The Three Pillars of Transforming care: Healing in the 'other 23 hours' [1]

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Abstract

This article identifies the three core defining characteristics of healing environments for children and young people who have been exposed to chronic adversity and trauma. A large body of evidence highlights the pervasive and devastating developmental impacts of such early experiences but there is also emerging evidence about the characteristics of living and learning environments that foster recovery and resilience. The *Three Pillars* framework has been developed to inform and empower those who live with or work with these young people but who are not necessarily engaged in formal therapy.

Chronic adversity and trauma

Dr Bruce Perry, one of the doyens of trauma research, has highlighted the plight of children who are 'safe nowhere', who are exposed to abuse and neglect, whose homes are chaotic, whose communities are fragmented and prone to violence, and whose schools can barely provide structure and safety:

> These children must learn and grow despite a pervasive sense of threat. (They) must adapt to this atmosphere of fear (Perry, 2001, p. 4).

Other children and young people may have lost their families due to civil conflict or disease; they may have been exposed to or forced to participate in extreme violence (as child combatants); or they may have undertaken perilous journeys into the unknown as unaccompanied and unsupported minors. We are beginning to understand how this early exposure can have devastating developmental repercussions across the life span.

We now know that such adverse developmental experiences affect multiple developmental domains. These including biology, cognition, behavioural control, the regulation of emotions and impulses, self-concept, and future orientation (Cook et al., 2005).The seminal research of Vincent Felitti and his colleagues (e.g. Felitti et al.,1998; & Felitti & Anda, 2010) has convincingly demonstrated that many physical and mental disorders (such as cardiovascular, pulmonary and liver disease, and depression); behavioural disorders (such as drug dependence, suicide attempts, chronic smoking, alcoholism, and risky sexual activity); and adverse adolescent and adult outcomes (such as being prone to violence and juvenile delinquency), have

[1] This article updates and expands on articles in the journal *Reclaiming Children and Youth* published in 2008b and 2015, and references the book: *The Three Pillars of Transforming Care: Trauma and resilience in the 'Other 23 Hours'* (H. Bath & J. Seita, 2018, Faculty of Education Publishing, University of Winnipeg, CA).

their roots in childhood adversity and trauma. This rapidly growing body of research has also demonstrated that the impacts are cumulative; the more sources of stress that are present early in life, the higher the risk of adverse outcomes across the lifespan.

Following Lenore Terr (1991), researchers into the impacts of trauma have distinguished between acute or type 1 trauma in which a person is exposed to a single traumatising event, and type 2 trauma that involves exposure to multiple stressful and traumatising events over a period of time. Bessel van der Kolk (2005), building on this distinction, has explored a form of type-2 trauma that he calls *complex developmental trauma*:

> …the experience of multiple, chronic and prolonged, developmentally adverse events, most often of an interpersonal nature…and early life onset' (p. 402).

It is this complex form of trauma, sometimes also referred to as 'relational trauma' because it usually occurs in a caregiving context (Schore, 2001), that is the focus of this discussion.

The context of healing

The *Three Pillars* framework is designed to inform and empower those who live with or work with young people who have been exposed to chronic adversity and trauma, including parents, foster carers, residential care workers, teachers, custodial workers and others. These care and education providers are not usually engaged in formal therapy but must, nevertheless, understand, support, nurture, mentor and sometimes provide behavioural controls for young people whose behaviours are frequently baffling and challenging. It is for people who are engaged with young people outside of the formal therapy hour, in what has been called *The Other 23 Hours* (Trieschman, Whittaker & Brendtro, 1969) - their everyday living and learning environments.

The *Three Pillars* framework builds on the understanding that much of the healing from exposure to chronic stress and trauma can and does take place in non-clinical settings. Greenwald (2005), for example, observes that:

> Parents, counsellors, teachers, coaches, direct-care workers, case managers, and others are all in a position to help a child heal (p. 37).

Briere and Scott (2006) concur:

> Healing relationships need not always involve psychotherapy. Many people recover from trauma exposure without seeking professional assistance, processing and resolving their injuries in the context of family, friendship, and other relationships (p.231).

