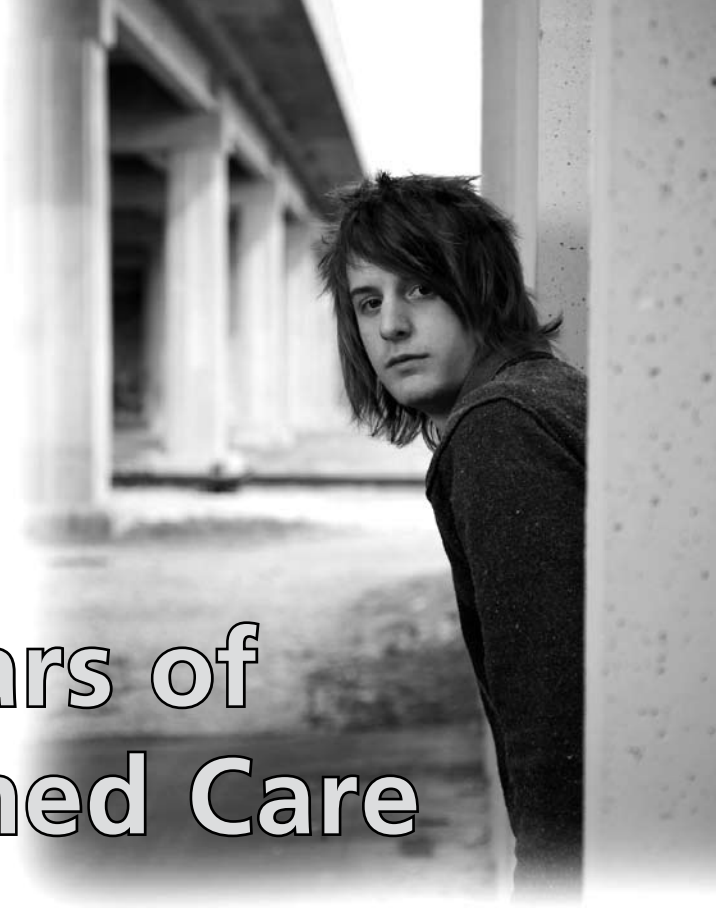
All who interact with traumatized children in home, school, and community can make important contributions to healing and growth. This care involves actions to strengthen three pillars: safety, connections, and managing emotional impulses.



# The Three Pillars of Trauma-Informed Care

***Howard Bath***

The past decade has brought with it a greatly increased awareness about the impact of trauma on children, which has, in turn, led to a focus on the treatment of trauma-related conditions. Much of the recent literature describes different approaches to therapy (e.g., Greenwald, 2005; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005; Perry, 2006). This burgeoning body of literature conveys the impression that to effectively respond to trauma-related conditions, it is necessary to have advanced therapeutic skills and years of formal study. However, there are a few consistent propositions arising from the research and clinical literature which suggest that much of the healing from trauma can 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). There is some evidence to suggest that trauma-informed living environments in which healing and growth can take place are a necessary precursor to any formal therapy that might be offered to a traumatised child. It might even be argued that the creation of these environments is the critical ingredient in therapeutic transformation.

## *Complex trauma*

Many of the children and young people found in child welfare, mental health, special education, and justice settings have been exposed to trauma in their early years. The literature differentiates between type 1, or acute trauma, which results from exposure to a single overwhelming event, and type 2, or complex trauma (a.k.a. developmental or relationship trauma), which results from extended exposure to traumatising situations. Bessel van der Kolk (2005) describes complex trauma as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature...and early life onset" (p. 402). Kinniburgh and her colleagues (2005) note that in terms of both experience and effect, "exposure to complex interpersonal trauma is qualitatively distinct from acute trauma" (p. 430).

## *Outcomes of complex trauma*

Following exposure to acutely traumatising events, some people develop the symptoms of post-traumatic stress disorder. These involve the repeated, cue-triggered, involuntary re-experiencing of the terror and helplessness (often through nightmares or flashbacks); a focus on avoiding cues that might be reminders of the trauma; hyperarousal and hypervigilence; problems with concentration and focus; and an exaggerated startle response (the formal criteria can be found in American Psychiatric Association, 1994).

