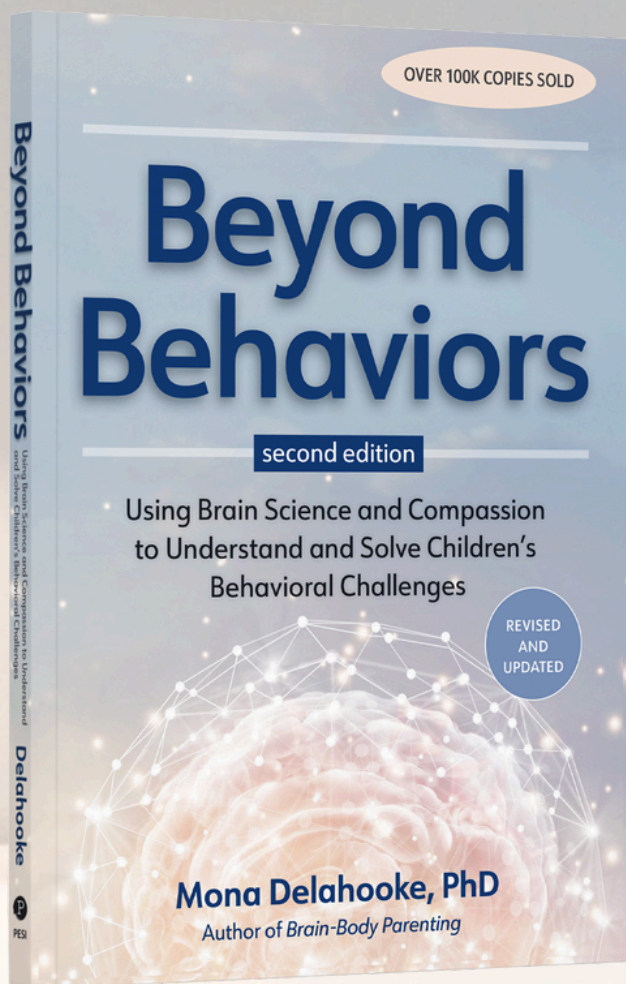


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Mona Delahooke, PhD
Author of *Brain-Body Parenting*

4

Safety Is the Starting Point

"Safety is treatment and treatment is safety."

Dr. Stephen Porges

It took only one day for me to see how Mateo's school team viewed him through a different lens than his parents and I did.*

His parents had noted his challenges early: He hadn't begun speaking yet at two and a half. After two years of in-home services and an autism diagnosis, he entered a special education program to address his challenges in communication, attention, peer relationships, and learning. Mateo's brain-wiring differences made it difficult for him to speak and to let others know what he was thinking. I was asked to work with him when he was eight, and I noticed he habitually wandered around his small special education classroom, incessantly touching the walls—and often his classmates as well.

I watched Mateo in a group-learning session, trying to get the attention of his aide seated beside him. When the aide didn't look his way, Mateo moved his arm until it glanced hers. Then she followed his IEP, which called for staff to ignore behaviors deemed as "nonpreferred." So instead of acknowledging him, she slid her chair sideways, out of Mateo's reach. He began to move his arms and torso more vigorously, leaning over and grabbing the arm of his aide, who then quietly asked him to pay attention to the teacher, and moved behind him, out of his view.

Seconds later, Mateo leaned back in his chair to see her—so far that he toppled over, landing loudly on his back. That prompted the teacher to instruct the aide to take Mateo to the "calm-down room," a plain, closet-like space in the back of the classroom with a padded floor. Looking in through the one-way window, I watched

* The ideas contained in this chapter reflect the application of Porges's Polyvagal Theory and the concept of neuroception as a guiding principle in helping children with persistent behavioral challenges.

Mateo, a flat and sad expression on his face, rhythmically kicking the wall while the aide sat to the side, avoiding any interaction.