The *Three Pillars* framework

The three inter-related Pillars are the core characteristics of social environments that promote healing and growth. They are responses to the three central *trauma-related* needs of these children and young people (see Bath & Seita, 2018):

1. **Safety**: the creation of an environment in which a young person can *feel* safe, relax, and attend to normal developmental tasks.

2. **Connections**: the development of positive, trust-based, interpersonal connections between the young person and caring adults as well as engagement with normative community supports such as sporting teams, youth groups, and recreational programs. Sometimes a young person needs to engage and re-connect with his/her cultural roots and role models.

3. **Coping**: helping the young person to develop adaptive **coping** skills to positively deal with life's challenges as well as the problematic emotions, cognitions and impulses that lie at the heart of traumatic stress.

In short, the *Three Pillars* are **Safety, Connections, and Coping**.

Pillar 1: Safety

The overwhelming and sustained stress of complex trauma leads to enduring changes in the brains of young people who have been affected. We now know that important brain functions (such as the response to threat, emotional control and certain cognitive abilities) are compromised by traumatic exposure during critical developmental periods (e.g. Enlow et al., 2012; Teicher et al., 2003; & van der Kolk, 2005). Referring to such young people, Bruce Perry (2006) observes that they:

> 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 (p. 32).

This can have serious repercussions for the young person because, as van der Kolk (2014) points out:

> Being able to feel safe with other people is probably the single most important aspect of mental health (p. 79).

The restless and wary behaviours we see in young people who have been seriously stressed in their early developmental years, tend to attract technical labels such as *hyperarousal* and *hypervigilance*. A traumatised young person needs to be alert to danger when in an abusive environment; unfortunately, that hypervigilance is carried into other environments where this survival strategy is not helpful. When a young person lacks the ability to discriminate between safe environments and dangerous ones, they will respond inappropriately to many perceived threats. It has been observed that many of the developmental problems that we see in abused and neglected children and young people appear to be linked to 'an over-concern with security issues reflecting an expectation of unresponsive, unavailable, rejecting adults' (Aber in Hughes 1997, p. 22).

Multiple facets of safety

Given this pervasive sense of feeling unsafe, it stands to reason that the first focus of those providing care for young people exposed to chronic stress and trauma, is to ensure that they *are* safe and *feel* safe. This necessarily involves *physical safety*, but also involves *social safety* in peer and adult relationships; *emotional or psychological safety* in terms of adult acceptance, empathy and compassion; and *cultural safety* in terms of recognition and respect for cultural identity, ways of understanding, language and priorities. Other young people feel unsafe because of attitudes and behaviours that are harmful to those struggling with gender or sexual identity issues.

A safe environment is one in which the nature of the physical environment, the adult caregivers, the mix of clients, the intervention models, and the adult-young person interactions, are all designed to minimise both the reality and the perception of threat to the young person. This does not mean that the young person will necessarily feel safe but that the program itself will seek to be a source of comfort and support, not a source of threat. It provides a calming context in which the child or young person can gradually move from a stance of reactive defensiveness to one of proactive engagement with caring adults (see Porges 2017, pp. 6-7).

Care providers and safety

Unfortunately, the characteristic behaviours of a young person who has been exposed to complex trauma, tend to trigger adult responses that reinforce the young person's lack of felt safety. Academic James Anglin (2002) looked closely at ten residential programs across Canada. He found that many young people in care described their inner experiences as being marked by emotional 'pain', a word they frequently used. He also found that many of the difficult behaviours of the young people reflected this inner pain but that carers frequently failed to recognise this fact in the punitive or controlling way they responded to the behaviours.

Anglin concluded that even though care providers may be caring individuals with the right motives, they often inadvertently end up becoming a source of pain and distress for the young people they care for. He concluded that the *'Central Problem'* for carers of traumatised young people is:

> dealing with…primary pain without unnecessarily inflicting secondary pain experiences on the residents through punitive or controlling reactions (2002, p. 55).

Van der Kolk (2003) comes up with a similar conclusion that would resonate with many who work with young people from backgrounds of chronic adversity and trauma:

> 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 (p.310).

Ensuring that we as carers do not slip into this abusive pattern of behaviour requires a sound understanding of the processes involved, training in trauma awareness, and

the ready availability of guidelines, support, debriefing and supervision (see for example, Bath, 2021).

The focus on safety will mean different things for different young people, and different developmental stages, settings, and care providers. However, the goal is always the same – that the young person *is* safe and *feels* safe and is thus able undertake the journey to healing and growth. Steele and Malchiodi (2012) have observed that:

> Safety is not about reason and logic but about how the child experiences us as helping professionals…. This includes the way we present ourselves to the child, our mannerisms, physical features, body language, and voice tones…either the child feels safe or he does not. The child ultimately determines who is a safe person (p. 91).

Safety is therefore closely related to the nature of interpersonal connections (the next pillar) because it is only by positively connecting with others that a young person can begin to feel safe.

Pillar 2: Connections

In his landmark book '*The body keeps the score'*, van der Kolk (2014) maintains that 'The essence of trauma is feeling godforsaken, cut-off from the human race' (p. 335). This is because the young person has experienced extreme adversity and trauma and the normally protective caregivers could not protect, would not protect, or were themselves the source of the harm – this leads to a lack of trust in, and sense of disconnection from adults. Seita and Brendtro (2005) suggest that many such young people develop an 'adult-wary' outlook on life.

For some, the lack of connection starts in infancy where the attachment relationships between children and their caregivers, both positive and negative, are of vital significance. Allan Schore (2012) points out that:

> the real relationships of the earliest stage of life 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.' (p. 27).

Unfortunately, many of the young people in special care settings have not had the benefit of a sound, secure relational foundation for development and a profound, interpersonal insecurity colours subsequent relationships. It is our job to create the conditions that help young people alter these maladaptive patterns and expectations and learn to connect with positive, caring adults and peers.

In addition to emotionally satisfying interpersonal connections, our young people need to establish normative connections with the broader community such as with schools, sporting teams, religious organisations, scouts, and for some, their birth culture (Bath, 2021). Bruce Perry tells us that:

> The most powerful predictor of your functioning in the present is your current relational connectedness and then the second most powerful component…is your history of connection (Perry cited in Maté, 2022, p. 249).

The hunger for normality

The young people we live and work with often have a strong drive to be 'normal', to feel 'normal', and to be treated as 'normal'. James Anglin (2002), in his landmark study, identified this drive for normality as a strong and somewhat unexpected theme in the young people he interviewed. This insight arose directly from discussions with the young people themselves, and was incorporated into the title of his book ('Pain, Normality and the Struggle for Congruence').

For most young people in special care and education settings their lives are anything but 'normal' - they live away from their family homes, they are often in non-mainstream 'special' schools, they understand that their behaviours set them apart from their peers, they may not dress or present like their peers, and they may not be cared for by parents. The underlying sense is one of shame, a very powerful and deep feeling of not being good enough; of not being the same as others; of not belonging; of being unworthy; of being 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).

Some young people embrace and even flaunt their differentness and with some this may be a healthy reflection of independence and defiance. However, for others it is likely to be a reaction to the deep sense of exclusion and shame that they feel.

One implication is that we need to consider how we can help young people engage in 'normal' activities and settings such as regular schools, youth groups, sporting teams, scouts, and 'sleepovers' with friends even if they need to be in some form of special care. These activities create opportunities for forming multiple connections and the development of 'normal' identities.

Connections with adults

We have long known that trusting connections with caring adults are of vital importance if young people are to recover from chronic stress and trauma. There is now growing scientific evidence suggesting just how important this is. From her analysis of the resilience research, Masten (2014) found that interpersonal support and connections are vital predictors of resilience (p. 148). Likewise, Luthar (2006) concluded that 'Resilience rests fundamentally on relationships' (p. 706), a finding echoed by Rutter (2013) and Werner (2013).

Building connections

Building positive connections with young people should be the primary goal of all care and education providers and there is ample evidence that attitudes, values and everyday skills are critical ingredients. For example,

- Being present and providing focused attention

- Spending time with them
- Actively listening
- Encouraging and motivating
- Noticing and remarking on their interests and strengths
- Finding shared interests
- Being aware of and responding to their 'inner worlds' – their thoughts, wishes, and feelings

There are many other strategies and techniques for building positive connections. For example, Fahlberg (1991) points out that care providers need to be alert to the possibility of exploiting the 'arousal-relaxation' cycle in facilitating attachment (p. 33). This involves being positively present with children during times of high emotional arousal (such as when they are angry, fearful, or disappointed), avoiding punitive responses and helping them to achieve calming and quiescence – this process, she points out, underlies the development of attachment in infancy and can be applied with older children who have insecure attachment patterns (see Bath, 2022).

Back in the 1960s, Larry Brendtro drew attention to this need for care providers to 'capitalise' on relationship opportunities in times of crisis:

> 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 (adapted from Brendtro, 1969, pp. 96-97).

Another everyday connection-building skill is the engaging of young people in activities characterised by *rhythmicity*. The late Professor Henry Maier (1992) observed that when two parties are involved in rhythmical interactions, such as playing table tennis, throwing a ball, dancing or playing music together, a positive connection is created, even if temporarily. He tells us that 'It is almost impossible to dislike someone while you are rhythmically *in synch* with them'. Similarly, van der Kolk (2014) maintains that:

> What begins as the attuned play of mother and child continues with the rhythmicity of a good basketball game, the synchrony of tango dancing, and the harmony of choral singing…all of which foster a deep sense of pleasure and connection (p. 84).

The use of these (and countless other) everyday interpersonal skills promotes the development of positive connections and helps to ensure a safe environment for young people, but they are also an important element in assisting them to cope with their challenging circumstances and turbulent inner lives.

In weighing the relative efficacy of formal intervention programs and relationships, Bruce Perry (Perry & Szalavitz, 2006) has observed that:

> …the more healthy relationships a (young person) has, the more likely he will be to recover from trauma and thrive. Relationships are the agents of change.

Pillar 3: Coping

Exposure to trauma and chronic stress in childhood has significant implications for who young people live with, where they go to school, how they learn, and how they relate to peers, quite apart from the impact it has on their inner lives. They need to develop coping strategies to survive and adapt to these external realities as well as the enduring strong emotions, thoughts and impulses that are at the heart of traumatic stress. As Louis Cozolino (2016) has observed:

> The traumatised young person is 'drowning in a sea of fragmented and overwhelming emotions, sensations, and frightening thoughts.' (p. 199)

Young people have a natural motivation to develop their own coping strategies to deal with the immediate impacts and ongoing 'fallout' from relational trauma, particularly as adults have so often let them down. Some of these strategies are helpful and adaptive, for example, the development of a 'radar' for danger and a tendency to be self-reliant. However, many coping strategies are not helpful or adaptive, especially in the longer term. Felitti and Anda (2010), reflecting on the lifetime outcomes of early exposure to trauma, have noted that:

> Many of the most intractable public health problems are the result of compensatory behaviors such as smoking, overeating, and alcohol and drug use, which provide immediate partial relief from the emotional problems caused by traumatic childhoods. These experiences are lost in time and concealed by shame, secrecy and social taboo… (p. 86).

In the same vein, Sandra Bloom and Brian Farragher (2011) have aptly observed:

> If trustworthy people are not available, it is more likely that the chronically distressed individual will turn to drugs, alcohol, smoking, sex, criminal activity, or risk-taking behaviour - any activity that relieves the unrelenting, emotionally driven, repetitive distress (p. 108).

Our role then is to empathically understand the coping strategies that the young person has employed, to provide safety and support so that they have less need to resort to maladaptive strategies, and to guide them toward safe, healthy, socially wise ways of coping.

Managing emotions and impulses

Allan Schore (2012) refers to struggles with emotional self-regulation as 'the most significant consequence of early relational trauma' (p.65), while Bloom and Farragher (2011) tell us that such young people '...may be chronically irritable, angry, unable to manage aggression, impulsive, anxious or depressed' (p. 108).

