the goal of creating and maintaining a safe and sane therapeutic experience for those whose patterns of life necessitate such a reconstructive experience (Bloom, 1997).

Like many other psychiatric units, *Sanctuary* found itself over a decade ago being hosted by a hospital located in a community which was ambivalent about having such a program in its midst. Stereotyped assumptions about psychiatric patients abounded, and there was great pressure put upon the program to be as inconspicuous as possible. Paradoxically, this meant that the unit would have to be, among other things, unlocked. In a rural community that still believed in the fantasy, if not reality of safe streets, locked doors would have brought even more attention to the unit from community leaders. Therefore, *Sanctuary*, from its inception, presented itself as a program which would not, and did not depend on

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the external security of locked doors to insure its own, and by extension, the community's safety. Not that such security was in total absence. Good psychiatric and nursing practices include learning techniques for the pharmacological and physical management of the out-of-control patient. Proper restraint procedures, quiet rooms, and pharmacological restraints are all accepted medical and milieu management practices. Perhaps most significantly, *Sanctuary* has always emphasised that such interventions should not distract from the inherent assumption of the program - that the locus of control over violent impulses must develop from within the individual. This contrasts with those programs and units that impose the control, sometimes arbitrarily, from externally placed structures. This assumption about the need for control to be developed from within may be the basic distinguishing feature that separates *Sanctuary* from many other clinical programs. There is a notable difference between therapeutic experiences that are supportive and protective in nature, and those that assume a truly rehabilitative nature. For the latter to occur, assumptions about personal limitations must be challenged, tested and allowed to develop. For this to occur there has to be a compelling community pressure for the violence-prone individual to adopt a different set of values. Although it is unarguable that the administration of *Sanctuary* has, as a primary responsibility, the security of its population to maintain, it is a recurrent theme that this responsibility is shared with all of the participants of the program.

Sanctuary is, first and foremost, a program that is voluntarily requested by those who decide to seek entrance. With only very rare exceptions, all participants must be willing to register themselves, and not be mandated by a civil or criminal court systems to engage in programming. This means, therefore, that there is a certain selectivity to the patent sample found in the program. This selectivity is not necessarily in terms of level of dangerousness, but certainly in terms of motivation to change. In its history, *Sanctuary* has included as participants in its programs whose who have attempted suicide by self-inflicted shotgun blast, overdosing to the point of coma, self-inflicted lacerations resulting in unconsciousness due to blood loss, and sexual acting-out with at-risk populations without any "protection". These represent only a small sampling of behaviours nearly guaranteed, eventually, to insure self-annihilation. Such violence is not, of course, only directed towards the self. Individuals who have served "hard time" for murder, for manslaughter (of a child), those who have served, or about to serve a jail sentence for paedophilic activities, and some who have attempted to poison, suffocate, or otherwise eliminate parents, and others who have been the perpetrators of violence or abuse themselves, have also participated in the *Sanctuary* program. Those who critique *Sanctuary* for its selectiveness can not do so based on clinical indicators solely. What is required of its participants however, is a commitment to *Sanctuary* that the program and its physical space and those enrolled in the program will be honoured and respected as a violence-free zone.

Trauma-based programming, as offered on *Sanctuary*, is comprised of a number of specific modalities of individual and group therapies, all intended to help the individual and community address issues of violence and recovery. There

are clear proscriptions against any form of physical or verbal violence while an individual is residing on the unit. All clinical interventions with the client are intended to allow for exploration of the themes of abuse while, at the same time, encouraging the individual to learn to set appropriate boundaries around such expressions so that they do not, in and of themselves, become provocative and damaging in their own right. All therapies found on *Sanctuary*, including the evocative therapies of Psychodrama, Movement Therapy, and Art Therapy, are titrated in their intensity so that the participants are able to remain focused and in control of the therapy and expressive process. Otherwise, such therapies can unintentionally lead to re-enactments of graphic portrayals of past traumas that do little to leave the group participants with a sense of mastery and control or safety.

One does not have to look far to find people who have been seriously impacted by the forces of violence. Directly or indirectly, our entire world is steeped in a culture of violence and exploitation. Aggression, when it does not actually destroy its victim, all too often serves to embolden the victim to pass it on, like a cold virus, to some other unsuspecting or vulnerable soul. This is why violence has been, and remains, a public health menace. There are too many people in the world who have been seriously hurt for us to ignore. They are prepared to expend the energy that violence begets in order to pass it on to others in a short-cut attempt to empower the self. When not passed on to others, this violence frequently becomes self-directed, and manifests itself as one of many forms of self-destructiveness. *Sanctuary* attempts to provide an alternative to the maintenance of a status quo in which violence and aggression is only recycled.

The inherent lure of violence is often seen in the context of doing therapy on the unit. In the same way that horrific accident scenes create a logjam of "rubberneckers" who often expose themselves to greater danger in order to catch a glimpse of an accident scene, the therapeutic arena is often the scene of clinicians and patients alike who are intrigued, if not outright entranced by the specific details of past traumas and abuses. Frequently, patients will request to do specific "work" about this material, and if this is done without proper safeguards of affect monitoring, such "work" often leads to regressive behaviour by participants and observers alike. Perhaps even more importantly, if patients are unable to learn the skills of affect modulation in the context of therapy, it is unlikely that such skills will be utilised after or in-between therapies, when the actual implementation of learned therapeutic skills can be practised. Often a patient or their therapist will feel that the patient has done "a lot of work" in an individual or group session. But if this work is not accompanied by affect modulation, insight, and closure, then there will often be a negative carry-over effect upon the rest of the client population after the "working day" is over, when the unit management becomes the primary responsibility of nursing staff alone. It is easy to mistake emotional expression occurring in a dissociated state for important therapeutic work. Abreaction is not sufficient, nor does it guarantee improvement unless it is accompanied by integration with affect, thought, and judgement.

Those who participate in the *Sanctuary* program often identify themselves as

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among the most thoughtful and considerate individuals to be found. Although they readily admit that they rarely are considerate or respectful to themselves, they often emphasise that "I would never hurt anyone else". In fact, these individuals rarely reflect upon the consequences that self-abusive destructiveness, or even tempestuous acting- out behaviours can have on the therapeutic milieu. The nature and impact of such behaviour is often minimised and distorted through the self-absorbed and, at times, narcissistically-biased filters of rationalisation and denial. It is amazing how a person can proclaim their safety to others even as their self-inflicted wounds are being sutured, or their stomachs pumped. People tend to maintain a marked distinction between violence against self and violence against others. In fact, as research demonstrates and patients often corroborate, self-harming behaviour and suicidal ideation are often experienced as being more soothing in nature than overtly threatening, and therefore are usually not appreciated for being of the violent nature that they, in fact, are. First and foremost, *Sanctuary* emphasises that in order for a constructive and restorative experience to be possible, violence in any form must be renounced as an acceptable coping skill. This is an orientation that is made early on and often in the treatment experience, and sets the stage for further interventions that may later question an individual's motivation for change.

A parable is frequently told that illustrates this point of violence and commitment to change, the story of Hernan de Cortes, and his arrival in the New World with a boatload of conquistadors. As the story is commonly told, Cortes, upon landing in South America after a frighteningly long and dangerous trip, had his boats burnt to the waterline. Needless to say, some explanation was demanded of him for this apparently insane and self-defeating behaviour, and when given the opportunity to describe his reasons for having the boats burned, he replied, "now you have no choice but to go forward". This act assured that there would be minimal risk of mutiny and retreat in the face of the very real and dangerous threats of conquering new peoples for fame and fortune. Escape is always an attractive alternative for those faced with exceptionally difficult and dangerous tasks, and there is little that any therapist can offer to a trauma survivor that compares to the allure of eternal peace when the therapeutic process encounters rough times. Escape through self- destruction is a powerfully seductive temptation, and when compared to the responsibilities that a person must maintain in order to remain alive and well, it is not surprising that many survivors find it easier to "give up" and die.

No therapist can assure the patient that future traumas will never occur, and that there will be no future heartbreaks or financial disasters. Therefore, with suicide always in the background as a viable option to the patient, therapeutic discussions often focus on safety issues, rather than the more reconstructive issues of grief, reconciliation (with oneself and others) and how to use emancipation from trauma as a way of moving on with one's life. Those who travel to *Sanctuary* and take advantage of the program are reminded that, in spite of distance travelled and money spent, therapy on *Sanctuary* does not even begin until one is able to harness

the impulse to escape from violence by the further violation of self or others.

In the past few years, there has been a significant reduction in the time available to provide inpatient services to those in need, and insight is a goal that is increasingly more difficult to achieve. Interventions must be clear, concise, and relatively unambiguous. Language must be relatively free of the "psychobabble" for which the field of psychiatry is noted. When addressing those with self-harming or aggressive impulses or histories, two words are frequently used to describe the roles of those who live either in a state of fear or of those who live by threatening others. These two words are terrorist and hostage. These words represent the extreme sides of the same violent, exploitative, and vulnerable relationship. This is exactly the type of relationship from which most traumatic abuse survivors come. Both words describe the early dynamics of a childhood steeped in abuse and violence. The unpredictable and dangerous authority of an abusive parent, exerting control over a vulnerable and terrified child, is quite similar to the process in which a violence-prone individual uses the threat of destruction of self or others if their immediate needs go are unmet. The terror of a hostage is a familiar concept easily appreciated by most abuse survivors. When the constant threat of suicide is discussed in the same context as the terror inflicted upon a child by an abusive or dangerous authority, there is usually an immediate recognition that the line between perpetrator and victim is finer than originally thought. It is often more difficult for the chronically suicidal or self-destructive person to realise that their violent behaviour represents the empowerment of an individual who uses terror to control. Suicidal and self-destructive threats represent the power of life and death. An individual who abuses such power, if and when he or she deems it appropriate, shows as little regard for their victim as their abuser originally showed for them. On *Sanctuary*, power is described in graphic terms such as this. The constructs of power and control are often raised in therapy and the client is encouraged to exercise both. However, the client is also encouraged to exercise a moral choice over how this power and control is to be exercised. Will it necessitate, as part of its expression, a damaging of self or another, or can this power be used to create constructive change? Will the patient identify with the perpetrator and carry on the violence, or will s/he choose for the good? This question is often asked of *Sanctuary* patients, who are reminded that any person powerful enough to take a life is equally powerful enough to save a life. Historically, clinicians were discouraged from wandering into areas of morality. In our work with abuse survivors, no such apparent indifference or avoidance is possible.

If in this discussion it appears that the *Sanctuary* program is insistent upon strict adherence to a code of non-violence, and that it exercises a dogmatic and judgmental approach in our reactions to behaviours involving violation of these tenants, so be it. Too frequently, *Sanctuary* patients have described backgrounds in which no clear messages or boundaries were established or maintained. Instead, messages within the family were filled with ambiguity and opportunity for misinterpretation. In a short-term, closely managed in-patient setting, messages must be as clear as the boundaries are defined. Otherwise, there are too many

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opportunities for the type of manipulation and limit-testing frequently found on more traditional in-patient units. When it comes to matters of life and death, and matters of respect for self and others, staff members are strongly encouraged to refrain from hiding behind a mask of therapeutic neutrality. Although the staff readily acknowledges that all *Sanctuary* patients do, indeed, have the power of life and death over themselves and others, it does not mean that the individual has the right to exercise this power in destructive ways. Having the power to potentially inflict havoc upon self or others is a reality that is readily conceded. This is one of the ways in which an individual's sense of power is readily acknowledged. However, once this presence of this power is recognised, the discussion turns to whether or not a person has the right to exercise this power in destructive ways. A survivor of trauma who insists upon the right to do so indirectly acknowledges that the perpetrator also had a right to do what he or she did, and this realisation creates a cognitive dissonance which allows for further exploration of alternatives to acting-out behaviour. Too often, abuse survivors were tortured and tormented by those who had the power to do so. An important part of the recovery process is to remind survivors that having the power to abuse and neglect is not to be equated with assuming the right to do so, and this is where the element of choice is introduced into the therapeutic process. It is this decision to exercise choice about whether to harm or to help that is the fundamental beginning of the therapeutic process. It is this decision that ultimately determines whether a survivor's life will be an improvement over a traumatic past, or will continue to be a re-enactment of one's traumatic past. A lifetime of being haunted by memories of abuse and trauma can leave anyone feeling emasculated, vulnerable, angry, and out of control. Chronic passivity and an identity as a victim are major impediments when initiating a therapeutic challenge. With little time allowed for treatment due to issues of financial reimbursement, the proper utilisation of clinical resources and therapeutic dilemmas must be quickly and clearly articulated if the treatment experience is to be anything more than an exercise in containment. As a result, a major shift in one's personal schema is pursued. The hope is that if an individual can truly perceive the intrinsic violent nature of self-annihilation, a significant challenge to the self-perception of impotency and vulnerability can occur. When such a shift occurs, there is then hope that power can be sought out and used in other, less destructive ways.

Thus far, it would appear that the primary mode of intervention in the cycle of violence is a quasi-philosophical or theoretical challenge to a survivor's sense of right and wrong. This is, indeed, a vital and inescapable part of the therapeutic process, but not the only intervention offered. All the words available to a therapist doing "talking therapy" seem insufficient to serve as a counterbalance to a lifetime of abuse, violence, pain, and intimidation of self or others. Equally important on *Sanctuary* is the availability of a clearly defined strategy of interventions to be used when the unit is subjected to the consequences of violent action. From the onset of the treatment process, participants in the program are invited, instructed, and expected to participate fully and collectively in the task of keeping *Sanctuary* safe.

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Although many newly admitted patients expect that *Sanctuary* is something that is being offered to them upon admission, patients are counselled that an admission to *Sanctuary* is, more accurately, an opportunity to learn how to create *Sanctuary* for oneself and others. In this manner, the safety that is alluded to in the *Sanctuary* name becomes a goal that is pursued, rather than a gift that is offered. The patient, therefore, becomes an active part of the *Sanctuary* process, instead of a passive recipient of an environmental condition. The avoidance of the passive role is critical in any therapeutic interaction between staff and patients, or amongst patients themselves. A re-enactment of a violent past is nearly inevitable if the patient maintains a passive role of receptivity, instead of assuming an active participant role. Although the term "patient" has thus far been used in describing the *Sanctuary* program, this is used in deference to *Sanctuary*'s present location at a psychiatric hospital rather than to any underlying assumption about trauma survivors. In practice, participants in the program are quickly discouraged from using, and hopefully believing that they are, indeed, the "patient". As a patient, there is an assumed passivity that directly contradicts the active model that the program espouses. The patient status also indirectly communicates the right of participation in the program even if one chooses not to adhere to safe behaviours. Historically, most participants in the program came from backgrounds in which there was direct or tacit acceptance of violent or destructive behaviours. Regardless of the activity or consequences upon children, families, or others, this background suggested that complacency or denial were accepted coping strategies to be used when faced with such activity. Such norms must be counter with an equally strong and consistent message that destructive behaviours are, indeed, a threat to ALL residents and staff on *Sanctuary*, and can not be accepted, condoned, nor ignored. Although this is rather easy to articulate, it is, in fact, a difficult construct to fairly and constructively instruct, and it can not be arbitrarily or unfairly enforced.

Norma B. was an obese, physically intimidating female who was given to angry, verbally aggressive outbursts when feeling overwhelmed by uncomfortable affect, or when she felt she was being treated unfairly. When sad, she would often begin wailing in loud and plaintive ways, and when angry, her wailing would be interspersed with equally loud and aggressive threats and complaints. After a few days of such behaviour, it was apparent that the community was becoming increasingly intimidated by her. Group leaders noticed less participation by other patient in the group therapy sessions when Norma participated. She was beginning to sense the isolating effects of an entire patient community engaged in avoidant behaviours. Although staff members took on an active role of identifying such behaviours and their consequences, this did not prevent Norma from throwing a tray of food in the general direction of a nurse when this nurse was attempting to engage in some dialogue with Norma. Immediately sensing that an important rule had been violated, Norma attempted to minimise this by emphasising that this should not be construed as a violent act, for "I would have thrown it right at her if I wanted to hurt someone". At this point, Norma was instructed to engage in a "staffing". This term is used to describe a meeting of patient and instrumental staff

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members, during which an individual's progress is discussed, and problem areas are identified and openly discussed. A staffing is an incredibly effective treatment strategy for it accomplishes much at one time. First and foremost, it provides for an opportunity for all participants in the therapy process to discuss the issues at the same time, thus reducing potential problems with miscommunication or splitting. Perhaps equally important is the message that staff is involved and caring enough to participate in such a discussion and eager to give the patient the "attention" they are seeking. Although most patients initially fear such an encounter, believing that it will be a group attack upon them, this fear is quickly dispelled if the staff members strive to remain focused on constructive alternatives to maintaining the same destructive or ineffective patterns. Many patients leave such a meeting with a sense that for perhaps the first time, they are being watched over and cared about in ways that do not recreate the same shaming and neglecting patterns of their families of origins. Staffings are often considered an important adjunct to the overall therapy experience. In Norma's case, however, a staffing proved to be ineffective as a way to influence a constructive change, and when she became more verbally threatening again, she was advised that she would have to be transferred to another, more secure unit. Although Norma strenuously opposed such a transfer, maintaining that such action was unwarranted since no one was injured, she did allow for this transfer when the detrimental impact such behaviour was having upon the community was emphasised. It was important to emphasise to Norma that this action was being taken as a safeguard to protect others from her aggressive nature, and was not merely punitive in nature. Norma was advised that when trauma-work seems to evoke an escalation of violence, then instead of doing more work, a different type of work is required. Norma was also told that if she showed an improved ability to provide proper containment of her affect in ways that allowed for ventilation without intimidation, readmission to the *Sanctuary* program would be considered. When the decision to transfer was then put into action, Norma reluctantly complied with the plan. Of course, Norma did not really wish to be extruded from the program. But Norma was reminded that on *Sanctuary*, the integrity of the overall community had to be maintained, and that if that conflicted with the specific requirements of any particular patient, then the community's needs would be addressed first. Norma, in a role as "woman-child", was thus reminded that she would not be able to hold hostage an entire community of patients and staff, and that it was her responsibility to recognise that this was the impact of her behaviour. The unit to which Norma was transferred had its own therapeutic milieu, although it was significantly different from *Sanctuary* in that it was locked and was lacking in any "trauma-based" work. Norma was also reminded that this transfer represented a failure on the part of *Sanctuary* to exert a strong enough positive influence upon her regarding her impulsive and disruptive behaviours. She was told that if she wished to continue working with a clinician from *Sanctuary* while on another unit, this would be arranged. After she "cooled off", she chose to maintain a connection with *Sanctuary* and staff members continued to meet with her on the other unit. Over the next few days, she was

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encouraged to reflect, write in her journal and discuss those ways in which she might be able to renegotiate a re-entry into the community should she be able to present herself in a more controlled way. After a few days of serious reflection and journaling, Norma signalled her readiness to reenter *Sanctuary*. Although promising to be "good" if allowed to return, Norma was reminded that it was not a matter of being "good", but rather in being effective in promulgating *Sanctuary* values regarding respect and safety. This was an important distinction to be emphasised, for a promise to be "good" maintained Norma in the role of a child who had to behave for the powerful parent figure (i.e. staff), whereas her agreement to be safe and respectful would suggest more the behaviour of an empowered adult. When this distinction appeared to be appreciated by the patient, Norma was told that she might be ready to address the entire community to renegotiate a re-entry into it. Norma thus had to face directly those individuals who were directly impacted by her past behaviours, client and staff alike. The context for this would be arranged during the usual morning community meeting, and Norma was coached on ways of accepting and acknowledging feedback from the community. For this patient, this event proved to be even more anxiety-provoking than the original events surrounding her transfer from *Sanctuary*, and the prospects of this exposure and consequent vulnerability tapped into other issues of vulnerability which her weight and bluster effectively masked. It was not an easy meeting for Norma, and required the active participation from staff to help reassure all parties that the process of reconstructing a safe relationship was essential not only for Norm's sake, but for all members of the community. In this fashion, it became a community task to re-establish the importance of safety and respect as vital elements in the *Sanctuary* program. Norma was able to manage a successful re-entry into the program, and later became a powerful ally and advocate for the milieu when later and unrelated events precipitated additional crises. Years later, she has successfully reintegrated into post-graduate studies, remains in outpatient therapy, and has not required rehospitalization for many years.

Unsafe behaviour does not always take its form in throwing things at walls, at others, or in the form of self-injurious actions. Continued disrespect and transgressions of important rules can also have a profound and corrosive impact on a community's sense of security. Anita C., a young adult woman, had an extensive history of hospitalisations and self-destructive behaviours. Carrying a diagnosis of Dissociative Identity Disorder, she customarily explained her resistance to change as "I don't know how to stop it" or "I don't remember doing that". During two different admissions, years apart, she demonstrated behaviour that was potentially very dangerous to her physical well being and overall community integrity. During her first admission, she eloped from the hospital and was found in the parking lot, leaning against the brick wall of the hospital. She began by slowly and lightly hitting the back of her head against the wall, and gradually started to hit her head harder against the brick. All efforts to engage in conversation were met with closed eyes and continued head banging, and it was clear that the next intervention would have to be of a physical nature. The obvious response was to call for assistance to

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physically and forcefully restrain her from this behaviour. This was, indeed, what was contemplated, but before this step was taken, the clinician lightly cradled the back of her head with his hand, imposing his hand between the wall and her head. This patient was reminded that there was now another body part to be considered in addition to her head as she continued to bang, and she immediately de-escalated the intensity of banging to just a slight tapping. As if to get the last word in, she tapped a few more times and then stopped entirely. She was thanked for her consideration of the clinician's health, strongly encouraged to exercise a similarly safe restraint when it came to her own health, and escorted back to the unit. Although Anita continued to test some limits, as well as the strength of the walls, with episodic periods of head banging, she did no harm to either wall or head for the rest of this stay. An important message in this vignette is the very real presence and awareness for the concern for others even when a patient is deeply entrenched in a dissociatively-induced pattern of self-damaging behaviour. During a later stay on *Sanctuary*, Anita's behaviour was especially disruptive to the smooth functioning of the unit, because it involved the continual testing of the open-door policy. Because there was great pressure on *Sanctuary* to curtail such behaviour by closing and locking its doors, staff felt extra pressure to make an effective, and timely intervention. Anita continued to elope from the unit, even when put on visual precautions within eyesight of staff. At times she would sneak off when thought to be unnoticed and, at other times, she would just run off the unit as quickly as possible. Each time she left the unit, she would not go very far; it was clear that for Anita, the thrill was in the chase rather than in the prospect of escape. Each time she left the unit, she blatantly advertised the impotency of staff to curtail a disruptive and destructive behaviour. For Anita this was a re-enactment of her father's inability to stop a neighbour from sexually abusing his daughter, even when there was a wealth of clinical signs that something terrible was happening. Eventually, more active intervention was required, since such a blatant disregard for unit rule was having a profoundly negative impact on clients and staff alike. It appeared that the only effective means of intervention would be to lock the doors of the unit, thus punishing the entire community, or transfer Anita to a more secure unit or hospital. Before this was done, however, an intervention was made just prior to another elopement. This intervention turned out to be quite effective, and was remarkably simple in its strategy. Anita was noted by staff to be pacing at an escalating speed, was becoming increasingly agitated, and was looking longingly at the open space beyond the open doors of the unit. It was obvious that another elopement was imminent. Just before this occurred, a staff member approached Anita, and invited her to the very edge of the threshold, just to the point where *Sanctuary* ended and the open hall began. Anita was asked to look closely at the invisible line on the floor that separated the outside world from *Sanctuary*. She was told that although this line was invisible, it was, in fact, the most important part of the *Sanctuary* program. It was that threshold between *Sanctuary* and the world that made the space inside the unit special, and that this boundary was as important to *Sanctuary* as her own flesh, skin and blood should have been vital and safe for her

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as a child. Anita was reminded that the reason she was on *Sanctuary* in the first place was due to the flagrant disregard and disrespect that her perpetrators had shown towards her own body as a child. They exhibited no regard at all for the barrier of her skin, flesh or body, and crossed and entered these boundaries at will. The staff member acknowledged that when Anita's boundaries were first abused and disregarded, there may have been no effective way for anyone to actually protect her physical, emotional and spiritual self from unlawful and immoral incursions, and for that lack of intervention, she still suffered. This summarisation of Anita's past earned the staff member her undivided attention, at which time the following point was made. Anita was reminded that her history of having her physical boundaries continually disregarded and violated was, indeed, unfortunate. However, this did not, in any way, warrant her continued active disregard and disrespect for boundaries defined by *Sanctuary* to be necessary to protect all within its confines. She was reminded that *Sanctuary* had to work very hard to maintain its open-door policy; current trends in hospital-based psychiatry tend to accept the premise that locked doors are a minimum requirement for good and safe treatment. Anita was reminded that each and every time she violated the boundaries defined by the threshold of the open door, she was violating accepted and agreed-upon boundaries of safety as codified by community mores. Therefore, each and every time she left the unit, she was actually assaulting the physical boundaries of *Sanctuary*, as she herself was assaulted as a child. This was a way of endangering the entire community, and, in fact, was not an exaggeration at all. As Anita's behaviour escalated, and staff was slow to respond in ways that constructively harnessed this energy, other members of the community began to complain about the patient. Many suggested that she be expelled from the community, and a significant minority, instead of complaining, actually began to demonstrate an escalation in their own maladaptive behaviours. This created an additional risk of other elopements or even more dangerous behaviours. Anita was given the choice, after some discussion, of helping to keep *Sanctuary* safe either by curbing her impulses to run, or to continue to be, in a sense, a perpetrator against community mores. This paradigm was met with a startled, guilty, and remorseful response, followed by a slow return to her room. Later that day, without prompting by staff, Anita apologised to the community. In a few subsequent admissions to Anita over a protracted period of time, Anita never again attempted to leave the unit.

Externalised aggression is managed in the same way. Community proscriptions against violence are explicitly reviewed in a variety of formats. Community meetings, group therapy, and individual therapy all provide forums in which the non-violent theme of recovery from traumatic events is continually emphasised. Having a unit that treats both men and women victims of violence has made maintenance of a safe unit more interesting, albeit more difficult. There is an assumption, based as much on gender-bias as on fact, that the unit is inherently more dangerous with men being allowed to be part of the program. Actually, in an eighteen year history of inpatient psychiatric management, there has yet to be a

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physical confrontation (either physical or sexual) between patients on the unit. Two staff members have been hit (both incidents involved female patients and staff), and neither incident required more of a response than an incident report. On both occasions, however, swift intervention was effected. In the first event, a request was made of the patient to meet with staff, was reminded of community proscriptions about violence, and the need for everyone to participate in the process of keeping *Sanctuary* safe. A failure to do so would be interpreted as a failure to agree to a basic treatment contract with the program. This particular patient accepted responsibility for her behaviour, apologised to staff and community alike, and completed her hospital stay with no further acting-out behaviour. The second incident involved a young women who was drug-dependent and who was unwilling to give any type of assurance that such behaviour would not reoccur. She reminded all that "no one was safe should they get in (her) face". She was unmotivated for treatment, and seemed to be using the program to fulfil a need for anti-anxiety and pain-reducing medication. Presenting no clear and present danger to self or others, (the physical assault was more of a push than a strike), the patient was administratively discharged back to the community. In following months, she made repeated attempts to secure a readmission to *Sanctuary*. Each time, she and her outpatient therapist were reminded of the requirements that she adhere to a non-violent and sober theme during her recovery. Although this particular patient made repeated assurances about her ability to remain safe on *Sanctuary*, she demonstrated no commitment at all to establishing a sobriety plan. She was advised that the theme of safety, once violated, needs to be re-established by way of behavioural responses; verbal assurances are insufficient to re-establish trust. She was advised that to secure readmission, a period of 90 days of sobriety would have to be maintained, either as an outpatient or as a participant in a chemical dependency program. This prerequisite has yet to be fulfilled. What was apparent in both of the above-mentioned incidents was the powerful impact the violence of one person had upon the entire community. It is true that if left unattended, violence is contagious.

The community has shown itself to be a powerful influence in efforts made to modify aggressive behaviour. In the same way, the community remains quite vulnerable to regression and subject to escalations in overall levels of aggression should isolated aggressive incidents not be quickly and effectively addressed. Any manager of any type of milieu should be able to describe the contagiousness of violence, or the copycat behaviour that some types of destructive behaviours seem to precipitate. A study once done on *Sanctuary* statistically confirmed a "feeling" that incidents of self-mutilation and other acts of destruction of physical property seemed to occur in clusters. In the same way that actual physical aggression is, in itself, escalating in nature, so too can verbal aggression be a contaminant in an otherwise stable population. This is another reason why, in its definition of violent behaviour, *Sanctuary* has always had a most liberal and broadly defined concept of violence. That which is violent is any behaviour, direct or indirect, that has a marked and destructive impact upon self or others. If this seems extraordinarily broad, so be it. By allowing for such a broad definition of violent behaviour, and by

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continually modelling intolerance to it, *Sanctuary*'s goal has been to use the therapeutic experience as an ongoing educational workshop on violence rather than serving as a more medical-model treatment experience.

In spite of constant, monitoring, modelling, and mediating, there have been some occasions in which violence, in its most extreme form, intruded upon the program. The consequences of this intrusion have been devastating and remarkable. Twice in an eighteen-year history, the unit has been the site of suicides by hanging. Twice, *Sanctuary* has served as a stage for an individual's choreographed ending, and each time there was, understandably, a profound impact upon patients and staff alike.

After a staff member found a male patient hanging from a doorjamb in his room, *Sanctuary* was rocked by a convulsion of affect never experienced before by any clinician in the program. Several patients had seen this victim of violence hanging, already dead, in his room. When senior management arrived within the hour (the event having occurred around 10:00 P.M.), the unit more closely resembled a combat zone than it did a hospital. Patients were crying hysterically, many were mute. Some were screaming, some were still, and some were punching themselves or hitting their heads against the wall. Staff intervened as best they could, but this seemed to have only a minimal impact upon the initial frenzied response to this death. Eventually, a few of the more grounded patients also began comforting the patients (including the previously discussed Norma B.), and it was only after these patients began the process of helping to soothe those more severely impacted by this event that some semblance of order was restored. The next day, a community meeting was held to discuss the event and everyone's response to it. Uniformly, all spoke of the anger that was felt towards the person who violated *Sanctuary* by doing this deed, on the unit, during their hospital stay. Patients and staff alike spoke as people who were subjected to violence, and no distinction was made by the role of the individual on the unit. This event had a powerful unifying and equalising impact upon all who were a part of it. There was some discussion, of course, about the reasons why this individual had succumbed to such a violent ending, and there was some appreciation of the pain and anger that must have prompted such behaviour. Without exception, however, patient and staff alike spoke of anger, and what occurred subsequent to this discussion and meeting was a powerful reminder of the potential for good that any powerful feeling can have, including feelings of anger, sadness and fear.

Following the community meeting, all participants, staff and patients alike, split off into two groups, each group intent upon addressing issues of grief in their own way. The larger part of the community requested and pursued a ritual of purification of the unit, and especially near the room where the death occurred. The other, smaller part of the community, uncomfortable with such a ritual, was allowed to pursue its own, more private way of transiting from the trauma and shock experienced the night before. Without exception, not one patient on the unit at that time exhibited any more self-destructive or self-mutilative behaviour. Not one person requested to leave the program because it was "unsafe", and there

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were many who contributed their own personal gifts to the unit in the form of personal condolences to the program. Songs, poetry, and a painting were all contributions from people who were not only impacted by violence, but who were struggling hard to find ways of transcending such violence.

Similarly, the second suicide, which occurred approximately four years later, was reacted to in like manner. The community initially wished to memorialise the deceased (a woman). Because of the beautifully landscaped location of the hospital, the suggestion was made to plant a tree in honour of the victim. There was considerable discussion about the wish to plant a living tree to memorialise a person who died by her own hand. The community decided to plant a tree on the grounds of the hospital and dedicate it to all those who are survivors of abusive experiences. The intent was to use this traumatic event to inspire those still struggling with their own violent impulses, rather than memorialising one who used violence to end the struggle forever. There now stands, outside *The Sanctuary* at Friends Hospital, a weeping cherry tree dedicated to all those who have been injured by violence and who continue to fight against the forces and consequences of such violence.

Keeping a *Sanctuary* safe for nearly two decades has not been an easy task. It has required, minimally, a patient-to-staff ratio that is slightly higher than found in more traditional inpatient units. It has also required a constant monitoring and maintenance of community mores, as evidenced in the day-to-day programming, and this is where the availability and presence of on-site active management is critical for the maintenance of a safe milieu. As previously mentioned, violence is contagious. The availability of management to support line personnel is a critical element in the design of a safe milieu. This management must be well-versed in skills that do not emphasise shame as a deterrent to incorrect actions. All too often, management employs a "shame-based" management style. This is a style of leadership in which the most important part of a problem-solving strategy is the location of a person to blame, rather than the construction of a solution. The consequence of this type of management is devastating. First and foremost, it discourages staff from using new and creative strategies in crisis management, preferring those strategies that emphasise control and quiet over those which might be more therapeutically effective. Secondly, staff in such an environment tends to become defensively entrenched, mostly in service of protecting their own jobs or reputations. Such a defensive posture can be extremely provocative in times of crises, for it tends to be dismissive of legitimate patient concerns about treatment issues. Such invalidation of real problems usually leads to an escalation of behaviours intended to draw attention. It is this escalation in service of drawing attention, as much as any other factor, that leads to a situation where events start to spiral out of control. Violence is a course of action taken when other, less patently destructive efforts to secure need gratification fail. Therefore, an environment that encourages individuals to become well versed and skilled in the art of listening is apt to be less prone to violent outbreaks. Comparable to the ability to listen to an aggrieved individual is the ability to speak to that person with the dignity and

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respect that all humans deserve. As police departments become more skilled in dealing with hostage situations, and other situations in which violent outcomes seem imminent, a recognised effective strategy is to maintain effective communication with the potentially dangerous person. As long as "negotiations" are taking place, it is possible to devise or stumble upon a non-violent solution to the problem. Too quick an effort to "fix" the problem before it is sufficiently understood often leads to increased alienation, resulting in an even greater likelihood that the outcome will be violent in nature. When frustration replaces patience, staff efforts often escalate towards controlling the person and the situation, instead of reconciling differences. Although control is important to maintain, so too is the intent to address a problem. In the words of the immortal Janis Joplin, "freedom is just another word for nothing left to lose", and when an individual feels unheard, invalidated, and abandoned, that person feels free to exercise a loss of control that can have a profound and long-lasting impact on self and others. When an aggrieved individual feels disenfranchised, powerless, blamed, and deprived of the legitimate use of his or her voice, a violent response is nearly inevitable. This type of response, as noted previously, may be either internally or externally directed, but destructive it will invariably be. In a trauma-based program, the entire patient community consists of those who were deprived of safety and respect. It consists of an entire community of individuals who were deprived effective use of their voices, and in most cases, consists of many who found themselves isolated to the point of being unheard, even if their voices did protest the abuse. Staff sensitivity to this point is crucial is violent re-enactments of past traumas are to be avoided.

CONCLUSION

A review of this chapter will note some very basic, but vital constructs required in the never-ending struggle to harness the violence that is ready to be leashed against self or others. There must exist a deep-seated and authentic belief that such behaviour is not an acceptable option to any but the most life threatening of provocations, and then only to stop further violence. Similarly, there must be an authentic and energetic reminder that such behaviours are not acceptable in a program dedicated to working with survivors of abuse or other traumatic events. These messages, coupled with an exceptionally broad-based definition of the meaning of violence set the tone for any therapeutic discussion or intervention that follows. This belief must be incorporated as a non-negotiable norm, as inviolate as the neutrality of Switzerland has become. This standard of safe, protective authority models a different kind of parenting experience that most *Sanctuary* residents have never previously experienced in the context of their own families of origin. In the absence of more constructive alternatives to conflict resolution and need gratification, violence becomes an acceptable recourse, and this is where the full and visible presence of all levels of management is required. Programs, hospitals, and communities that have disinterested, inaccessible, or disconnected administrations are not only deprived of the expertise and authority to create a

climate conducive to change, but, more importantly, may be less likely to have the full and enthusiastic support of line personnel and other ancillary staff to help teach and support non-violent community standards. Violence has always been an attractive short-cut to empowerment, and is more likely to occur in a program when there is an absence of active, caring, committed, and consistent management of the unit.

Even with active management of the unit, another critical element is required if there is to be an increased subscription to non-violent norms. The active participation of each community member is required, and each person must feel empowered enough to believe that they do, in fact, play a significant role in keeping *Sanctuary* safe. This sense of importance and empowerment can be used a few important ways. An expectation is explicitly set that when conditions exist in the community that contribute to an increased sense of individual or collective vulnerability, people will feel emboldened and responsible enough to discuss the situation with other member of the patient and staff community. This can be especially difficult if such a discussion is interpreted as "telling" on another patient. In fact, this is one of the most common impediments to enlisting community support in monitoring community problems. Too often, it is believed that by openly discussing a patient's difficulties, or by discussing the impact that these difficulties might be having on the community, such discussions constitute a form of betrayal to the patient. The message must be reinforced that such discussions actually empower the patient and the community. Failure to do so leads to increased secretiveness, anxiety, and a sense of impending doom. These feelings, more than any other, often serve as a reminder of earlier times when abuse and danger appeared imminent. It is the failure to help in the monitoring process that ultimately leads to the degradation of a sense of safety and security.

Although much more could be said about specific responses to specific events that are precursors to violent or destructive outbreaks in a therapeutic milieu, it is more important to reaffirm one basic, most critical point. Those creating *Sanctuary* have noted, time and time again, that all people have an ability to raise themselves up to a higher, more constructive level of existence. Likewise, these people also have the ability to act out one's worse fears. What often accounts for the difference between a constructive sublimation of angry impulses and an explosive and dangerous response is the mind set and expectations of those staff who must engage with the survivor of trauma and abuse. Expect the worse and it is likely to happen. This is not to say that one must be ill prepared to handle the worse. To the contrary, clinical preparedness is essential if the clinician is to maintain any credibility. But hopelessness can be read in the eyes of the clinician, and the survivor of a past trauma is extremely adept at perceiving whether the clinician does, indeed, have any hope for the individual. Time and time again, *Sanctuary* has worked with those who have failed at more traditional and restrictive in-patient programs. Reasons for a more successful outcome vary greatly attributable, at least in part, to the inherent belief that all who participate in the *Sanctuary* program are sufficiently empowered to not only improve the quality of

their own personal life, but can, and should contribute to the improvement of the *Sanctuary* program. This expectation is an expectation of empowerment and hope, and often is identified as one of the critical lessons learned or appreciated in the program. An environment that promotes, teaches, encourages and expects constructive resolution to long-standing problems is increasingly rare in today's health-care field. As economic factors dictate a more time-limited and less costly alternative to humane and respectful treatment, some very basic principles of recovery continue to be eroded. More frequently, there is an expectation that those who require treatment must be, by nature, so impaired and potentially dangerous that locked confinement and minimal therapy is acceptable. Not only is this position morally decrepit, but it is also, according to many mental health regulations promulgated by many communities, patently illegal. People have a right to be treated in the least restrictive environment capable of meeting their therapeutic needs, and a presumption of dyscontrol usually elicits the behaviours that are meant to be avoided.

As is apparent by now, keeping *Sanctuary* safe is a time-consuming, demanding, and, at times, difficult task. It requires a firm grounding in principles of humane treatment, and an equally firm commitment to principles of safety and the maintenance of boundaries. Most of all, it requires a belief that being subjected to violence is not, in itself, a condemnation to living a life of recreating similar violence. *Sanctuary* has been, and remains, a living workshop that attempts to demonstrate, on a daily basis, that the ongoing cycle of violence can, indeed, be broken. It is hoped that all who participate in *Sanctuary* eventually believe that it is their duty to insure that the cycle of violence is broken.

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