In that one exchange, I saw evidence of all three of the concerns described in Chapter 1 about how our systems fall short in helping children with behavioral challenges: **(1) we fail to evaluate the underpinnings of behavioral challenges before we try to decrease them; (2) we don't put behaviors into the larger context of the child's social-emotional development; and (3) we use one-size-fits-all approaches.**

*As I sat in the back of the room that day, I
was reminded that we often target behaviors
for elimination before we understand
their adaptive purpose for a child.*

Too often, we assume that a child is intentionally misbehaving when the child is actually responding to basic survival instincts, including the need to feel safe.¹ We need to consider whether or not children like Mateo are misbehaving on purpose or displaying that basic human response—and to design our approaches accordingly if that ability is still under construction. In Chapter 1, we learned that there are many reasons beneath the surface for children's behaviors. For Mateo, his ability to control his own motor actions was under construction, making “appropriate” communication impossible because of his brain wiring. *Adults mischaracterized his movement challenges as challenging behavior when, in fact, they were his attempts to feel safe.*

That moment between Mateo and his aide also illustrates the most profound concern I have about how many of our systems serving children view challenging behaviors: We see *the behaviors themselves* as the main problem or target, without recognizing that relationships and social engagement are key to helping children build behavioral and emotional control.² **Before we attempt to suppress behaviors, we need to ascertain whether the behaviors we are observing are a sign of a child's social engagement system in need of relational help.**

As I sat in the back of the class, watching Mateo descend into increasing levels of emotional distress, I heard Dr. Porges in the back of my mind: “To connect and to co-regulate with others is our biological imperative.”³ I was there to observe, but I had to stop myself from approaching the child and connecting with him myself. I looked around the room, expecting to see other adults who were concerned as I was about the child's emotional state. Instead I saw everyone trying to ignore the situation and continue teaching the other kids. It was a snapshot of valiant teachers and support staff following a mainstream approach to behavioral management,

with the best of intentions. But as I mentioned in Chapter 1, that approach stands in contrast to what I have learned from translational neuroscience: the importance of relational safety in all aspects of child development. I returned to my office that day and wrote about the experience, adding it to similar entries in my journal and pondering how to explain to his loving parents and his dedicated school team what I had witnessed.

When the aide misread Mateo's bids for help as noncompliance and moved her chair away, he moved from the green to the red pathway. Ironically, the plan to help the child *increased* his distress and further compromised his ability to co-regulate his emotions with others. The behavioral signs I observed—flat facial expression, kicking the wall, giving up on asking for help—were all signals that his social engagement system had fatigued, yielding to the older brain circuitry linked to more basic survival instincts.

Personalized Attunement

The rest of this book focuses on how we can update the ways we help children by using approaches that respect the role of relationships in all areas of a child's development. I call this overarching approach personalized attunement: a way to tailor our interactions to meet each child's physical and emotional needs. We will learn how to use our knowledge of individual differences and how to leverage relationships and the environment in order to build the strongest foundation for development through the following steps:

1. Prioritizing the child's feelings of safety in relationships
2. Addressing the causes and triggers underlying the behaviors
3. Helping the child to develop new ways to cope

Practicing personalized attunement allows us to determine what each child needs in order to promote responsiveness, warmth, and engagement.

In this chapter, we'll focus on the first of the three steps: prioritizing relational safety for each child. We start here because I have observed that often, once a child's relational safety needs are properly met, many behavior challenges fade away naturally because the underlying reasons for the behaviors no longer exist.

Priming a Child for Success

Many of the techniques I learned decades ago in my psychology training conflict with what we now know about the workings of the autonomic nervous system. I was taught to view behaviors mainly at face value—as easily amenable to an array of cognitive and behavioral techniques aimed at changing them. This was

well before the 1990s, known as the “Decade of the Brain,” when neuroscientists’ new understandings of the brain became widely known. The approaches I learned in school oversimplified ways to alter behaviors, mostly emphasizing the child’s *thinking brain* without considering the essential foundation that underlies all brain development: relational safety and emotional co-regulation.

