# Sanctuary in a residential treatment center: creating a therapeutic community of hope countering violence

Michael George Kramer

Michael George Kramer is a Adjunct Professor at the LaSalle University, Philadelphia, Pennsylvania, USA.

**Abstract**

**Purpose** – *The purpose of this paper is to present insights into how and why the Sanctuary and SELF models are effective in decreasing trauma symptoms with a population of court-committed male adolescents in a residential treatment program. The Sanctuary model is a trauma-focussed, trauma-sensitive, organizational change model, and treatment protocol approach to working with clients who have experienced trauma, loss, and toxic stress to the degree that they interfere with social and personal functioning. The SELF model within Sanctuary is a treatment protocol that is an acronym for the organizing categories of safety, emotion management, loss, and the future. In essence, Sanctuary's purpose is to create therapeutic community.*

**Design/methodology/approach** – *Qualitative research methods of observation of groups and meetings, content analysis of existing quantitative data and agency documents, focus groups with staff and residents, and individual interviews with staff were utilized.*

**Findings** – *Data show that the Sanctuary model ameliorates the symptoms of complex trauma. The substantive theory that emerges is that relational and neurological integration and recovery occur in the lives of residents as shaped first by the therapeutic community that supports the level of interpersonal relationships experienced with staff within a therapeutic milieu, along with shaping the organizational culture.*

**Research limitations/implications** – *As a complex intervention, it is evident that reducing the Sanctuary model into its component parts cannot capture fully the essence of the intervention. A complex system can never be understood fully by observing it at single points in time.*

**Practical implications** – *It is suggested that future research and programmatic planning within this therapeutic community need to demonstrate how to continue enhancing staff-resident relational integration vis-à-vis staff training and vehicles that offer residents more of a representative voice while in placement.*

**Social implications** – *It is suggested that future research and programmatic planning within this agency need to demonstrate how to continue enhancing staff-resident trauma-informed therapeutic milieus and relational integration vis-à-vis staff training and vehicles that offer residents more of a representative voice while in placement.*

**Originality/value** – *This is a unique study in that it employs qualitative methods to explore how and why the Sanctuary model contributes to its working in a residential treatment facility. The Sanctuary model is the only trauma-informed organizational intervention of its kind, with limited published evaluations in the current literature (Esaki et al., 2013). This study used focus groups with residents and staff that allowed them to influence the research and its processes. The residents expressed their views about the experience of being placed outside of their homes and of living in a therapeutic community within the Sanctuary Network. Staff spoke of aspects of working in a trauma-informed milieu and its effect on clients, colleagues, and the organization as a whole.*

**Keywords** *Integration, Residential treatment, Therapeutic community, Trauma, Juvenile justice, Sanctuary model*

**Paper type** *Research paper*

Received 23 January 2015
Revised 2 July 2015
23 August 2015
26 August 2015
27 August 2015
Accepted 28 August 2015

## Introduction

Adolescents placed into residential treatment by the juvenile justice system come into placement with histories of trauma, violence, and chronic stress. The extent of adolescent exposure to violence is viewed as a national concern (Glodich *et al.*, 2006; Staggs *et al.*, 2007), even as a national epidemic (Attorney General, 2012), whereas engagement in violence often results in the adolescent being removed from the community and placed by the juvenile justice system. Further, juvenile justice systems are becoming overpopulated with children and adolescents in need of mental health services (Kramer and Zimmerman, 2009; Shelton, 2001, 2004), often with placements as barriers to positive mental health in that they tend to exacerbate trauma (Bloom and Farragher, 2011; Woodall, 2007).

Trauma is a ubiquitous presence within residential treatment settings, with injured, abused and neglected children often shaping these institutions more than the institutions shaping those confided to care. Often, this leads to intervention protocols more interested in control, thus further traumatizing the youth who need treatment (Farragher and Yanosy, 2005). The challenge is for residential treatment to be therapeutic milieus, safe and nurturing communities where youth can recover (DeLeon, 2000). Residential treatment is challenged to confront the effects of trauma head-on by creating an organizational culture and treatment protocols that dampen, buffer, and eliminate traumatizing factors in placement settings (e.g. use of physical discipline, belittling punishments, violence among residents). The need exists to create and replace traumatizing factors with attractors (a state or behavior toward which a dynamic system tends to evolve) and change processes that will contribute to healing and rehabilitation. Creation of such therapeutic milieus can offer a safe community in which recovery and healing occur.

The residential treatment facility where this study was done had considered itself a therapeutic community, but desired to become a trauma-informed milieu committed to a theoretical and organizational framework that primarily would improve outcomes for the residents placed here by the juvenile courts. There was concern that the treatment was not as effective as desired, especially with the increasing level of violence from where residents came, and within the agency. The administration's search found that the Sanctuary model had demonstrated strong evidence as an effective treatment model (Esaki *et al.*, 2013; Sanctuary Institute, 2012) and would enhance their current organizational culture. Thus, the three year commitment of implementing the Sanctuary model began (for a detailed history of its implementation, refer to Kramer, 2013).

The Sanctuary model is a full-system intervention model that has been found to reclaim treatment and recovery in residential placements. The Sanctuary model is a trauma-sensitive and trauma-focussed theoretical and treatment protocol that creates safe environments and enhanced therapeutic communities. Sanctuary aims to promote healing and sustain human growth, learning and health, and instill hope as evidenced by emerging evidence (Bloom, 1997, 2013; Bloom and Farragher, 2011). Sanctuary is an "intervention event" (Hawe *et al.*, 2009) within the specific contextual and complex reality of this residential treatment facility. The Sanctuary model encourages transformational learning during the process of programmatic implementation and on-going utilization.

Quantitative data at this residential treatment facility already had demonstrated statistically significant decreases in residents absconding from facility (dropping 40 percent over the three-year implementation of Sanctuary), psychiatric and more secure placements (close to 50 percent decrease), physical altercations (50-75 percent decrease), and recidivism (12 percent). Pre-/post-test data from the Trauma Symptoms Checklist for Children (Breire, 1996) demonstrated decreases in the domains of anxiety, depression, post-traumatic stress, and dissociation (for details see Kramer, 2013). Having this data on hand, the author undertook the next step using qualitative research in order to determine how and why Sanctuary works in decreasing trauma symptoms with a population of court-committed youth. It was driven by the following questions:

1. For residents, how is implementation of the Sanctuary model at this residential treatment facility affecting/shaping change, transformation, and recovery in their lives? What is the lived experience of the resident in a placement that utilizes the Sanctuary model, i.e. what meaning is given to Sanctuary?

2. What insights have been gained in making a connection between trauma and current life problems? What evidence indicates different behaviors?

3. For staff, what are attractors, mechanisms, components, factors and/or strategies of Sanctuary that shape how the therapeutic milieu will emerge as transformed and changed?

As a descriptive and exploratory study, the following emergent foundational perspectives may account for change and transformation in the lives of research participants and the organizational culture. These were based on knowledge of substantive Sanctuary tools and the Sanctuary model's theoretical framework, as well as on trauma theory:

1. The Sanctuary model can create a safe, holding environment, by emphasizing non-violence and a democratic atmosphere with the goal to increase residents' ability to express affectivity, trust in adult relationships, and better regulate their emotional states (Bloom, 1997, 2013).

2. The Sanctuary model, in creating a safe milieu and therapeutic community, can influence neuropsychological deficits and how trauma histories, and consequent timely treatment, change brain chemistry *vis-à-vis* distorted thought processes and neural network pathways. This is evidenced by decreases in distorted thought patterns, dynamic insights connecting past trauma to current functioning, and decreasing levels of depressive and anxious symptomology (Beaver *et al.*, 2010; Bogestad *et al.*, 2010; Cozolino, 2010).

3. The Sanctuary model in operation should afford opportunities for residents to replace reenactment and acting-out behaviors with narratives during community meetings and sessions with clinical staff. Personal conversations and interactions with staff and peers offer the potential for increased self-mastery and self-esteem, moving to an internal locus of control, and viewing their futures with hope, with a renewed sense of their life's meaning (Bloom, 2013; Rivard *et al.*, 2005).

4. The complexity and multiplicity of interactions over time within this residential setting may account for non-linear causalities and effects of change in the lives of residents, with the introduction of Sanctuary. The Sanctuary model is compatible with the pre-existing systemic culture of this "host" organization (Haggis, 2008; Hawe *et al.*, 2009), demonstrated after its three-year implementation process. Sanctuary has the potential to offer safety and hope to court-committed youth in residential placement, which can offer them a move from a culture of violence to a culture of hope (Bloom, 1997, 2013).

## Literature review

### *Trauma theory as it relates to youth in residential treatment*

Research demonstrates that from 70-90 percent of adolescents in residential placement have had significant traumatic events and multiple trauma types in their lives (Bloom and Farragher, 2011; Cohen *et al.*, 2004). The concept of trauma as applied to children is defined as "the mental result of one sudden external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defense operations" (Scheidlinger, 2004, p. 64). Types of trauma are numerous (e.g. Aronson, 2005; Bloom, 2013; Cohen *et al.*, 2004; Cox *et al.*, 2007; De Mendelssohn, 2008; Duffany and Panos, 2009; Edlesson, 1999; Foy, 2008; Irving and Ferraro, 2006; Layne *et al.*, 2008; Quas *et al.*, 2003).

Youth are coming into residential treatment with traumatic stress and complex trauma symptoms (Rivard *et al.*, 2005). The most recent research shows how trauma disconnects mind and body, with the body keeping the traumatized person trapped in the past with wordless emotions. Trauma interrupts the plot of life's narrative (van der Kolk, 2014). Recent shifts have explored the concept of Pervasive Developmental Trauma (D'Onofrio, 2007; van der Kolk, 2005) where there is an on-going traumatization of an individual that is chronic and persistent, influenced by the related constructs of neural fear networks, fear schema, and assumptive world theory (Cozolino, 2010; Foa and Rothbaum, 1998; Janoff-Bulman, 1992; McCann and Perlman, 1990; van der Kolk, 2003). It is not the event itself that causes traumatization, but the mind and body's response to the event that may cause psychosocial problems: "The intensity of the emotional reaction, rather than the events themselves, precipitates psychopathology" (van der Kolk and van der Hart, 1989, p. 1533).

The conceptualizations of the overwhelmed and the fragmented mind, based on Freud's (1955) theory of repression and Janet's (1889) conceptualization of dissociation in response to trauma, come together with the etiology, diagnosis, and treatment of Post-traumatic stress disorder (PTSD; American Psychiatric Association, 2013). PTSD is most typically understood as resulting from exposure to events that involve actual or threatened death or serious injury or a threat to one's physical integrity, when both internal and external resources are inadequate to cope with the threat. The individual's response to these events may involve fear, helplessness, and horror, the danger being responded to physically, cognitively, emotionally, socially, and behaviorally (Bloom, 1997; van der Kolk, 1989). These are the individuals that are entering residential treatment facilities.

## Sanctuary model

Sandra Bloom (1997, 2013) introduced her trauma-focussed, therapeutic community-based, theoretical and treatment model with her first book, *Creating Sanctuary: Toward an Evolution of Sane Societies*. She developed the Sanctuary model, composed of two primary components that lead to change: the creation and maintenance of a non-violent, democratic, therapeutic community; and psycho-educational exercises and modules to increase self-awareness and insight. The SELF model is a psycho-educational construct that educates around four stages of recovery: safety; emotional intelligence; loss; and future plans. This curriculum includes 12 hours of training for staff each year and psycho-educational groups for residents three to four times a year at this facility. Residents receive a handbook explaining all of Sanctuary's commitments, the SELF model, tools/strategies, i.e. the "common language" of the Sanctuary community. Education in safety includes physical, social, emotional, and moral safety. Emotional IQ teaches how to manage emotions, connecting them to cognitions and behaviors. Moving through loss teaches how to grieve and deal with personal losses. Future planning calls for aspiring to new roles and a hopeful future.

Bloom's premise is that trauma deconstructs the social and personal world of the individual, attachment constructs this world, and the creation of Sanctuary reconstructs and restores the social and personal world of the individual. In this creation of a safe milieu where one can recover, society is spared from "post-traumatic deterioration whereas trauma becomes a central organizing principle of human thought, feeling, belief, and behavior" (Bloom, 1997, p. 9). As an organizational change model, organizations and communities can be transformed through integration, understanding trauma, avoiding reenactments, fighting rigidity, and embracing non-violence (Farragher and Yanosy, 2005). When an organization can respond effectively to its own trauma issues, it can be more effective in treating traumatized youth entrusted to its care. This is done by enhancing the therapeutic community to strengthen mutual support, autonomy, and cognitive, social and behavioral strategies (Rivard *et al.*, 2005). The community can be enhanced by faithfulness to the Sanctuary commitments of non-violence, emotional intelligence, democracy, open communication, social responsibility, social learning, and growth and change (Esaki *et al.*, 2013).

Sanctuary creates the context and framework for change to occur. The complex web of change variables include: creation of a safe community; the Sanctuary commitments; the SELF model; psycho-education; Sanctuary tools (refer to Esaki *et al.*, 2013); the therapy modalities and the therapeutic milieu where relationships occur. Specifically, when looking at relationships, it is not just that there is a relationship. The type of relationship is one of caring, supportive and healthy interactions, of staff taking an active interest in the lives of residents. Staff and residents were in relationship long before Sanctuary was ever implemented, very well-being caring and supportive relationships. However, Sanctuary shapes an understanding of how trauma leads to differing types of relationships. A traumatizing relationship may lead to acting-out behavior and consequent placement outside of the home. A Sanctuary culture that realizes specific commitments in order to shape a culture of healthy relationships, puts forth a trauma-sensitive "way of doing things." There is a paradigm shift from staff asking residents, "what is wrong with you?" to "what has happened to you?" The resultant relationships are shaped within the therapeutic community that is safe and enriching, encouraging and coaching residents to express feelings, the very essence of Sanctuary culture.

## Methods

This study explored how an organization, in this case a residential treatment facility, implemented and utilized an organizational change and treatment protocol, the Sanctuary model. In order to get underneath to the "how" and "why" of Sanctuary's effectiveness over the three year time period of implementation, and to capture youth and staff's voices and actions, qualitative methods were utilized in an attempt at explanation and development of a substantive theory.

## Study design

This is a qualitative study whose data included group observation, content analysis of agency documents and quantitative data, focus groups, and individual interviews. The administration of this residential treatment facility agreed to grant this researcher full access to the agency in order to observe team, service plan, and community meetings. Access was granted to review organizational records and documents, and minutes of numerous meetings, all related to implementation and utilization of the Sanctuary model. Furthermore, permission was granted to engage residents and staff in focus groups and individual interviews. Institutional Review Board protocols were followed: participants were introduced to this researcher and invited to participate in the study after an explanation of the research purpose, possible risks and benefits were reviewed, and written informed consent was obtained. This researcher was known to this agency and had been employed there 15 years prior. This was an independent study, in that the researcher was no longer an employee during his three years of research here. However, he had the full support of the residential treatment facility's administration because of his extensive working history with at-risk youth at this agency and elsewhere. They vouched for his character and were interested in the findings of his research as an evaluative tool further assessing Sanctuary's effectiveness.

Data analysis was used to investigate the effectiveness of the Sanctuary method as a trauma-sensitive and trauma-focussed treatment modality for delinquent male adolescents in residential placement. The design's purpose was to explore how the Sanctuary commitments were implemented through the skills, strategies, and outcomes already provided to the researcher as quantitative data. Also, the design explored why symptoms of trauma decreased, specifically through using focus groups and interviews. After the focus groups and interviews were completed and transcribed, the study design included identifying codes, themes, and a potential substantive theory.

### *Group observations*

This researcher began his study as a non-participatory observer of administrative and clinical team meetings (staff participants), individual service plan (ISP) meetings (resident with clinical treatment team), and community meetings (mix of youth care workers, clinicians, and residents). This took place over a year and a half period of time, whereas field notes were kept and general themes were gleaned from what was observed (Kramer, 2013).

### *Content analysis of documents*

During the same time that the researcher was observing groups, he obtained access to organizational records and documents, and minutes of Core Team (administrative Sanctuary leadership group at this agency), and Red Flag Review (team meetings to discuss lack of progress by residents) meetings, covering the three-year period of implementing Sanctuary. This researcher gleaned their content for emergent themes (Kramer, 2013).

### *Focus groups*

Focus groups were conducted that lasted from 30-60 minutes: two for staff and three for residents. The rationale for using focus groups was to deepen understanding and gain insight into how and why the Sanctuary model is (or is not) working to change the lives of the residents and the organizational culture of the agency. Focus groups were conducted by the author as researcher. The groups were audio-recorded and transcribed verbatim.

Two homogeneous groups of ten staff participated in 45 minute focus groups. One group consisted of youth care workers (the line staff) with a representation of new hires (less than one year), and experienced workers (three to five years). The second group consisted of clinical staff. Both groups were representative of their colleagues (10 and 30 percent, respectively). Focus groups were held in an administrative conference room. Administrative staff had been included in group observations and it was impossible logistically to have them participate in a focus group.

Originally, 19 residents consented to participate. In the end, 13 residents participated in 30-60 minute focus groups. Focus groups were held in residential conference rooms. Six residents chose not to participate because of their fear of being audio-recorded. They recalled negative experiences of being recorded by police. They also were not interested in being interviewed individually. This brought down the representational power below 10 percent of the current population (i.e. 13 participating from a census of 160). Being a qualitative study, numbers are not as significant, but capturing the "voice" of residents was weakened. Further research needs to include a larger number of youth and to include "outliers," i.e. youth who experience difficulties in placement.

### *Interviews*

Three 30-60 minute individual interviews were conducted: two impromptu and one planned with staff. Two interviews occurred after chance meetings (not transcribed since the researcher did not have the audio-recorder available and did not want to pass on this opportunity to interview two research participants). These interviews were conducted in a school office, with the third interview requested in lieu of being a staff focus group participant. This interview was audio-recorded and transcribed, conducted in an administrative meeting room.

## Factors and indicators

### *Focus group questions and staff individual interview questions*

In order to operationalize the Sanctuary commitments, this researcher developed questions linked to the seven Sanctuary commitments. The commitments are organizational conceptualized structures and factors that may account for countering traumatizing factors in this agency among its staff and residents. Research had shown that assessing the utilization of these commitments demonstrated a complex, adaptive process (Rivard *et al.*, 2005). Further evidence found that the commitments are transformative in ameliorating complex trauma (Sanctuary Institute, 2012).

The questions used for the staff and resident focus groups and the staff interviews are found in Table I.

## Data analysis

The digital audio-recordings for focus groups and the planned interview were transcribed verbatim by this researcher. Grounded Theory (Charmaz, 2006; Connolly, 2003; Glaser and Strauss, 1967; Padgett, 1998) and utilization-focussed evaluation (Patton, 2002) were employed to analyze the data. Initially, the transcripts were explored word by word and line by line to generate open codes and to create a codebook. Staff and resident participants were compared with each other as well as with other focus groups – the Constant Comparison Method – to interpret, de-limit, and focus in on emerging conceptual categories. A potential theory emerged from these categories, the "weaving of the fractured story back together" (Glaser and Strauss, 1967). Member checking was utilized by giving staff a written copy of the open coding themes, conceptual themes, and interpretive potential substantive theory generated and emerged from the analysis of the transcriptions. This was to co-construct results, allowing participant to take the lead in the research. It also moved the data toward authenticity, credibility, dependability, confirmability, and representation of what was said in the focus groups, i.e. "did we get it right" (Charmaz, 2006; Padgett 1998; Patton, 2002)? This was followed-up one month later with an informal verbal interview. No written response was received from any staff; the verbal follow-up all were affirmative as to what was written and represented by this author. Member checking was utilized with residents with an informal follow-up focus group and

**Table I** Sanctuary commitments linked to focus group and individual interview questions

| *Commitment* | *Questions* | |
|---|---|---|
| | *Staff* | *Residents* |
| Non-violence | In what ways do you believe that the implementation of Sanctuary and its commitment to non-violence has changed the way residents behave/act now compared to before?<br>What more can be done to promote safety in the workplace? | In what ways do you handle and resolve conflict (on the unit, in school, when at your home)?<br>In what ways does Sanctuary influence you not to get into fights?<br>What does the commitment of non-violence mean to you? |
| Emotional intelligence | What new knowledge or learning has taken place since using Sanctuary to understand how residents act (traumatic reenactment) and how to treat residents in a more helpful manner?<br>In what ways do you think differently about how trauma can affect lives and change thinking and behavior? | In what ways do you work with the SELF model? How has it changed how you live your life? |
| Social learning and social responsibility | What do you believe are the desired outcomes for residents and how can these be reached by the residents?<br>How could residents be more responsible for themselves? | What have you learned about the connection of trauma and current life problems in your own life? |
| Democracy/shared governance and open communication | In what ways has Sanctuary changed the organizational culture (e.g. the democratic process of leadership)? How would you envision engaging everyone in this process?<br>In what ways have barriers been overcome among staff, between administration and staff, and between staff and residents? | Tell me about your relationships with youth care workers, teachers, therapists, and other staff, in relationship to the Sanctuary commitment of open communication<br>In what ways do you see Sanctuary changing the way that the staff acts toward residents? How do those in charge run this place because of Sanctuary?<br>In what ways would things be better around here if you were in charge? What would you do differently? |
| Growth and change | What are desired outcomes for change in the lives of residents and for the organization?<br>In what ways have you added Sanctuary to your own training and experience to deepen your own purpose and give meaning to your working with residents?<br>What are the ingredients of Sanctuary that you believe have accounted for change? | What are your hopes for the future, for when you are released from here? |

verbal presentation of the results. Residents made no suggestions for changes to the results, stating that they felt the results represented authentically what they said during the focus groups. No follow-up interviews were conducted with residents.

## Findings

The range of findings that emerges from our qualitative data includes codes and substantive themes that are reflected in and potentially resultant from the commitments of the Sanctuary model that inductively formulate theory. The questions from Table I represent indicators of how and why the commitments affect organizational, relational, and personal change. The commitments to non-violence, emotional intelligence, social learning and social responsibility, democracy/shared governance, open communication, and growth and change are theory-driven constructs. In responding to questions, residents and staff spoke to the reality of how these seven commitments led to and shaped skill sets by making use of Sanctuary strategies and protocols. Furthermore, these commitments shaped and led to desired outcomes. Table II outlines an overview of the relationship between processes and outcomes with evidence emerging from the data. In other words, it is a description of specific evidence of skills and strategies that led to outcomes, all the while occurring along a learning curve, i.e. the process is the product. The skill sets, strategies, outcomes, and evidence were observed and experienced directly by this researcher. Skill sets are specific life skills that participants said increased via the Sanctuary commitments, through the use of specific strategies. For example, committing to non-violence helped participants to feel safe and encouraged safety by using safety plans, the SELF model, and expressing feelings in community meetings. The strategies are taken directly from Sanctuary's tool kit and protocols, being observed by the researcher and discussed in the focus groups and interviews. The qualitative research data supports

**Table II** Overview of the relationship between sanctuary commitments, skills, strategies, outcomes, and evidence

| *Sanctuary model commitments:* Lead to | *Observed skill sets enacted by staff and residents* | *Via observed strategies in partnership by staff and residents* | *With documented outcomes* | *As evidenced by* |
|---|---|---|---|---|
| Non-violence | Conflict resolution and trust-building skills | Psycho-education; community meetings; relationships; safety plan and SELF model | Decreases in all forms of violence and increases in all forms of safety for staff and residents; increased relational integration | Decreases in AWOL's, restraints of residents, secure placements; use of safety plan; decreases in PTSD; theme of "feeling safe" |
| Emotional IQ | Affect/emotional management/regulation skills | Relationship-building; use of SELF model; psycho-education; community meetings; psychotherapy* | Systematic and dynamic insight into complexity of trauma/loss effects; increased attachment and integration | Decreases in anxiety, depression, and PTSD symptoms; expression of feelings as the norm; "gets a pound off my heart" |
| Social learning and social responsibility | Sharing info. and listening skills; social justice/fairness skills; community-building skills; solution-focussed problem-solving skills | Articulation of feeling, goals, strategies for change via community meetings, psycho-education and psychotherapy* | Increased integration, attachment, and community-building; healthy interpersonal boundaries; linkage between rights and responsibilities | Decreases in AWOL's; discharge planning; narrating meaning to life and hope for the future: "life lessons" being internalized |
| Democracy and shared governance' | Civic responsibility skills; decision making and shared problem-solving skills; solution-focussed and trust-building skills | Becoming an active participant in treatment plan; community meetings; relationships | Increased democratic processes, attachment, empowerment and integration | Decreases in secure placements; AWOL's; having a "voice"; "buy in" to program; "active strategists" |
| Open communication | Verbal and non-verbal articulation, expression and interpretation skills; self-protecting and self-correcting skills | Psycho-education: using "I" statements; community meetings relationships; all team meetings | Healthy boundaries; integration of thoughts and feelings; increased attachment | "Active strategists"; having a "voice"; dissent-tolerance within the agency's organizational culture |
| Growth and change with hope for the future | Meaning/purpose; restorative/loss-resolution; self-determination | SELF model across all daily activities; community meetings discharge planning and reintegration services; relationships | Full integration and attachment; hopeful and planned future; increased well-being and sense of self | Realistic future planning; bringing "life lessons" back to the community; continued contact with staff after release |

Notes: [a]Trauma-focussed cognitive behavioral (TF-CBT), trauma art and narrative therapy (TANT), reality therapy, and psychodynamic therapy are all therapeutic modalities utilized in response to client's treatment needs during weekly individual therapy; monthly family therapy included

the quantitative research data: both quantitative and qualitative data are listed in Table II. A more detailed elaboration of the evidence and outcomes follows.

The commitment to a culture of non-violence builds, teaches, and models safety skills, conflict resolution skills, and trust-building skills. Residents stated that they "come back to love": they experience a safety net in placement whereby adult role models are teaching "life lessons" by words and deeds. There is a sense of community; as a youth care worker stated, "we call this a family, not a unit." The participants are making use of the community by speaking about their feelings during group in order to create safety, restore well-being, and change themselves by engaging in relationships. They are actively participating in their healing process, becoming "active strategists" by creating and utilizing a safety plan (a visual reminder of addressing triggers that may lead to acting-out) and engaging in conflict resolution. Specifically looking at the outcome of decreased violence and increased relational integration, one youth said that getting into fights is "a waste of time, it's useless," and detrimental to the family atmosphere that is being created. Quantitatively (as reported earlier), residents absconding from the facility, needing to be restrained or removed from program has decreased significantly, providing strong evidence for how Sanctuary creates a safe milieu that encourages healing. There is an active movement from a culture of violence to a culture of hope.

The commitment to a culture of emotional intelligence builds, teaches, and models affect management skills, and understanding the sources of reenactments, collective disturbances, and emotional contagions. As residents opined, keeping feelings "in check" is important so as not to hurt others or hurt one's self while being honest ("keeping it real") with how behaviors affect feelings. "Expressing feelings gets a pound off my heart": a resident spoke of making use of the SELF model to do this, especially around issues of loss, the loss of loved ones to violence and incarceration. He spoke of the loss of his own freedom by being in placement and offered the insight that in order never to be placed again, he needs to be in control of his behavior, and be willing to express feelings to others. Throughout all of their sharing of feelings, the residents spoke of the paramount importance of having positive staff support in an empathic relationship. Making use of the formal relationships with clinical staff and the informal relationships of residential staff in community meetings help to heal the symptoms of trauma and loss.

The commitment to a culture of social learning and social responsibility builds, teaches, and models cognitive, sharing, social justice, and social connection skills *vis-à-vis* establishing healthy attachment relationships and a healthy organizational culture. The outcomes for residents, as evidenced by their own words, are: less victim-blaming, punitive, and judgmental responses. They spoke of more clear and consistent interpersonal boundaries, and higher interactional expectations. Staff and residents reported increased linkages between rights and responsibilities, an increased ability to identify and confront perpetrator and reenactment behaviors. Further, they stated an increased ability to articulate realistic goals while creating strategies for change, and an increased hope for the future. This researcher saw evidence of this in observing groups and as articulated by residents and staff during focus groups and staff interviews. A number of residents and staff used the term "life lessons" as a reference point to social learning and responsibility, learning "what is the right thing to do."

Commitment to a culture of democracy, shared governance, and open communication (all taken together) builds, teaches, and models civil-responsibility skills of self-control, self-discipline, utilization of healthy authority, shared problem-solving and decision making, trust-building, and empowerment. It further builds, teaches, and models verbal and non-verbal communication skills. Residents spoke of the need for more democratic processes, e.g. more say in activities of daily living (ADL's) around issues of personal hygiene. Specifically, some residents requested lengthier showers and more frequency to do laundry each week. Others asked for the ability to plan activities on and off the unit. Staff spoke of having a Resident Core Team or student government to facilitate giving the residents a voice, of their being "active strategists" by learning how to negotiate power in their overall treatment while in placement. An outcome of open communication as evidenced by the data (e.g. group observations) is "to say what you mean and mean what you say" and "to say what you mean and don't be mean about what you say." In other words, communicate effectively by using "I" statements, connecting behaviors and feelings, and not using blaming language (i.e. "You" statements). This is still a work in process: as stated by residents in focus groups, some staff members are negative role models, not employing these communication skills effectively or appropriately. Yet, residents have learned to represent their needs in a respectful way (e.g. the request for more time with ADL's was presented to the administration and acted upon), and feel that they can achieve what they have requested when articulated appropriately. This was evidenced by residents speaking about their treatment goals during ISP meetings.

Commitment to a culture of growth and hope for the future builds, teaches, and models the restoration of hope, meaning, and purpose in an individual's overall life *vis-à-vis* creating hope and loss-resolution skills. Residents spoke of having more hopeful outlooks on their lives, on their futures through planning for it and stating desired goals. These goals include continuing education, employment and career paths, and a lifestyle plan, e.g. "I want a wife and children." Residents spoke of giving back to the community by volunteering: "I want to return back here to work or volunteer one day." The residents spoke with confidence, a sense of meaning, and of obtaining realistic objectives in the short and long term. Staff said that they reminded residents "you are preparing for the world out there, not in here." This was observed further as residents and staff spoke of discharge planning meetings (whereas a reintegration worker meets with

residents two months before a planned discharge back into the community in order to plan educational, therapeutic, and career services).

The strongest antidote to traumatic and loss experiences is healing within the communal context of relationships and safety. As evidenced by the data, the residents who participated in focus groups and who were observed during meetings feel empowered and able to trust in others enough to narrate their stories in individual, family, and group therapies and within the Sanctuary milieu. Relational attachments are becoming change agents. Sanctuary culture is providing a framework which overlays and builds upon the current organizational culture so as to offer a "sea change" (in the words of one clinician) that is moving this facility forward by creating a safe, therapeutic community. In other words, there are enough processes that bring Sanctuary to life at this residential placement facility. The Sanctuary strategies (e.g. safety planning, psycho-education, community meetings) make the community work as a therapeutic milieu. As we look at organizational change, we need to touch briefly on the complexity of this residential treatment system.

Staff participants spoke of how to achieve desired outcomes within Sanctuary culture and what known (and unknown) factors that they perceived account for change in the lives of residents, in relationships across the agency, and changes to the organizational culture as a whole. Furthermore, this is tied into "buy-in." Staff who do not agree with the Sanctuary model as an effective trauma-focussed protocol may be less committed to its guiding principles and to comply with utilizing its strategies, and may believe that there are other confounding variables that account for change. This moves us into the complex arena of attempting to discern and intersect the polydimensional pathways of causality, correlation, and association. The data gleaned from the complex implementation and intervention of the Sanctuary model framework demonstrate the emergence of explicit themes (outcomes) from the processes of Sanctuary protocols, i.e. guiding principles as "condition-action rules." For example, the condition of feeling safe sets up a feedback loop of deciding not to fight, an action. Lessened violence leads to a safe milieu. The complexity of change agents is a limitation of this study is that linear and non-linear explanations coexist without a clear means to make direct predictions.

A summary of the findings points to a potential theory of change that emerges directly from the data: Sanctuary offers the framework that shapes a positive role-modeling and parental love-type caring relationship between residents and their staff, within a therapeutic community. Sanctuary creates the context for relationships to be an agent of transformation, change, healing, recovery, and integration. Within such a trauma-sensitive relationship, residents have a voice and feel safe. They are able to assign meaning to their trauma and loss. Residents gain a sense of well-being, attachment, and hope for the future.

## Discussion

Sanctuary is a transformative model for treating traumatized youth in placement. It has the potential to change lives. Life is not so much linear as it is circular, multidimensional, adaptive, and complex. Thus, the complexity of changes in life may be better served by using the term integration: new experiences are integrated into current life experiences. For a traumatized youth, integration has the potential to fill developmental gaps and diminish experiences of trauma, loss, and alienation. On a deeper level, integration can be viewed within neurobiological and interpersonal relational systems. Trauma and loss experiences restructure neurobiology, interfering with attachment systems, in particular, disrupting emotional communication, which is at the heart of attachment (Siegel, 2001). Effective and timely trauma treatment also restructures these neurobiological and attachment systems by integrating meaning into the events of trauma and loss. As was mentioned earlier, Sanctuary espouses a paradigm shift from "What has happened to you?" to "What meaning do you assign to what has happened to you?" In other words, how will you integrate these events and experiences into a narrative that will make sense for you and help you to gain insight and put meaning into these events and experiences? Sanctuary augments and influences life changes through the effects that the seven commitments have on changing individuals, communities, and organizations.

Integration also affects the attachment types (e.g. disorganized, ambivalent, anxious) that have powerful predictive capacity for the lifespan of a traumatized youth, especially *vis-à-vis*

interpersonal relationships. Just as "hurt people hurt people," so the healing mechanism of "feeling felt" comes into play. The integration of a healthy, positive adult relationship has the power to counter Relational Trauma (Courtois, 2012) and to create a more secure attachment that encourages positive self-esteem, self-regulation of affect, independence and interdependence, and hope for the future. This is where the community steps up by creating a secure, safe milieu that has the strong potential to shape relational integration through fully embracing the Sanctuary commitments.

"One can see that the general approach to (treatment) for individuals with unresolved trauma, grief (and loss) would be to attempt to enhance the mind's innate tendency to move toward integration, both within the brain and within interpersonal relationships" (Siegel, 2001, p. 89). Siegel goes on to say that caregivers have the ability to attune the youth's verbal communication skills as well as to connect with the child on a non-verbal emotional level (commitments to social learning and open communication). This is all in the service of helping the youth to overcome a disorganized sense of self and cognitive intrusions brought on by trauma and loss, enabling him toward autobiographical reflections. The desired outcome is to enhance achievement of internal and interpersonal integration through more adaptive and flexible self-regulation, i.e. the commitment to emotional intelligence. This may augment the youth's ability to have a "learning brain" vs a "survival brain." Relational integration also may further ameliorate feelings of shame of being stigmatized by others as "evil," "bad," and/or "damaged." In the words and actions of residents, often they view themselves as "worthless" and set themselves up to be rejected by adults.

Care providers have the potential to become the "co-regulator" of a youth's affect, sense of personal control and self-efficacy (Ford *et al.*, 2005) with the interpersonal relationship serving as both container and catalyst (Courtois, 2012). In containing the traumas and losses of the youth, the care providers are forming a loving bond with the youth alongside with facing head-on his affective dysregulation, impulsivity, and aggression. As catalysts, the caregivers are encouraging the process of the resident having a voice by coaching and modeling the expression of feelings. "The concept of relationships as regulators suggests that other relationships can eventually replace the regulatory processes that were originally lost" (Hofer, 1994, p. 200).

This brings us full circle back to the Sanctuary model: our findings demonstrate trauma theory in action via effective utilization of the Sanctuary model. Ideally, the single most consistent factor in ameliorating the psychopathological effects of trauma and loss is a caring, attuned relationship with someone who can contain and regulate the emotions of a resident while he processes the impact that a traumatic or loss event has had. Thus, when an "upset, dis-integrated brain comes into the presence of a calm, integrated brain, the upset brain has a good chance of being supported in its natural movement toward complexity". It is more beneficial when this occurs in an atmosphere of safety, within the therapeutic community of Sanctuary, whereas the whole community enacts the seven commitments in order to help heal the wound of trauma/loss. The restorative process may use relational goodness that has the potential to become an internalized relationship that the resident can "carry the other" with him upon release. The youth can utilize this internalized object (the healthy adult/parental nurturing relationship) as a means to self-sooth and to increase a positive sense of self-worth and well-being.

The type of relational integration described above is a tall order for any staff, most especially for the youth care workers who spend the most time supervising residents, being the lowest paid and, often, the least educated at this residential facility. Yet, the bonding with, trust in, and acceptance by youth care workers is enough to reduce trauma and loss symptoms in residents. Furthermore, as witnessed by this researcher, these relationships create a sense of belonging to a community. All staff work together as a supportive team in creating a therapeutic milieu with the residents as the center of treatment. They encourage the residents to internalize Sanctuary commitments and strategies of maintaining safety, regulating emotions, taking responsibility for their actions, and having hope for the future. Further research would be needed to see how strong the relational attachment becomes over the short period (ten months) in placement, and how much it helps to recover from earlier attachment losses. At least one resident said that the youth care worker "is like the father I never had." Attempting to stay faithful to the emergent data through the voices and actions of residents and staff, the restorative process is on-going at this

residential facility, dedicated to sustaining Sanctuary, especially through its faithfulness to the commitments. Most particularly, the relational healing as one of the strongest factors could be summed up in their own words: "we are a family where we are loved."

## Conclusion

Although what emerges from this research is that the Sanctuary model is greater than the sum of its parts, strong data findings support that the Sanctuary model accounts for the healing of trauma. In essence, this is a case study, a snapshot in time that shows a developing therapeutic community. As a qualitative research study, the data emerged the themes of relationships, safety, and having a voice that has the strong potential to lead to integration. The complexity of the Sanctuary Model presents the seven commitments and the organization/therapeutic community influencing each other, and, ultimately affecting the lives of the residents by lessening their symptoms of trauma. The SELF model is embedded into the organizational culture, as evidenced by residents creating murals and posters representing safety, emotional intelligence, loss, and future (along with the seven commitments). It is the "common language" used by staff in treatment planning. The limited data that this study has shown in this point in time could serve well as a baseline for further research to be done at this residential treatment facility.

It is hoped that care providers engaged in residential treatment of at-risk youth will find the Sanctuary model a theoretical, epistemological, research- and evidence-based treatment protocol that is advantageous in shaping integration and transformation in the lives of traumatized youth and the organizations in which they are found.

## References


American Psychiatric Association (2013), *Diagnostic and Statistical Manual of Mental Disorders V*, American Psychiatric Association, Washington, DC.

Aronson, S. (2005), " 'A war that had come right to them': group work with traumatized adolescents following September 11", *International Journal of Group Psychotherapy*, Vol. 55 No. 3, pp. 375-90.

Attorney General (2012), "Defending Childhood: report of the Attorney General's National Task Force on children exposed to violence", Washington, DC, available at: www.justice.gov/defendingchildhood/ccv-rpt-full.pdf (accessed December 22, 2012).

Beaver, K.M., Vaughn, M.G., DeLisi, M. and Higgins, G.E. (2010), "The biosocial correlates of neuropsychological deficits: results from the national longitudinal study of adolescent health", *International Journal of Offender Therapy and Comparative Criminology*, Vol. 54 No. 6, pp. 878-94.

Bloom, S. (1997), *Creating Sanctuary: Toward an Evolution of Sane Societies*, Routledge, New York, NY, (2013 Revised edition).

Bloom, S. (2013), *Restoring Sanctuary: A New Operating System for Trauma-Informed Organizations and Systems of Care*, Oxford University Press, New York, NY.

Bloom, S. and Farragher, B. (2011), *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*, Oxford University Press, New York, NY.

Bogestad, A.J., Kettler, R.J. and Hagan, M.P. (2010), "Evaluation of a cognitive intervention program for juvenile offenders", *International Journal of Offender Therapy and Comparative Criminology*, Vol. 54 No. 4, pp. 552-65.

Breire, J. (1996), *Trauma Symptom Checklist for Children: Professional Manual*, Psychological Assessment Resources, Inc., Palo Alto, CA.

Charmaz, K. (2006), *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*, Sage Publications, Los Angeles, CA.

Cohen, J.A., Deblinger, E. and Mannarino, A.P. (2004), "Trauma-focused cognitive-behavioral therapy for sexually abused children", *Psychiatric Times*, Vol. 21, pp. 1-5.

Cohen, J.A., Deblinger, E., Mannarino, A.P. and Sheer, R.A. (2004), "A multi-site, randomized controlled trial for children with sexual abuse-related PTSD symptoms", *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 43, pp. 393-402.

Connolly, M. (2003), "Qualitative analysis: a teaching tool for social work research", *Qualitative Social Work*, Vol. 2 No. 1, pp. 103-12.

Courtois, C.A. (2012), "Treating complex trauma: the state of the art", Psychotherapy Networker 2012 Symposium, Washington, DC, March 25.

Cox, J., Davies, D.R., Burlingame, G.M., Campbell, J.E., Layne, C.M. and Katzenback, R.J. (2007), "Effectiveness of a trauma/grief-focused group intervention: a qualitative study with war-exposed Bosnian adolescents", *International Journal of Group Psychotherapy*, Vol. 57 No. 3, pp. 319-31.

Cozolino, L. (2010), *The Neuroscience of Psychotherapy: Healing the Social Brain*, W.W. Norton & Company, New York, NY.

D'Onofrio, A.A. (2007), *Adolescent Self-Injury: A Comprehensive Guide for Counselors and Health Care Professionals*, Springer Publishing Co., New York, NY.

De Mendelssohn, F. (2008), "Transgenerational transmission of trauma: guilt, shame, and the 'heroic dilemma' ", *International Journal of Group Psychotherapy*, Vol. 58 No. 3, pp. 389-402.

DeLeon, G. (2000), *The Therapeutic Community: Theory, Model, and Method*, Springer Publishing Company, New York, NY.

Duffany, A. and Panos, P. (2009), "Outcome evaluation of a group treatment of sexually abused and reactive children", *Research on Social Work Practice*, Vol. 19 No. 3, pp. 291-303.

Edlesson, J.L. (1999), "Children's witnessing of adult domestic violence", *Journal of International Violence*, Vol. 14 No. 8, pp. 839-70.

Esaki, N., Benamati, J., Yanosy, S., Middleton, J.S., Hopson, L.M., Hummer, V.L. and Bloom, S.L. (2013), "The sanctuary model: theoretical framework", *Families in Society*, Vol. 94 No. 2, pp. 87-95.

Farragher, B. and Yanosy, S. (2005), "Creating a trauma-sensitive culture in residential care", *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, Vol. 26 No. 1, pp. 97-113.

Foa, E.B. and Rothbaum, B.O. (1998), *Treating the Trauma of Rape: Cognitive-Behavioral Therapy for PTSD*, Guilford Press, New York, NY.

Ford, J.D., Courtois, C.A., Steele, K., van der Hart, O. and Nijenhuis, E.R.S. (2005), "Treatment of complex posttraumatic self-dysregulation", *Journal of Traumatic Stress*, Vol. 18 No. 5, pp. 437-47.

Foy, D.W. (2008), "On the development of practice guidelines for evidence-based group approaches following disaster", *International Journal of Group Psychotherapy*, Vol. 58 No. 4, pp. 567-74.

Freud, S. (1955), "Studies on hysteria", in Strachey, J. (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Hogarth Press, London.

Glaser, B.G. and Strauss, A. (1967), *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Aldine Publishing Company, Chicago, IL.

Glodich, A.M., Allen, J.G., Fultz, J., Thompson, G., Arnold-Whitney, C., Varvil, C. and Moody, C. (2006), "School-based psychoeducational group on trauma designed to decrease reenactment", in Lightburn, A. and Sessions, P. (Eds), *Handbook of Community-Based Clinical Practice*, Oxford University Press, New York, NY, pp. 349-63.

Haggis, T. (2008), " 'Knowledge must be contextual': some possible implications of complexity and dynamic systems theories for educational research", *Educational Philosophy and Theory*, Vol. 40 No. 1, pp. 158-76.

Hawe, P., Shiell, A. and Riley, T. (2009), "Theorizing interventions as events in systems", *American Journal of Community Psychology*, Vol. 43 Nos 3-4, pp. 267-76.

Hofer, M.A. (1994), "Hidden regulators in attachment, separation, and loss", *Monographs of the Society for Research in Child Development*, Vol. 59 Nos 2-3, pp. 192-207.

Irving, S.M. and Ferraro, K.F. (2006), "Reports of abusive experiences during childhood and adult health ratings", *Journal of Aging and Health*, Vol. 18 No. 3, pp. 458-85.

Janet, P. (1889), *Psychological Automatism*, F. Alcan, Paris.

Janoff-Bulman, R. (1992), *Shattered Assumptions: Towards a New Psychology of Trauma*, Free Press, New York, NY.

Kramer, M. (2013), "From a culture of violence to a culture of hope: creating Sanctuary in a residential treatment facility", Published Dissertation, Fordham University, New York, NY.

Kramer, U. and Zimmerman, G. (2009), "Fear and anxiety at the basis of adolescent exter-nalizing and internalizing behaviors", *International Journal of Offender Therapy and Comparative Criminology*, Vol. 53 No. 1, pp. 113-20.

Layne, C.M., Saltzman, W.R., Poppleton, L., Burlingame, G.M., Pasalic, A., Durakovic, E., Music, M., Campara, N., Dapo, N., Arslanagic, B., Steinberg, A.M. and Pynoss, R.S. (2008), "Effectiveness of a school-based group psychotherapy program for war-exposed adolescents: a randomized controlled trial", *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 47 No. 9, pp. 1048-62.

McCann, I.L. and Perlman, L.A. (1990), *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation*, Brunner/Mazel, New York, NY.

Padgett, D.K. (1998), *Qualitative Methods in Social Work Research: Challenges and Rewards*, Sage Publications, Thousand Oaks, CA.

Patton, M.Q. (2002), *Qualitative Research & Evaluation Methods*, 3rd ed., Sage Publications, Thousand Oaks, CA.

Quas, J., Goodman, G. and Jones, D. (2003), "Predictors of attributions of self-blame and inter-nalizing behavior problems in sexually abused children", *Journal of Child Psychology and Psychiatry*, Vol. 44 No. 5, pp. 723-36.

Rivard, J.C., Bloom, S.L., McCorkle, D. and Abramovitz, R. (2005), "Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment", *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, Vol. 26 No. 1, pp. 83-96.

Sanctuary Institute, E. (2012), "Our Network", Sanctuary Institute, available at: www.thesanctuaryinstitute.org/our-network (accessed June 27, 2015).

Scheidlinger, S. (2004), "Group interventions for treatment of psychological trauma: Module 2: group interventions for treatment of trauma in children", American Group Psychotherapy Association, pp. 62-83.

Shelton, D. (2001), "Youthful offenders with emotional disorders", *Journal of Nursing Scholar-Ship*, Vol. 33 No. 3, pp. 259-63.

Shelton, D. (2004), "Experiences of detained young offenders in need of mental health care", *Journal of Nursing Scholarship*, Vol. 36 No. 2, pp. 129-33.

Siegel, D. (2001), "Toward an interpersonal neurobiology of the developing mind: attachment relationships, 'mindsight', and neural integration", *Infant Mental Health Journal*, Vol. 22 Nos 1-2, pp. 67-94.

Staggs, S.L., White, M.L., Schewe, P.A., Davis, E.B. and Dill, E.M. (2007), "Changing systems by changing individuals: the incubation approach to systems change", *American Journal of Communiy Psychology*, Vol. 39 Nos 3-4, pp. 365-79.

van der Kolk, B.A. (1989), "The compulsion to repeat the trauma: reenactment, re-victimization, and masochism", *Psychiatric Clinics of North America, 12: Treatment of Victims of Sexual Abuse*, W. B. Saunders, Philadelphia, PA, pp. 389-411.

van der Kolk, B.A. and van der Hart, O. (1989), "Pierre Janet and the breakdown of adaptation in psychological trauma", *Journal of Psychiatry*, Vol. 146 No. 12, pp. 1530-40.

van der Kolk, B.A. (2003), "Posttraumatic stress disorder and the nature of trauma", in Solomon, M.F. and Siegel, D.J. (Eds)", *Healing Trauma: Attachment, Mind, Body, and Brain*, Norton, New York, NY, pp. 168-95.

van der Kolk, B.A. (2005), "Developmental trauma disorder: toward a rational diagnosis for children with complex trauma histories", *Psychiatric Annuls*, Vol. 35 No. 5, pp. 401-8.

van der Kolk, B.A. (2014), *The Body Keeps the Score: Brain, Mind, & Body in the Healing of Trauma*, Viking Press, New York, NY.

Woodall, J. (2007), "Barriers to positive mental health in a young offenders institution: a qualitative study", *Health Education Journal*, Vol. 66 No. 2, pp. 132-40.

## Further reading

Bloom, S. (2008), "Chaos, complexity, self-organization and us", *Psychotherapy Review*, Vol. 2 No. 8, pp. 1-5.

Creswell, J.W. (1998), *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*, Sage Publications, Thousand Oaks, CA.

Greenberg, M.T. (1999), "Attachment and psychopathology in childhood", in Cassidy, J. and Shaver, P.R. (Eds), *Handbook of Attachment: Theory, Research, and Clinical Applications*, Guilford, New York, NY, pp. 469-96.

Gully, K.J. (2003), "Expectations test: trauma scales for sexual abuse, physical abuse, exposure to family violence, and posttraumatic stress", *Child Maltreatment*, Vol. 8 No. 3, pp. 218-29.

van der Kolk, B.A., Pelcovitz, D., Roth, S., Mandel, F.S., McFarlane, A. and Herman, J.L. (1996), "Dissociation, somatization, and affect dysregulation: the complexity of adaptation to trauma", *The American Journal of Psychiatry*, Vol. 153 No. 7, pp. 83-93.

van der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S. and Spinazzola, J. (2005), "Disorders of extreme stress: the empirical foundation of a complex adaptation to trauma", *Journal of Traumatic Stress*, Vol. 18 No. 5, pp. 389-99.

## Corresponding author

Michael George Kramer can be contacted at: brofsc1@yahoo.com