The Three Pillars of TraumaWise Care:

Healing in the Other 23 Hours[1]

Howard Bath

The Three Pillars framework informs and empowers those who deal directly in care or education with children of trauma. This article identifies three critical factors for creating environments of healing and resilience.

While many trauma treatment models are available for therapists, there are few research-grounded approaches for those who work with children in what is called *the other 23 hours* (Trieschman, Whittaker, & Brendtro, 1969). *The Three Pillars* is designed to provide key knowledge and skills for those who live or work directly with these children, including parents, teachers, foster carers, residential care workers, community youth workers, and mentors. On a daily basis, they must deal with behaviour that is frequently baffling and challenging.

The Three Pillars builds on the fact that much of the healing from exposure to chronic stress and trauma takes place in non-clinical settings. "Parents, counsellors, teachers, coaches, direct-care workers, case managers, and others are all in a position to help a child heal" (Greenwald, 2005, p. 37). This does not necessarily involve psychotherapy since many recover from trauma through support from family, friends, and other supporters (Briere & Scott, 2006). There is a growing synergy of the sciences of trauma and resilience. As van der Kolk (2014) notes, many supposed "symptoms" of psychiatric disorders might better be seen as strategies for self-protection. Adults who know how to provide secure relational support and guidance enable these young people to not only survive but thrive (Perry & Szalavitz, 2010).

Relationship Trauma

Every trauma survivor I've met is resilient in his or her own way, and every one of their stories inspires awe at how people cope.

~ Bessel van der Kolk (2014, p. 278)

Adverse childhood events such as neglect, abuse, and family disruption can have long-term negative effects (Felitti & Anda, 2010) that include physical diseases, behaviour disorders, and adverse life outcomes. Moreover, adversity is cumulative; the more sources of stress that are present early in life, the higher the risk of adverse outcomes across the lifespan.

Healing starts with creating an atmosphere of safety; formal therapy is unlikely to be successful unless this critical element is in place.

Researchers distinguish between simple or Type I trauma, in which a person is exposed to a single traumatising event, and complex or Type II trauma, which involves exposure to multiple traumatising events over a period of time (Terr, 1991). Bessel van der Kolk (2005) defined complex trauma as "the experience of multiple, chronic and prolonged, developmentally adverse events, most often of an interpersonal nature…and early life onset" (p. 402). Such exposure to extreme adversity in childhood affects many developmental domains. While trauma can have widespread developmental repercussions across the life span, there is clear research and clinical evidence about elements that influence healing and growth (van der Kolk, 2014).

Since interpersonal factors are key in both trauma and healing, the term *relationship trauma* will be used in this article to refer to complex or developmental trauma. The literature on trauma and resilience has produced long lists of risks and protective factors, but these can be distilled into a few fundamental principles (Masten, 2014). These are closely related to the core growth needs of the Circle of Courage (Jackson, 2014). Here are The Three Pillars for creating an environment that fosters healing and resilience:

1. **Safety** entails an environment where one can feel secure, calm, and attend to normal developmental tasks. Maslow (1954) describes safety needs as closely connected to survival, but also to higher level growth needs.

2. **Connections** involve trusting relationships with caring adults as well as normative community supports such as sports teams, youth groups, and recreational programs. Building connections fosters resilience by meeting growth needs for *belonging* and *generosity*.

3. **Coping** enables the individual to meet life challenges as well as to manage emotions and impulses underlying traumatic stress. In resilience terms, successful coping strengthens growth needs for *mastery* and *independence*.

Pillar I: Safety

Major developmental theorists such as Abraham Maslow, Erik Erikson, John Bowlby, and Mary Ainsworth saw safety as a core developmental need of children. Unfortunately, the defining experience of relationship trauma is that of feeling unsafe. Healing starts with creating an atmosphere of safety; formal therapy is unlikely to be successful unless this critical element is in place (Greenwald, 2005).

The overwhelming stress of recurrent trauma leads to changes in the brains of children who have been affected. Trauma can impact reactions to threat, emotional control, and cognitive abilities (Enlow, Egeland, Blood, Wright, & Wright, 2012; Teicher et al., 2003; van der Kolk, 2005). Bruce Perry observes that such children "reset their baseline state of arousal, such that—where no external threats or demands are present—they will be in a physiological state of persisting alarm" (Perry, 2006, p. 32). A person who lacks the ability to discriminate between safe and dangerous environments will respond inappropriately to many perceived threats.