Although emotional turbulence is a central concern, so too are intrusive thoughts, frightening memories, painful sensations and dangerous impulses. Carers and mentors can assist with the management of a young person's internal turbulence by employing a range of practical, everyday skills (Bath, 2021).

Verbal skills

Many of the adjectives that we use to describe traumatic experiences suggest that our ability to verbally process such experiences is impaired - that the intensity of the experience defies verbal description. For example, we hear about ‘unspeakable horror’, ‘mute terror’ and ‘indescribable fear’.

Bessel van der Kolk (2014) observes that, ‘while trauma keeps us dumbfounded, the path out of it is paved with words’ (p. 232). He states elsewhere that:

> a critical element in the treatment of traumatised people is to help them find words for emotional states. Naming feelings gives patients a subjective sense of mastery…’ (van der Kolk, MacFarlane & Van Der Hart 1996, p. 427).

In a pointer to the therapeutic possibilities of harnessing language, research has also revealed that the act of consciously naming the emotions we experience (affect labeling) reduces amygdala arousal as effectively as formal emotion management techniques (Burklind et al., 2013; Lieberman et al, 2007). Such discoveries highlight the promise of verbal strategies in working with traumatized young people.

Direct care providers, teachers and other mentors are not trained to provide therapy for their charges, but they can help develop the verbal and emotional competencies the young people will need in order to manage their difficult emotions. Active listening strategies, used on a day-by-day basis, help young people identify and name emotions and thereby develop skills that are often lacking in traumatised young people (van der Kolk, 2005). Such approaches should be a key component of every mentor’s toolkit.

Co-regulation

Infants and small children cannot regulate their own emotions – they need the adults to do it with them. 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 learning from their carer’s responses that there are means to relieve distress; hunger is relieved by food; hurt knees are soothed by attention and a bandage; emotional distress by calming words and a hug, and so on – most importantly, they learn that there is a responsive, committed caregiver on hand to assist.

Developmental psychologists call this interactive process between carer and infant ‘co-regulation’ because it involves an ‘interactive’ dance and as the infant calms down it helps the adult to do the same.

With older children and young people who have not yet learned the skills of self-regulation, adults can choose to respond to ‘dysregulated’ behaviour by either co-regulating with the child, or, as is sometimes the case, by attempting to coercively control the child’s behaviour (Bath, 2008a, 2022). Mollon observes that ‘without…soothing by reliable and consistent caregivers, the traumatised child is

unable to regulate his or her mental state and restore emotional equilibrium' (cited in Schore, 2003, p. 123).

The use of co-regulation with older children and young people requires an acceptance that they may temporarily need the carer's assistance to safely manage intense emotions; a willingness to respond to the emotions and struggle with self-control rather than the child's hostility and threats; and a commitment to the use of non-retaliatory and non-provocative words or actions. It also requires an ability to distinguish between problematic behaviours that are goal-directed and instrumental, and those that result from emotional flooding. This is consistent with Allan Schore's (2012) contention that, at its root, the ability to learn self-regulation is dependent on there being available trustworthy, empathic and committed caregivers (Chapter 1).

There are now many publications and training programs that promote a range of 'mindfulness' techniques, including some that are targeted at children and youth. Other 'life space' techniques (Brendtro & DuToit, 2005; Holden et al., 2001; & Long, Wood & Fecser, 2001) encourage children to reflect on crisis events as a way of promoting insight and change. Indeed, any technique that assists young people to reflect on actions and emotions or that provides a means to uncouple impulse and action, can contribute to the objective. Such interventions contribute to a growing arsenal of 'everyday' techniques that can be used to therapeutic effect with young people affected by developmental trauma.

Conclusion

The *Three Pillars* are, of course, closely inter-related. There can be no felt safety for young people in the absence of positive connections, and as Allan Schore and others have pointed out, 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 they are fundamental to positive growth. Moreover, they provide a useful roadmap for success with young people who have been exposed to chronic adversity and trauma and a focus for the myriad tasks and transactions that occur in the 'lifespace' of young people in special care and education settings.

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