CHAPTER FIVE

Creating, destroying, and restoring Sanctuary within caregiving organisations: the eighteenth John Bowlby Memorial Lecture

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Introduction: changing paradigms

In the nineteenth century, an American poet named John Godfrey Saxe retold in verse, an old Indian parable about the blind men and the elephant. In the poem, six blind men travel to see what an elephant looks like and in so doing, each one individually grabs hold of a part of the elephant and mistakes it for the whole. This poem stands as a superb metaphor for our understanding of human nature up until now, with every discipline declaring its own explanations for various aspects of reality.

But a new paradigm is emerging from neuroscience, medicine, developmental paediatrics, evolutionary science, genetics, psychology, sociology, anthropology, and philosophy that is destined to change our view of human beings and our place in the world. Although still lacking an appropriate, encompassing word, this new way of thinking is already beginning to have significant impact on caregiving services under the general rubric of "trauma-informed care", because it originated in the study of post traumatic stress disorder and related complex problems.

However the study of specific reactions to traumatic experiences is only the tip of the iceberg. What is actually beginning to surface is

the whole iceberg—the interconnected and fundamentally creative experience of every human being that is substantially determined by the quality and nature of early childhood attachment relationships, as Dr John Bowlby so thoroughly explored (Bowlby, 1972, 1980, 1982). Since Dr Bowlby's death, we have learned a great deal about facilitating individual growth and recovery and this chapter will briefly summarise some of the key concepts that have emerged (Bloom, 1997, 2013a). It has become evident however, that individual change should not be the only focus of intervention. Individual change is often significantly impeded by the failure of caregiving systems to change.

Unfortunately, changing systems often takes much longer than individual change, usually because groups of people tend to become stymied by the complexity of large group change and the budgets that are required to fix what is broken. It has been challenging at a practice and policy level to help people understand that we are addressing the need for what amounts to monumental change. Our minds can grasp complex concepts more quickly if we have a meaningful metaphor. Computer metaphors can be useful because just about everyone has to grapple with the challenges of these important, useful, and exceedingly frustrating devices and because now, computers are individually parts of interconnected networks. Computers have hardware and software. A wide variety of software programs can be "learned" (installed) in the computer as long as each one is compatible with the computer's "operating system"—software that allows the other software to work.

The amazing brain of a human being is constantly learning new programmes but what is the operating system for the brain? My colleagues and I think there is a sufficient body of evidence now to convince us that "attachment" is the operating system for human beings—what Dr John Bowlby, the grandfather of attachment studies, originally called the "internal working model". Exposure to trauma and other toxic forms of stress create disrupted attachment and in this metaphor, disrupted attachment can be understood as similar to a computer "virus" that wreaks havoc on the functioning of a computer. In computer networks, viruses are spread rapidly to everyone that is connected. So too do the effects of violence spread across generations and down through the generations.

At the same time we have observed that many of the staff people at every level in caregiving organisations have had experiences similar to the people they are helping. We know first-hand and have observed in

virtually all varieties of human service organisations that the stress and strain of doing this work with steadily diminishing resources combined with increased regulation, loss of control, and fear of risk has taken a toll. The result is that the operating systems of our helping organisations, usually referred to as "organisational culture", have become widely dysfunctional. One of the many challenges in this work then becomes how do you purge the "virus" that has infected our systems and restore a working operating system that is upgraded, more responsive, has less bugs, crashes less, and is less vulnerable to viral attacks?

Such an upgrade requires an approach to organisational culture as a whole that is "trauma-informed" and "attachment-based", that contributes new knowledge and know-how and eliminates some of the damaged or obsolete "programming", while retaining whatever "code" is still useful and viable. The complex problems of our children cannot be fixed like you might fix a broken lamp. For them to make significant change, they need to participate in that process of change. And in the process, learn how to steer themselves into a better future. Ultimately they will have to decide what choices to make, which path in the forest will lead them out of the woods, not deeper into them.

We need to look at ways that we can rapidly shift entire treatment environments to be more effective, efficient, and speedy in helping children to change the trajectories of their lives.[1] Every caregiving organisation is a living complex adaptive system and if you want it to change, the living parts of that system must be the ones empowered to make those changes or they will not happen. Top-down change works for machines but it is not very good at all for changing children, families, or organisations. In this chapter, I will briefly describe the underpinnings of an approach to change in complex adaptive systems that is called the "Sanctuary ® Model",[2] and describe the methods we are using to transform whole cultures, creating parallel processes of recovery.

Attachment: the human operating system

Early childhood attachment determines whether a child's brain, body, sense of self, capacity for relationships, and conscience all develop properly. In our understanding of the attachment literature, we sort out seven key domains necessary for healthy growth and development. These seven domains provide the structure for the human operating system (Bloom & Farragher, 2013).[3]

Safety and security

From the moment of birth, the first responsibility of all mammalian mothers is to protect her child from harm. Every child needs the sense of safety and security provided by a stable, secure mothering relationship to use as the scaffolding for all further neuro-regulatory development.

Emotional management

The infant and early childhood relationship with mother provides the early context for emotional management. When it goes well, the mother begins the process that helps the child interact in a stable and secure way with his or her environment, using emotions to provide a basis for valuing what is worthy and unworthy in the world, ultimately informing but not dominating thought and action.

Learning

Beginning at birth, the mother must help the child learn about the world around him and how to be safe in that world, balancing learning with risk and altering the expanse of that risk as the child experiments with the world and learns from those experiments. In order for the child's cognitive abilities to unfold, the child must be protected from being overwhelmed by emotions he is not yet prepared to deal with, yet his emotional system must be stimulated enough to provoke learning.

Communication

The mother is the first great communicator for the child. In what has been described as the "serve and return" relationship between the infant and mother, the baby is learning the rudiments, the basic building blocks of communication. This flow of information back and forth must be both open so that information can come from the outside world and yet be sufficiently boundaried so that the child is not overwhelmed. The child must learn how to communicate, when to communicate, how much to communicate, and who to communicate to, and all of that will vary over time, with different people, and under differing circumstances.

Participation in relationship

Every mother must teach her child the skills necessary to survive and thrive in an increasingly interconnected and networked world. The child must learn to: listen to other people; integrate ideas and concepts; negotiate and compromise; recognise that there is no absolute truth in any situation, only the process of seeking truth. As the mother listens to the child's input, respects the child's point of view, while still asserting her own, the mother teaches the child that there are limits to one's individual strivings in interaction with others and that power is to be used, not abused.

Reciprocity and justice

In interaction with his mother, the child has his first experience with fair play. In their interaction the child begins to develop what ultimately will be a sense of justice and the basis for how just relationships are to be conducted. The child must learn how to put aside his own strivings and satisfaction of his own needs in service of "the other". If the child has experienced justice then the child will develop a concern with justice, social justice, and the common good.

Dealing with change

Within the caring scope of his mother, the child will have his first experience with loss and all of the emotional pain that accompanies loss for human beings. Every new developmental experience means learning something new and giving up something old. The child's feelings of sadness, anger, remorse, helplessness, despair will be recognised, respected, and supported by a loving mother who will provide comfort and hope that the future holds better feelings and experiences. In the process of recovering from loss, letting go and moving on in time the child will learn how to adapt, roll with life's inequities, and welcome what life holds.

Exposure to trauma, adversity, and disrupted attachment

Terminology

English is a beautiful and flexible language but there is no word that encompasses the topic of severe stress in childhood. The word "trauma" is being used as a shorthand term for what is a far more complex

phenomenon. There is a stress continuum, more like the continuum that we understand goes from excellent health to terminal illness, with the constant possibility of moving back and forth on that continuum. Movement along that continuum is determined by many different factors such as the state of pre-existing health, the age of the person, the nature of the disease process, and a multitude of socio-cultural factors. Early experiences are particularly weighted because the brain is still developing and thus those experiences help to determine the way the brain gets "wired" from the very beginning, even before birth (Center on the Developing Child at Harvard University, 2010).

Similarly, in the last few decades we have learned a great deal about the continuum of stress moving from positive stress, to tolerable stress, toxic stress, traumatic stress, and all complicated by allostatic load. Stress and health interact in complex ways so that taken together exposure to stress can be seen as our number one public health problem, particularly when too much stress is experienced in childhood. All living systems deal with the stress of changing conditions and both positive and tolerable forms of stress can help us grow and develop.

Toxic stress, on the other hand, is associated with prolonged and intense activation of the body's stress response to such an extent that it can change the very architecture of a child's developing brain with problematic long-term consequences. Many factors determine the ways in which toxic stress affects a developing child—the nature of the stressor, the age of the child, the level of pre-existing health and mental health, the family situation, the number and extent of protective factors that exist within the child and the child's environment. But because human children are dependent on adult care for such an extended period of time, any experience of disrupted attachment can increase the likelihood that the child will experience toxic stress. Toxic stress exposure is being used as a way of understanding the profound effects of situations such as child physical abuse, sexual abuse, neglect, witnessing domestic violence, and being exposed to community violence, particularly when these events are repetitive, even chronic (Shonkoff, 2012; Shonkoff et al., 2012).

Traumatic stress occurs when a person experiences or witnesses an event that is overwhelming, usually life-threatening, terrifying, or horrifying in the face of helplessness. As with toxic stress exposure, the effects of traumatic stressors will be multi-determined and therefore are highly individual. The young person's pre-existing vulnerability,

the nature of the stressor, the child's immediate reactions to the event or events, and what happened after the event or events, all may play a contributing role in determining the complex outcomes that the paediatrician then witnesses in practice. Traumatic events that may be experienced directly by young people include, but are not limited to, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attacks, torture, incarceration, natural or human-made disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that an attachment figure has a life-threatening disease.

Allostatic load is the term being used to describe the wear-and-tear on the body and brain that can be a result of things such as poverty, bigotry, chronic hunger, and lowered socioeconomic status. All can have a profound effect on a child's development and later health outcomes secondary to the constant stress load on the child and on his or her caregivers, even in the absence of perceivable traumatic events (Marmot, 2004; McEwen & Gianaros, 2010).

In multi-problem families, toxic stress, traumatic stress, and allostatic load factors may complexly interact, potentially creating a wide range of problems for the young people in the family. This work serves to bridge the scientific gap between long-term physiological changes, attachment theory and our growing understanding about the social determinants of health, disease and maladjustment.

Exposure to trauma, adversity and violence

In 2009, the United States Department of Justice released the findings of a comprehensive nationwide survey of the incidence and prevalence of children's exposure to violence (Finkelhor, Turner, Ormrod, Hamby & Kracke, 2009). The findings are extremely disturbing,

confirming that most United States (U.S.) children are exposed to violence in their daily lives, over sixty per cent in the past year. Nearly half of the children and adolescents had been assaulted at least once in the past year. We have not even begun to reckon with the long-term public health effects of this kind of violence exposure, nor have we addressed the reality that in less than twenty years, the number of children with incarcerated parents has increased by eighty per cent (Glaze & Maruschak, 2008).

Studies of the lifespan implications of this exposure provide sobering illustrations of the long-term consequences of child maltreatment. The purpose of the adverse childhood experiences (ACE) Study done by Kaiser Permanente in San Diego and the Centers for Disease Control and Prevention in Atlanta, Georgia was to examine the impact of exposure to toxic levels of stress across the life span (Felitti & Anda, 2010). The researchers asked 18,000 willing participants—all members of the Kaiser Permanente Health Maintenance Organization in San Diego—if they would take a survey. The majority of participants were Caucasian, fifty years of age or older, and were well-educated, representing a solidly white, middle-class population.

An adversity score or ACE score was calculated by simply adding up the number of categories of exposure to a variety of childhood adversities that the person had experienced before the age of eighteen to a maximum score of ten. These categories included severe physical or emotional abuse; contact sexual abuse; severe emotional or physical neglect; living as a child with a household member who was mentally ill, imprisoned, or a substance abuser; or living with a mother who was being victimised by domestic violence; or parental separation/divorce (See: www.cdc.gov/ace/; also http://acestudy.org/; http://acesconnection.com/).

Of this largely white, middle-class, older population, almost two-thirds had an ACE score of one or more, while one in five was exposed to three or more categories of adverse childhood experience. Two-thirds of the women in the study reported at least one childhood experience involving abuse, violence, or family strife. The researchers compared the ACE score to each person's medical, mental health, and social health data and found startling and disturbing associations. The higher the ACE score, the more likely a person was to suffer from one of the following: smoking, chronic obstructive pulmonary disease, hepatitis, heart disease, fractures, diabetes, obesity, alcoholism, intravenous drug use, depression and attempted suicide, teen pregnancy, sexually transmitted

diseases, poor occupational health, and poor job performance. Worse yet, the higher the ACE score, the more likely people were to have a number of these conditions interacting with each other. In other words, the higher the ACE score, the greater the impact on a person's physical, emotional, and social health.

According to the study findings, if you are a woman and have adverse childhood experiences your likelihood of being a victim of domestic violence and rape steadily increases as the ACE score rises and if you are a man, your risk of being a domestic violence perpetrator also rises. The study showed that adverse childhood experiences are surprisingly common, although typically concealed and unrecognised and that ACEs still have a profound effect fifty years later, although now transformed from psychosocial experience into organic disease, social malfunction, and mental illness.

In 2009, the results of incorporating the ACE's questions into the health surveys of five other states was released by the Centers for Disease Control indicating that fifty nine per cent of this much more diverse population had an ACE score of one or more, while nine per cent had an ACE score of five or more (Centers for Disease Control, 2010). As of 2012, at least twenty-one U.S. states are incorporating the ACE's questions into their state-wide health surveys.

A full replication of the adverse childhood experiences study—one that would take into account, for example, the other kinds of exposure that inner-city children have, in addition to the existing categories of adversity—has not yet been attempted. We do know, however, that many children who live in conditions of urban poverty are exposed to dreadful experiences. Surveys done in Detroit, Chicago, Los Angeles, and New Orleans suggest that about a quarter of young people surveyed had witnessed someone shot and/or killed during their lifetime (Bell & Jenkins, 1993; Groves, Zuckerman, Marans & Cohen, 1993; Osofsky, Wewers, Hann & Fick, 1993; Richters & Martinez, 1993). Among children at a paediatric clinic in Boston, one out of every ten children witnessed a shooting or stabbing before the age of six (Groves, Zuckerman, Marans & Cohen, 1993). Youth violence is the second leading cause of death for young people between the ages of fifteen and twenty-four in the United States. On an average day, thirteen young people are victims of homicide and almost 2,000 are treated in an emergency for injuries related to physical assault (Centers for Disease Control, 2013). In a 1998 study of 349 low-income black urban children (ages nine–fifteen), those who witnessed or were victims of violence showed symptoms of

post traumatic stress disorder similar to those of soldiers coming back from war (Li, Howard, Stanton, Rachuba & Cross, 1998). The burden of violence and incarceration falls disproportionately on families of colour (Alexander, 2010; Glaze & Maruschak, 2008).

Poverty is associated with many problematic stressors that increase the likelihood that children will be exposed to both reduced opportunity and toxic stressors (Duncan, Magnuson, Boyce & Shonkoff, 2010). According to the most recent U.S. census data, one in five American children are now living below the poverty line (News, 2012).

Disrupted attachment: when things go horribly wrong

When the child has a less than optimal attachment experience as a result of exposure to trauma, adversity, neglect, and other conditions of toxic stress, the damage to the normal development of body, brain, mind, and soul can be extensive, but may have differential effects across different kinds of abilities, at different ages, in different people, even those within the same family. The people who come into any kind of caregiving setting, therefore, are likely not to have *simple* problems but instead have very complex, interrelated problems that are often related to inadequate integration of complex brain functions. Here we group these complex problems in parallel with the main attachment domains we have already articulated (Bloom & Farragher, 2013).

Lack of safety, trust, and chronic hyperarousal

Any erosion in the protective barrier that parents provide against the world can result in disrupted attachment, regardless of whether the breach in that protective envelope was intentional or not. Exposure to overwhelming events and the emotions that accompany them can change the person's central nervous system so that it takes very little stimuli to create a significant threat response—a problem called chronic hyperarousal. The loss of basic safety in early childhood has long-term consequences in the capacity to trust other people and keep oneself safe in the world.

Lack of emotional management

When a child has inadequate adult support in the face of toxic or traumatic stressors, the child is exposed to overwhelming emotions. Research has shown that toxic stress exposure has very negative

consequences for normal brain and body growth and development and these effects can extend throughout adulthood. Disruptions in the capacity to manage emotional states make people much more vulnerable to a wide variety of pathological adaptations that negatively impact themselves and other people.

Learning problems

Our prolonged period of immaturity combined with high demands for complex learning means that any disruption in safety and emotional management in childhood is likely to jeopardise the unfolding of cognitive functions. Impairments in learning can be wide-ranging and far-reaching and include everything from school failure to cognitive rigidity and a failure to develop creative problem-solving skills, fully integrate disturbing elements of memory, and develop the skill-set necessary to effectively manage conflict.

Alexithymia—failure to communicate

If the child does not feel safe, cannot manage distress, and has difficulty using his cognitive capacity, then the ability to use language to communicate with others and to communicate with oneself internally is likely to be seriously impaired. The inability to give words to feelings is known as "alexithymia". We are more likely to act out in the world whatever feelings we cannot put into words and we will demonstrate through our behaviour what we are unable to convey through healthy relational communication.

Abusive power relationships

If the child does not feel safe and secure in the world, cannot adequately manage distressing emotions, cannot think well, and has difficulty openly communicating with others, then he is likely to experience increasing difficulties over time in developing the complex skills required to participate in, and resolve conflicts about, social relationships with others in school and later at work and as members of a civil society. He is likely to model power relationships based on the abusive power relationships to which he has already been exposed. This increases the likelihood that he will be bullied, bully others, or both.

Injustice and narcissism

If the child has been treated unjustly then the child's moral development will not unfold as it should. This means that the child and the adult he becomes develop a very skewed sense of right-and-wrong, ethical premises, and justice. It increases the likelihood that the child will be unable to progress to higher levels of moral functioning and instead remain preoccupied with crime and punishment, vengeance, and fulfilling his own selfish and self-gratifying needs, regardless of the consequences his behaviour may have on others.

Failure to grieve, foreshortened future

If a child has learned that the world is a dangerous place, that other people cannot be trusted, and that you can count on no one but yourself, then he is likely to resist change. All change requires loss and without emotional management, the emotions evoked by loss overwhelm the capacity to cope. This is dangerous when survival depends on constant adaptation to changing conditions. Additionally, the cognitive impairments that accompany the lack of safety and inadequate emotional management may also jeopardise the ability to use imagination effectively to anticipate the consequences of one's action or inaction. Lacking the ability to imagine alternatives, the person is more likely to simply repeat, to re-enact, what he already knows whether such a strategy is effective or not.

Adversity in caregiving staff

This terrible situation affects far more children—and the adults they become—than we would like to believe. Research evidence is confirming what all of us in social service environments have been witnessing first hand—that exposure to toxic stress is epidemic. Most people in the United States will experience a traumatic event at some time in their lives.

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 and one formal survey 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 (Esaki & Larkin, 2013). Recognising 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 (Knudsen, Heckman, Cameron & Shonkoff, 2006).

And then there is the danger that is present, even at work. Since the 1980s, violence has been recognised as a leading cause of occupational mortality and morbidity. On average, 1.7 million workers are injured each year (about half of these injuries occur in health care and social services), and more than 800 die as a result of workplace violence (NIOSH, 2006). After law enforcement, people working in the mental health sector in the United States are the most likely to be victimised while at work (Bloom & Farragher, 2010).

National reports declare that at present and in the foreseeable future, the social services are experiencing a workforce crisis (Hoge et al., 2007). This crisis is evident in high turnover rates in many social service organisations—sometimes as high as fifty per cent. If we want to keep good workers and attract more, then we must create organisations within which their deficits are minimised and their strengths maximised. We do not believe that our present human service delivery environments can measure up to those expectations.

Trauma-organised systems

People who have a history of exposure to adversity, toxic stress, and trauma have complex problems and are challenging to all health and human service delivery environments (Bloom, 2011; Bloom & Farragher, 2010, 2013). At the same time, the people who work in these organisations may have experienced traumatic events themselves and many will have experienced adversity as children. And the organisation as a whole often has in its history some terrible events that have occurred. It is impossible to understand the full impact of the last thirty years of changes in human service delivery without understanding the impact of acute and chronic stress on workers at every level of the system.

In most human service delivery organisations, workload and job complexity have increased while financial incentives have decreased. Because of decreased funding, many organisations hire fewer people with advanced training and experience, depending more on a

non-professional, often unskilled and inexperienced workforce to provide twenty-four-hour-a-day care for the most injured people in our culture. The higher the turnover rate, the more of a problem this is. Budgets for education, training, supervision, case review have all declined while the regulatory demands of federal, state, local, and managed care organisations have skyrocketed. Rampant programme closures have put extreme pressure on existing organisations to cope with the demands for service, while insurance company constraints require increasingly rapid turnover of clients.

We believe that organisations—including human service organisations are, like individuals, complex, adaptive, living systems (Pascale, Millemann & Gioja, 2000). Being alive, they are vulnerable to stress, particularly chronic and repetitive stress. Chronic stress stealthily robs an organisation of basic interpersonal safety and trust and thereby robs an organisation of health. Organisations, like individuals, can be traumatised and the result of traumatic experience can be as devastating for organisations as it is for individuals. As a result, many human service delivery networks are functioning as "trauma-organised systems" (Bentovim, 1992).

Parallel process

Since organisations are living complex systems and as such are vulnerable to the impact of trauma and chronic stress, we suggest that as a result of acute and chronic organisational stress, destructive processes occur within and between organisations that mirror or "parallel" the processes for which our clients seek help. In an organisational context, parallel process can be defined as what happens when "two or more systems—whether these consist of individuals, groups, or organisations—have significant relationships with one another, they tend to develop similar affects, cognition, and behaviours, 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" (Smith, Simmons & Thames, 1989, p. 13).

The result of these complex interactions between traumatised clients, stressed staff, pressured organisations, and a social and economic environment that is frequently hostile to the aims of recovery is often the opposite of what was intended. Staff in many treatment programs suffer physical and psychological injuries at alarming rates and thus become

demoralised and hostile. Their counter-aggressive responses to the aggression in their clients help to create punitive environments. Leaders become variously perplexed, overwhelmed, ineffective, authoritarian, or avoidant as they struggle to satisfy the demands of their superiors, to control their subordinates, and to protect their clients. When professional staff and non-professionally trained staff gather together in an attempt to formulate an approach to complex problems they are not on the same page. They lack a common theoretical framework that informs problem-solving. Without a shared way of understanding the problem, what passes as treatment may be little more than labelling, the prescription of medication, and behavioural "management." When troubled clients fail to respond to these measures, they are labelled again, given more diagnoses and termed "resistant to treatment." In this way, our systems inadvertently but frequently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to help.

Destroying Sanctuary

Just as the lives of people exposed to repetitive and chronic trauma, abuse, and maltreatment become organised around the traumatic experience, so too can entire systems become organised around the recurrent and severe stress of trying to cope with a flawed mental model based on individual pathology that is the present underpinning of our helping systems. When this happens, it sets up an interactive dynamic that creates what are sometimes uncannily parallel processes (Bloom & Farragher, 2010). Focusing on the seven domains we have explored above, let's look at how these parallel processes appear in an organisational context.

Lack of safety, trust, and crisis driven

The human service system and virtually every component of it, including the mental health system, have been and continue to be under conditions of chronic stress, individually and collectively experiencing repetitive trauma. In many helping organisations, neither the staff nor the administrators feel particularly safe with their clients or even with each other. Acute crisis often leads to chronic states of organisational crisis and organisational hyperarousal. This lack of safety may present as a lack of physical safety, workplace violence, abusive behaviour on the part of managers and/or staff, and a pervasive mistrust of

the organisation. A perceived lack of safety erodes trust, which is the basis for positive social relationships. As a result these organisations are very tightly wrapped and tensions run high. Under such unrelenting stress, helping professionals and the agencies themselves become more highly reactive and are more ready to see threat rather than opportunity, pathology rather than strength, and risk rather than reward. The protection that we provide for each other in groups—our "social immunity" becomes eroded under conditions of chronic crisis and unrelenting stress and no one feels safe.

Loss of emotional management

A core challenge for clients served by human services is the ability to manage distressing emotions, while at the same time being able to extend empathy to their clients and not become emotionally anesthetised. Emotional intelligence is recognised as an important component of any workplace environment that hopes to be productive and healthy. But emotional intelligence is slow to develop or eroded when fear, recurrent crisis, unrelenting stress, and unmanaged conflict come to dominate a work environment. Emotions are contagious and under any conditions, human service delivery environments demand the highest levels of emotional labour from workers. Stress and trauma exacerbate those demands. Atmospheres of recurrent or constant crisis severely constrain the ability of staff to manage their own emotions, and this makes it difficult to provide healing environments for their clients and in this way contribute to poor services. Negative emotions become collective emotions. Under these circumstances, conflict escalates and both relationships and problem-solving suffer.

Organisational learning disabilities, dissociation, and amnesia

Under the conditions we have been describing, stress interferes with organisational learning, organisational memory is lost, organisational amnesia affects function, and service delivery becomes increasingly fragmented and dissociated. Decision making becomes compromised and reactive so that short-sighted policy decisions are made that appear to compound existing problems. Dissent is silenced, leading to simplification of decisions and lowered morale. The organisation becomes

progressively learning disabled and this severely compromises its capacity to adapt to changing conditions.

Organisational miscommunication, conflict, and alexithymia

Human communication in groups is always challenging. The discoveries we made as children about how easily a message can become garbled as it is transmitted one-by-one through a group are just as relevant to adult workplaces, complicated even further by the elimination of nonverbal information via email and texting. Under conditions of chronic stress, breakdowns in organisational communication networks occur. The feedback loops that are necessary for consistent and timely error correction no longer function. Without adequate networks of communication, the normal conflict that exists in human groups will escalate and increasing amounts of important information becomes "undiscussable"—arising as the "elephants" in the organisational room. As a result the organisation as a whole becomes increasingly alexithymic, unable to talk about the issues that are causing the most problems and that remain, therefore, unsolvable. Without the ability to discuss vital subjects, the organisational grapevine becomes poisoned, conflict compounds, and without adequate communication, collective disturbances emerge that, if not stopped, will lead to chronic unresolved conflict and violence.

Authoritarianism, learned helplessness, silenced dissent

Rarely does the subject of power—who has it, who doesn't, and how it is used and abused—come up for open discussion in social service environments and yet it is a critical component of any organisational setting. As communication breaks down, errors compound, and the situation feels increasingly out of control, organisational leaders become more controlling and authoritarian. Under these circumstances, workplace bullying is likely to increase at all levels, and organisations may become vulnerable to petty tyrants. As the organisation becomes more hierarchical and autocratic, there is a progressive and simultaneous isolation of leaders and a "dumbing down" of staff, with an accompanying "learned helplessness" and loss of critical thinking skills. The organisation and the individuals in it become highly risk avoidant. Efforts

to empower workers may pay only lip service to true participatory processes resulting in what amounts to bogus empowerment. Dissent is unwelcome in environments characterised by chronic stress because dissent is seen as a threat to unified action. As a result the quality of problem analysis and decision making deteriorates further. Because dissent serves as corrective feedback within an organisation thus averting disaster, the silencing of dissent is dangerous to organisational and individual well-being.

Punishment, revenge, and organisational injustice

The notion that "punishment works" is simply taken for granted as true, as part of our existing mental model for dealing with other people. An abundance of scientific research shows that the utility of punishment is largely a myth. But as leaders become more stressed they become more authoritarian, controlling, and coercive. When these efforts to correct problems are ineffective, organisational stress increases further. Under these conditions, punitive measures are likely to be employed in an effort to control workers and clients. Organisational practices that are perceived as unjust evoke a desire for vengeance. Human beings who believe they have been punished unfairly quite naturally seek revenge in their interpersonal relationships and in the workplace and this response can produce more injustice as well as workplace sabotage. As in the case of the chronically stressed individual, shame, guilt, anger, and a desire for justice can combine with unfortunate consequences. When this is happening, the organisation may become both socially irresponsible and ethically compromised and otherwise decent people may stand around and do nothing to intervene.

Unresolved grief, re-enactment, and decline

Because the existing mental model for organisations is based on notions of rationality, control, and social engineering, the human reactions to loss of attachments is given little recognition. Nonetheless, loss, grief, and traumatic loss have become commonplace components of human service environments. Staff, leaders, and programs depart. Neighbouring systems close. Standards of care deteriorate and quality assurance standards are lowered in an attempt to deny or hide this deterioration. Over time, leaders and staff lose sight of the essential purpose of their

work together and derive less and less satisfaction and meaning from the work. People begin to question whether they are actually successful at what they do or just permanently failing. When this is occurring, staff members feel increasingly angry, demoralised, helpless, and hopeless about the people they are working to serve: they become "burned out." Unresolved loss increases the tendency of human beings to repeat the past and re-enact tragedy and loss. All change involves loss, but without an ability to acknowledge, honour, and work through repetitive loss, organisations are likely to develop ever-increasing problems and a powerful tendency to repeat ineffective strategies. This re-enactment behaviour can ultimately lead to decline and even organisational death. Most disturbing is the idea that the broader society may unconsciously set up the social service sector to actually be successful failures (Seibel, 1999).

The Sanctuary Model

The four pillars of Sanctuary

"Creating Sanctuary" refers to the shared experience of creating and maintaining physical, psychological, social, and moral safety within a social environment—any social environment—and thus reducing systemic violence (Bloom, 1997, 2013a, 2013b, 2013c; Bloom & Farragher, 2013; Esaki et al., 2013). As it became clear that the process of "creating Sanctuary" had to aim at organisational culture we realised that there are key aspects of changing culture and creating community. There has to be a shared knowledge base, shared values, shared language, and shared practice. We call these the four pillars of Sanctuary.

Our shared knowledge comprises our present knowledge about trauma, toxic stress, adversity, attachment, and recovery. Trauma-informed, attachment-based organisational change requires radical alterations in the basic mental models upon which thought and action are based and without such change, treatment is bound to fall unnecessarily short of full recovery or fail entirely. This change in mental models must occur on the part of the clients, their families, the staff, and the leaders of the organisation. Mental models exist at the level of very basic assumptions, far below conscious awareness and everyday function and yet they guide and determine what we can and cannot think about and act upon (Bloom & Farragher, 2013; Senge, 1994).

The seven commitments of Sanctuary are a value system tied directly to trauma-informed treatment goals. S.E.L.F. provides us with a shared language and organising framework. The Sanctuary toolkit then offers practical skill-building that reinforces and strengthens individual and group commitment to change. The process of "creating Sanctuary" begins with getting everyone on the same page—surfacing, sharing, arguing about, and finally agreeing on the basic values, beliefs, guiding principles, and philosophical principles that are to guide attitudes, decisions, problem-solving, conflict resolution, and behaviour. Out of this process our shared mission emerges: creating and sustaining a parallel process of recovery for clients, families, staff members, organisations, and even societies.

The Sanctuary Commitments

The Sanctuary Model is structured around a philosophy of belief and practice that creates a process enabling organisations to shift their mental models. For a complex organisation to function you need just the right number of principles that guide short-term, everyday conduct as well as long-term strategy. Too many rules and a system becomes rigid, inflexible, and even paralysed. Too few and it becomes purely individualistic and chaotic. The Sanctuary Commitments structure the organisational norms that determine the organisational culture. The Sanctuary Commitments represent the guiding principles for implementation of the Sanctuary Model—the basic structural elements of the Sanctuary "operating system"—and each commitment supports trauma recovery goals for clients, families, staff, and the organisation as a whole.

We didn't invent these principles. Other than the newer scientific findings around toxic stress, trauma, and attachment, these commitments represent universal principles, ancient wisdom that is as old as human groups. We have simply compiled them, articulated them into a cohesive whole, and developed a methodology to get disparate groups organised around them. And they cannot be "cherry-picked". All seven Sanctuary Commitments are complexly interactive and interdependent. Take away one and the whole structure may fall apart.

The Sanctuary Commitments apply to everyone. Organisational leaders must be fully committed to the process of the Sanctuary Model for it to be effective—that means the board of directors, managers

at all levels, and every person who works in the organisation. If the organisational leaders do not get on-board, it will not work. At first glance, many organisational leaders hear a review of the seven commitments and believe that those commitments already constitute their organisational culture. In many cases this is at least partially true. It is only when leaders engage in a different kind of dialogue with other members of their organisational community that they find out how divergent people's views are on what these commitments mean and how to make them real in everyday interactions. Experience has taught that courageous leadership is critical to system change and without it, substantial change is unlikely to occur. In the following sections we will briefly describe the Sanctuary Commitments as they run in parallel with the individual and organisational domains (Bloom & Farragher, 2013).

Commitment to Nonviolence

The Commitment to Nonviolence refers to the active creation of nonviolent environments important not just because our caregiving environments have become dangerous and unsafe for the people who work in them and who seek help. It is because we must learn—as a whole species—how to practice nonviolence in our daily lives, everywhere, all of the time. Institutions then—hospitals, mental health programs, group homes, prisons, shelters, schools—become laboratories for what is required if life is to survive—a social revolution. Working and living non-violently takes tremendous discipline, self-reflection, and group support. Many of the components of the Sanctuary Toolkit, like community meetings and safety plans are designed to facilitate nonviolent action.

Commitment to Emotional Intelligence

Emotional intelligence refers to the ability to identify, understand and put into words one's own feelings, to accurately read and comprehend emotional states in others, to manage strong emotions and to express them in a constructive manner, to regulate one's own behaviour, to develop empathy for others and to establish and sustain relationships. Since this is a primary problem in all of our institutions, the development of emotional management skills is a primary function. To do that

organisations must build respect for the tough emotional labour that all staff members engage in, minimise the paralysing effects of fear, and expand awareness of problematic cognitive-behaviour patterns and how to change them—in everyone.

Commitment to Social Learning

The Commitment to Social Learning is a whole organisational culture vow to create a "living-learning" environment for clients, their families, and everyone that works in the setting (Jones, 1968). An underlying assumption in this is that we are in the market of positive change, that if people are exactly the same (or worse) after leaving our care, then we have done a terrible job. The Sanctuary Model is not about stabilisation. We believe that everybody can change, even if it is just a little bit. But change that is self-determined has to come about by learning something. We learn things in the context of relationship. So we believe that the Sanctuary Model has to guide an organisation in creating an environment where everyone within that institution has multiple opportunities to learn, grow, adapt, and change in a way that benefits them and their society. That means we must all unlearn some things, learn some new things, remember useful information from the past, and let go of things from the past that are no longer useful. It requires us to develop better decision-making and problem solving capacities, part of which is learning to honour dissent.

Commitment to Open Communication

In an organisation, the communication network is an analogue to the vascular system of our bodies. Any breakdown in that system causes dysfunction and potentially, death. The goal of this commitment is to help organisational members overcome barriers to healthy communication. There are many barriers today from the overuse of electronic communication, to the lack of productive meetings and to the absence of meaningful dialogue. To overcome these barriers, people will have to dare to discuss the "undiscussables"—the important things that are talked about only in the meetings-after-the-meetings (Hammond & Mayfield, 2004). Only by doing so can they overcome the organisational alexithymia—the inability to put into words the most disturbing aspects of organisational function. This means increasing transparency,

developing better conflict management skills, and establishing or reinforcing healthy boundaries.

Commitment to Democracy

This is the commitment that is the most misconstrued and the least understood, largely because our understanding of what democracy is has become so watered down, unpractised, and marginalised that most people seem to think it just means voting. In the Sanctuary Model, the commitment to democracy means much more than that. The definition we use is that democracy "represents the ideal of a cohesive community of people living and working together and finding fair, nonviolent ways to reconcile conflicts" (Gastil, 1993, p. 5). The commitment to democracy is really about how we deal with the issue of power and its abuse in our organisations accompanied by a recognition that people support what they help to create and if they don't help to create it they are not likely to support it. It fully recognises that the problems we face are collective and that the only good solutions will also be collective. In order to get to those solutions—regardless of whether we are talking about a child in residential care or the state of our global climate—we are talking about the need for emergent solutions and those have to emerge from the brains of people who know how to get along together, how to civilly disagree with each other, how to compromise, bargain, negotiate, and synthesise. Along with the commitment to nonviolence, creating participatory environments is fundamental to any real and lasting change within our human service delivery environments.

Commitment to Social Responsibility

Social responsibility is a notion that has become almost passé in our fiercely competitive, market-driven, consumer culture. But human nature hasn't changed and we are deeply programmed for justice for ourselves and social justice for each other. In the Sanctuary Model, this commitment urges us to harness the energy of reciprocity and a yearning for justice by rebuilding restorative social connection skills, establishing healthy and fair attachment relationships, and transforming the desire for revenge into a driving need for social justice and concern for the common good.

Commitment to Growth and Change

This final commitment focuses on two significant domains: loss and change. An unavoidable fact of life is that all growth, all change necessitates loss. In fact, we usually have to give something up before we get the rewards of something new. Our experience tells us that the fundamental sign of a failure to finish the grieving process is repeating the past or "re-enactment". That means that an organisation that hopes to be productive, useful, and healthy for all organisational members must face this fundamental fact and cease repeating irrelevant or destructive past patterns of thought, feeling, and behaviour. Human beings avoid pain and we will not let go of old habits—comforting because they are predictable—unless we have a vision of a possible future that we want to get to, worth the risk of letting go to see what happens next.

S.E.L.F.

What we have just described is a value system, relatively easy to agree with, *really* difficult to practice consistently—that's why we call them "commitments"—it's what we want to do in our hearts, even if sometimes our actions fall short. The better we get at it, however, the fewer messes we have to clean up. Nonetheless, it's complicated and S.E.L.F. makes it a bit more manageable on a practical level.

S.E.L.F. is an acronym that represents the four key interdependent aspects of recovery from bad experiences. S.E.L.F. provides a nonlinear, cognitive-behavioural, psychoeducational approach for facilitating movement through the Sanctuary Commitments—regardless of whether we are talking about individual client, family, or staff problems, or whole organisational dilemmas. It is a framework that helps to organise what are often chaotic amounts of information and as a result imposes a sense of coherence upon that information, making it more comprehensible, manageable, and meaningful (Antonovsky, 1987).

S.E.L.F. is a compass that allows us to explore all four key domains of healing, all of the time. As the importance of one or another of these domains shifts over time, sometimes within minutes, the interpersonal dialogue can shift as well and just as rapidly. *Safety* is about attaining safety—physical, psychological, social, and moral safety—within oneself, in relationships, and in a variety of different environments. *Emotional management* focuses on identifying levels of various emotions

and developing skills to modulate emotion in response to memories, persons, or events in a way that fosters safety to self and others. *Loss* addresses feelings of grief in dealing with personal losses and recognising that all change involves loss, that working through loss is a process, and that letting go can be facilitated by the support of others. *Future* is about "the vision thing" and encourages people to try out new roles, ways of relating and behaving as a "survivor" to ensure personal safety, envisioning a different and better future. We believe that the energy for change actually resides in the future and is always there to be drawn upon as a motivating force.

Using S.E.L.F., the clients, their families, and staff are able to embrace a shared, non-technical and non-pejorative language that allows them all 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 everyone.

Sanctuary Toolkit

The Sanctuary Toolkit comprises a range of practical skills that enable individuals and groups to more effectively and consistently use the Sanctuary Commitments in daily practice, build a sense of community and develop a deeper and more comprehensive understanding about the effects of trauma and adversity while gaining the ability to respond to those effects in a positive way.

The Sanctuary Institute

The Sanctuary Institute is a five-day intensive training experience.[4] Teams of five to eight people, from various levels of the organisation, come together to learn from our faculty, who are colleagues from other organisations implementing Sanctuary. Together teams begin to create a shared vision of the kind of organisation they want to create. These teams will eventually become the Sanctuary steering committee for their organisation. The training experience usually involves several organisations at the same time and generally these organisations are very different in terms of size, scope, region, and mission. This diversity helps to provide a rich learning experience for the participants.

During the training, the steering committee engages in prolonged facilitated dialogue that serves to surface the major strengths, vulnerabilities, and conflicts within the organisation. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organisation are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been overtly surfaced before. Many of these questions have not been raised before because participants have never felt safe enough to say what has been on their mind or in their hearts, even after many years of working together. Although the continual focus is on the fundamental question of: "Are we safe?", participants quickly learn that in the Sanctuary Model being safe means being willing to take risks by being willing to say what needs to be said and hear what needs to be heard.

Participants look at the change process itself and are asked to anticipate the inevitable resistance to change that is a fact of life in every organisation. They look at management styles, the way decisions are made and conflicts resolved. In the process of these discussions, they learn about what it means to engage in more democratic processes on the part of leaders, staff, and clients in terms of the simultaneous increase in rights and responsibilities. They evaluate the existing policies and procedures that apply to staff, clients, and families and ask whether or not they are effective in achieving their shared goals. They are asked to learn about and become thoroughly familiar with the psychobiology of trauma and disrupted attachment and the multiple ways that post traumatic stress in all of its manifestations are present in the lives of the children, adults and families they work with. They are challenged to begin thinking about the implications of that knowledge for treatment. They also learn how high levels of stress in the organisation can impact relationships, emotions, and decision making at every level of the organisation. They develop an understanding of the conceptual tool for organising treatment that we refer to as "S.E.L.F.". They learn about vicarious trauma, traumatic re-enactment, and the importance of understanding themselves and providing support for each other. And they are introduced to the various components of the Sanctuary Toolkit including community meetings, safety plans, red flag reviews, S.E.L.F. psychoeducation, S.E.L.F. treatment planning, and Sanctuary team meetings.

Participants report that the week-long training is a powerful experience—some have said even life-changing. It needs to be because they have a big job to go home to. They will need to go back to their respective organisations and begin to change the culture of the organisation and change long standing paradigms and patterns of behaviour.

Developing a core team and guided implementation manuals

The Sanctuary steering committee is instructed to go back to their organisation and create a "core team"—a larger, multidisciplinary team that expands its reach into the entire organisation. It is this core team that will be the activators of the entire system. The core team should have representatives from every level of the organisation to insure that every "voice" is heard. It is vital that all key organisational leaders become actively involved in the process of change and participate in this core team. The core team is armed with a Sanctuary direct care staff training manual, a Sanctuary indirect staff training manual, a Sanctuary implementation manual, several psychoeducational curricula, and on-going consultation and technical assistance from Sanctuary faculty members to guide them through the process of Sanctuary implementation that extends over three years and hopefully leads to Sanctuary certification.

Organisational change takes several years to really get traction and then continues—hopefully—forever. The objective of the implementation and technical assistance is to edge an organisation closer and closer to the "edge of chaos" where creative, self-organising change occurs, without destabilising it to such a point that it becomes chaotic and dangerous. As the former C.E.O. of Andrus Children's Center, Nancy Ment, has noted, "The Sanctuary Model doesn't keep bad things from happening but it allows an organisation to deal with those bad things without losing its way so it can bounce back and continue to function" (In a conversation, 2011).

The responsibility of core team members is to actively represent and communicate with their constituents and to become trainers and cheerleaders for the entire organisation. The core team works out team guidelines and expectations of involvement for individual team members as well as a meeting schedule and decide on safety rules for the constructive operation of the team itself. The core team is ultimately

responsible for the development of an implementation process aimed at including the entire organisation in the change process that involves teaching everyone about the Sanctuary Commitments, attachment theory, trauma theory, S.E.L.F., and the Sanctuary Toolkit. The core team facilitates the development of educational programs for direct care staff as well as indirect care staff who work in human resource, finance, facilities management, food service, and administration. It is likely that the core team will facilitate changes in admissions, interviewing of new staff, orientation programmes, supervision, as well as training and education policies. They oversee a plan for significantly greater client participation in planning and implementation of their own service plan and figure out how they are going to engage a wider network of their stakeholders in the Sanctuary change process. The ultimate goal is to take meaningful steps to change the organisation's culture and engage as many community members as possible in that process.

As discussions begin in the core team, participating staff begin to make small but significant changes. Members take risks with each other and try new methods of engagement and conflict resolution. They feed these innovations and their results, back into the process discussions. The core team must always maintain a balance between process and product. It is not enough to talk about how we will change things. We must also make actual changes in the way we do business. The core team therefore not only plans together how best to share what they are learning with the larger organisation, and trains all agency personnel and clients in the Sanctuary principles, but also decides how to integrate the Sanctuary Toolkit into the day-to-day operation of the organisation and how to evaluate how these initiatives are taking hold in the organisation.

Through the implementation steps of the Sanctuary Model, staff members engage in prolonged dialogue that serves to surface the major strengths, vulnerabilities, and conflicts within the organisation. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organisation are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been overtly surfaced before. As this happens, the development of more democratic, participatory processes begin to emerge. These processes are critical because they are most likely to lend themselves to the solution of very complex problems while improving staff morale, providing checks and balances

to abuses of power, and opening up the community to new sources of information.

Evaluation and expected outcomes

Finally, the core team must decide on indicators they want to use to evaluate their Sanctuary program in an on-going way—their Sanctuary program evaluation plan. The indicators should be observable and measurable and consistent with standards established by Sanctuary leaders. There should be a regular process of evaluation and review that involves all core team members. It is vital that there be a thorough method for reviewing problems and failures and establishing remedial courses of action. But likewise there must be methods for reviewing and capturing successes.

The impact of creating a trauma-informed, Sanctuary Model culture should be observable and measurable. The outcomes we expect to see include and are applicable to all community members: less violence including physical, verbal, emotional forms of violence, including but not limited to reduced/eliminated seclusion and restraint; system-wide understanding of complex biopsychosocial and developmental impact of trauma and abuse and what that means for the service environment; less victim-blaming; less punitive and judgmental responses; clearer more consistent boundaries, higher expectations, linked rights and responsibilities; earlier identification of and confrontation with abusive use of power in all of its forms; better ability to articulate goals, create strategies for change, justify need for holistic approach; understanding and awareness of re-enactment behaviour, resistance to change and how to achieve a different outcome; more democratic environment at all levels; more diversified leadership and embedding of leadership skills in all staff; better outcomes for children, staff, and organisation.

The Sanctuary Network

Our belief in the power of community led us to develop the Sanctuary Institute. The Sanctuary Institute is the gateway to the Sanctuary Network a community of organisations committed to the development of trauma-informed services. We are all committed to the belief that we can do better for our clients and our colleagues as well as our society if we can accept that the people we serve are not sick or bad, but injured

and that the services we provide must provide hope, promote growth and inspire change.

At the present time over two hundred and fifty human service delivery programmes from around the United States and internationally are working through the implementation process. A number of programs have become Sanctuary-certified. They include adult inpatient psychiatric and substance abuse facilities, domestic violence shelters, residential programs and group homes for children, schools and educational programs, juvenile justice facilities, and a number of large programs that have a wide variety of inpatient, outpatient, partial, and residential programs. The Sanctuary Model is still evolving, and we remain engaged in the process of co-creation with other members of the Sanctuary Network.

Sanctuary certification and research

Sanctuary is a registered trademark and the right to use the Sanctuary name is contingent on engagement in the Sanctuary Institute training and certification program and an agreement to participate in an on-going, multi-year, peer-review certification process. Programs usually seek Sanctuary certification in the two to three year period after participation in the Sanctuary Institute. Research is underway in the hope of moving the Sanctuary Model from an "evidence-supported" to an "evidence-based" approach. In this way we hope to establish a method for guaranteeing an acceptable level of fidelity to the original model upon which the research was based (Bloom, 2013b; Esaki et al., 2013; Rivard et al., 2003; Rivard, Bloom, McCorkle & Abramovitz, 2005; Rivard et al., 2004).

Summary

We believe that the current operating system for the human service delivery system is outdated, mechanistic, and inappropriate to human health and well-being. This helps to explain why there are so many chronic clashes between our organisations and the living individuals who entirely comprise them. In order to adequately address the needs of the traumatised clients who fill the ranks of our trauma-organised human service delivery system, we need a new operating system—what is being referred to now as a "trauma-informed" operating system—for human service delivery organisations. Just as attachment

is the basis of the individual operating system, social relationships are the basis of organisational functioning as well. We believe that in a parallel way, traumatic experience and adversity can profoundly disrupt the operating systems of organisations. We believe that the current mechanistic model of organisational functioning is a result of destructive and potentially lethal parallel processes secondary to chronic stress that have created a seriously flawed operating system for human service organisations and entire systems. The Sanctuary Model represents an evidence-supported, attachment-based, trauma-informed, theoretical, and practical approach to changing organisational cultures so that human service delivery organisations serving children, adults, and families can be healthier, safer places to work and to heal.

Notes

1. The reader will note a switch in this document from single to plural, from the "I" to the "we". This is because the knowledge I am writing about as a singular author has been derived largely from complex, long-lasting group processes that can only be reflected in this way. In the previous pages, for the sake of brevity, I refer to the mothering person as a "she" and the child as a "he", knowing full well that half of the children in the world are "she-s" and some of the mothering people are "he-s". I wish we would find some grammatically new words that are more gender neutral but I do not like calling child an "it". I apologise in advance for any unintended offence.
2. For more information about the Sanctuary Model, see www.sanctuaryweb.com as well as Bloom and Farragher (2013).
3. For an up-to-date review of critical work in the field of attachment studies and exposure to adversity go to Center on the Developing Child, Harvard University at http://developingchild.harvard.edu/
4. The Sanctuary Institute (www.thesanctuaryinstitute.org) is a part of the Andrus Children's Center in Yonkers, NY. www.andruschildren.org. For more information contact Sarah Yanosy, Director, 914-965-2700 x1117 or syanosy@jdam.org.

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