As we learned in Chapter 2, the Polyvagal Theory sheds new light on the importance of adults’ behaviors on the child’s feelings of safety.⁴ When a child feels truly safe with a trusted adult, social-engagement behaviors emerge naturally. When a child experiences the neuroception of safety, defensive strategies are “turned off.”⁵ In other words, the child doesn’t need to fight, run away, or freeze up in order to feel safe on a subconscious level.

As in Mateo’s case, when our actions diminish a child’s sense of safety, we prime the child’s system for defensive behaviors.⁶ The behaviors that concerned his teacher—his wandering and constantly touching things in the classroom—were his way of coping with a neuroception of threat. He was a child with sensory overreactivity to sounds and underreactivity to proprioception, a child whose body needed to move in order to feel calmer and to find comfort in the physical environment and in others. **His attempts to touch his aide were not acting-out behaviors but rather reaching-out behaviors. They reflected a biologically based strategy that human beings use to feel better when they are distressed. Yet we often label this strategy as misbehavior or negative “attention seeking.”**

In short, I viewed Mateo’s behaviors in class that day as his way of adapting to a suboptimal relational and physical environment that was ill suited to his individual needs. All children will benefit when we consider how to prime a child’s nervous system for success by acknowledging and respecting the child’s individual differences *and* need for relational connection.

Determining Neuroceptive State

When a child experiences a neuroception of safety, there’s no need for protective, defensive behaviors characteristic of the red pathway.⁷ As the child relaxes onto the green pathway, cooperation, learning, play, and curiosity emerge naturally. Let’s look at characteristics of the red and blue pathways that signify a child’s adaptive responses to stress. Notice that I suggest that blue-pathway behaviors indicate very high levels of perceived threat. This is because the red pathway involves activation, or doing something active to feel better, which is more adaptive than disengaging, fading away, or dissociating. The blue pathway, in its final stages, indicates that the child’s mind/body is essentially giving up and beginning to shut down in the face of a perceived life threat.

Is the Child Feeling Safe?

Characteristics of the **Red Pathway**

Look at the child's behavioral features, and mark any that you see.

- ☐ Face is angry, disgusted, clenched jaw, grimacing
- ☐ Face has raised eyebrows, furrowed brow, trembling lips or mouth, fake forced grin, startled expression, looks worried or scared
- ☐ Eyes may dart around, avoid or have intense eye contact, roll upward
- ☐ Child has fast or repetitive movements, trembling hands, clings, grabs, or flails around
- ☐ Child moans, groans in pain, quivering, whimpering sounds
- ☐ Voice is high-pitched, loud, sarcastic, screaming, hostile, grumpy; uncontrolled laughter
- ☐ Body in motion, hitting, kicking, biting, spitting, pushing, shoving; threatening gestures
- ☐ Body motions are impulsive; child may bump into things or fall

How much time did the child spend in the red pathway?

_____ minutes

What did adults do with the child when they were in the red pathway?

If you checked multiple boxes, consider that the child may be picking up threat in the physical or relational environment.

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Is the Child Feeling Safe?

Characteristics of the **Blue Pathway**

Look at the child's behavioral features, and mark any that you see.

- ☐ Face looks flat, especially around eyes and forehead
- ☐ Voice sounds monotone, soft, and lacking in inflection or prosody
- ☐ Child is not talking or is making few sounds
- ☐ Child does not appear to be hearing what you are saying
- ☐ Body is slow-moving; posture is slumped or frozen
- ☐ Child cowers or hides
- ☐ Child avoids interaction

How much time did the child spend in the blue pathway?

_____ minutes

What did adults do with the child when the child was in the blue pathway?

If you checked multiple boxes, consider that the child may be picking up **very** high levels of threat in the physical or relational environment.

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Signs that a child is in the blue pathway often include a flat facial expression, a monotone voice, and a lack of interaction. In the red pathway, a child can physically have difficulty hearing, caused by the loss of neural tone that regulates the middle-ear muscles.⁸ Before we decide on how to intervene, we should carefully observe these features of the child's face, voice, and postures.

