

Colby Pearce

Connected Classrooms that CARE:

**Supporting children
recovering from a tough
start to life in an era of
COVID-19**

Secure Start® Publications

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Prologue: *Punishment is Problematic*

People do not act for no reason.

They may act in response to a thought.

They may act in response to an emotion.

They may act in response to a need that requires satisfaction.

They may act in response to something that has occurred in their environment.

They may act because the way their brain developed impairs their capacity to think before they act in the presence of a trigger (stimulus).

If we accept the truth that people do not act for no reason, then we must similarly accept that when we punish a child for their actions without any effort to try to understand why they did what they did, we are essentially communicating to them that their thoughts, feelings, needs, experiences and biological characteristics are unimportant or invalid. Repeated often enough, the child develops the belief that **they** are unimportant and invalid.

The consequences of invalidation include behavioural problems, emotional problems, preoccupation with needs and a lack of regard for the impact of one's behaviour on others.

We can avoid reinforcing problem behaviour in children by responding with understanding to the reason for their behaviour and, in doing so, nourish connections that support self-regulation and positive behaviour.

Introduction

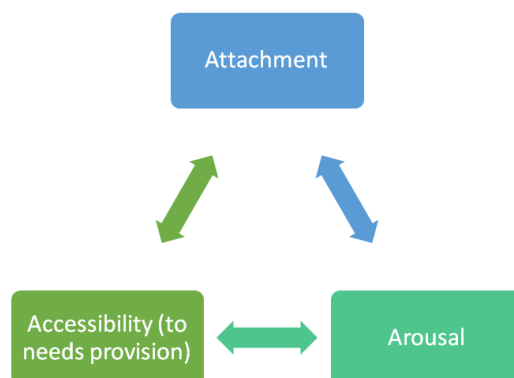
Hi. I'm Colby Pearce. I am a Clinical Psychologist in Australia and author of *A Short Introduction to Attachment and Attachment Disorder*, and *A Short Introduction to Promoting Resilience in Children*. I am also the author of the Triple-A Model of Therapeutic Care, a comprehensive training program for general and relative foster carers which is in its fifth year of implementation in the TUSLA Fostering Service in Donegal Ireland. Further, I am the author of the CARE Curriculum, which was delivered as part of the Kinship CARE Project to statutory kinship carers in South Australia over the past two years.



Very few people will get through this global pandemic without being affected in some way. Some will cope better than others. Our prior life experiences can be a help, or a hindrance. Those who have experienced adversity in the past, and overcome it, will likely fare better during these difficult times. Those who have experienced overwhelming adversity, from which they have not or are yet to recover, are likely to be particularly impacted.

Children and young people who are recovering from a tough start to life are vulnerable to being particularly impacted by the current pandemic, and measures to control it. The pandemic has suddenly, and with little or no prior warning, made uncertainty, confinement, and restriction (including in relation to access to basic needs) salient aspects of our day-to-day experience. While this is stressful for most of us, it can be particularly stressful for children and young people in who are recovering from a tough start to life. It can put (additional) strain on their home and educational placements at a time of reduced capacity to absorb additional pressures.

Uncertainty, including in relation to our health and the health of our loved ones, our access to basic needs, and what the future holds, is anxiety-evoking. It can leave us preoccupied with accessing basic needs and lead us to behave in ways that increase our chances of being able to achieve needs provision, and feel safe. Uncertainty, coupled with the media coverage of the pandemic, can leave us experiencing ourselves as inadequate, others as threatening and dangerous, and the world as unsafe.



The current uncertainty, and its psychological impacts on us, provides an insight into what life is like for children and young people who are recovering from a tough start to life. It affects the beliefs we hold about ourselves, others, and our world that influence our approach to life and relationships. I refer to these beliefs as attachment representations. They are also commonly referred to as internal working models, or schema. It leaves our motor (that is, our nervous system) running too fast, or too highly activated, and vulnerable to blowing up. It is shaping our learning about our access to needs provision and what actions are required to assure access. Our own response to the pandemic reflects the Triple-A Model¹, which I developed to explain what I have observed across a long career about the impact of a tough start to life on the psychological functioning of children and young people and their approach to life and relationships.

If, in these troubled times, we are vulnerable to becoming a little (or a lot) like children and young people who are recovering from a tough start to life, imagine what it is like for them. In these times there is a heightened vulnerability to regression to approaching life and relationships under the influence of negative beliefs about self, other, and world, heightened arousal and anxiety proneness, and a preoccupation with accessibility to needs provision.

The current times, with its change and uncertainty, restriction, and increased physical closeness to adults who themselves are stressed are likely to be trauma-triggering for children and young people who are recovering from a tough start to life. As adults who interact with them in a care and management role, you may see emotional displays and behaviours you have not seen in some time, or a heightening of emotional displays and behaviours. Managing these trauma-related emotional displays and behaviours can leave you feeling below your best and negatively impact your approach to your role. A problematic cycle can emerge where stressed children and young people and stressed adults heighten each other, leaving classroom placements under pressure and vulnerable, notwithstanding our best intentions in less troubled times.

What is needed now, more than ever, is a plan for how adults who interact with them in a care and management role can reduce the impact of these troubled times on the children and young people they are working with, and themselves. The CARE Curriculum offers such a plan.

In the CARE Curriculum, CARE stands for:

- Consistency
- Accessibility
- Responsiveness
- Emotional Connectedness

Children and young people who are recovering from a tough start to life benefit from a little extra CARE.

After reading this resource you can expect to have a conceptual framework for understanding the impact of a tough start to life on the developing child and be able to develop and implement a plan to support their positive approach to life and relationships based on familiar aspects of caregiving and relating. You will also be able to problem-solve in relation to ongoing behaviours of concern and implement practical steps to address them. Further you will be able develop and implement a practical self-care plan that supports your best efforts on behalf of children and young people who have experienced a tough start to life, and positive outcomes for them.

Throughout the resource I mostly refer to *child* or *children* for ease of expression, but would have you keep in mind that the information and strategies contained herein are applicable to *children*

and young people – including teens. I also use the more generic words ‘caregiver’ and ‘caregiving’ instead of ‘teacher’ and ‘teaching’ in recognition of the *in loco parentis* role educators fulfil while children and young people are at school.

I wish you well in your endeavours and hope that this resource:

- confirms and validates what you already know and already do; and
- enriches, in some way, your knowledge and approach to the care and management of children who have experienced a tough start to life.

Colby Pearce
May 2020

¹ Pearce, C.M. (2010). An Integration of Theory, Science and Reflective Clinical Practice in the Care and Management of Attachment-Disordered Children – A Triple A Approach. *Educational and Child Psychology (Special Issue on Attachment)*, 27 (3): 73-86

If you can't explain it simply, you don't know it well enough.

- Albert Einstein

Part 1: Three things you need to know about the impact of a tough start to life

A tough start to life adversely impacts three key factors that play an important role in the developing child's approach to life, learning/development, and relationships:

- Attachment (or, how the child thinks about, and interacts with, themselves, others and their world);
- Arousal (or, the psycho-physiology of performance, emotion and behaviour activation systems);
- Accessibility to needs provision (or, what the child has learnt about the accessibility and responsiveness of adults in a caregiving or caretaking role).

Attachment refers to the dependency relationship an infant develops to his or her primary caregivers during the first years of life. Our knowledge of attachment derives from Attachment Theory. Attachment Theory was initially developed in the 1940's, in part to account for observations that were being made of institutionalised children and those who experienced prolonged separation from their primary caregivers; including by reason of lengthy hospital admissions and those children displaced from their families during World War II². Since its early development, Attachment Theory has been the focus of an enormous amount of research and has become widely used in child protection as it offers an explanatory framework for differential outcomes for children based on caregiving practices. In addition, Attachment Theory informs us about a child's relationship with themselves, others and their world.

Relationship with:

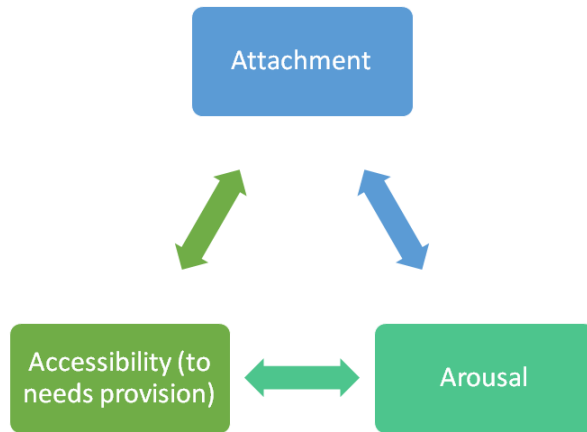
- Self
- Other
- World

- Performance
- Feelings
- Behaviour

Arousal refers to the level of activation of the nervous system. From a psychological point of view, arousal is significant for (at least) three reasons. Firstly, arousal affects how well we perform tasks, and activities more generally. Secondly, arousal is implicated in how we feel. Thirdly, arousal is implicated in how we behave, including our approach to life and relationships. In particular, arousal is implicated in the behaviour activation system that is activated when individuals perceive a threat to themselves or someone close to or close by them and their associated feeling of anxiety (known as the *fight-flight-freeze response*).

Accessibility to needs provision refers to what children have learnt about the reliability and predictability with which their needs will be addressed by adults in a caregiving role, and learnt behaviours that serve to reassure the child that their needs will be satisfied. Accessibility to needs provision is based on Learning Theory and the Operant Conditioning paradigm^{3,4}.

What children have learnt



In combination, I refer to these three factors as the “Triple-A Model”; or “Triple-A” for short⁵. In the sections that follow I will explain each factor further and how it is impacted by a tough start to life. Thereafter, I will present practical strategies and a plan for supporting optimal adjustment at school that supports and extends endeavours to facilitate the child’s recovery from a tough start to life.

Attachment

I am always moved by images of lions and other wild animals forming a strong bond of love and affection towards a human. Whenever I see such images a question forms in my mind as to just what the human did to engender such a relationship? The conclusions I draw in the case of lions is that the human would have had to:

- Be recognisable to the lion;
- Spend time connecting with the lion;
- Assure the lion that he or she posed no threat and could be trusted and relied upon (*provide* the food, as opposed to *being* the food);
- Take time to understand the experience of the lion and adapt their approach to the lion based on its moment-by-moment experience; and
- Enjoy being with the lion.



Similarly, I have long been fascinated with the bonds human infant’s form to the human adults on whom they depend. For a human infant to form a joyful bond to an adult caregiver that person would have had to:

- Be recognisable to the infant;
- Spend time connecting with the infant;
- Assure the infant that he or she posed no threat and could be trusted and relied upon;
- Take time to understand the experience of the infant and adapt their approach to the infant based on its moment-by-moment experience; and
- Enjoy being with the infant.

Like other species in the animal kingdom, human infants are thought to be genetically *programmed* to form a dependency relationship to the most available adult. They cry to attract the attention of a caregiving adult and, over time, they develop an expanding repertoire of behaviour to maintain contact and involvement with that adult (e.g. smiling, reaching, calling and following). So long as the adult spends some time with the infant and addresses at least some of their needs, the infant will form an *Attachment* to this adult.

The quality of care the infant receives from the nearest and most available adult impacts the type of attachment the infant develops to that adult, and the infant's *attachment style*. An attachment style reflects the manner in which an infant approaches and responds to adults in a caregiving role, and influences the infant's approach to all relationships. A child's attachment style *actively* develops during the period 6-8 months of age through to four years of age. Children can form different attachment relationships to different caregivers, depending on their experience of caregiving from that caregiver. However, their attachment style reflects their experience of dependency on, and relatedness to, their main caregivers during the early attachment period, whom we refer to as the child's *primary attachment figures*.

There are four main types of attachment style that have been identified via extensive research^{6,7}:

- Secure
- Insecure Avoidant
- Insecure Ambivalent
- Disorganised

A *Secure* attachment style is recognised in those children who use attachment figures as a safe base and source of feelings of wellbeing from which to launch into the world and explore without undue anxiety. When these children are distressed during the early developmental period, they are easily soothed at reunion with their primary attachment figures and soon launch back into the world again. They check back in with their attachment figures at longer and longer intervals, thereby increasing their tolerance of separation and distance from their attachment figures. Approximately 60% of children in western countries are thought to have a secure attachment style. A secure attachment style is optimal for exploration and development.



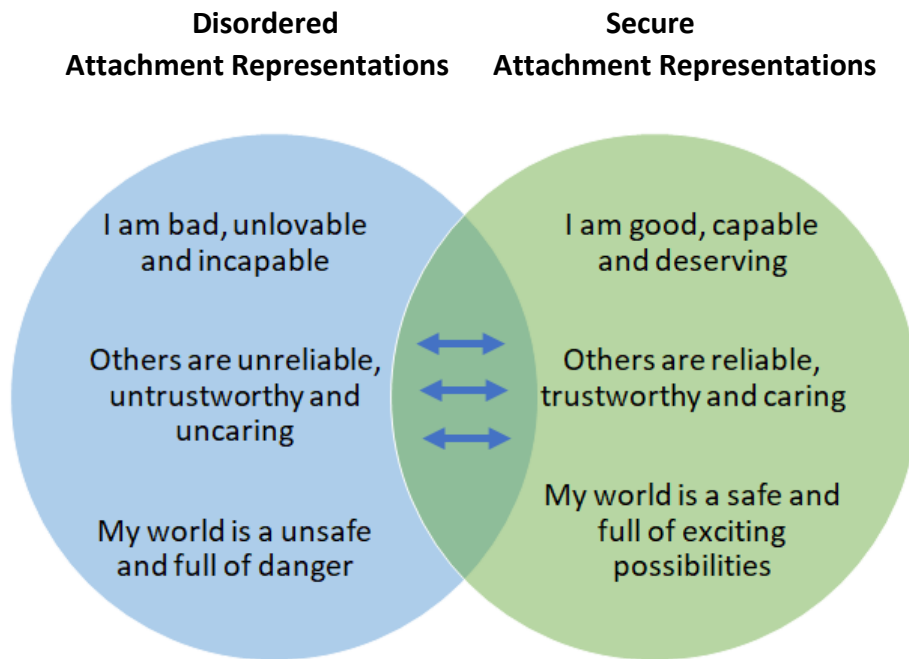
An *Insecure Avoidant* attachment style is recognised in those children who do not consistently use their primary attachment figures as a safe base and source of feelings of wellbeing from which to launch into the world. When these children are distressed during the early developmental period they are not readily soothed by reunion with or closeness to their primary attachment figures. Their exploration of, and interaction with, their environment/world is limited by the restricting and debilitating effects of unresolved distress, which arises from their tendency to not seek relief from distress from their attachment figures. Though they may appear self-reliant, they are in-fact highly anxious.

An *Insecure Ambivalent* attachment style is recognised during the early developmental period in those children for whom closeness to or reunion with their primary attachment figures is not sufficiently comforting or reassuring for them that they can launch out into their world and tolerate separations. As a result, they appear preoccupied with maintaining closeness to their primary attachment figures and might be observed to be clingy and/or demanding. As is observed with *insecure avoidant* children, their exploration of, and interaction with, their environment/world is limited by the restricting and debilitating effects of unresolved distress, which arises from their inability to draw comfort from the presence of, and interaction with, attachment figures.

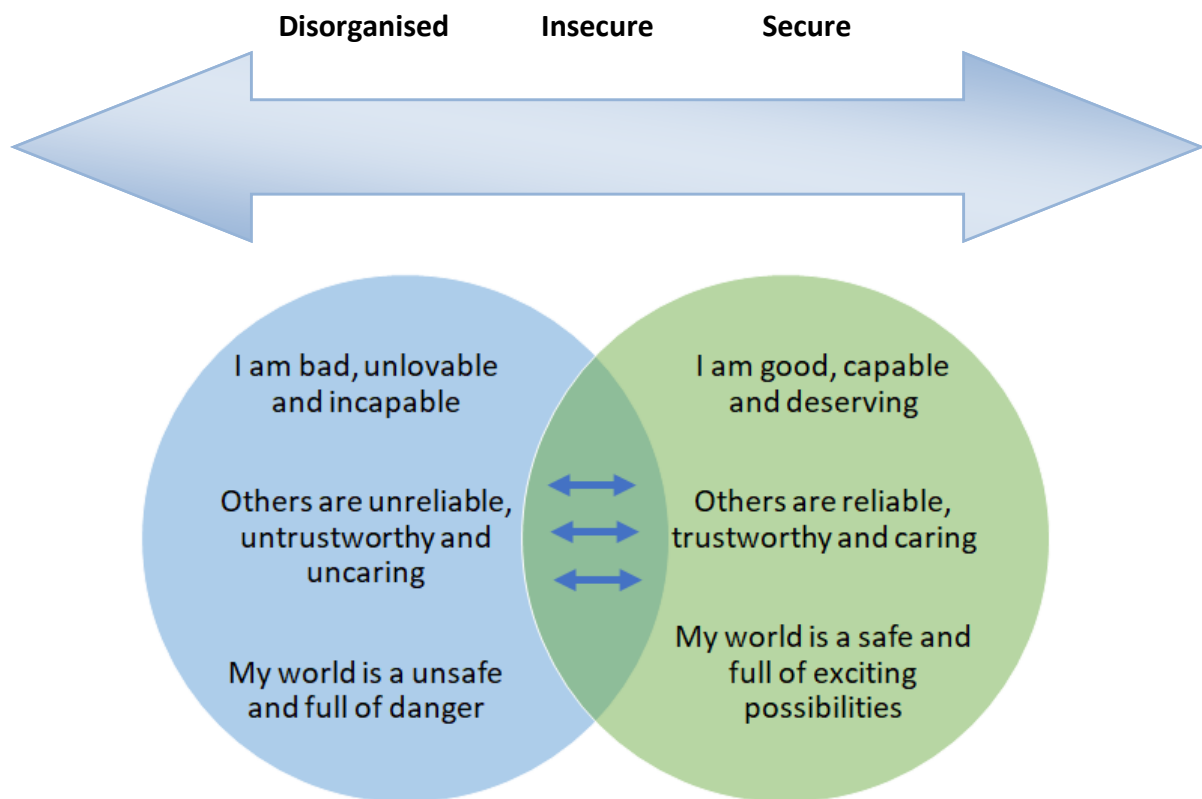


While insecure attachment styles make up the greater proportion of children who do not have a secure attachment style, a relatively small group of children develop what is referred to as a *Disorganised* attachment style. A Disorganised attachment style is recognised during the early developmental period in children who show contradictory behaviour towards their primary attachment figures. They might be observed to need their attachment figure, as all children do, but also appear as though they want to create distance from that person. They might be observed to approach their attachment figure, only to stop and look away before full reunion occurs. They may also seek to be held but do not orient to their attachment figure from the lap. As is observed with *insecure* children, their exploration of, and interaction with, their environment/world is limited by the restricting and debilitating effects of unresolved distress. However, unlike insecure children, their first attachment figures are likely to have been the *source* of fear and distress. Children who have a disorganised attachment style approach life and relationships in a grossly disturbed manner and require specialist intervention and guidance for their parents and caregivers.

Attachment styles are influenced by the care children experience, initially from their primary attachment figures, and on an ongoing basis by adults with who interact with them in a care and management role. Attachment styles are reflected in the beliefs children and young people form in relation to themselves, others and the world in which they live. I refer to these beliefs as **Attachment Representations**. Other names include *internal working models*, *core beliefs*, and *schema*. Attachment representations vary according attachment style. Attachment representations are not always held in conscious awareness, but they are easily made conscious and are recognisable in the way they influence a person's approach to life and relationships via the feelings and behaviours they evoke.



Attachment representations are positive (secure) or negative (disordered). However, contemporary attachment theorists think of attachment security as a spectrum. In terms of attachment representations, this spectrum provides an indication of the relative influence of attachment representations over a person's approach to life and relationships.



Children who have a secure attachment style approach life and relationships predominantly under the influence of secure attachment representations. Though they sometimes think in a disordered way (as we all do) depending on their contemporary experiences (hence the bi-directional arrows), their predominant way of thinking about themselves, others and their world is optimistic. As a result, their approach to life and relationships is generally optimistic and they attract positive experiences that maintain and strengthen their secure attachment representations.



In contrast, children who have a disorganised attachment style are most likely to approach life and relationships under the influence of disordered attachment representations. A consequence of this is behaviour that serves to control and regulate their circumstances and interactions with others in order to feel remotely safe and secure access to needs provision. Such behaviour often provokes a negative reaction in others, such that their negative attachment representations are reinforced and strengthened. For these children, an important goal in any caregiving endeavour is to provide experiences of care that support the adoption and maintenance of secure attachment representations.

Children who have an insecure attachment style occupy the middle ground. They appear to be unsure about themselves, others and their world and somewhat under the influence of *both* positive and negative attachment representations. This leaves them prone to engaging in behaviours intended to resolve their uncertainty, such as attention- and reassurance-seeking behaviours. Unfortunately, such behaviours may provoke a negative reaction in others, such that their insecurity is reinforced.

A secure attachment style, and associated secure attachment representations, is optimal for a positive approach to life, learning, and relationships. Children who have experienced a tough start to life are vulnerable to spending increased time approaching life and relationships under the influence of disordered attachment representations. This negatively impacts all aspects of their approach to life and relationships; in the home, at school, and elsewhere. And yet, a child's predominant attachment style (and time spent under the influence of associated attachment representations) is continuously evolving and responsive to their experience of life and relationships. *It is imperative that adults who care for children who have experienced a tough start to life do so in a manner that promotes and strengthens time spent under the influence of secure attachment representations.*

Arousal

Cast your mind back to the lion and the man. The affectionate bond the lion appears to have towards the man, as also occurs between human infants and their primary caregivers, is founded on the lion experiencing the man as safe and non-threatening. It is also founded on the lion seeing the man as a *provider* of food, as opposed to *being* the food! In fact, as mentioned above, it is likely that the lion has little to worry about in the care of such a man, and this is highly significant. Were the lion to experience the man as unpredictable and threatening, the lion is more likely to approach the man in a very different manner!

Anxiety is the term we use to refer to our emotional experience when we feel unsafe and/or threatened. Anxiety is an unpleasant emotion, characterised by feelings of uneasiness, distressing thoughts, and unpleasant physical sensations. Like shame, for example, anxiety is an emotion that most people avoid experiencing, if they can. In this sense, anxiety is an emotion that exerts an important regulating influence over our behaviour. It stops us from doing risky things. However, in children it also has the effect of restricting their exploration and, in turn, aspects of their development¹.

Through human evolution, anxiety became part of the emotional repertoire of all human beings for some very important reasons. Anxiety kept our ancestors alive long enough to have children and pass on their genetic characteristics, including the capacity to experience anxiety, to the next generation. When life-threatening situations could not be avoided, anxiety became associated with the activation of an instinctive physiological and behavioural response system that served to enhance survival under conditions of extreme threat of loss of life. Thus, the anxiety response was passed from generation to generation, such that it is now a universal aspect of being human.

Physiologically, when we experience anxiety our body reduces blood flow in the extremities of our vascular system in order to increase the chance of survival from physical injury. This happens throughout the body, including in the brain. The consequence of reduced blood flow to the outer parts of the brain is that the parts that are responsible for thoughtful consideration, planning and effective action (a.k.a. executive functions) are turned down or off and the parts of the brain that are responsible for instinctive, survival responses are turned on. Where the blood goes, that is that part of the brain that is in control.

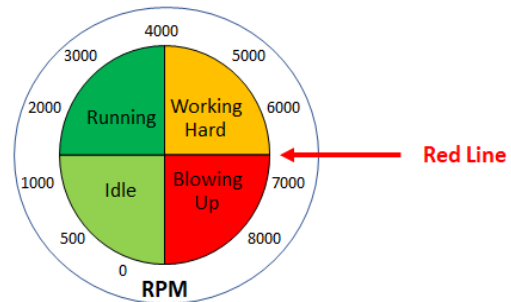
The instinctive behaviour response system that is initiated when a human is anxious is referred to as the fight-flight-freeze response. In children, this presents as:

- **Fight:** Controlling, Demanding, Aggressive, Destructive;
- **Flight:** Avoiding, Running, Hiding, Hyperactivity; and
- **Freeze:** Reduced Responsiveness.

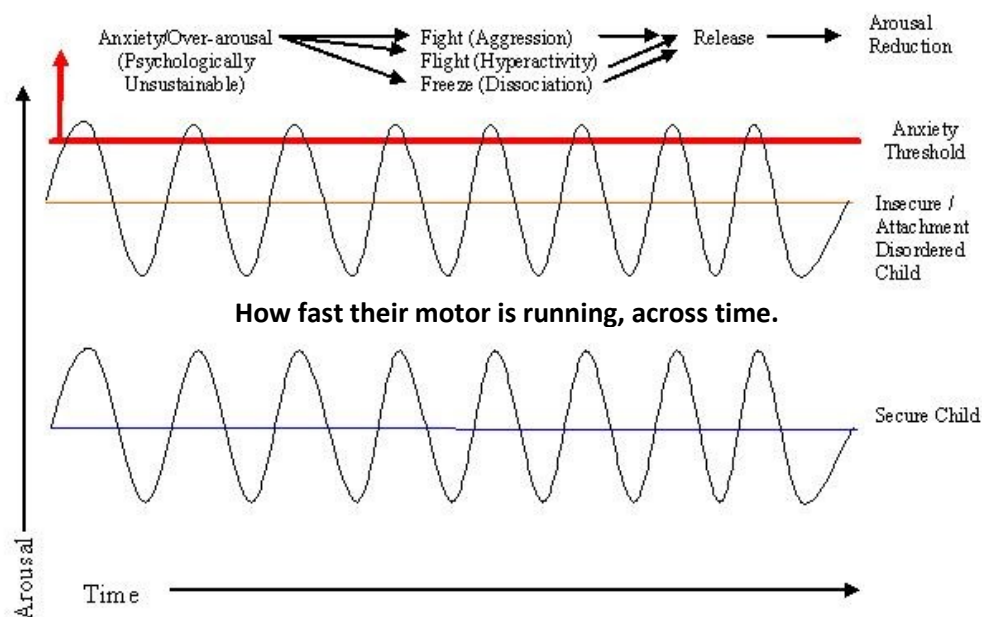
¹ A child's understanding of their world and development of skills are supported by exploration. Hence, any restriction to exploration will likely have a corresponding impact on the child's developing understanding of their world and skills to negotiate it.

The underlying physical and psychological imperative that drives these non-volitional behaviours (that is, the behaviour is not the result of any decision by the child, or choice of the child) is self-preservation and the restoration of feelings of safety. Sadly, for a great many children it is not often seen as such or responded to as such by adults who are responsible for their care and management at a given time.

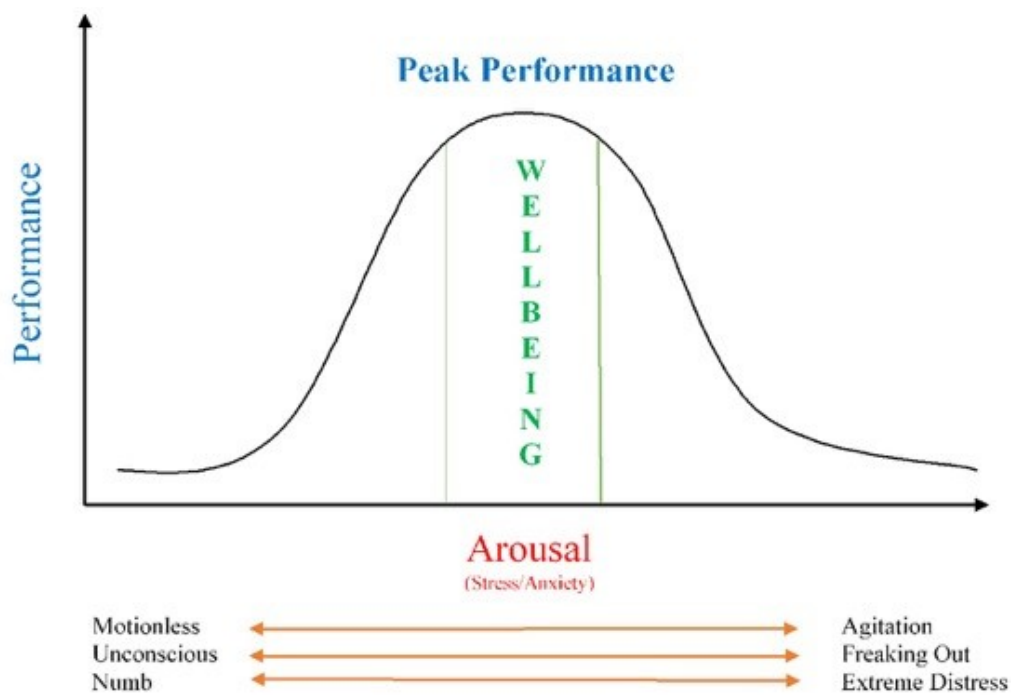
The anxiety response is tied to high levels of physiological *arousal*. Arousal refers to the level of activation of a person's nervous system. Each person's nervous system can be likened to the motor in a car. As with the motor in a car, a person's 'motor' has a speed at which it idles, a typical running speed, and a speed at which it 'red-lines'. The level of activation of the nervous system (arousal) increases with sensory stimulation, just as the speed at which the motor is running increases with depression of the accelerator. The 'speed' at which the person's 'motor' is running also increases depending on how the person interprets experiences. Negative interpretations increase arousal, and the combination of high arousal and the perception of threat will almost always precipitate anxiety and the fight-flight-freeze response.



The difference between one person and another is how close to the 'red-line' their idle is set and, therefore, how much they can tolerate increases in arousal when they perceive a threat. The 'motor' of children who have experienced a tough start to life typically idles faster than those who have not. This is the result of repeated experiences of emotional distress and/or inconsistent soothing of their distress. These children are also more likely to feel threatened and unsafe as a result of the way in which they predominantly think about themselves, others and their world (*attachment representations*). This combination leaves them more prone than others to anxiety and activation of the fight-flight-freeze response (see below).



A further problem among children who have experienced a tough start to life is that their proneness to high levels of arousal can impair their performance in all settings, including their learning at school. This is due to the relationship between arousal and performance, as represented in the figure below. Going by the name Yerkes-Dodson's Law⁸, we do not think at our best, feel at our best and perform at our best when our arousal is too high or too low. Rather, we perform best in a state of calm alertness.



In order to reduce the incidence of behaviours associated with anxiety and the fight-flight-freeze response, and support development and learning, it is vital that strategies are implemented that help to maintain more optimal levels of arousal in the child that has experienced a tough start to life, and slow their idle!

Accessibility to Needs Provision

I am going to return to the lion and the man one more time. It is apparent that the lion views the man as a source of care and positive relational experiences. As mentioned earlier, it is also likely that the lion sees the man as a *source* of food, as opposed to seeing the man *as* food. That is, he appears to *have learnt* that the man is a reliable and responsive source of needs provision.



Similarly, infants *learn* what to expect from adults based on their experience of needs provision. Infants learn to trust and depend on the nearest available adult when that person:

- feeds them;
- soothes them;
- cuddles them;
- plays with them;
- talks to them; and
- protects them . . .

. . . reliably, predictably, and accurately.

In the 1930's, a psychologist by the name of Skinner was carrying out experiments in relation to his ideas regarding learning. Skinner theorised that humans learn what behaviours or actions are useful to them, and what are not, depending on whether the behaviour or action achieves a desired outcome. Those that achieve a desired outcome are incorporated into the person's behaviour repertoire; those that don't are not. Skinner was particularly interested in language acquisition in infants and had observed that, over time, infants tend to vocalise using words that precipitate a desirable emotional and behavioural response from their caregivers and drop those that do not. If you are unsure what I am referring to here, think about what happens the first time an infant says "Ma" while vocalising in the presence of their mother.



In order to test his ideas, Skinner developed an apparatus that has since been known as a "Skinner Box". As the name suggests, the Skinner Box is a box-like apparatus that contains a chute and a button or lever that controls the release of food via the chute. At different times Skinner placed rats or pigeons in the skinner box and observed what happened. The idea was that sooner or later the animals would depress the button or lever and receive a food reward via the chute as a result of doing so.

Skinner considered that if the animal received a food reward for depressing the button or lever, they would continue to do so as the behaviour is reinforced. And this is exactly what happened. As might be observed in the classroom where children learn to raise their hand to get the attention of the teacher, the animals in Skinner's experiments soon learnt to press the button or lever to access food.

Having established that his theory/apparatus worked, Skinner set about testing his ideas. He began to manipulate the conditions under which food was delivered for presses of the button or lever. For a given group of subject animals, one-third were placed in a condition where they received a food reward for every press of the button or lever. In this condition the behaviour (pressing the button/lever) was **consistently reinforced**. The animals in this condition *quickly* learnt to press the button or lever in order to access food and, once they did, only pressed the button/lever at a rate that might be interpreted to reflect their desire or need for food.

The second group of animals received a food reward inconsistently (**intermittent reinforcement**) when pressing the button or lever. Sometimes they did, and sometimes they did not. These animals were *slower to learn* to press the button or lever to access food than the animals that were consistently reinforced. However, once they did learn that they could access food in this way, they pressed the button/lever at a high rate and with great persistence. They appeared to be preoccupied with the means of achieving needs provision and displayed a degree of agitation in doing so.

A third group of animals did not receive a food reward (**no reinforcement**) for pressing the button or lever. These animals soon lost interest in the button/lever.

There are two conclusions to be drawn from these findings:

1. Consistent responsiveness is optimal for learning; and
2. Inconsistent responsiveness to needs provision is stressful.

After Skinner had 'conditioned' animals about what to expect from the button or lever, he changed the conditions. He made a food reward available to those animals who had not received it in the first condition. Having lost interest in the button/lever, these animals were unlikely to learn that they could now access food by pressing it.

Skinner also stopped offering a food reward to those animals that had been conditioned to expect food every time they pressed the button or lever. These animals were quick to learn that they could no longer rely on the button/lever for needs provision, and soon stopped pressing it. In conventional behaviour management, this is akin to ignoring an undesirable behaviour.

The third group of animals is the most interesting of all. These are the ones who received a food reward inconsistently. This is the group most akin to children who have experienced a tough start to life; whose care needs overwhelm even the most attentive and competent caregiver, or whose caregivers have unresolved personal issues that detract from their caregiving capacity. In Skinner's experiments (and subsequent research using Skinner's apparatus and methodology) when you stop providing a food reward to this group, they are slow to learn that conditions have changed and continue to press the button or lever at a high rate and with great persistence. This is where the conventional behaviour management strategy of ignoring undesirable behaviours breaks down, as the child who has experienced inconsistent responsiveness from adults in a caregiving role will persist in thinking that they will get the desired response for their behaviour eventually, and they often do! Conversely, if you switch the animals to consistent reinforcement, they are still slow to learn that conditions have changed and continue to press the button or lever at a high rate and with great persistence, such that uneaten food piles up in the bottom of the Skinner Box.

It is as if they are no longer focused on whether they receive food or not, but rather are preoccupied with the means by which needs provision might occur.

Children who have experienced a tough start to life can be inordinately demanding and/or overly self-reliant. Often, their early learning is that adults are unreliable as a source of needs provision. Combine this problematic learning with a poor sense of their own deservedness and heightened arousal and the conditions are present for significant maladjustment at home, at school, and elsewhere.

In order to support recovery for children who have experienced a tough start to life it is imperative that they are managed in a way that promotes secure attachment representations, optimal arousal, *and new learning that adults in a caregiving role can be relied upon for needs provision.*

² Bretherton, I. (1992) The Origins of Attachment Theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 28: 759-775.

³ Skinner, B. F. (1938) *The Behaviour of Organisms: An Experimental Analysis*. New York: Appleton-Century

⁴ Ferster, C.B. and Skinner, B.F. (1957) *Schedules of Reinforcement*. New York: Appleton-Century-Crofts

⁵ Pearce, C.M. (2010) An Integration of Theory, Science, and Reflective Clinical Practice in the Care and Management of Attachment-Disordered Children: A Triple-A Approach. *Educational and Child Psychology (Special Issue on Attachment)*, 27 (3): 73-86

⁶ Ainsworth, M., Blehar, M., Waters, E., and Wall, S. (1978) *Patterns of Attachment: A Psychological Study of the Strange Situation*. New Jersey: Laurence Erlbaum and Associates.

⁷ Main, M. and Solomon, J. (1990) Procedures for Identifying Infants as Disorganised/Disoriented during Ainsworth Strange Situations. In M.T. Greenberg, D. Cicchetti and E.M. Cummings (eds) *Attachment in the Preschool Years: Theory, Research and Intervention* (pp 121-160). Chicago: University of Chicago Press.

⁸ Yerkes R.M. and Dodson J.D. (1908) The relation of strength of stimulus to rapidity of habit-formation". *Journal of Comparative Neurology and Psychology*. 18: 459-482.

Part 2 – Addressing the impact of a tough start to life on functioning and performance at school

Enrichment

Across a career spanning more than 25 years I have spent much of my time engaging with caregivers of children who are recovering from a tough start to life.

Caregivers of these children often ask: ***What can I do to help this child?***

This is an interesting question.

Which of the following statements best reflects the first answer you would like to receive to this question?

1. This is what you are doing wrong.
2. This is what you should be doing.
3. This is what you are doing right!

When I ask this question of a group of caregivers, almost all indicate that the *first* answer they would like to receive is about what they are doing right. Some say they want to know what they are doing wrong, and what they should be doing, as well. However, it is my opinion that we need to focus, at least initially, on what caregivers are doing right.

I follow-up the previous question with the following:

Which are you more likely to keep doing over time:

1. What you already know and do that is helpful for the child in your care?
2. A completely new regime of care and management strategies?

Participants in my training programs almost always acknowledge that they are more likely to keep doing what they already know and already do.

I believe that addressing the impact of a tough start to life, and supporting optimal adjustment in the home and education environments, must start with conventional care and relational strategies that support recovery.

Why? Two reasons, really:

1. Because change is stressful, and children who have experienced a tough start to life can be particularly sensitive to change (consistency and predictability, on the other hand, are reassuring and actually reduce stress).
2. Because it is difficult to make significant changes to how we approach caregiving and relating and sustain them over time (we all are susceptible to falling back in to old habits and ways in which we have always done things. This is a big problem for children who have experienced a tough start to life as to change the way one approaches caregiving, only to revert to old ways, is experienced by the child as inconsistency, which is stressful and can have the effect of further unsettling the child's emotions and behaviours).

My recommended approach to addressing the impact of a tough start to life is to identify particular aspects of *conventional* caregiving and relating (that is, we all do them, at least some of the time) that we know from science provide strong foundations for children's development and the achievement of their potential. I then ask that they be implemented intentionally and in an organised and ordered (that is predictable) way.

Let's have a go. In the table below, write in the space available what experiences of care infants need to grow up happy and healthy and to achieve their potential. Next, do the same for children and teens. Finally, make a list of the experiences of care adults need to be happy and healthy and perform to their potential.

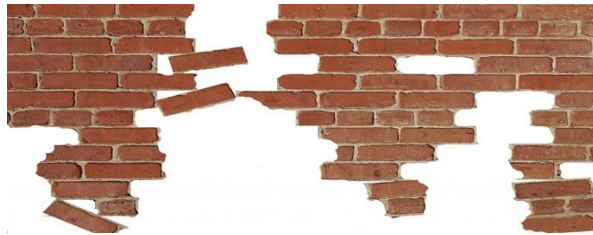
Infant	Child	Teen	Adult

I expect that your lists are pretty similar, whether we are talking about an infant or an adult or all the ages in between. We all need certain experiences of care. It can just look a bit different in how it is put in to practice for an infant versus a teen, and so on

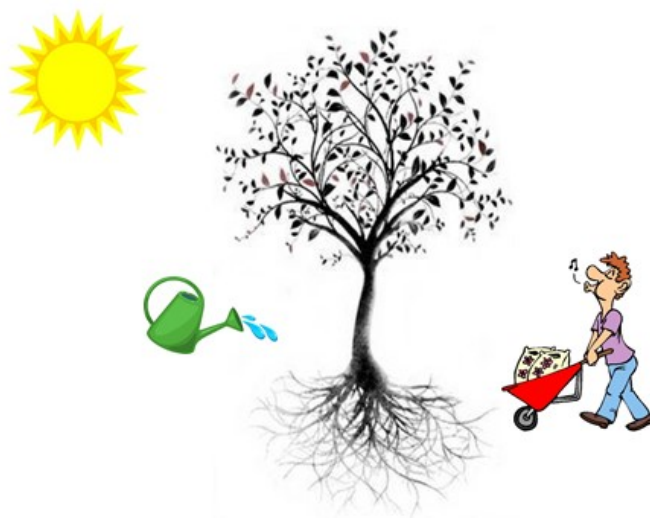
Children who have had a tough start to life have often missed out on important experiences of caregiving and relating that support optimal development and wellbeing. They have not enough of these experiences or they have not had them consistently enough. Consistency is important, as I explained in the previous section about what children learn about accessibility to needs provision. Consistency of caregiving suffers where a parent or parents are experiencing mental health problems, substance abuse problems, or extreme relationship problems. When children miss out on the important experiences of care you included in your lists above, their development and wellbeing is impacted.



So, what do we do to address this? We fill in the gaps. We enrich the child's experience of important aspects of caregiving and relating that support their wellbeing and development. In doing so, we are not 'babying' them or 'spoiling' them. Remember your list above. Our experiences of care are very similar, whether you are an infant, child, teen, or adult. By enriching aspects of care we are filling in the gaps in their early experience. Because you can't build a strong wall on shaky foundations.



So, from my perspective, therapeutic care and management is an **enrichment** process, at least to begin with. It enriches conventional aspects of caregiving and relating that support what we know about how to raise healthy and happy children who achieve their developmental potential. For those children who are recovering from a tough start to life, it fills in the gaps in their experience of caregiving.



Connection

Imagine a scenario where you are offered the opportunity to swap places with a person who is about to be delivered an extremely painful, though non-life-threatening, electric shock.

On a scale from 0-100, where 0 is that you never would and 100 is that you always would, come up with a number that represents how likely you would be to swap places with the following people:

1. A complete stranger _____
2. Your employer _____
3. A work colleague _____
4. A friend _____
5. A brother or sister _____
6. A child who is not biologically related to you _____
7. A child who is biologically related to you, but not your child _____
8. Your life partner _____
9. Your own child _____

When I ask people to do this task, I sometimes get asked questions like how old is the stranger or whether there is some other issue that impacts their functioning (e.g. a disability). Of course, factors such as age and observations of whether you think the person can 'take it' play a role in your decision-making. People are more likely to swap places with the elderly and children. Nevertheless, what I generally find is that the closer the relationship you have or feel towards the person you are being asked to consider swapping places with, the more likely you are to offer to trade places with them.

That is, the closer the *connection* you feel to the person, the greater the influence the *connection* has over your decision-making and behaviour.

Now, I want you to recall a time when, as a child, your parent learnt that you had committed some form of misbehaviour. What were you most worried about at that time? The temptation is to report that it was the punishment that was the greatest source of worry. However, when I ask this question to groups, we generally find that most people are more worried about parental disapproval; of feeling like they have let their parents down.

What stops you from, say, exploiting an elderly person for financial gain? What stops your partner from doing so? Again, when I ask people these questions, often they advise that it is how they would be perceived by those close to them if those persons knew about the act they had committed.

The connection we have with others, and their connection with us, is a powerful form of influence over behaviour. When a person feels connected to others, the expectations and standards of those others exert a powerful influence over the person's behaviour. The stronger the connection, the stronger the influence. The same applies to a sense of connection to groups, and to society.

The more connected and integrated a person feels in their society, the greater the influence of the society's rules and norms over their behaviour.

Connection influences more than just behaviour. In a 2012 survey of 14,500 young people in Ireland aged 12-25 years, those young people who did not report having at-least one person in their life who listens, can be relied upon, and is trusted to help in times of difficulty (often referred to as *One Good Adult*) reported higher levels of:

- Depression and Anxiety
- Anti-social behaviour
- Risk of suicide . . .

. . . than those young people who reported having at least one adult that they can depend on⁹.
Connection matters!

Sadly, many troubled children who have experienced a tough start to life are growing up without making and maintaining close connections with others; especially adults. As such, they are at increased risk of emotional and behavioural problems that adversely impact functioning and adjustment at school. We can facilitate improved life *and learning* outcomes for these children by making connections with them that support them having *at least one person in their life who listens, can be relied upon, and is trusted to help in times of difficulty*. We can all be that One Good Adult that makes a difference to the developmental and life trajectory of a troubled child.

This is your *primary task*¹⁰; or that one thing that you need to get right in order to have the best chance of success in your endeavours. To connect, and be one of the 'good adults' in their life.

Making Connections

Connecting with a troubled child who has experienced a tough start to life involves facilitating, for them, the experience that they are in your head and in your heart. That is, you are thinking about them, you care about them, and you are there for them.

Primary Task:

Connection

*I am with you. You
are in my head and
in my heart.*



Making connections starts with adopting a certain mindset:

- That nobody does anything for no reason;
- That behaviour is communication;
- That it is not what a person does, but why they do it, that is important;
- That we learn from experiences (and it is from new experiences that new learning occurs); and
- It is the relationship we share with others, and their relationship with us, that is the most powerful form of influence we have over their behaviour.

Consider the child who steals from other children's lunch boxes at school.

The child is hungry, because there is no food at home.

Everything a child does, they do for a reason.

Consider the child who refuses to settle to sleep at night.

They are scared of the dark and of their dreams, which involve recurrent themes of their being harmed and killed.

It is not simply what a child does, but why they do it, that is important.

Consider the child who boasts compulsively of their physical prowess.

The child feels unsafe.

Behaviour is a form of communication.

Consider the child who seeks comfort from familiar adults when they are distressed.

The child had learnt that adults are a source of comfort and the restoration of feelings of wellbeing.

Children learn from experience.

Consider the child who, in response to another child's aggression, does not hit the child back but, rather, approaches a trusted adult for assistance.

The child believes that they can rely on adults to keep them safe.

It is the relationship an adult shares with a child that is the greatest source of influence they have over the child's wellbeing and adjustment.

This mindset gives rise to required thinking:

- What is going on for you?
- What can I do to communicate that you are in my head and in my heart?

The answer to what is going on for the child who has experienced a tough start to life lies in part one of this resource; that is, their behaviour is likely to be under the influence of one or more of:

- Their thoughts about themselves, others and their world;
- Their arousal level; and,
- What they have learnt about accessibility to needs provision.

Thinking:

What is going on for you?

What can I do to show that you are in my head and in my heart?

Enriched CARE:

Consistency
Accessibility
Responsiveness
Emotional-
Connectedness

In terms of what to do to address the performance and adjustment at school of children who have experienced a tough start to life, I recommend that you implement a CARE Plan:

- Consistency
- Accessibility
- Responsiveness
- Emotional-Connectedness.

Consistency

Remember the operant conditioning experiments I referred to earlier? These experiments highlight the importance of consistency and the impact of inconsistency. Though children who have experienced a tough start to life might be slow to learn that school (and the behaviour and responsiveness of adults there) is different to that which they have experienced in the home, a consistent approach to their care and management in the school setting still represents the best approach to facilitating new learning and change. Whatever you endeavour to do for and behalf of children who have experienced a tough start to life, the consistency with which you do it is important. Similarly, it is important that children who have experienced a tough start to life

observe you to be consistent in your approach to all children in the classroom; including them. This means that any strategy you implement for and on behalf of children who have experienced a tough start to life you need to also be doing for the other children. Hence, the strategies that I recommend hereafter need to be generally applicable (and they are) and readily implemented. In my opinion this is best achieved by confining oneself to conventional aspects of caregiving and relating. You are more likely to do them and keep on doing them over time.

Being generally applicable and able to be implemented consistently across time is vital. Inconsistency is a nervous system irritant (speeds up the motor) and will reinforce problematic learning that has occurred in the home. In contrast, consistency is, ultimately, soothing. We all need consistency. Some children who have experienced a tough start to life can be uncomfortable, initially, in a consistent and consistently responding environment; as it is *inconsistent* with their experience and learning at home. By confining yourself to conventional aspects of caregiving and relating, your behaviour is at-least familiar and the child is less likely to be reactive to the consistency of your approach to care and management. If you change too much you are unlikely to maintain it over the time and the child will react poorly to the inconsistency in their experience between home and school.

Consistency does not only 'slow the idle' (and therefore, the general running speed of the 'motor'). Consistency ensures that the child who has experienced a tough start to life perceives the classroom as a predictable environment and, in turn, safe. Consistency of approach to the child who has experienced a tough start to life reassures the child that they are just as worthy as the next child and, so long as you implement the remaining aspects of the CARE Plan, new learning that you (and adults like you) can be depended upon. Consistency addresses all three things you should know about children who have experienced a tough start to life.

In order to enrich consistency, I would first ask you to make a list of the routines and behavioural expectations that already exist in the classroom:

Next, I would ask you to make a list of aspects of classroom life that occur some of the time (that is, you do them and you are happy to do them; you just do not always do them or do them to a predictable schedule):

Finally, I would ask you to pick at least one of those aspects of classroom life that occurs some of the time, but which is no great trouble to implement consistently. Make it something that the children in the class would notice and be familiar with.

This activity is the first part of implementing a CARE Plan. Implement it consistently.

Accessibility

Think of two people whom you regard as friends, where:

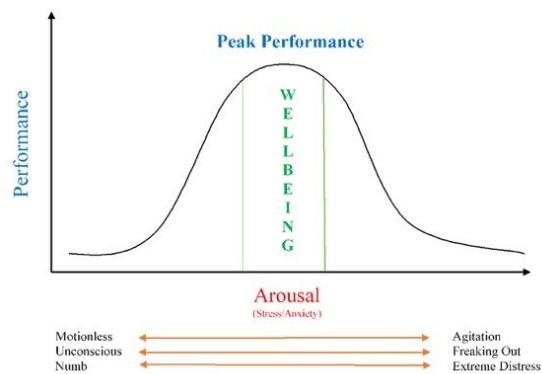
- one of these friends rarely initiates contact with you, and
- the other friend initiates contact with you on a regular, non-intrusive basis.

Which do you prefer?

Which friend are you more likely to turn to for support when you are going through a tough time?

Why?

It is my contention that people feel closer to, and are more likely to turn for help from, those who show interest in them without them having to do anything to make it so. We experience such people as more *accessible* to us. It is reassuring to have such people in our life. It supports feelings of wellbeing, which occurs when arousal is in an optimal range. It supports healthy ideas about our worth and the reliability of others. It supports trust in accessibility to needs provision.



Children who grow up in a conventional nurturing environment experience their parents as being accessible to them. From infancy, the parents of such children do not leave them alone for long periods of time. They hover. They attend to the infant/child *whether they are crying or quiet*; hour by hour, day by day, week by week, and so on. As a result, these children learn that adults in a care and management role are available and attentive without them having to go to any great lengths to make it so. And, the process by which they have learnt this is that their caregivers have attended to them *proactively*.

In contrast, children who have experienced a tough start to life experience their parents to be inconsistently accessible; whether this be due to parental mental health issues, substance issues, relationship issues, or inadequate parenting skills (often, parents of children who have experienced a tough start to life experienced a tough start to life themselves when they were children). These children have learnt that they cannot always rely on adults in a care and management role to be available and attentive to them when needed. Rather,

they have learnt that in order to secure the attention of adult caregivers they need to do something to make it so. That is, they have learnt that they must engage in behaviours that maintain adult attention and proximity. Where their caregivers responded to them inconsistently, they learnt that they must engage in these attention-seeking behaviours at a high rate and with great persistence.

Simply responding to such a child when they perform some action or other to secure your attention is problematic. They are more likely to interpret your response to them as evidence of their success in obtaining your attention, as opposed to learning that you are thinking of them, you care about them and you are available to them without them having to control and regulate your proximity and attention to make it so.

In contrast, attending to the child before they do anything to secure your attention facilitates new learning that you are thinking of them and you are there for them without them having to engage in attention-seeking behaviours at a high rate and with great persistence. That is, it supports new learning that you are *accessible* to them; just as was learnt by children who were raised in a conventional nurturing care environment. In order to support new learning that you are accessible and that the child is deserving of your attention, thereby reducing the incidence of coercive behaviours to secure and maintain your attention, you need to attend to them *proactively*.

In order to enrich a child's experience of your *accessibility* to them, first make a list of the times you already attend to the child without them having to do anything to make it so (even if you do not always do it consistently):



Now, I would like to you think about times in which the child who has experienced a tough start to life seeks your attention and proximity before you get a chance to attend to them first:

The third step is to do one or both of two things; either:

1. Make consistent at-least one of the times you already engage with the child before they do anything to make it so; or
2. Choose one of the times that you respond to the child's endeavours to seek your attention and proximity (and you are happy to respond) and get in first – attend to them proactively (that is, before they do anything to make it so).

Some children who have experienced a tough start to life are inordinately self-reliant and do not make any great demands of adults in a care and management role. For these children I recommend engaging with them at regular intervals throughout the day; such as once in each of the three parts of a conventional school day. Initiating engagement with a child who has experienced a tough start to life in this way offers them the experience that they are in your thoughts, that they are real, that they are worthy, and that you are accessible and interested in them.

Responsiveness

There are two parts to the responsiveness dimension of the CARE Plan. Both aspects relate to the experience of infants and small children who are raised in conventional, nurturing care environments. In such environments adults in a caregiving role spend a lot of time asking and answering the question *what's going on for baby?* They then respond (that is perform some action) to what is going on for baby. Of course, they do this because baby cannot tell them what is going on for them and what they want. Rather, the adult who is caring for them must work it out. In a conventional

nurturing care environment, the adult usually does, and baby's experience is *this person understands me and responds to my needs. I can trust and depend on this person*. Later, when they have developed the capacity to use language, they are encouraged to use it to express their needs and wishes. Though they might put up a bit of a fuss initially and some of the time, the young child who has experienced their adult caregivers asking and answering the question *what's going on for baby* hour-by-hour, day-by-day, week-by-week, and month-by-month tolerates being instructed to use their words because the foundational learning that adults understand and address the needs of the child has occurred, and the adult responds to them anyway.

I have already explained that this is unlikely to be the case for the child who has experienced a tough start to life. Their adult caretakers may have asked and answered the question *what's going*



on for baby, but due to their circumstances they may have done so inconsistently, or insufficiently, or relied on a very limited understanding and got it wrong too much of the time. As a result, the child who has experienced a tough start to life is likely to have:

- Low expectations of their worth and deservedness; and
- Low expectations of the adults in a caretaking role understanding their experience and responding to it.

That is, they are likely to maintain disordered attachment representations, high levels of arousal due to distress and worry about their worth and deservedness, and have a preoccupation with accessibility to needs provision.

There are two steps to addressing these issues. The first is to enrich the child's experience that their inner world is understood and important, thereby facilitating for the child the experience that they are important. The second step is to address the child's experience, including their needs, without the child having to control and regulate your responsiveness to make it so.

Understanding

Observe the child and the situation/activity. In your head, ask *what is going on for you* (the child) *right here; right now?* Say the answer. Say what you see. Make it a statement. Another way to think about it is if you find yourself asking the child a question about their experience (e.g. How are you going?) and you can anticipate what the real answer might be (whether they would respond or not), don't ask the question; just say the answer. Again, say what you see. Say it with congruent feeling. Speak their mind. Communicating in this way offers the child an enriched experience that they are understood, that their experience matters, and that they matter. Avoid asking questions, as questions communicate that you do not know them.

Record some of the statements you typically make about a child's experience (you may wish to do this over a couple of days):

Describe an activity or situation involving a specific child who may have experienced a tough start to life:

What do you think is likely to be the child's experience of the activity or situation?

What are some short (less than 10 words) statements you could say that communicate understanding of the child's experience of the activity or situation? Say them.

Providing experiences of being understood in this way supports the child who has experienced a tough start to life to develop a vocabulary for expressing themselves, as opposed to expressing themselves through (often problematic) actions. It provides experiences of understanding that are one of the foundations for the development of secure dependency on adults in a caregiving role, which usually occurs in infancy but is likely to have been inadequate during their own early years. Start with the easy stuff, such as what they like, what they feel good at, or what they are having difficulty with. Get them used to the closeness that is a by-product of experiences of being understood before you tackle more difficult experiences, such as feelings of anger. When they are angry, and after a period of getting the child used to you communicating with understanding, you might observe that they *just want to be left alone right now*. Verbalising understanding generally reduces arousal levels. Used correctly, it can help defuse anger levels in children who are prone to emotional dysregulation as a result of inadequate parental care and responsiveness during infancy.

Addressing the child's experience (proactively)

The infant experiences that their inner world is understood and important when the adult performs an action that confirms that this is so. Repeated over and over, the infant *learns* that their experience is understood and important and will be addressed without them having to control and regulate caretakers to make it so. They no longer worry about the responsiveness of their adult caretakers. They develop optimistic beliefs about the responsiveness of adult caretakers and their own deservedness (attachment representations), they worry less and, therefore, maintain lower levels of arousal, and they expect that their needs will be provided for without them having to control



and regulate their environment, including adult caretakers, to make it so.

Sadly, this is not the case for children who have experienced a tough start to life. In order to support more optimistic ideas about their worth and deservedness, the responsiveness of adult caretakers, and lower arousal levels (and reduced proneness to behaviours associated with the fight-flight-freeze response) we need to enrich their experience of their thoughts, feelings, sensations or needs being addressed without them having to do anything to make it so.

Firstly, I would ask you to record below all the things you do for and on behalf of the children in your classroom without them having to do anything to make it so:

Next, I want you to think about a specific child who has or may have experienced a tough start to life, and I want you to make a record of the things *they* ask for or the things *they* do to satisfy a need or some other aspect of their experience:

Now, I want you to identify at least one aspect of the child's experience or need that they have that you can address before they do anything to make it so:

Make sure it is something that you are happy to address and can keep doing consistently over time!

Verbalising understanding of the child's experience and addressing their needs proactively supports experiences for the child that they are cared for and cared about, thereby supporting secure attachment representations, optimal arousal for wellbeing and success at school, and trust in adult caretakers at school for needs provision.

Emotional Connectedness

Emotional connectedness is the final element of implementing a CARE Plan that I will address in this resource. Emotional connectedness initiated by an adult caretaker is important because it supports several extremely important aspects of a child's emotional development. Connecting with the emotional experience of the infant supports a reciprocal emotional connection from the infant. Within this emotional connection the infant is supported to be self-aware of their emotions as a result of their adult caretaker mirroring and reflecting back the child's emotional experience; including with words that ultimately become the vocabulary with which children can describe their emotional experience. Within this emotional connection the infant is supported to be aware of

the emotions of others, which ultimately manifests as a capacity to feel and express empathy and to regulate their behaviour out of a concern for the experience of others (also known as socio-emotional reciprocity). This is vital for getting along with others and experiencing mutually-satisfying relationships. By connecting with the infant and returning to calm themselves, adult caretakers assist the infant to regulate their emotions (co-regulation) until the infant can do so themselves (self-regulation). Through adult caretakers tuning in to the emotions of the infant and helping them to return to calm, the adult caretaker supports the infant's safe exploration of emotions and a broad emotional repertoire. Further, within this emotional connection the adult caretaker offers experiences of being *heard* and understood on an emotional level, thereby supporting positive representations of self and other, reassurance (and, thereby, lower arousal levels), and trust that the caretaker can be relied upon, including for needs provision.

As the experience of emotional connectedness from their adult caretakers is likely to have been inadequate for the child who has experienced a tough start to life, it is not surprising that these children might be observed to display the following characteristics:

- Heightened emotionality (arising from poor capacity for self-regulation);
- A restricted range of affect (arising from limited opportunity for safe exploration of emotions);
- Limited expressions of empathy (arising from a lack of experiences of being heard themselves – *nobody cares about me so why should I care about anybody*);
- Poor regulation of emotions and behaviours out of a concern for the experience of others; and,
- Poor social skills and limited peer relationships.

Adult caretakers in the school environment can make a valuable contribution to addressing these difficulties and, in doing so, promote optimal functioning and learning, by enriching the experience of emotional connectedness for children who have experienced a tough start to life.

Emotional connectedness is a by-product of interaction. When you are interacting with a person you are likely to feel an echo of their emotion. This is referred to as instinctive empathy and, with few exceptions, we all have a capacity for instinctive empathy. The challenge when endeavouring to enrich a child's experience is not to mask your emotional echo in an endeavour to set the emotional tone of the interaction (such as by projecting calm when the other person is distressed or angry), but to allow yourself to show a little of the emotion that is congruent with the emotion of the child, thereby making a connection. Once the connection is achieved, you can regulate back to calm and, as the child becomes more and more used to the experience of being connected with, they will return to calm themselves.

It is important to be moderate in your congruent emotional expressions, to not overwhelm the child who has experienced a tough start to life and amplify their emotion. Similarly, it is important to limit the length of time before you regulate to calm. Even a momentary expression of congruent emotion is likely to be detected by the child who is used to being hypervigilant for signs of danger in the expression of others. In the absence of your expression of congruent emotion the distressed child will never feel fully heard, and nor will the angry child. Unfortunately, such experiences of not being heard not only confirm disordered beliefs about self and other, the child who has experienced a tough start to life may amplify their emotional display in an endeavour to 'make' you feel as they do. This kind of 'payback' is common among children who have experienced significant a tough start to life and might be diagnosed with Reactive Attachment Disorder.

In order to enrich emotional connectedness for the child who has experienced a tough start to life I first suggest that you make a list of the emotions commonly presented by children in your classroom and the emotions you experience during the day:

Children:

You:

I would anticipate that the lists are similar, which is evidence that there are times when you already tune in to, and connect with, the emotional experience of individuals in the classroom, and the emotional tone of the class as a whole.

Next, I recommend that you identify a child in your class who you know or suspect has experienced a tough start to life and times that you interact with them over an activity or task. Write down the activity or task in the space provided and your observation of the child's emotional presentation during the activity/task.

Activity/task:

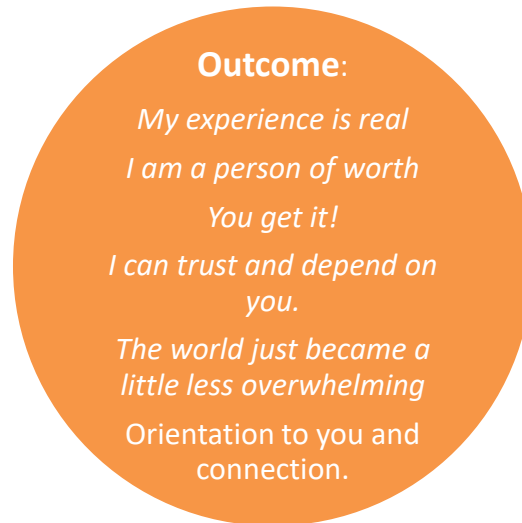
Child's Emotion:

Finally, identify at-least one of the activities/tasks and regularly spend time interacting with the child over the task, connecting with their emotional experience and allowing yourself to feel and express congruent emotion (even if only briefly), before regulating yourself to calm. As you get increasingly confident with this, you can add words that reflect the child's experience.

Putting it all together: The CARE Plan

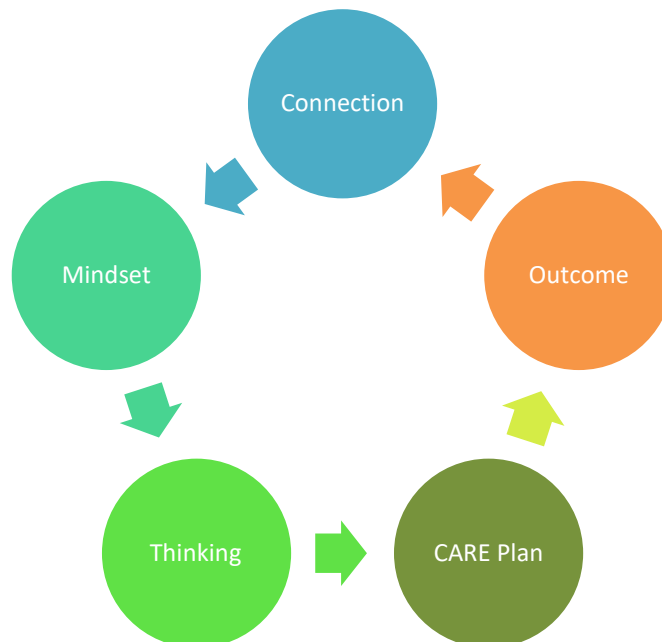
So now you have five strategies for supporting the child's experience of connection from you. Anticipated outcomes for the child are thoughts that:

- Their experience is real;
- They are a person of worth;
- You get it;
- They can trust and depend on you; and,
- The world just became a little less overwhelming.



Implemented consistently, the strategies recommended above promote secure attachment representations, optimal arousal for performance and wellbeing, and trust in accessibility to needs provision. Implemented consistently, the child who has experienced a tough start to life will connect back with you, with the result that their functioning at school will increasingly be regulated by a concern for their relationship with you and with being and remaining on good terms with you.

Relationships are the most powerful form of influence we have over the behaviour of children. Where deficiencies in care created the problem, enriched CARE will address it!



⁹ *My World Survey*; Dooley and Fitzgerald (2012)

¹⁰ Kahn, W. A. (2005) *Holding Fast: The Struggle to Create Resilient Caregiving Organisations*, Hove and New York: Brunner-Routledge.

Part 3 Addressing Behaviours of Concern Using the CARE Model

I would like for you to re-read this section after you have been implementing a CARE Plan. When you do so, I anticipate that you will have experienced a positive change in the way you think and feel as an educator, and that you have noticed positive changes among children in your classroom who have experienced a tough start to life. You may even have noticed positive changes in other children, and the classroom as a whole.

Though I consider that, most often, the frequency, intensity, and duration of behaviours of concern will decrease as a result of implementing a CARE Plan, it would be unrealistic to expect that simply by doing so there will be no more behaviours of concern in your classroom.

So, what do I suggest for addressing behaviours of concern, as they arise, and following implementation of a CARE Plan?

The CARE Plan is drawn from the CARE Therapeutic Framework¹¹. The CARE Therapeutic Framework incorporates the Triple-A Model (Attachment, Arousal, Accessibility), which helps us understand the psychological characteristics of all children and young people, including those who have experienced a tough start to life. In this next section I will offer a methodology for applying the CARE Therapeutic Framework (and the Triple-A Model) to understanding the reason for behaviours of concern, and formulating strategies to address them.

The CARE Framework

- Consistency
- Accessibility
- Responsiveness
- Emotional Connectedness

Step 1: Review implementation of CARE

In the first instance, I recommend that you review your implementation of the CARE Plan to ensure that you are continuing to enrich consistency, accessibility, responsiveness and emotional-connectedness.

Step 2: Remember your Primary Task – to *Connect*

A 'primary task' is the foundation upon which the success or otherwise of all your efforts in a particular endeavour rests. It is the one thing you need to get right. In CARE, the primary task is to achieve a stable and meaningful *connection* with the child who has experienced a tough start to life. The connection you make provides the platform for you to have the greatest impact on their growth and development. It also supports their adherence to social rules and behaviour conventions, and their mental health and wellbeing.

The connection process starts with maintaining a mindset that supports you to look beyond the behaviour of concern the child is exhibiting to the reason or reasons why they are exhibiting it. In CARE the mindset that supports this involves maintaining the following ideas:

- *That nobody does anything for no reason;*
- *That behaviour is a form of communication* (the child is communicating with you through their behaviour, usually about a current need, or needs that were met

inconsistently in the past and, about which, they continue to be unsure whether they will be met);

- *That it is not what a person does, but why they do it, that is important;*
- *That we learn from experience* (and the child will need new experiences for new learning); and
- *It is the relationship we share with others, and their relationship with us, that is the most powerful form of influence we have over their behaviour.*

These ideas are extremely important, as is illustrated by ‘Punishment is Problematic’, which appeared as the **prologue** to this resource.

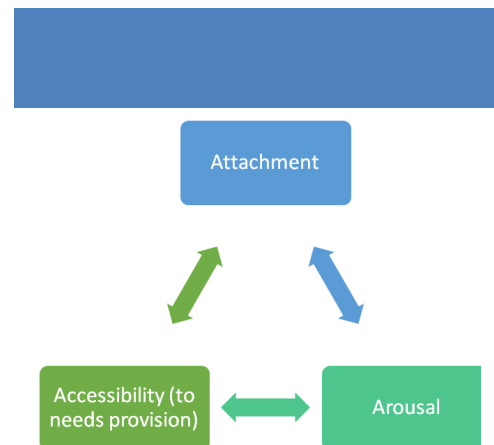
In order to put these ideas into practice, thereby facilitating the child’s experience of connection, there are two key questions you need to keep foremost in your mind:

- What is going on for the child; right here, right now?
- What can I do, right now, to show that you (the child) are in my head and in my heart?

Step 3: What is going on for the child; right here, right now?

Having read sections one and two of this resource you have received information and guidance about why children who have experienced a tough start to life behave the way they do and what to do about it. The information contained therein can be used to assist you to make reasonable guesses as to

- What is going on (why the behaviour is being exhibited),
- What is being communicated through the behaviour, and
- What you might do to address the reasons for the behaviour and, in so doing, the behaviour itself.



In the table over the page I have included several behaviours commonly exhibited by children who have experienced a tough start to life, and how they relate to the CARE Framework (and the Triple-A Model). Once you have identified where a behaviour fits in terms of the CARE Framework (that is, which aspects of the framework explain what is going on and/or what is being communicated), we can progress to the next step – what to do to address the reasons for the behaviour.

Disclaimer: Although I have categorised each behaviour in relation to one or other of the CARE concepts, it is important to acknowledge that some behaviours may relate to deficiencies in more than one aspect of CARE. This is because a behaviour might also be understood in terms of attachment, arousal and accessibility – the Triple-A Model. For example, meltdowns are a sign of high arousal (motor is running too fast) and deficiencies in all four aspects of CARE increase arousal. Similarly, enriching the child’s experience of each aspect of the CARE Framework can have the effect of reducing arousal and reducing the frequency, intensity and duration of meltdowns. I have chosen to confine this discussion to the CARE Framework for the sake of simplicity.

Deficiencies in CARE	Behaviours	Reason(s) for the behaviour
Deficiencies in Consistency	<ul style="list-style-type: none"> Controlling Manipulative Demanding Charming/Seductive Asking lots of questions about arrangements Tantrums and Meltdowns 	To relieve pervasive feelings of uncertainty and mistrust of adults in a caregiving role, reduce arousal (slow the idle/motor) and promote feelings of safety, and reassure themselves about access to needs provision.
Deficiencies in Accessibility	<ul style="list-style-type: none"> Indiscriminate sociability (any adult is a potential carer) Exaggerated dependency Clingy Demanding Separation Anxiety 	To relieve fears of rejection and abandonment and reassure themselves of access to a person who will protect them and respond to their needs ² .
Deficiencies in (understanding and) Responsiveness	<ul style="list-style-type: none"> Low Self-Worth Low expectations of deservedness Poor Self-Care Bodily Function Disturbances (e.g. wetting, soiling) Lying Defiance Stealing Hoarding/gorging food Acting out, as opposed to speaking out 	<p>Arise from inadequate understanding and responsiveness to the most important question when parenting an infant:</p> <p><i>What's going on for baby?</i></p> <p>To relieve (and because of) fears of rejection and abandonment.</p> <p>Habitual reliance on demonstrative behaviour (crying, tantrums, charm) to reassure oneself about access to needs provision.</p>
Deficiencies in Emotional Connectedness	<ul style="list-style-type: none"> Restricted range of affect Inconsistent affect Reduced empathy Emotionality (poor self-regulation) 	<p>Impaired emotional development.</p> <p>Insecure/Disordered Attachment</p> <p>Heightened arousal</p>

² It is a central aspect of professional understanding of human infants (and many other species) that they are genetically programmed to orient to someone who is bigger, stronger and more able to keep them safe and address their needs.

Step 4: What can I do to address the reason for the behaviour?

Once you have consulted the table of behaviours arising from deficiencies in CARE, and thereby have a sense of what is going on for the child right here, right now, I recommend that you *further* enrich the child's experience of the CARE dimension associated with the behaviour.

For example, if the behaviour of concern a child in your school or classroom is exhibiting is that they are highly *controlling* and *demanding* of you (and, possibly, others), this is likely to have arisen in the context of a care environment where important needs were understood and addressed on an inconsistent basis. If, after the implementation of a CARE Plan the child is still exhibiting these behaviours at a frequency, intensity and duration that is overwhelming your (and others') resources and capacity to respond, you might consider making additional aspects of the day-to-day routine more predictable to the child; and more obvious. This might include using visual reminders of what is going to happen, when it is going to happen, how it is going to happen, and why it is going to happen (the latter being offered by way of verbal explanation). Enriching a child's experience of consistency, alone, will contribute to them maintaining lower arousal levels at school and reduced proneness to behaviours associated with the fight-flight-freeze response (where *controlling* and *demanding* behaviour might be manifestations of the *fight* response). Further enriching the consistency and predictability of the child's experience of your accessibility, responsiveness and emotional connectedness might also be expected to address the issue of them being overly controlling and demanding, so you might consider adding additional activities to your CARE Plan on these dimensions. This is particularly true of *Accessibility*, and the recommendation to attend to the child before they do anything to gain your attention. Attending to the child proactively (that is, without them having to do anything to get you to respond to them) reassures them that you are thinking of them and that you are there for them without them having to control access to you. Similarly, addressing needs and reasonable wishes (those that you would respond to anyway) proactively, verbalising understanding, and making emotional connections all reassure the child that they are real, their needs are real and understood, and that you are there to help.

If the child in your classroom who has experienced a tough start to life continues to exhibit low self-worth, low expectations of deservedness and poor attention to self-care after you have been implementing a CARE Plan, I would suggest that you pay attention to enriching their experience of the recommended strategies for *Responsiveness*. That is, I would recommend that you try to find further needs or reasonable wishes to address proactively and further opportunities to say out loud what you anticipate the child is thinking or feeling. Remember, *if you know the answer to the question don't ask it; rather, say the answer. Say what you see!*

If the child in your classroom who has experienced a tough start to life is lying or stealing, remember that these behaviours often occur because they believe that their needs are poorly understood and that they will be easily rejected or abandoned by adults in a caregiving role. Essentially, they do not feel loved or lovable enough for others to take the time to understand and respond to their needs and stick with them through tough times. Again, your response according to the CARE Therapeutic Framework is to further enrich their experience that their thoughts, feelings and needs are understood and important and will be addressed without them having to go to great lengths, or take matters in to their own hands, to make it so.

Putting it all Together

To put it most simply, when you are faced with a behaviour of concern, I suggest the following process:

1. Remember, the child is doing it for a reason;
2. Consult the table on page 5 to help with working out what the reason might be; and
3. Enrich the child's experience of the most relevant dimension or dimensions of CARE that relate to the reason.

Troubleshooting

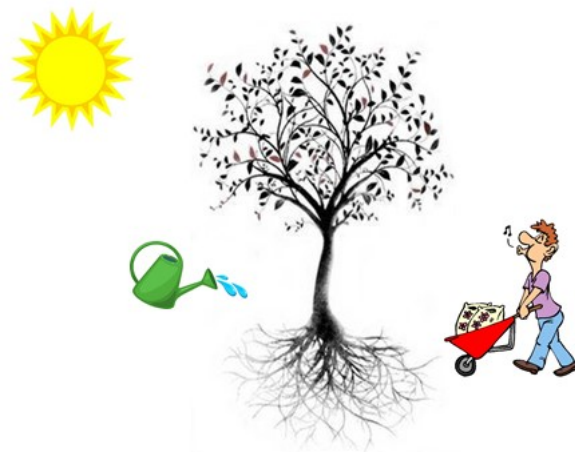
The main thing I would have you remember is that you do not have to be right all the time when attempting to answer *what is going on here(?)*. Enriching the child's experience of any of the aspects of CARE recommended above will not cause them harm. If you do not see a reduction in the frequency, intensity and/or duration of the behaviour of concern, you might consider further enriching another aspect of the framework and its recommended strategies. Verbalising understanding (saying out loud what the child is likely to be thinking or feeling) is particularly useful for clarifying the nature of the issue that is the driving force for the behaviour of concern. If, however, you continue to experience the behaviour at levels that cause difficulty for the child and/or for you, I recommend that you engage with the child's caregivers about accessing advice from a professional with relevant knowledge of, and expertise in, the care and management of children and young people who have experienced a tough start to life.

¹¹ Pearce, C. (2016) *A Short Introduction to Attachment and Attachment Disorder (Second Edition)*. London: Jessica Kingsley Publishers

Part 4: Adopting a balanced view

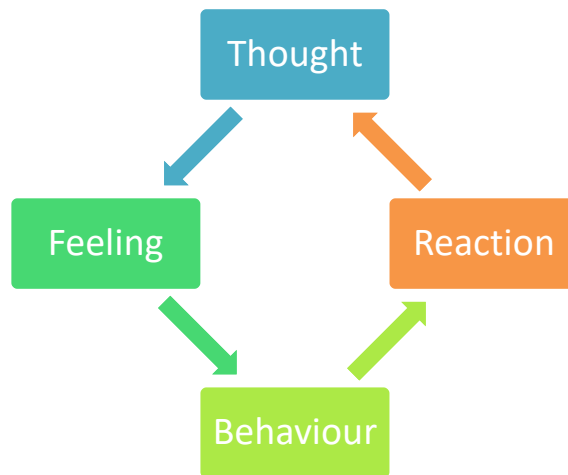
I was born in January, which is the height of summer in Adelaide, South Australia. As such, I have always thought of myself as a “summer baby” and considered that this is why I enjoy the warmer months as opposed to the cooler months. I have a lifelong aversion to feeling cold and for many, many years I felt below my best during winter. I have questioned many people about this and have discovered that most people prefer either the warmer months or the cooler months. Many of them are just not happy until their preferred season returns.

Several years ago, and with the emergence of joint aches and pains during the colder months, I had the thought that it was a bit of nonsense really to consider myself a “summer baby” and defer happiness until it was warm again. I have always been a keen gardener and have a large hills garden. Looking after my garden is an act of self-care. Water is an issue as it is scarce and expensive, my garden is large, and summer is hot. So, I bought some rainwater tanks and now I ‘pray’ for as much ‘bad’ weather as possible during the cooler months. I check the weather radar often and feel let down if forecast wet and wintry weather blows south or north. I still have my aches and pains and look forward to the warmer months when they trouble me less, but I also look forward to cooler, wetter months now as it is a boon for my efforts to maintain a magnificent garden. And the garden? Well, with the additional water supply it has never looked better.

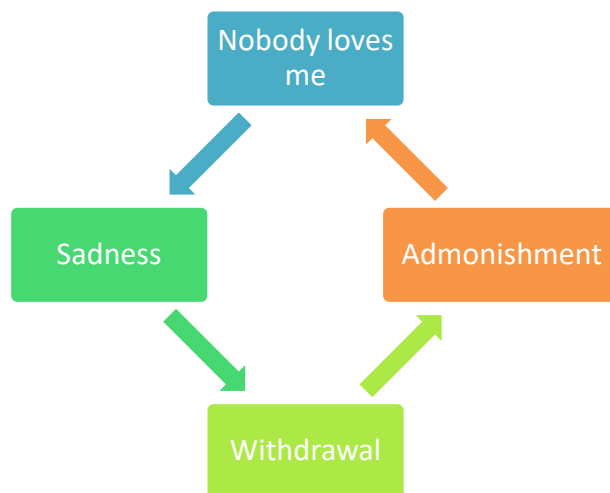


What has all this got to do with the care and management of children who have experienced a tough start to life? Well, it has to do with how we perceive them and the effects of this; both in terms of our own experience of interacting with them and their experience of us.

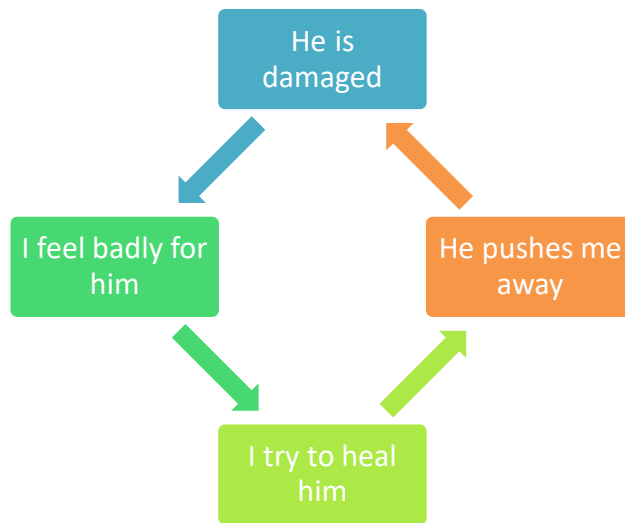
I am particularly interested in the idea of “self-fulfilling-prophecies”. In Psychology, these take the following form. I have a thought. My thought induces an emotion. My emotion activates a behavioural response. My behavioural response precipitates a reaction in others. The reaction of others often confirms my original thought.



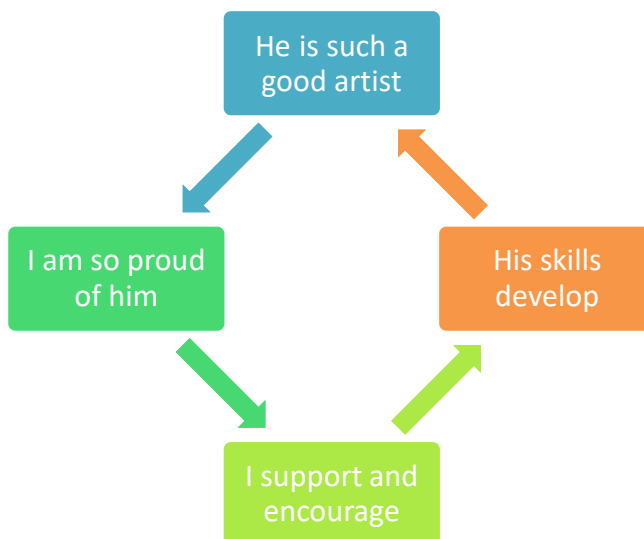
Let's try one. Thought: ***nobody loves me***. A common feeling associated with this thought: ***sadness***. A common behavioural response to feeling sad: ***withdrawal***. An all-to-common reaction from others to my withdrawal: ***admonishment***. An (almost) inevitable result: confirmation of the original thought - ***nobody loves me***.



Let's try another. *He is damaged by his early experiences.* I feel badly for him. I try to heal him. He keeps pushing me away³. He is obviously damaged.



And, another: *He is such a good artist.* I am so proud of him. I support and encourage his interest in art. His skills develop and he is often affirmed for his artistic achievements. He is such a good artist!



³ Children who have experienced a tough start to life are often defensive about a fuss being made about them. Conversely, they can soak up fuss and present as so 'needy' that they never seem to get better; notwithstanding our best efforts.

Children who have experienced a tough start to life are commonly referred to as “traumatised”. There is much literature about how early trauma impacts the developing child, including their acquisition of skills and abilities, their emotions, their relationships with others, and even their brain. This literature focuses on the damage early trauma does and there is a risk that we, the adults who interact with them in a care and management role, see these children as damaged.

One of my favourite allegories is the one that the author Paulo Coelho tells in his book, *The Zahir*¹². Coelho tells the story of two fire-fighters who take a break from fire-fighting. One has a clean face and the other has a dirty, sooty face. As they are resting beside a stream, one of the fire-fighters washes his face. The question is posed as to which of the fire-fighters washes his face. The answer is the one whose face was clean, because he looked at the other and thought he was dirty.



The idea of the looking-glass-self (Cooley, 1902)¹³, whereby a person’s self-concept is tied to their experience of how others view them, has pervaded my life and my practice since I stumbled across the concept as a university student. Empirical studies have shown that the self-concept of children and young people is shaped by their experience of how others view them. In my work, this has created a tension between acknowledging the ill-effects of a tough start to life and encouraging a more helpful focus among those who interact with so-called ‘traumatised children’ in a care and management role.



I am just as fallible as the next person, and I do not have all the answers. But as a professional who interacts with these children and their caregivers daily, I strive to find a balance between acknowledging and addressing the ill-effects of a tough start to life and promoting a more helpful perception of them. I strive to present opportunities to these children for them to experience themselves as good, lovable and capable; to experience me and other adults in their lives as interested in them, as caring towards them and as delighting in their company; as well as experiences that the world is a safe place where their needs are satisfied. I strive to enhance their

experience of living and relating, rather than dwelling on *repairing the damage* that was done to them. Most of all, I see precious little humans whose potential is still yet to be discovered.

Eyes are mirrors for a child's soul. What do children see in your eyes?

¹² Coelho, P (2005), *The Zahir*. London. Harper Collins

¹³ Cooley, C.H. (1902). *Human Nature and the Social Order*. New York. NY: Scribner Publishers

Part 5: Take care of yourself too!

Eyes are Mirrors for a child's soul. What do children see in your eyes?

In reflecting on these important words, I cannot help but draw your attention to a phenomenon that in psychology we refer to as *selective attention*. Selective attention refers to a process by which we notice certain things in our environment but filter out other, equally obvious or noticeable things. We tend to selectively notice things that appeal to us on some level and those things that are consistent with our thoughts, such as when we decide to purchase an item and find ourselves noticing the item in greater numbers. It also works with ideas, such that we tend to notice evidence that confirms our ideas and fail to notice evidence that does not confirm our ideas. We refer to this as a *confirmation bias*.

Have a look at the array of simple maths equations below. What stands out for you?

$$7+8=15$$

$$6-3=3$$

$$2 \times 2 = 4$$

$$10+3=13$$

$$4+4=9$$

©Colby Pearce

$$1+3=4$$

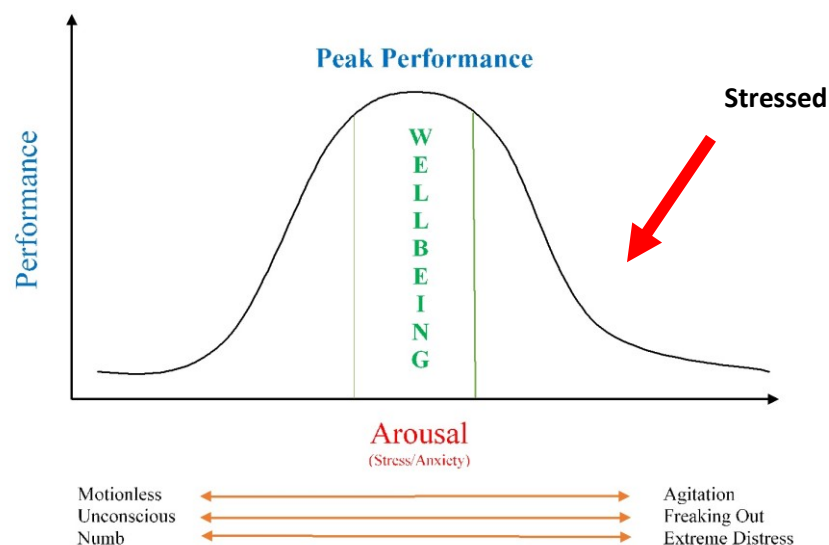
$$7-6=1$$

$$4 \div 2 = 2$$

$$5 \times 5 = 25$$

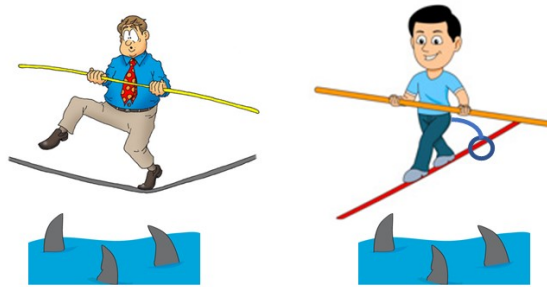
$$20 \div 2 = 10$$

When I ask people to report what stands out for them, they almost always say it is the equation in the bottom left corner ($4+4=9$). There is a *problem* with this equation. It is wrong. It is the only one that is. Nine out of ten are right, but we have a tendency to focus on the problem and not on what is right. When you are caring for a child who is recovering from a tough start to life, this selective focus on problems is a problem. It carries the risk of undermining your wellbeing and, in turn, your endeavours on behalf of the child. It will make you feel stressed. When we are stressed, we are unable to perform at our best in a task or role, as reflected in the image below¹⁴.



Our thinking is important! Our thinking influences what we see and, in turn, how we see ourselves and the children in our care. It also influences how children see themselves.

We need to work on seeing the positives; both in how we are performing your role, and in the child or children in our care.



This is reflected in the two main aims of the self-care approach we favour at Secure Start:

1. To support you to be more aware of the things that you already know and do that help the child or children in your care; and
2. To see evidence of the child or children breaking free of the effects of their tough beginnings in association with your efforts on their behalf. That is, to notice evidence of their recovery.

Both focus your attention on what is going right. Both support your wellbeing and ability to do your best. If I get you to think about what you already do that helps the child or children in your care you are more likely to consciously attend to doing those things and feel better about the role you are performing. This can be especially necessary when a child is exhibiting particularly challenging behaviour. If I get you to think about the signs that the child is recovering in your care, this too will support your wellbeing. It will also nurture the child's own positive self-image, with associated benefits in terms of their emotions and behaviour, and approach to life and relationships.

In addition to paying attention to the things that you do that help the child recover from a tough start to life, I encourage you to write a list of three to five behaviours or attributes that you consider are evidence that the child is progressing and keep a record of dates and/or times and/or places and/or situations in which you observe them. At the very least, keep a record of when you notice them, using the table on the next page. The level of detail is up to you but, at the very least, keep a tally of each instance. In doing so, you will become better and better at observing evidence of progress and maintain a more optimistic view of the child, and of the contribution you are making to their life. Better yet, you will help them to adopt a more optimistic view of themselves.

Eyes are Mirrors for a child's soul. What do children see in your eyes?

¹⁴ Yerkes R.M. and Dodson J.D. (1908) The relation of strength of stimulus to rapidity of habit formation". *Journal of Comparative Neurology and Psychology*. **18**: 459–482.

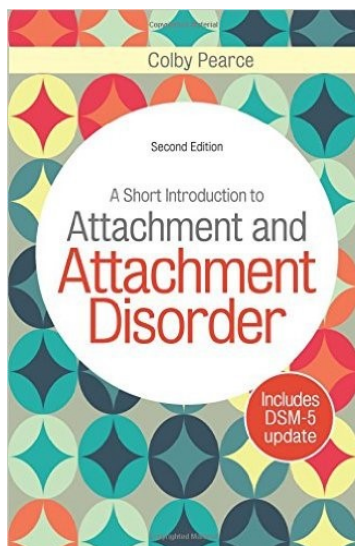
	Things I do to support the child	Signs the child is recovering and/or thriving	Observation of signs (Date or tick)
Self-Care			
Our thoughts are important!	1. _____ _____ _____	1. _____ _____ _____	1. _____ _____ _____
We ‘see’ what we are thinking.	_____ _____ _____	_____ _____ _____	_____ _____ _____
To feel successful, we need to be thinking about the things we do to support the child, and the signs the child is recovering and/or thriving.	2. _____ _____ _____ _____ _____	2. _____ _____ _____ _____ _____	2. _____ _____ _____ _____ _____
Feeling successful supports wellbeing!	3. _____ _____ _____ _____	3. _____ _____ _____ _____	3. _____ _____ _____ _____
Wellbeing Index (Rate from 0 – poor - to 10 – great – week-by-week)	_____		

Conclusion

Thank you for taking the time to read and consider this resource. I do hope that you will find it to be useful in your work with children who have experienced a tough start to life, especially in this difficult time, and that you experience the satisfaction that comes from making a positive contribution to their lives. I hope that both the children and you will thrive during your time together and that you are experienced by them as 'One Good Adult' who, in years to come, they will think back on as someone who supported their self-worth and willingness to make meaningful connections with supportive others. In achieving this, you will have made a valuable contribution to their longer term physical and emotional wellbeing and successful approach to life and relationships. I wish you well!

If you find this resource helpful and are able to make a donation towards the cost of production, please click [here](#).

Further Reading:

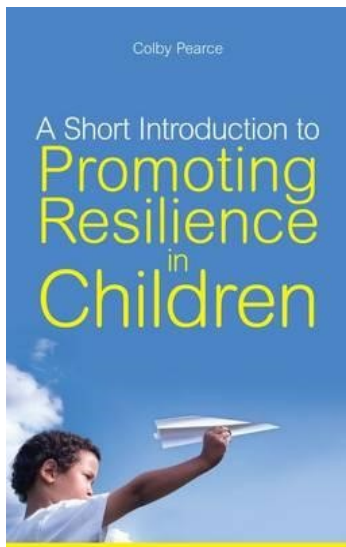


Accessible and jargon-free, after reading this book you will gain:

- A better understanding of attachment theory and how attachment impacts children's development and approach to life;
- A better understanding of what happens when attachment relationships go awry and how to get things back on track;
- A better understanding of the treatment of Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED)

This book is widely-regarded as the ideal starting point for those interested in attachment theory, what happens when attachment relationships go awry, and what to do about it. Written in an accessible style, it is suitable for diverse audiences; including foster parents, adoptive parents, kinship carers, and residential care workers. Highly regarded among teachers and educationalists who interact with children that have experienced complex developmental trauma, it is also rated highly as a resource for mental health professionals, including psychologists, psychiatrists, social workers, occupational therapists, psychotherapists and counsellors.

A Short Introduction to Attachment and Attachment Disorder can be purchased through securestart.com.au.

Further Reading:

Throughout our long history, humankind has been remarkably successful at overcoming adversity and thriving on the opportunities presented by world in which we live. You could argue that humans are one of the hardiest species to inhabit the earth. Theories of evolution claim that abilities and attributes that aid in survival are passed on from generation to generation because the individual passing them on lived long enough to have children. Given the length of time humans have been evolving in their present form (roughly 30,000 years), it might be argued that all people have within them the inherited potential to be resilient.

Ensuring that children achieve their potential to be resilient is a universal concern of parents, caregivers and professionals who work with children. A child's capacity to cope with adversity and 'stand on their own two feet' is seen by those who have a caring concern for children as an important part of a child's development and essential in order to achieve independence and success in later life. However, perhaps just as universal is the concern for shielding children from physical and emotional distress. These seemingly competing concerns are a source of confusion and heartache for those who have the best interests of children at heart and have the potential to obscure their vision of what is, indeed, in a child's best interests. I wrote this book in order to provide parents, caregivers and professionals who work with children a clear vision of how to ensure that children realise their natural inheritance to be resilient, without precipitating conflicts and confusion about a child's best interests.

*A Short Introduction to Promoting Resilience in Children was written with a general parenting audience in mind. The book sets out an evidence-based model of care in the home, educational and professional care setting that is fundamental to the promotion of wellbeing and resilience in children. Written in an accessible style, it is suitable for most readers and is an obvious companion to those who want additional information about caregiving that promotes attachment security after reading *A Short Introduction to Attachment and Attachment Disorder*.*

A Short Introduction to Promoting Resilience in Children can be purchased through securestart.com.au.

Additional Resources:

securestart.com.au

colbypearce.net