The restless and wary behaviour of children who have been traumatised can lead to more formal descriptions such as hyperarousal and hypervigilance. A traumatised child learns to be alert to danger when in an abusive environment; unfortunately, that survival strategy is carried into other environments where it is not appropriate. Many behavioural problems of abused and neglected children are linked to concern about security and expectations that adults will be unresponsive or rejecting (Seita, 2010).

Children have a strong drive to be normal, to feel normal and to be treated as normal.

Many Facets of Safety

Given a pervasive sense of feeling unsafe, it stands to reason that the first focus is to insure that children are safe and feel safe. This involves not only physical safety, but social safety in peer and adult relationships; emotional safety through acceptance, empathy, and compassion; and cultural safety in a world where diversity can be marked by discrimination. While the young person may in fact feel unsafe from time to time, the people and program are not a source of threat. Rather, these should have a calming effect so the child or young person can gradually move from reactive defence to proactive engagement with adults.

Care Providers and Safety

Unfortunately, the behaviours of children who have been exposed to relationship trauma tend to trigger adult reactions that reinforce the children's lack of felt safety. James Anglin (2002) interviewed youth in care in ten residential programs in Canada. Many described their inner experiences as being marked by emotional pain. While many of their problems reflected this inner pain, staff who focused only on observable behaviour failed to recognise this fact.

Even caring adults can inadvertently end up becoming a source of pain and distress for the children they serve. Anglin concluded that the *central problem* for carers of traumatised children is to deal with primary pain without inflicting secondary pain through punitive or coercive reactions (Anglin, 2002, p. 55). A similar concern is expressed by van der Kolk:

> *Faced with a range of challenging behaviours, caregivers have a tendency to deal with their frustration by retaliating in ways that uncannily repeat the children's early trauma.* (van der Kolk, 2003, p. 310)

Ensuring that we do not slip into this abusive pattern of behaviour requires a sound understanding of trauma and the availability of support, debriefing, and supervision. While the focus on safety will vary with different situations, the goal is always the same—that the child *is* safe and *feels* safe and is thus able to join in the journey to healing and growth.

Children carefully study how adults present themselves, their mannerisms, tone of voice, and body language, and it is the child who "ultimately determines who is a safe person" (Steele & Malchiodi, 2012, p. 91). Safety is therefore closely related to the quality of interpersonal connections (the next pillar) because it is only in relationship with others that a child can begin to feel safe.

Pillar II: Connections

The second pillar is building or rebuilding social bonds. Connections include emotionally satisfying relationships with caring adults, but also normative connections such as with schools, sporting teams, churches, and community. These social supports help children to surmount adversity and develop resilient life outcomes. However, by definition, relationship trauma is a disruption of supportive connections. When the child faced terror and helplessness, adults were unable or unwilling to protect or were themselves the source of the trauma.

Relationships in early development "indelibly shape us in basic ways, and, for the rest of the life span attachment processes lie at the centre of all human emotional and social functions" (Schore, 2012, p. 27). People carry scripts of early attachment which serve as blueprints for later relationships, behaviour, and communication (Siegel, 2012). Unfortunately, many children and young people have not had the benefit of a sound, secure relationship, so a profound insecurity colours interactions. It is our job to create the conditions that help children alter these maladaptive scripts and learn to connect with positive, caring adults and peers.

The Quest for Normality

Children have a strong drive to be normal, to feel normal, and to be treated as normal. James Anglin (2002) identified this quest for normality as

an unexpected but strong theme among youth in care. This arose from discussions with the young people themselves, and the struggle for normality was incorporated into the title of his book.

For children of trauma, even well-meaning interventions can imply that they are anything but normal. Children are assigned to special classes or schools, referred to therapists, sent to live in placements away from their family—constant reminders that set them apart from their peers. They express a sense of shame, a deep feeling of not being good enough, of being unworthy, different, and defective. Brené Brown (2012) defines shame as "the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging" (p. 69).

Research on resilience reaches similar conclusions: caring relationships between children and caregivers, teachers, or mentors are foremost.

Some young people embrace or even flaunt their differentness which may be a healthy sign of independence and defiance. However, most retreat into a deep sense of exclusion and shame. Thus, we need to help young people engage in *normal* activities and settings such as regular schools, sporting teams, scouts, and sleepovers with friends—even if they need some special care. Normalized activities create opportunities for forming new connections. The more healthy relationships children have, the more likely they will be to recover from trauma and thrive. Relationships are the agents of change (Perry & Szalavitz, 2006).

Building Connections

There is solid scientific evidence about the therapeutic value of trusting relationships (Assay & Lambert, 1999; Wampold & Imel, 2015). Decades of research on psychotherapy shows that it is not specific treatment models or techniques, but positive relationships (i.e., a therapeutic alliance and empathy) that drive change. Research on resilience reaches similar conclusions: caring relationships between children and caregivers, teachers, or mentors are foremost (Benard, 2004; Werner, 2013).

Li and Julian (2012) describe relationships as the active ingredients of positive change. Using concepts drawn from Bronfenbrenner (1979), they define *developmental relationships* as involving four key qualities: attachment, reciprocity, progressive complexity, and balance of power.

> *Attachment* includes natural, positive emotional connections. A sense of belonging fosters respect without the need to resort to coercive measures.
>
> *Reciprocity* refers to the mutually responsive quality of caring relationships. Helping adults give necessary supports, but gradually remove this scaffold to foster growth.
>
> *Progressive complexity* means mastering increasingly more complex developmental tasks. The adult provides challenges within the *zone of proximal development* to develop strengths and potentials (Vygotzky, 1978).
>
> *Balance of power* refers to the need for the adult to progressively shift control in the relationship to the increasingly independent young person.

The primary goal for all who care about children and young people is to be responsive to their needs. Vera Fahlberg (1991) describes the arousal-relaxation cycle that comes naturally in parenting infants: caregivers respond to needs instead of reacting adversely to the child's distress. This fosters secure attachment in infancy and also can be applied with older children with insecure attachment. During times of high emotional arousal (e.g., when children are angry, fearful, or disappointed), the adult helps to restore calm and quiescence.

Children are particularly vulnerable in times of crisis, and these situations can provide an opportunity to build relationship beachheads (Trieschman, Whittaker, & Brendtro, 1969). When hurt, frightened, lonely, or sick, a previously guarded young person may abandon well-entrenched defences against adults. Decades of research on the significance of crisis suggests that humans are more susceptible to helping relationships and more responsive to therapeutic attempts at these times of stress. The valence of a relationship can undergo a marked change after some crucial incident which draws the adult and child closer together.

Another everyday connection-building skill is the engaging of children in activities characterised by reciprocity. The late professor Henry Maier (1992) observed that when two parties are involved in reciprocal interactions—such as playing table tennis, throwing a ball, dancing, or playing music together—a positive connection is created. "It is almost impossible," he observes, "to dislike someone while you are rhythmically *in synch* with them." The use of such everyday skills promotes positive connections and helps to ensure a safe environment. Respectful connections are necessary as we help children cope with their challenging circumstances and unruly emotions.

Pillar III: Coping

Coping involves the ability to manage external problems as well as internal emotions and impulses. Young people need to develop coping strategies to survive and thrive. Conscious and intuitive strategies enable a child to cope with external challenges resulting from relationship trauma, as well as the enduring strong emotions and impulses that are at the heart of traumatic stress.

Children of trauma develop their own coping strategies to deal with the *fallout* from relationship trauma, particularly since adults have so often let them down. Some such strategies are helpful and adaptive, for example, self-reliance and development of a *radar* for danger. Other coping strategies are counterproductive in the long term:

> *Many of the most intractable public health problems are the result of compensatory behaviours such as smoking, overeating, and alcohol and drug use, which provide immediate partial relief from the emotional problems caused by traumatic childhoods.* (Felitti & Anda, 2010, p. 86)

Without trusting relationships, many chronically distressed individuals rely on addictions, criminal activity, or risk taking behaviour to relieve their pain (Bloom & Farragher, 2011). Our role is to empathically understand the coping strategies children employ; provide safety and support so that they have less need for maladaptive strategies; and guide them toward safe, healthy, socially wise ways of coping.

Alan Schore (2012) considers struggles with emotional self-regulation to be the defining characteristic of early relationship trauma. Such children "may be chronically irritable, angry, unable to manage aggression, impulsive, anxious or depressed" (Bloom & Farragher, 2011, p. 108). Thus, the third pillar focuses on helping survivors of relationship trauma safely manage strong emotions and impulses and maintain their emotional equilibrium.

Verbal Skills

Many of the adjectives that we use to describe traumatic experiences suggest that the intensity of these experiences defies verbal description. For example, we hear about unspeakable horror, mute terror, and indescribable fear. Trauma is not experienced in the higher brain where reason prevails, but in deep brain areas where there is no language (Steele & Kuban, 2013). Thus, cognitive therapy may be ineffective until trust calms the sensory brain.

Even if traumatised children are not yet ready for verbal therapy, caregivers can help young people develop verbal competencies and the capacity for self-reflection. Just as parents would do with small children, we can help children verbally process their day-to-day experiences. Research shows that the mere act of consciously naming feelings can calm the brain's amygdala and reduce emotional intensity (Lieberman et al., 2007).

Active Listening, a foundational human relations skill, assists children in identifying and naming emotions, skills that are often lacking in traumatised children (van der Kolk, 2005). Attuning to nonverbal cues, asking questions, and reflecting

both content and feelings are part of the Active Listening toolkit. Setting aside our adult as expert role, we become witnesses to the child who shares stories on the journey from trauma and loss to healing (Steele & Kuban, 2013).

Co-regulation

Infants and young children cannot regulate their own emotions but need adults to loan them this control. By being soothed, stroked, rocked, and spoken to in a calm, soft manner when they are upset, they experience calming through the adult's presence and support. In time, they learn to self-soothe by mirroring their carer's responses. Most importantly, they learn that there is a responsive, committed caregiver to offer support.

We become witnesses to the child who shares stories on the journey from trauma and loss to healing.

Developmental psychologists call this interactive process between carer and infant *co-regulation.* With older children and young people who have not yet learned the skills of self-regulation, adults either respond to problem behaviour by co-regulating with the child or attempting to coercively regulate the child (Bath, 2008a). Without soothing by caregivers, the traumatised child is unable to learn to restore emotional equilibrium (Schore, 2003).

The use of co-regulation with older children requires that adults manage this intensity with self-control rather than mirror the child's hostility and threats. This also requires an ability to distinguish between problematic behaviours that are goal-directed and instrumental and those that result from emotional flooding. At its root, the ability to learn self-regulation requires trustworthy, empathic caregivers.

There are now many publications and training programs that promote the development of self-regulation. These include life space techniques that encourage children to reflect on crisis events as a way of promoting insight and change (Brendtro & du Toit, 2005; Holden, Mooney, Holden, & Kuhn, 2001; Long, Wood, & Fecser, 2001). The process of reflecting on thoughts, emotions, and actions fosters the development of mindfulness. Such everyday interventions are powerful strategies for healing and growth with children affected by relationship trauma.

Conclusion

Each of The Three Pillars is closely inter-related. There can be no felt safety in the absence of positive connections. Adaptive coping and self-regulation only develop in the context of sound connections with adult carers. *Safety, connections,* and *coping* are not the only important priorities in a healing environment but are fundamental to positive growth. These essentials provide a roadmap for success with children and young people who have been exposed to chronic adversity and trauma.

Howard Bath, PhD, *has served as the first Commissioner for Children in the Northern Territory of Australia. He has a rich career in work with children and adolescents and consults worldwide. Information about The Three Pillars of TraumaWise Care training is available at www.reclaiming.com. Dr. Bath can be contacted at* howardianbath@gmail.com

References

Anglin, J. (2002). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth.* New York, NY: Haworth.

Assay, T., & Lambert, M. (1999). The empirical case for the common factors in therapy: Qualitative findings. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 33-56). Washington, DC: American Psychological Association.

Bath, H. (2008a). Calming together: The pathway to self-control. *Reclaiming Children and Youth, 16*(4), 44-46.

Bath, H. (2008b). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*(3), 17-21.

Benard, B. (2004). *Resiliency: What have we learned?* San Francisco, CA: West Ed.

Bloom, S., & Farragher, B. (2011). *Destroying sanctuary: The crisis in human services delivery systems.* Oxford, UK: Oxford University Press.

Brendtro, L., & du Toit, L. (2005). *Response Ability Pathways: Restoring bonds of respect.* Cape Town, South Africa: Pretext.

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, and treatment.* Thousand Oaks, CA: Sage.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead.* London, UK: Penguin Books.

Enlow, M., Egeland, B., Blood, E., Wright, R., & Wright, R. (2012). Interpersonal trauma exposure and cognitive development in children to age 8 years: A longitudinal study. *Journal of Epidemiology and Community Health, 66,* 105-110.

Fahlberg, V. (1991). *A child's journey through placement.* Indianapolis, IN: Perspectives Press.

Felitti, V., & Anda, R. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorder, and sexual behaviour: Implications for healthcare. In R. Lanius, E. Vermetten, & C. Pain (Eds.), *The impact of early life trauma on health and disease* (pp. 77-87). New York, NY: Cambridge University Press.

Greenwald, R. (2005). *Child trauma handbook: A guide for helping trauma-exposed children and adolescents.* New York, NY: Haworth.

Holden, M., Mooney, A., Holden, J., & Kuhn, F. (2001). In M. Nunno (Ed.), *Therapeutic Crisis Intervention* (5th ed.), Trainer's Manual. Ithaca, NY: Cornell University.

Jackson, W. (2014). The Circle of Courage: The socialization of youth in the 21st century. *Reclaiming Children and Youth, 23*(3), 16-20.

Li, J., & Julian, M. (2012). Developmental relationships as the active ingredient: A unifying working hypothesis of "what works" across intervention settings. *American Journal of Orthopsychiatry, 82*(2), 157-166.

Lieberman, M., Eisenberger, N., Crockett, M., Tom, S., Pfeifer, J., & Way, B. (2007). Putting feelings into words: Affect labelling disrupts amygdala activity in response to affective stimuli. *Psychological Sciences, 18*(5), 421-428

Long, N., Wood, M., & Fecser, F. (2001). *Life space crisis intervention: Talking with students in conflict.* Austin, TX: PRO-ED.

Maier, H. (1992). Rhythmicity—A powerful force for experiencing unity and personal connections. *Journal of Child and Youth Care Work, 8,* 7-13.

Masten, A. (2014). *Ordinary magic: Resilience in development.* New York, NY: Guilford Press.

Maslow, A. (1954). *Motivation and personality.* New York, NY: Harper Row.

Perry, B. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children. In N. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27-52). New York, NY: The Guilford Press.

Perry, B., & Szalavitz, M. (2006). *The boy who was raised as a dog: What traumatized children can teach us about loss, love, and healing.* New York, NY: Basic Books.

Perry, B., & Szalavitz, M. (2010). *Born for love: Why empathy is essential—and endangered.* New York, NY: Harper Collins.

Schore, A. (2003). *Affect regulation and the repair of the self.* New York, NY: W. W. Norton.

Schore, A. (2012). *The science and art of psychotherapy.* New York, NY: W. W. Norton.

Seita, J. (2010). Missing data: Discovering the private logic of adult-wary youth. *Reclaiming Children and Youth, 19*(2), 51-54.

Siegel, D. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York, NY: The Guilford Press.

Steele, W., & Kuban, C. (2013). *Working with grieving and traumatized children and adolescents: Discovering what matters most through evidence-based sensory interventions.* New York, NY: Wiley.

Steele, W., & Malchiodi, C. (2012). *Trauma-informed practices with children and adolescents.* New York, NY: Routledge.

Teicher, M., Anderson, S., Polcari, A., Anderson, C., Navalta, C., & Kim, D. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience & Behavioural Reviews, 27,* 33-44.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*(1), 10-20.

Trieschman, A., Whittaker, J., & Brendtro, L. (1969). *The other 23 hours: Child-care work with emotionally disturbed children in a therapeutic milieu.* Piscataway, NJ: Transaction.

van der Kolk, B. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America, 12*(2), 293-317.

van der Kolk, B. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 33*(5), 401-408.

van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* New York, NY: Viking.

Vygotzky, L. (1978). *Mind in society: The development of higher psychological processes.* Cambridge, MA: Harvard University Press.

Wampold, B., & Imel, Z. (2015). *The great psychotherapy debate. The evidence for what makes psychotherapy work.* New York, NY: Routledge.

Werner, E. (2013). Risk, resilience, and recovery. *Reclaiming Children and Youth, 21*(1), 18-23.

(Endnotes)

1 This article expands on previous publications in this journal by the author (Bath, 2008a, 2008b).