Safety Is in the Eye of the Beholder

How can we know whether a child feels safe? What's important is the child's own *perception* of safety—not what adults think *ought to* constitute relational or environmental safety. In short, safety is in the “eye” (brain and body) of the beholder: the child. It is “defined by how the child feels, and not simply by the removal of threat.”⁹ I call this determining whether a child feels “Brain-Safe.” We need to work toward providing what each child *interprets* as safety. What's critical isn't the general notion of an “optimal” environment, but each child's *response* to the environment. Many current treatment approaches and plans don't consider this important distinction. As much as possible, we need to tailor the physical, sensory, and relational environments to the needs of *each* individual child with persistent behavioral challenges and not make assumptions about what the child perceives as environmental or relational safety.

Providing relational support on the front end can be more cost-effective in the long run because it saves us from spending time and money on plans that don't target the root causes of the behaviors. We can recruit new or existing personnel as emotional co-regulators to help support a child back to the green pathway as the first line of treatment. This concept is often overlooked when we fail to see relationships (with, for example, sensitive classroom aides) as essential elements of treatment plans. That obsolete view is not supported by current neuroscience principles about psychological resilience.¹⁰

We can recruit new or existing personnel as emotional co-regulators to help support a child back to the green pathway as the first line of treatment.

A powerful modulator of a child's stress response is the safety of a relationship. That doesn't mean that the mere presence of a qualified adult is sufficient. We need to know *how* to help each child feel safe in mind and body. In my experiences as a child psychologist, I've found that with a modicum of training, adults can learn ways to *titrate their interactions* to provide the right cues of safety, according to each child's unique needs.

Max Tailoring Relational Safety

Ten-year-old Max had multiple developmental delays and suffered from such severe anxiety that he routinely refused to leave his home to go to school. He was referred to my office for his long history of “school refusal.” His parents had to “talk him out the door” each morning, and at school he often refused to speak, sometimes suffering meltdowns. He also had difficulty attending to his classroom work. The school assigned an aide to assist him academically, yet his difficulties continued.

During a subsequent school observation, I witnessed Max sucking on his fingers and biting his nails. His well-intentioned aide tried to help him follow the teacher’s directions and keep up with his classwork by whispering to him to pay attention and helping him focus on each worksheet. What seemed to be missing, though, was an approach that considered Max’s emotional state before focusing on academic tasks. He was clearly showing signs of distress throughout the school day, but his support plans didn’t specifically address ways to support his emotional and regulatory state. When his parents asked the school to provide additional individualized, relationship-based training for the teacher and aide, the administrators refused, insisting that the aide was a long-standing employee with a good track record.

The problem was that Max’s IEP plans were not effective in curbing his anxiety. His aide was in a losing battle to help him academically because his development was shaky at the foundations of regulation, attention, and social engagement. I suggested that the teacher and aide hone their emotional co-regulation skills with Max. (I explain how educators and other providers can do this in my book *Social and Emotional Development in Early Intervention*).

In short, Max was not progressing at school because his treatment plans failed to recognize the powerful importance of relational safety underlying his anxiety and affecting his ability to learn.

Instead of using a generic lens to define emotional safety for all children, we should use the lens of each child’s perceptions, based on the child’s individual differences. Schools are wise to engage in discussions with parents and include them in the process of selecting the appropriate types of relational support for their child, because a child’s emotional state has direct impact on the ability to learn. In my experience, classroom aides and paraprofessionals often are excluded from children’s IEP team meetings. Instead, we need to honor the important role of paraprofessionals as essential emotional co-regulators with children and include them in those important gatherings.

Personalized Attunement: Safety Is in the Eye of the Child

Ask: Does the child perceive the adults in their life as supportive and providing cues of safety?

If so, what are the behavioral indications that the child perceives the adults in their life as providing safety cues?

If not, what are the behavioral indications that the child *does not* perceive the adults in their life as providing safety cues?

Determine how to increase safety cues to the child by communicating with the child's parents/caregivers and through careful observations of interactions.

What kinds of social interactions with caregivers help propel the child onto the green pathway of relational safety?

List:
