

A RECIPROCAL SUPERVISORY NETWORK: *THE SANCTUARY MODEL*

Sandra L. Bloom, M.D.
Landa C. Harrison, L.P.C.; M.Ed.
Sarah Yanosy, L.C.S.W.

Introduction: Adapting To Paradox

The treatment of trauma survivors begins with a paradox: relationship is at the heart of healing from traumatic experience while relational damage is at the core of our clients' problems. Similarly, supervision of psychotherapeutic work has always been thought to be an essential component of clinical care. But today, with increasingly diminished economic resources going to mental health and social services, supervision of clinicians is frequently focused on "productivity schedules" and "billable hours" and not on the actual relationships unfolding between clients and clinicians.

Adding to this paradoxical situation is the fact that the clients with the most severe and complex problems related to a past history of exposure to childhood adversity, toxic stress, and disrupted attachment end up in the foster care system, in residential treatment programs, hospitals, substance abuse facilities, homeless shelters, juvenile justice facilities and prisons. Historically, caregivers in these settings who spend the most time with the clients are the least well-trained and the least supervised. To make things worse, we live in an age when most forms of intensive relational treatment particularly those that occur in complex multi-relational situations such as hospitals and residential treatment programs, are discouraged, depleted, or completely unavailable when they are most needed.

For these reasons, we must take a radical approach to creating an effective methodology for sustaining supervision within organizations like these. This method we subscribe to is part of the Sanctuary Model, a clinical and organizational, trauma-focused intervention. Using Sanctuary to re-think supervision includes redefining the field's traditional understanding of "therapist" of "supervisor" and of "supervision" itself. This chapter will outline the scope of the problem facing supervisors and therapists in the current service delivery climate in putting the therapeutic relationship at the heart of trauma therapy, and present a proposal for improving the support that trauma therapists so desperately require to serve their clients.

The Gaping Hole

Another dimension of the many-sided paradox of trauma healing is the call for “evidence-based practices” (EBPs). Though admirably scientific in intent, it has led to the simplistic notion that if one employs any of these EBPs, the clients for whom these practices have been created, should get better. Likewise, clinicians who are not providing an EBP are slightly suspect, subject to a condescending skepticism about their approach as if they had suggested herbal supplements as a cure for AIDS. Unfortunately, even the most studied of evidence-based procedures frequently fail to achieve the hoped for results in the treatment of “simple” PTSD, much less the more complicated cases that populate our social service delivery systems. Worse yet, clients who suffer from complex mixtures of Axis I and II disorders are frequently excluded from the very research studies that prove the efficacy of EBPs [1].

Thus, a fundamental question must be asked and ultimately addressed as we evaluate the effectiveness of today’s human service practices: Do the current trends - evidence-based and mandated practice parameters - place appropriate emphasis, value and relevance on understanding our world? Has our field addressed this complexity or with the best of intention, unwittingly created a large gaping hole as a result of “worldview blindness”. As one philosopher of science has noted *"our scientific theories have failed to explain what matters most to us: the place of meaning, purpose, and value in the physical world. Our scientific theories haven't exactly failed. Rather, they have carefully excluded these phenomena from consideration, and treated them as irrelevant. This is because the content of the thought, the goal of an action, or the conscious appreciation of an experience all share a troublesome feature that appears to make them unsuited for scientific study. They aren't exactly anything physical, even though they depend on the material processes going on in brains."*(p. 22)[2].

The experience of penetrating behind what is our self-protective wall of denial about the fragile nature of human existence is what happens to survivors of traumatic life experience at a deep and existential level. For them the shield that we each maintain between ourselves and the loneliness and unpredictability of existence, is shattered, often suddenly and irrevocably. Healing from this kind of insult requires healing not just the body and not just the mind but the soul as well. Mechanistic approaches to trauma healing may significantly reduce symptoms such as chronic hyperarousal, flashbacks, and nightmares. For some people symptom reduction may be enough to enable them to reconstitute a world that has made sense to them in the past and makes sense to them once again. But for others particularly those who have had multiple experiences of betrayed trust, loss of safety and disrupted attachment, symptom relief alone is likely to be insufficient. They have gone down the rabbit hole, have been changed profoundly by their experience, and there is no going back. They can only go forward. But for a social species going forward into what is experienced as the dark unknown is so filled with terror that it is far more likely that without supportive relationships they will stay in place, treading water, often repeating a traumatic past because it is all that they know how to do and because they must keep picking at an unhealed wound.

Largely as a result of this large gaping hole, complex problems are frequently viewed as simple problems; minds are seen as machines and parts are viewed as wholes. We often do our best to avoid recognizing the social, economic, and political contexts within which traumatic experiences inevitably occur. Our social environments seem to undergo such rapid change, and the problems are so complex, that the individual is left feeling unable to exert control. Subsequent feelings of helplessness and incompetence across systems drive the need to apply what are often believed to be easily replicable, manualized treatment approaches. In the process, the context of experience can be lost and the issues of meaning and purpose that derive from extended relationships are relegated to unimportance. In this way it becomes possible to believe that the application of specific manualized treatment is all that needs to be done.

RESTORING ORDER

Pioneers in the traumatic stress studies world have consistently recognized this serious gap in standard professional discourse. Helping clients to make meaning out of their traumatic experiences has been central to many practitioners involved in the treatment of survivors of overwhelming life experiences. Dr. Jonathan Shay has spent his career working with combat veterans. Much of his work has focused on the undermining of our sense of humanity that trauma brings in its wake. As he writes "war destroys the trustworthy social order of the mind" (p.32) [3]. Dr. Judith Herman describes the "central dialectic of psychological trauma", the conflict between the will to deny horrible events and the will to proclaim them aloud"(p.1)[4]. As she makes clear," to study psychological trauma is to come face-to-face both with human vulnerability and the natural world and with the capacity for evil in human nature. To study psychological trauma means bearing witness to horrible events..... It is morally impossible to remain neutral in this conflict. The bystander is forced to take sides." (p.7) [4]. The "bystander" that Dr. Herman refers to here includes the therapist who bears witness to the trauma narrative.

Bearing witness both solidifies trust and connection within the therapeutic relationship and renders the therapist vulnerable to his or her own psychological turmoil. It is essential that supervision acknowledges, respects and addresses these risks without succumbing to the inherent risk of denying or dismissing these realities [5].After traumatic experience a fundamental part of healing is restoring a sense of social and moral order. Without that restoration, the survivor is likely to continue to feel outside of normal human relationships, unable to adequately integrate their past and present experience. For many survivors the journey of healing requires what has been called "trauma transformation" or "posttraumatic growth" accompanied by the development of a "survivor mission" [4, 6].

There is no known manualized treatment program that can bring about such crucial existential change. Childhood adversity can be devastating because children are still trying to make sense of the world they live in. The impact of negative previous experiences can splinter across the life span and present significant challenges to the development of healthy relationship [7].

Holism is a theory that postulates the universe and especially living nature as interacting wholes. To be effective, a therapist must deal with the wholeness of each individual client. But this requires a level of supervision that is supported through a safe, emotionally intelligent, collaborative and reciprocal network of supervisory relationships. Helping trauma survivors – particularly those who have experienced complex trauma - to heal from their moral, spiritual, characterological, and existential posttraumatic injuries requires a relational scaffolding that the survivor and helpers must build together. This scaffolding must provide pathways to a different future, a future that doesn't yet exist but that is only a possibility, a co-created possibility.

The Complex Problem of Supervision

Helping people who have lost a sense of meaning and purpose in their lives is an awesome responsibility. Supervising people whose job it is to help do this is equally challenging, particularly during these arduous economic times when funders are seeking to expend shrinking resources. Let's assume, for a moment, that a traditional, individualized, regular supervisory relationship is still available and accessible. To what will supervisors need to attend? And how will supervisors collaborate with and engage supervisees in a reciprocal relationship that aims to support all parties involved?

COMPLEX TRAUMATIC STRESS DISORDERS

Clients who suffer from what can be most aptly described as "complex traumatic stress disorders" have significant problems in developing and maintaining therapeutic relationships [8]. Healing and recovery is dependent on the establishment of a therapeutic relationship and yet the failures in earlier relationships often sabotage the possibilities of creating healthy therapeutic relationships. It is these clients who present the greatest challenges to caregivers and hence to any supervisory relationships.

Dr. James Chu, a psychiatrist with extensive experience in treating people with complex trauma disorders, described these as the *Ten Traps for Therapists in the Treatment of Trauma Survivors*: difficulties with interpersonal trust, maintaining too much or too little distance in the therapeutic relationship, poor boundaries, insufficient limits, flaws in the therapeutic contract, unclear expectations for clients, reluctance to penetrate the client's wall of denial, difficulties in managing intense countertransference, inability to successfully manage idealized transference, and setting unrealistic goals. So challenging are the therapeutic tasks necessary for healing that he has observed, "given the extreme emotional pain that is often a part of the therapy of patients with abusive pasts, it often seems quite remarkable that patients can tolerate their own treatment" (p30)[9]. Supervision that appreciates the fragmentation, information overload, and intensity of trauma responses in clients will also comprehend client "no-shows" as a multifaceted issue that can be explored and use the supervisory relationship to explore them.

COMPLEX COUNTERTRANSFERENCE

These treatment traps illustrate the challenges that clients present to the therapeutic relationship that are inherent in the nature of complex trauma exposure and the damage such exposure inflicts on the capacity for healthy relationship. But there are other layers of difficulty. There are those that are inherent in the person of the therapist widely described using the term countertransference. Countertransference problems may arise secondary to therapists' past life issues and their own experiences of trauma that are triggered by the clients' narratives. Therapists are people too, going through their own present life challenges in real time, and they may be more vulnerable at key life stages relevant to the presenting material of their clients, such as when a therapist's daughter has her sixth birthday just as a client is revealing a history of sexual abuse when she was that age. And then there are the emotions that therapists experience upon hearing about, empathizing with, and trying to help trauma survivors referred to variously as "vicarious traumatization", "compassion fatigue", or "secondary traumatic stress"[10-12]. Then there are the countertransference beliefs secondary to the therapists' own familial or cultural beliefs that may interfere consciously or unconsciously with the therapeutic relationship, as when the therapist's cultural group endorses the role of corporal punishment while the client experienced corporal punishment as traumatic. Supervisors need to be attuned enough to explore, without being invasive – to balance the line between offering supervision and therapy.

As if this were not enough, there is also the reality that most of the people working in the social service delivery system in the United States will have been exposed to Adverse Childhood Experiences before they themselves were fully mature [13]. People who have experienced the impact of toxic stress as children do not just "leave it at the door" when they enter the workplace. In our own informal surveys of people working in health care, social services, education, and mental health service delivery for children and for adults we have found that most of the staff members we surveyed had suffered some kind of serious childhood adversity. This suggests that many of the providers of services to traumatized people will be themselves vulnerable to the same symptoms as their clients. Supervisors need to look for these symptoms, not only in the clients, but in the workers they supervise – and not only in the workers, but in themselves as well.

A recent U.S. Justice Department survey has confirmed that most U.S. children are exposed to violence in their daily lives, over 60% of them in the previous year alone. Nearly half of the children and adolescents had been assaulted at least once in the year prior to the study [14]. Recognizing this reality, the National Academy of Science has asserted that a growing proportion of the U.S. workforce in the future will have diminished cognitive and social skills secondary to being raised in disadvantaged environments [15]. National reports declare that at present and in the foreseeable future, the social services are experiencing a workforce crisis [16]. This crisis is evident in high turnover rates in many social service organizations - sometimes as high as 50%. If we want to keep good workers and attract more, then we must create organizations within which their deficits are minimized and their strengths maximized.

In Murphy, D., Joseph, S. and Harris, B.(editors) (2013) *Trauma, Recovery, and the Therapeutic Relationship: Putting the therapeutic relationship at the heart of trauma therapy*. London: Palgrave Macmillan.

We do not believe that our present human service delivery environments can measure up to those expectations. Supervising these workers then means balancing the need to demand what may be perceived by workers as unachievable results in billable hours or client outcomes with maintaining quality services. This also must be accomplished within a context of constant turnover, requiring supervisors to oversee cases through the eyes of worker after worker after worker.

TRAUMA-ORGANIZED SYSTEMS

Finally, there are the challenges that occur when our organizations and systems of care are themselves, traumatized, something my colleagues and I have referred to as “trauma-organized systems”, building on the original work of Bentovim, who applied the term “trauma-organized system” to families [17, 18]. Organizations are, like individuals, living systems [19]. Being alive, they are vulnerable to stress, particularly chronic and repetitive stress. Chronic stress stealthily robs an organization of basic interpersonal safety and trust and thereby robs an organization of health. Similarly organizations, like individuals, can be traumatized and the result of traumatic experience can be as devastating for organizations as it is for individuals. Supervising in such an environment poses further complications.

For decades our social service delivery system has been under stress. Clients with increasing numbers of diagnoses and multiple treatment experiences have vastly increased the complex demands put on all helping professionals. There has been an alarming increase in rates of injuries to clients and staff with subsequent demoralization of staff accompanied by an increase in hostility towards clients. An increase in aggressive behaviors has resulted in staff counter-aggressive responses and the subsequent development of punitive environments that can be difficult to supervise when the dangers are real and apparent. When professional staff and nonprofessionally trained staff gather together in an attempt to formulate an approach to complex problems they are not on the same page, while every behavior is attributed to conscious intent and unconscious motivation is denied. They may share no common theoretical framework that informs problem-solving. Without a shared way of understanding the problem what then passes as treatment is often little more than labeling, the prescription of medication and behavior management. The inherent trap for supervisors in this scenario is being cast in one of the roles in the reenactment, most likely that of persecutor to the staff person’s victim role [17].

In a supervisory context, the impact of chronic stress and adversity on organizations has been thus far minimized and denied except in the most dramatic of circumstances. As a result, supervisors, managers and organizational leaders remain largely unaware of the multiple ways in which organizational adaptation to chronic stress creates a state of dysfunction that can significantly impede, if not prohibit the beating of the organization’s heart: safe, consistent and morally ethical client service delivery. In many systems there is loss of memory of former competencies. Direct care staff are often working at cross purposes with clinical staff, if they are grounded in any theory at all, and supervision for these staff members is minimal and

usually directed at specific problems or egregious infractions of rules and policies. It is not uncommon to find a mishmash of training approaches all diluted without any attempt at integrating these different approaches. Under these circumstances leaders become variously perplexed, overwhelmed, ineffective, authoritarian, avoidant, hostile and burned-out. Then when troubled clients fail to respond to what passes as "treatment", they are labeled again given more diagnoses and termed "resistant to treatment". The damaging consequences of such dysfunction for clients, workers, supervisors and even communities ultimately impairs their ability to heal and move forward.

In many settings, supervision does not focus on any of these critical issues but on productivity demands and whether or not the therapist has met those demands. Training programs are still not adequately preparing therapists to deal with the complexity that they will inevitably encounter in any kind of social service or mental health setting so that when the supervisor and supervisee encounter each other, they do not necessarily have a common framework of understanding or meaning to inform their interactions. When this is the case the supervisees are more likely to keep hidden any conflicts they are having with their clients that relate to their own countertransference and just tell the supervisor what they think the supervisor wants to hear.

Economic challenges and high turnover rates have meant that at the same time supervisors are unlikely to have had much training or experience in supervision themselves and it is highly unlikely that they have had any management training. As a result many people placed in supervisory roles know little themselves about countertransference relationships and find themselves far more comfortable in focusing on productivity, bill collection, and scheduling, rather than the more demanding issues that really need to be addressed. Supervisors with clinical training may not find themselves uncomfortable with these conversations, but follow the same route as they succumb to organizational pressure for financial rather than clinical performance and the business or sustainability models that human service systems adopt to survive.

PARALLEL PROCESSES

A useful way of defining this set of complex interactions between troubled clients, overwhelmed staff members, and chronically stressed organizations is the concept of "parallel process". The definition used here derives from work done in industrial settings: *"when two or more systems – whether these consist of individuals, groups, or organizations – have significant relationships with one another, they tend to develop similar affects, cognition, and behaviors, which are defined as parallel processes Parallel processes can be set in motion in many ways, and once initiated leave no one immune from their influence"* (p.13) [20].

The effect of chronic and repetitive stress on social service and caregiving organizations is that these workplaces tend to have problems that parallel or mirror the problems of their clients. Chronically stressed organizations are crisis-driven, unsafe and hyperaroused, having lost the

capacity to manage emotions institutionally. As a result of poorly managed emotions, interpersonal trust is absent. This results in a failure to learn from experience, a form of “organizational learning disability” that is accompanied by “organizational amnesia” as knowledge formerly gained is systematically lost. Under such circumstances, the most emotionally charged information in any organization becomes “undiscussable” resulting in a form of “organizational alexithymia”. As this dysfunction unfolds, organizational leaders are likely to become more authoritarian and punitive, while workers respond with more aggressive and passive-aggressive behavior, and an attitude of learned helplessness, while the entire environment becomes progressively more violent, punitive and unjust. Despite this apparent deterioration, the likelihood is that unless this process is stopped, chronically stressed organizations will simply continue to repeat the past, engaging in reenactment and as a result, steadily deteriorate in function. In this way, an entire organization and even the larger system within which it is embedded, become organized around a past history of chronic stress, adversity and trauma, unable to adapt to changing circumstances and therefore chronically failing [17].

As a result our systems frequently recapitulate the very experiences of abuse of power that have proven to be so toxic for the people we are supposed to help. “Sanctuary trauma” is the term that has been used to define the experience of expecting a protective environment and finding only more trauma [21]. This perplexing combination of forces – complex exposure to trauma of the clients, complex problems among the staff, combined with organizational dysfunction creates a toxic and interactive set of problems.

In the face of the overwhelming nature of these problems a model that relies on individual supervision set within fixed, hierarchical supervisory structures cannot hope to succeed. Given these multiple difficulties and the economically treacherous times we live in what is to be done? Should we go on pretending that supervision, just by scheduling it, is effective? Should we give up on the idea of supervision entirely? Should all treatment only be explicit and manualized so that supervision can be more easily structured and certified? Under the circumstances we must adapt to, how do we get many people from diverse backgrounds, with a wide variety of experiences, on the same page speaking the same language sharing a consistent, coherent and practical theoretical framework?

If we are to make our clients’ problems better and not worse, then we need a supervisory network where everyone in the system is supporting and empowering client healing in a consistent, trauma-informed way. The reciprocal network model of supervision that we are suggesting requires increased innovation, leadership and knowledge to promote a socially responsible, interactive supervisory network that is supported, nurtured and continuously evaluated by the organizational culture.

Redefining Supervision

Dr. Bloom and her colleagues operated an acute-care psychiatric unit and an outpatient setting for 20 years between 1980 and 2001. Beginning in 1985 we recognize that most of the clients we were seeing as adults had experienced extensive exposure to childhood adversity [22]. This recognition radically changed our approach to treatment, to each other, and to our understanding of the world around us. We were undergoing this change process at a time when the ability to implement the innovations we were discovering was becoming increasingly difficult. Beginning in 1991, we called our program “The Sanctuary” and specialized in treating people with complex traumatic stress disorders usually secondary to childhood abuse. Most of our clients had multiple diagnoses, had previously had negative therapeutic experiences, and were admitted to the hospital because they were a danger to themselves and/or others. One of the “discoveries” we made was in recognizing how frequently we were caught up in the reenactment behavior of our clients – how often we were helping them to repeat destructive relational patterns simply because we did not recognize these patterns, when our most critical job was to change those patterns. It became obvious to all of us that to keep them safe and to keep ourselves safe, while still creating opportunities for change, we needed to watch out for each other. We needed to be “supervising” each other all the time, not just via some structured and limited supervisory system. We needed to be able to constructively criticize each other, regardless of where each one of us existed in the typical medical hierarchy. It had to be safe for our clients to critique us, even while we were setting limits on them.

Out of this interactive, prolonged, and communal group experience we began to develop what is now called “The Sanctuary Model”, a theory-based, trauma-informed, evidence-supported, whole culture approach with a clear and structured methodology for systematically introducing organizational change [23]. At this writing we have trained over two hundred mental health and social service organizations in our model, which has given us extensive experience in wrestling with the thorny issue of supervisory systems [24].

360-DEGREE SUPERVISION

In the industrial world there is now extensive experience with what has become called “360-Degree Feedback” [25, 26]. Many Fortune 100 programs find such processes time-consuming, people-intensive, rife with conflict and expensive but worth the investment because of the many benefits particularly when it comes to staff development, coaching, positive influence, and leadership development. Companies that derive the highest benefit from it use individual development as a primary goal with the emergence of a “development culture” as the payoff for the company as a whole. The major benefits include: providing people with information on how they are perceived by others; providing information on improvement by addressing weaknesses; and offering feedback from a variety of sources and points of view [26]. Programs that take a 360-Degree approach have also been recommended as a protection against what has been termed “abusive supervision” because they help to create a culture of civility that is

incompatible with abusive behavior [27]. Major problems associated with the method include: providing an overwhelming amount of information that is hard to process; differences between self-ratings and others' ratings; need for someone to resolve the conflicting information [26].

Another problem of these approaches, particularly in a variety of high-impact, intensive mental health and social service programs is that formal systems of supervision are usually point-in-time evaluations. These serve many useful purposes but can only begin to address the need for rapid-response, immediate innovation, and concerted teamwork that is basic to working in these settings to bring about significant change. Thanks to the efforts of by now several hundred programs and thousands of people we can state that a method exists that enables entire organizations to develop interactive networks of supervision and accountability. We believe a network model of supervision is the most economically feasible and appropriate to the times we live in. Networks are self-organizing they scale up to networks of networks, they take advantage of the power of peer influence, they can last indefinitely, even when individual members sever their connections, they are self-annealing meaning they fill in gaps, they are intelligent and they have memory [28]. To accomplish this it is necessary to work at the level of organizational culture, while still respecting individual development and experience. Organizational culture represents a pattern of shared basic assumptions that a group has learned as it solved its problems and that has worked well enough to be considered valid and taught to new members. It represents how we do things around here, the accumulated wisdom of the group and in most cases organizational culture is largely unconscious [29].

RECIPROCAL SUPERVISION

In light of the overwhelming challenges that confound traditional supervision and the growing evidence that there are more effective methods, we propose a departure from the conventional construction of supervision that offers a richer and more holistic interpretation of the support needed to enhance the therapeutic relationship that grounds trauma treatment. This construction offers an expanded understanding of the term “therapist”, to include an entire team of service providers. In the Sanctuary Model, it is understood that a clinician often have much less direct contact with clients than other types of support staff (ie: milieu workers, foster parents, paraprofessionals, youth counselors, peer counselors, etc.) do. This reality requires that we consider the need for every member of this team to have a therapeutic impact on clients. In short, the team is the treatment.

If the team is the therapist, then we must also consider an expanded understanding of “supervisor”. Weighted by the challenges presented earlier in this chapter, individual supervisors cannot be expected to provide for all the needs of a multidisciplinary team. For this reason, the Sanctuary Model expands the role of supervisor to encompass the whole community to supplement the support of individual supervision.

Finally, the concept of “supervision” through the Sanctuary lens is not simply a dyadic relationship, but a complex dynamic web of reciprocal relationships within a community and an

organic interplay among multiple parties. In the context of the reciprocal supervisory network, supervision from the community includes client critique in shaping feedback and acknowledges client contributions to shaping the therapeutic environment. It involves equal focus on individual performance and relational dynamics, recognizing that treatment is a collaborative and participatory process in service of the therapeutic relationship between the client and the treatment team, community and organization as a whole.

Another component of reciprocal supervision is the constant acknowledgment of traumatic reenactment and active re-scripting of these events [23]. That means that every member of the team is aware of how easy it is for any of us to be drawn into playing a role in the other person's life that recreates a previous problematic relational dynamic and that it is our mutual responsibility to work within this knowledge base to bring about significant change. There is also a shared ownership of clinical practice, client care and excellence. In addition, reciprocal supervisory networks include building trust among staff through praise and celebrations of their successes. To operationalize this definition of supervision, Sanctuary relies on its relational value system, known as the Seven Commitments.

Operationalizing Reciprocal Supervision

The Sanctuary Model rests on four main “pillars”: trauma theory, the seven Sanctuary Commitments, S.E.L.F., and the Sanctuary Toolkit. Together, these four domains create a consistent, scientifically-based framework from which everyone in an entire organization can derive meaning, purpose, and practice so that everyone can be “on the same page” and can see when someone is not on that “page”. To do so, however, requires universal training of everyone including the Board of Directors, administrators and managers, clinicians, direct-care staff, indirect-care staff (everyone else in an organization), clients and families.

TRAUMA THEORY

Trauma Theory is the foundation for creating a trauma-informed environment. Simply put, trauma, adversity and chronic stress are universal to the human experience and affect individuals and organizations in predictable ways. Understanding the ways in which trauma impacts functioning and health and the use of the Sanctuary model to mitigate these effects are at the core of the Sanctuary Model. A Sanctuary agency understands trauma theory and uses the lens of Sanctuary to make connections about behaviors and events, to problem solve and ultimately to create a high-functioning, compassionate, healthy community.

THE SANCTUARY COMMITMENTS: CREATING A SYSTEM OF MEANING

The value system of the Sanctuary Model is embodied in the seven Sanctuary Commitments: to Nonviolence, to Emotional Intelligence, to Social Learning, to Open Communication, to Social

Responsibility, to Democracy, and to Growth and Change. They serve as the ground upon which all meaningful decisions, strategies, supervisory interventions, and conflict management occurs.

The Sanctuary Commitments work together and interactively. They help us think systemically, placing relationships and meaning-making at the heart of healing and also at the core of all interactions. They engage everyone in the community or organization and they are supportive and positive, focusing more on what *to do* and less on what *not to do*. These values guide every interaction at every level in every situation throughout an organization. These are the terms with which our community agrees to operate in order to thrive. Adoption of the Sanctuary Commitments creates processes that are a vehicle for 360-Degree supervision. Team members use these guiding principles as anchors for evaluation, reflection, deliberation, hypothesis formation, experimentation, conflict management, and as the touchstones for measuring their construction of a trauma-informed community.

THE COMMITMENT TO NONVIOLENCE

The Commitment to Nonviolence represents the commitment to creating a safety culture. To create a safety culture there must be physical safety, psychological safety (safe with oneself), social safety (safe with other people), and moral safety (safe to know what the right thing is and to do it). Dr. Martin Luther King described the commitment to nonviolence not as a lofty value but as a practical solution for humanity's greatest problem. As he wrote, "We have learned through the grim realities of life and history that hate and violence solves nothing. Violence begets violence; hate begets hate; and toughness begets toughness. It is all a descending spiral, and the end is destruction – for everybody" (p.87)[30].

The Commitment to Nonviolence represents a shift toward the group social body, analogous to the immune system in the physical body as the means to protect its members. The social immune system is the social body's ability to recognize and respond to threats to its well-being. When such a threat enters the social body, complex social activities are set into motion to defend and protect the social body against the emergence of violence. It must include everyone to be effective. Just as good trauma treatment focuses on building a therapeutic alliance, the Commitment to Nonviolence means building that same alliance of trust among the team through a strength based approach and an agreement not to hurt each other with words or actions.

THE COMMITMENT TO EMOTIONAL INTELLIGENCE

Emotional intelligence has been defined as the ability to perceive accurately, appraise, and express emotions; to access and/or generate feelings when they facilitate thought; the ability to understand emotions and emotional knowledge; and the ability to regulate emotions so as to promote emotional and intellectual growth [31]. As this definition implies there are many elements of emotional intelligence. Clients and staff must identify and have words for feelings and understand their feelings. They must be able to integrate thoughts and feelings and

accurately read the emotions in others. They must accurately interpret emotions and other people and manage strong emotions in themselves. They must be able to regulate their own behavior develop empathy for others and establish and sustain healthy relationships.

An emotionally intelligent culture is inherently contagious. Clients and staff alike assimilate to their environment. A therapeutic and supervisory relationship that takes into account how I am feeling, how you are feeling and what the impact of my behaviors is on you is a relationship that enables all members to thrive.

Emotional intelligence in our world is especially vital because caregivers must perform what has been termed emotional labor [32]. This means work performed by any service employee was required, as part of his or her job, to display specific sets of emotions with the aim of inducing particular feelings and responses among those for whom the services are being provided. Emotional labor is what clinicians do. People who cannot adequately perform emotional labor should not choose any form of caregiving as a profession. Rude, emotionally unintelligent behaviors are often replicated by those people who have been targets of such behavior. As a result, individuals sabotage themselves and others. Collaboration at both the treatment level and the supervisory level produces positive emotions that help an individual negotiate future challenging dynamics.

Emotional intelligence also requires the ability to manage conflict successfully. There are different kinds of conflict. These include task related conflict and interpersonal forms of conflict interpersonal conflict creates tension between members, impedes group performance, decreases the possibility of synthesis, and results in oversimplified solutions. Task related conflict on the other hand means that people disagree on specific tasks and how to accomplish those tasks. Task related conflict stimulates discussion, stimulates creativity and synthesis, and makes it more likely that the system will be able to deal with complex problems.

THE COMMITMENT TO SOCIAL LEARNING

The Commitment to Social Learning requires that an organization become a learning organization that adapts to changing conditions, values staff, and extends the learning environment to everyone. A social learning environment is what Maxwell Jones, one of the founders of the original therapeutic community movement called a “living-learning environment”, one that promotes good decisions and good decision-makers who search for alternatives, consider short and long-term consequences of decisions, are sensitive to group process, learn from past experience, rely on multiple sources of information, are able to weigh the pros and cons of the situation, are still able to listen to gut feelings, and are aware of their own blind spots.

Good decisions often require what is been called “double loop learning” in which we review our basic assumptions, beliefs and values to understand what is behind what we do and the results that we get rather than just having a simple feedback loop where we try to improve upon what

already exists [33]. A social learning environment is not only about adopting evidence-based practice. It's also about using practice-based evidence to constantly informed innovations in approach and in relationship, in order to get better results.

THE COMMITMENT TO OPEN COMMUNICATION

In the Sanctuary Model the Commitment to Open Communication is about building organizational transparency and creating a culture of candor [34]. A transparent organization is a place for information sharing. When individuals get stuck in repetitive, tedious environments, they lose desire, momentum and inspiration. There is no reason to take risks and challenge yourself if you cannot see the future and how it will be replicated. A place where it is ok to reflect, brainstorm, experiment and evaluate your experience of the work and the emotions that come with the work is vital. Such a climate facilitates and promotes understanding by decreasing uncertainty.

We recognize that communication among and between human beings is difficult and that there are many physical, psychological, social and philosophical barriers that can interfere with good communication. In order to communicate adequately we have to mean what we say and say what we mean while not being mean when we say it. It is important to gather information from a variety of sources, be able to manage our emotions, while being able let our guard down and be vulnerable to the influence of others. It means admitting mistakes, apologizing when necessary, learning how to deliver bad news well and routinely showing care and concern for others.

THE COMMITMENT TO DEMOCRACY

There are several reasons why we need more not less democracy in our caregiving environments. Staff at every level as well as clients are energized by the ability to provide information and make decisions that affect their life and work. We constantly confront adaptive problems – problems that we have never seen before, that are different day-to-day, that require adaptive change. Maintaining a high level of adaptability is tiring for lone individual. It is a drain on the brain. We are more likely to maintain adaptive change if we do not have to do that alone. In the Sanctuary Model we use the definition of democracy described by Dr. John Gastil "democracy represents the ideal of a cohesive community of people living and working together and finding fair, nonviolent ways to reconcile conflicts" (p.5)[35]. Empowering clients and staff through collaborative and reciprocal therapeutic relationships with individuals gives them a greater sense of control, an increased say in how things get done and more opportunities to learn, grow and change. The same is true for the relationship between the therapist and supervisor. The challenge in human services is to avoid decreasing empowering interactions when mistakes happen and productivity levels wane.

Democracy evolved in order to minimize the abusive use of power so it is a vital component of helping people to heal who have been exposed repeatedly to the abusive use of power, often

at the hands of people upon whom they were so supposed to be able to depend. In many ways democratic participation is an antidote to the effects of trauma because it requires: patience; the ability to manage emotions; using words as a substitute for action; building trust; and exercising social skills including learning how to negotiate and compromise. Democratic participation is a demonstration of fair play and restorative justice in action. Democratic workplaces tend to be those where there is more communication, or interaction, more coordination, greater information rich as this, greater commitment, more analysis of results, more productive conflict, and more innovation and creativity.

Reciprocal supervision is an inherently democratic process because it insists that each of us, at times, may have to supervise the other, regardless of where we are placed in the organizational hierarchy. This is the most radical part of what we see happening in the adoption of the Sanctuary Model, that people who have little formal power can civilly and nonviolently confront problems they see unfolding, even with people who have power over them. In interaction with the Commitment to Democracy, the Commitment to Emotional Intelligence, to Growth and Change, to Open Communication and to Nonviolence makes such change possible. The Commitments to Social Learning and to Social Responsibility make such change necessary.

THE COMMITMENT TO SOCIAL RESPONSIBILITY

In the Sanctuary Model, the Commitment to Social Responsibility is about balancing the needs of the individual with the common good of the entire community. This implies that even as an individual therapist, you can't ignore your role in the community or in the ways in which other therapeutic relationships play out in the community. This commitment holds every individual accountable to look for opportunities to make more meaningful impacts and to take risks. It also implies that it is important to create and maintain an organizational justice climate that enhances trust, predicts performance, and predicts good citizenship within the community. In the context of the supervisory relationship, supervisors are a critical part of maintaining this balance within the context of the overall environment.

THE COMMITMENT TO GROWTH AND CHANGE

In any supervisory relationship, all parties must keep in the forefront of their actions that the goal of therapy is growth and change, not just stabilization and acceptance of the status quo. We must always be asking ourselves and each other – “Are we getting change or are we helping the other person to repeat what he or she has always done?” In cases of trauma and particularly chronic exposure to traumatizing circumstances, there is a very high likelihood that the client will repeat their past, an exaggeration of what comes naturally to human beings. It is vitally important that everyone in any therapeutic environment understand the dynamics of reenactment [23]. Without that understanding, we are always in danger of simply helping our clients stay arrested in time, reliving destructive relational dynamics. Likewise, in the supervisory relationship, it is important to routinely consider the Commitment to Growth and Change, expecting that learning must be occurring for all of us, all of the time.

S.E.L.F.: THE SANCTUARY DIRECTIONAL COMPASS

The road to recovery from trauma and adversity can be a long one for both individuals and organizations. When you are lost, it's useful to have a compass and that's what S.E.L.F. is – a compass on the road to healing. S.E.L.F. is an acronym that represents the four interactive key aspects of recovery from bad experiences. S.E.L.F. provides a nonlinear, cognitive behavioral therapeutic approach for facilitating movement – regardless of whether we are talking about individual clients, families, staff problems, or whole organizational dilemmas.

The four key domains of healing: *Safety* (attaining safety in self, relationships, and environment); *Emotional management* (identifying levels of various emotions and modulating emotion in response to memories, persons, events); *Loss* (feeling grief and dealing with personal losses, recognizing that all change involves loss, and understanding that signs of grief are embedded in reenactment of the past), and *Future* (trying out new roles, envisioning a different future). Using S.E.L.F., the clients, their families, and all levels of staff members are able to embrace a shared, non-technical and non-pejorative language that allows them to see the larger recovery process in perspective. The accessible language demystifies what sometimes is seen as confusing and even insulting clinical or psychological terminology that can confound clients and staff, while still focusing on the aspects of pathological adjustment that pose the greatest problems for any treatment environment.

S.E.L.F. is a vitally important tool for Reciprocal Supervision because it is such a useful problem-solving tool. It can simultaneously be employed in a parallel process manner to deal with problems that arise within the treatment setting between staff and clients, among members of staff, between staff and administration, and between supervisor and supervisee. Applied to such issues of staff splitting, poor morale, rule infraction, administrative withdrawal and helplessness, and misguided leadership, S.E.L.F. can also assist a stressed organization to conceptualize its own present dilemma and move into a better future through a course of complex decision making and conflict resolution.

THE SANCTUARY TOOLKIT

The Sanctuary Toolkit comprises the concrete activities that individuals and organizations use to inoculate themselves against the effects of trauma and chronic stress. Think of them as the medicine or vitamins used to ensure the health and functioning of a community. They are vital for the implementation and sustained success of Sanctuary and they are inherently supervisory in nature.

Every organization that adopts the Sanctuary Model has a *Sanctuary Core Team* comprised of usually several dozen people that meets regularly to execute implementation tasks, monitor use of Sanctuary and sustain its use in the organization. Additionally, all staff members must complete the ten modules of *Sanctuary Training* in addition to participating in ongoing training that includes orientation training and booster training, if appropriate.

In Murphy, D., Joseph, S. and Harris, B.(editors) (2013) *Trauma, Recovery, and the Therapeutic Relationship: Putting the therapeutic relationship at the heart of trauma therapy*. London: Palgrave Macmillan.

Community Meetings, held regularly, become the routine way that we check in with each other. Everyone in the community is expected to manage distress without harming others and one of the tools for this is a *Safety Plan*. *Red Flag Reviews* are used to respond to critical incidents and are practiced with fidelity. Every staff member participates in a *Sanctuary Team Meeting* which is held regularly, is used to build a strong community, and reinforces the tenets of Sanctuary. *Sanctuary Psychoeducation* about trauma and recovery as well as the Sanctuary Model is used with clients and/or families. *Sanctuary Treatment Conferences* or *Sanctuary Service Planning Conferences* incorporate the principles of Sanctuary and a trauma-informed perspective. Every staff member participates in formal, consistent *Sanctuary Supervision or Coaching*. All community members have a *Self-Care Plan* that they share with each other and are expected to adhere to for the benefit of themselves and the welfare of the community.

CONCLUSION

In this chapter we have endeavored to begin the definition of the way we view supervision in a trauma-informed therapeutic community using the Sanctuary Model, where relationship is at the heart of all that we do. We have used the term “reciprocal supervision” with the intention of undermining the implicitly hierarchical nature of the term “supervision” while at the same time not diminishing the importance of how much we have to learn from each other.

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