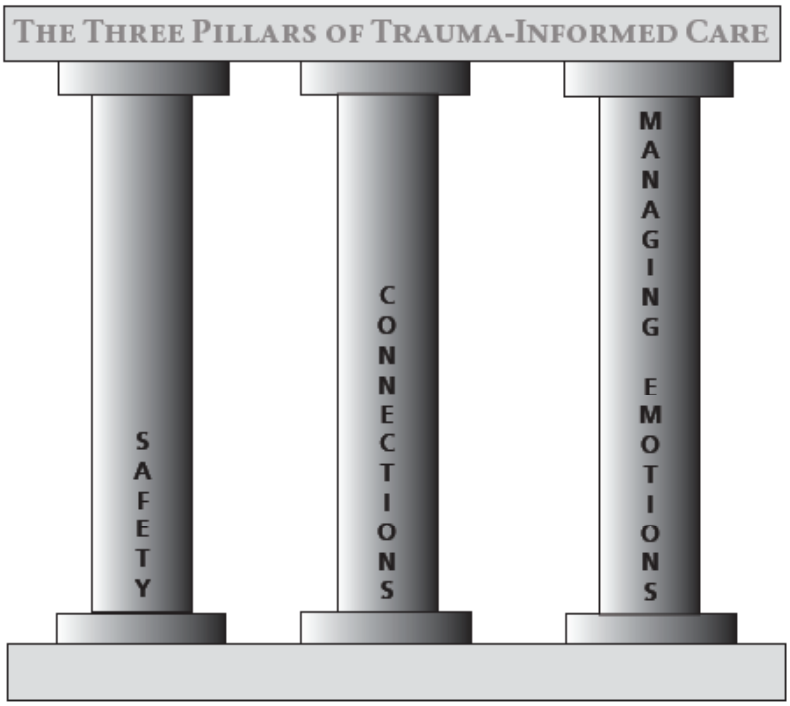
Although many traumatised children do experience these symptoms, many of them do not fully meet the formal diagnostic criteria which were originally formulated with adults in mind. Given that the exposure to complex trauma usually takes place at an early age and the exposure is sustained, the developmental impacts tend to be more pervasive. The brain-based stress response systems of these children appear to become permanently changed as they focus attention on the need to ensure safety rather than on the many growth-promoting interests and activities that secure children find attractive and stimulating. Bruce Perry (2006) has observed that "Traumatized children reset their normal level of arousal. Even when no external threats exist, they are in a constant state of alarm" (p. 32). In particular, such children come to view adults as potential sources of threat rather than sources of comfort and support. In substitute care and school settings such children are often described as hypervigilant because they constantly scan the environment for potential sources of danger. A recent neurological study of people who were in the vicinity of the events of September 11, 2001, in New York found that their brain threat detection systems were significantly over-active a full five years after the events of that one day (Ganzel et al., 2007). It is as if their brains have become permanently re-tuned to the possibility of harm.

Cook and her colleagues (2005) have observed that children who have suffered complex trauma may meet the diagnostic criteria for many different disorders (beyond post-traumatic stress disorder) and that a number of developmental domains can be affected including attachment systems, biology, affect regulation, dissociation, behavioural control, cognition, and self-concept.

Although the outcomes of complex trauma can be many and varied, there is one impact that appears to stand out above the rest. Allan Schore (2003) observes "The most significant consequence of early relational trauma is the loss of the ability to regulate the intensity and duration of affects" (p. 141). In a similar vein, van der Kolk (2005) states that "at the core of traumatic stress is a breakdown in the capacity to regulate internal states" including fear, anger, and sexual impulses (p. 403).

## *Contexts of healing*

It stands to reason that the treatment of children exposed to complex trauma will itself be complex and long-lasting. However, there appears to be a remarkable consensus about the key prerequisites for healing—those critical factors or therapeutic pillars that need to be in place if healing is to take place. Although there is debate about the number of critical factors, there are three that are common to most approaches. van der Kolk and Courtois (2005) put it this way: "Clinicians have learned to focus on issues of safety, affect regulation, coping and self-management skills as well as on the therapeutic relationship itself" (p. 387). One does not need to be a therapist to help address these three crucial elements of healing: the development of safety, the promotion of healing relationships, and the teaching of self-management and coping skills. Some trauma intervention models add more treatment elements to the three canvassed here, such as a focus on experiences of loss and the development of future goals (Abramovitz & Bloom, 2003). In particular cases, a range of other treatment elements may need to be considered, but the three critical pillars for intervention outlined here are fundamental and universal.




## *Safety*

Major developmental theorists such as Abraham Maslow, Erik Erikson, and John Bowlby saw safety as a core developmental need of infants. Maslow numbered it among the primary survival needs while Erikson understood that the first "psychosocial" crisis for any infant is the establishment of trust (which is based on a sense of being safe).

Bowlby understood that the primary function of the so-called attachment behaviours displayed by infants (e.g., the finger grasp, the reflex smile, crying, babbling) was that of ensuring safety—where an infant fails to ensure its safety it cannot survive.[1] Harry Harlow's famous experiments with rhesus monkeys graphically showed how infant monkeys deprived of their biological mothers preferred to cling to wire-framed, towelling-covered substitute "mothers" that passively provided some measure of comfort, than to bare wire-framed "mothers" that had milk-producing teats.

Unfortunately, the defining experience of any child who has experienced complex trauma is that of feeling unsafe. These children develop a pervasive mistrust of the adults with whom they interact, and as Seita and Brendtro (2005) point out, they become "adult wary," employing a range of strategies that keep adults at bay.

## *The first imperative...is creating a safe place for them.*

It stands to reason then, that the first imperative in working with traumatised children is creating a safe place for them. Ricky Greenwald (2005), echoing the thoughts of many therapists, observes that any healing must start by creating an atmosphere of safety (p. 37), and he goes on to suggest that establishing a sense of safety may take some time but formal therapy is unlikely to be successful until this critical element is in place.

The notion of safety is multi-faceted and has many elements that need to be considered by care providers in addition to the more obvious needs for physical and emotional safety. For example, consistency, reliability, predictability, availability, honesty, and transparency are all carer attributes that are related to the creation of safe environments for children. Including the child in decision-making is also important as is the provision of knowledge about their circumstances (where appropriate). Bruce Perry (2006) places considerable emphasis on ensuring that children have appropriate power and control over their circumstances where it is developmentally and practically possible.

1 References to the works of Bowlby, Ainsworth, Erikson, and Maslow can be found in most basic social science text books, e.g., Sroufe et al. (1992) contains reference to Bowlby on pp. 20-22 and Ainsworth on pp. 205-213; Myer (1992) contains references to Maslow on p. 355 and Erikson on pp. 102-103.

The challenging behaviours of many traumatised children elicit controlling and even punitive responses from the adults who care for them. James Anglin (2002) points out that it is this phenomenon that often creates unsafe environments for children. Noting that many of the challenging behaviours of troubled children reflect their inner pain, he observes that care providers often respond to pain-based behaviours with pain-based reactions. The central challenge for carers of troubled children, Anglin maintains, is "dealing with primary pain...without unnecessarily inflicting secondary pain...through punitive or controlling reactions" (2002, p. 55).

### *Connections*

Safety itself depends on the development of the second pillar of trauma-informed care—comfortable connections between traumatised children and their care providers and mentors. Positive relationships are necessary for healthy human development, but trauma undermines these life-giving connections. Although the importance of positive relationships has long been recognised, there is now good scientific evidence from human services that these are the critical ingredients in healing and growth. For example, Asay and Lambert (1999) in their major study of what leads to positive outcomes

in psychotherapy, determined that, on average, the qualities of the therapeutic relationship itself account for twice as much positive change as the specific therapeutic techniques that are used. This mirrors the findings of research into resilience, which again points to the primacy of positive connections with caring adults (Benard, 2004).

***Treatment of children exposed to complex trauma will itself be complex and long-lasting.***

From a neurodevelopmental perspective, it appears that the brains of traumatised children have learned to associate adults with negative emotions which, in turn, lead to behaviours characterized by suspicion, avoidance, and/or outright hostility. The task for care providers and other mentors is to help restructure these associations so that the children can develop positive emotional responses (e.g., happiness, joy, feelings of security) with some adults and can learn to accurately distinguish between those who threaten harm and those that do not. If the establishment of safety is the first consideration with traumatised children and yet it is the responses of adults that often bring further pain to the children, Anglin's central challenge might be re-formulated as follows: How to prevent the corrections adults use from sabotaging connections they need!

## *Emotion and impulse management*

As indicated earlier, the most pervasive and far-reaching impact of complex trauma is the dysregulation of emotions and impulses. It has also been observed that the ability to manage emotions adaptively or to self-regulate is one of the most "fundamental protective factors" for healthy development (Alvord & Grados, 2005).

This being the case, it stands to reason that a primary focus of work with traumatised children needs to be on teaching and supporting them to learn new ways of effectively managing their emotions and impulses. Interestingly, van der Kolk (1996) has suggested that "the primary function of parents can be thought of as helping children modulate their own arousal by...teaching them skills that will gradually help them modulate their own arousal" (p. 185). Should this not then become a primary goal for the intervention efforts of others who come into contact with traumatised children?

From a neurodevelopmental perspective, the orbitofrontal cortex, which is immediately above the "orbit" of the eye sockets, has been identified as the part of the brain that is most powerfully involved in the management and regulation of emotion. The good news is that it is also the part of the brain that is the most "plastic" or amenable to change. Allan Schore (2003) has observed that "more than any other part [of the brain it] retains the plastic capacities of early development" even in adulthood (p. 265). This suggests that the capacity to learn new skills of emotion management is not limited to childhood.

There are many approaches to the teaching of self-regulation skills. For example, some traumatised children have not had the benefit of parental figures who have taught them how to calm themselves down. These children may need adults who are willing to "co-regulate" with them when their emotions run wild, rather than relying on coercive approaches (e.g., Bath, 2008). The basic skills of active listening have a central role, especially the reflective skills which promote the labelling of feelings. Recent research has confirmed that the process of consciously labelling troublesome emotions has a direct calming effect on those emotions (Lieberman et al., 2007). Active listening can lay the foundation for self-reflection and thus help children develop "stories" about their experiences, a critical element in the trauma recovery process (van der Kolk, 2003).

The literature describes a number of other promising approaches that can be used by care givers and mentors. Greene and Ablon's (2006) Collaborative Problem-Solving model is an interactive approach that teaches a young person a range of affect management skills, as are intervention formats such as Response Ability Pathways (Brendtro & du Toit, 2005) and other Life Space Crisis Intervention models (Long, Wood, and Fecser, 2001; Holden, 2001). Any approach that promotes the use of rational processing and the development of the capacity to reflect on feelings and impulses (sometimes referred to as "mindfulness") would appear to have a role in helping children to develop self-regulation skills.

## *Conclusion*

Children affected by developmental trauma need adults in their lives who can understand the pervasive impact of their experiences and who recognise that the pain from ruptured connections can lead to a range of challenging behaviours. They need adults who can develop trauma-informed approaches that

promote healing and connection. The three treatment elements outlined here can be applied by anyone who has a role in caring for, teaching, or otherwise mentoring these children and constitute the essential features of healing environments.

***Howard I. Bath, PhD,*** *is newly appointed Children's Commissioner of the Northern Territory and based in Darwin, Australia. A licensed psychologist, he is a Response Ability Pathways (RAP) trainer and has coordinated Circle of Courage activities in Australia. He can be contacted by e-mail:* hbath@twi.org.au.

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