CONNECTED CARE

Small Moments. Repeated Consistently. Change Lives.

The companion guide to
AURA by **Secure Start**

ATTACHMENT | AROUSAL | ACCESSIBILITY | RELATIONSHIP

By Colby Pearce

Grow . . .
AAA
Model of Therapeutic Care

securestart.com.au

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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 challenging behaviour in children by responding with understanding to the reason for their behaviour and, in doing so, nourish connections that support self-regulation and a positive approach to life and relationships.

Introduction

Imagine you are at work at 4:45pm on a Friday afternoon. Your supervisor (who is also your mentor) calls you into their office. You are asked to close the door and be seated. Once seated, your supervisor advises you that a serious complaint has been received about your performance and conduct at work. You are told by your supervisor that they are conducting further enquiries into the matter and that a meeting has been scheduled for 9am on Monday morning to discuss the complaint and what action will be taken. You are advised that you are required to attend the meeting.

Hold in mind that you are not aware of any wrongdoing you may have committed. Now, take a few moments to place yourself in the same or similar scenario and think about how you would feel.

I anticipate that you may feel considerable unease and worry about the matter. You may have a lot of questions about what it could be. The person with whom you would like to discuss your worries is your supervisor/mentor and, unfortunately, they are conducting the investigation. You are unsure who knows about the complaint, who does not, and who among your colleagues to trust. The potential for shame and embarrassment are impediments to approaching close colleagues for support and guidance.

You are heavily committed financially and not in a position to resign. You are not aware of any other comparable jobs that pay at the same level. Effectively, you do not have the option to leave your job.

Now, imagine you are at the Monday meeting, where you learn that it is, in fact, a colleague that has made the complaint and that a further complaint has been received from a second source that corroborates the first complaint.

What thoughts go through your mind now?

Taken together, I anticipate that your thoughts might be summarised as *who can I trust?* You may well be experiencing shock, disbelief and high levels of fear of what may happen next. That is, you might be wondering where the next blow is coming from.

Now, imagine a child who is experiencing a prolonged period of fear and emotional pain with limited or no coping strategies and the person they should be able to rely on for help is the source of their fear. Imagine this happens to the child over and over, though not with any predictability. This is the experience of children for whom Complex Trauma is or has been a part of their life.

Complex Trauma occurs where children experience:

- prolonged and debilitating fear and distress
- as a result of adverse experiences that occur recurrently and/or in combination, and

where the person or person's who are responsible for keeping the child safe from harm and alleviate their distress is/are:

- unable to alleviate the child's distress, or . . .
- are the one's responsible for the child's fear and distress.

The type of trauma being referred to here is also known as:

- *Complex Developmental Trauma* – because it occurs during a period of formative development and shapes all aspects of the child's development;
- *Attachment Trauma* – because it usually occurs in the context of the child's first attachment relationships, where one or other or both of the child's first attachment figure(s) is responsible for the trauma experience;
- *Abuse* – an act of commission that results in physical and/or emotional and/or psychological harm; or
- *Neglect* – an act of omission that results in physical and/or emotional and/or psychological harm.

Hereafter, and throughout this resource, I will refer to the experiences of these children generically as *early trauma* and *trauma at home*.

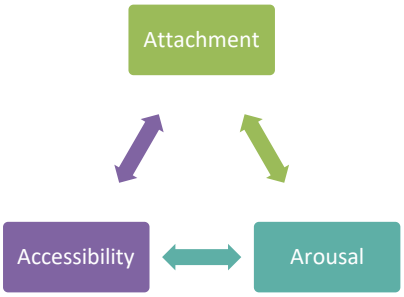
My name is Colby Pearce and I am a Clinical Psychologist with thirty-five-years-experience as an applied researcher, clinician, writer and trainer in child and adolescent mental health and child welfare. For almost all my working life I have offered professional services to children and young people who have experienced trauma at home, and adults who interact with them in various roles (including parents, foster carers, kinship carers, residential carers, adoptive parents, teachers, social workers, youth workers, and judicial officers). I am the author of the Triple-A Model of Therapeutic Care, which is in its eleventh year of implementation by the TUSLA (Child and Family Agency) Fostering Service in Donegal, Ireland. I am also the author of the CARE Curriculum, which was delivered to statewide statutory kinship care programs in South Australia between 2018 and 2025.

This resource serves as a handbook for the **Triple-A Model of Therapeutic Care** (Residential Child Care Version) and a companion to the **AURA by Secure Start** app, which is available now in the Apple App Store and the Google Play Store. The AURA by Secure Start app offers a conceptual frame for understanding, reflecting on, and maintaining a therapeutic approach to the care of children and young people impacted by early trauma and adversity, drawn from evidence-based conventional caregiving and relational activity. The app reflects a need for alignment in care and relational experiences between adults who deliver reparative, therapeutic care; where inconsistencies in caregiving and relational behaviours manifest as primary trauma triggers.

The word 'aura' is defined as the unique characteristics and qualities projected by a person or place, and which are experienced by others. As such, it represents a useful way of thinking about what a therapeutic environment looks like. The word 'aura' can also be represented as an acronym for the following fundamental caregiving and relational behaviours that support development and facilitate recovery from relational trauma:

Accessible: The child or young person in your care experiences you as being *there for them*.
Understanding: The child or young person in your care experiences you as acknowledging their experience in your words, actions, and projected emotions.
Responsive: The child or young person in your care experiences you to be responsive to their needs without them having to control or regulate your behaviour to make it so.
Attuned: The child or young person in your care experiences you to have and project empathy for their experience.

The AURA framework represents an accessible way to maintain a trauma-informed, therapeutic caregiving environment based on conventional aspects of caregiving and relating that are evidence-based. It also supports repair to key aspects of the internal world of the child or young person who experienced trauma at home, especially their:



Attachment Style - incorporating the beliefs about themselves, others and their world that influence the manner in which they approach life and relationships;
Arousal – the level of activation of their nervous system which influences emotions, learning, behaviour, and, in combination with attachment beliefs, their anxiety proneness; and
Accessibility, to needs provision – what they have learnt about how to get their needs met.

This is the Triple-A Model which provides a comprehensive explanatory framework for how early trauma impacts the developing young person, what should be the focus of therapeutic endeavours, and what recovery from trauma looks like.

After reading this resource you can expect to be able to develop and implement a therapeutic care plan to support a child's recovery from early trauma and 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 *behaviours that are not yet understood* and implement practical steps to respond therapeutically to the reasons for 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 early adversity, and positive outcomes for the children and young people themselves.

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 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 caregiving and relationships with children and young people who have experienced early adversity.

Children are not preoccupied with physical, emotional, and relational needs that were met consistently during the (early) developmental period. They are preoccupied with needs that were met inconsistently. Their behaviour, in turn, reflects their preoccupation. To address preoccupied behaviour, we must first meet the need that gave rise to the preoccupation.

Part 1: Three things you need to know about the impact of early trauma and adversity

Early trauma and adversity impact three key factors that play an important role in the developing child's approach to life, learning/development, and relationships:

- **Attachment** (or, more specifically how the child's attachment experiences have shaped their unconscious representations/beliefs about themselves, others and their world);
- **Arousal** (or the psychophysiology 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 role for needs provision).

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 II[1]. Since its early development, Attachment Theory has been the focus of an enormous amount of research and has become widely used as it offers an explanatory framework for differential outcomes for children based on caregiving experiences.

Relationship with:

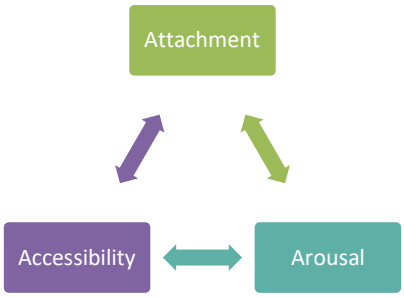
- Self
- Other
- World

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*).

- Performance
- Feelings
- Behaviour

Accessibility to needs provision refers to what children have learnt about the reliability and predictability with which their needs will be responded to by adults in a caregiving role and learnt behaviours that serve to reassure the child that their needs will be provided for. Accessibility to needs provision is based on Learning Theory and the Operant Conditioning paradigm[2, 3].

What children have learnt



In combination, I refer to these three factors as the "Triple-A Model"; or "Triple-A" for short[4]. In the sections that follow I will explain each factor further and how it is impacted by early adversity. 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 early adversity.

Attachment

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[5, 6]:

- Secure
- Insecure Avoidant
- Insecure Ambivalent
- Disorganised

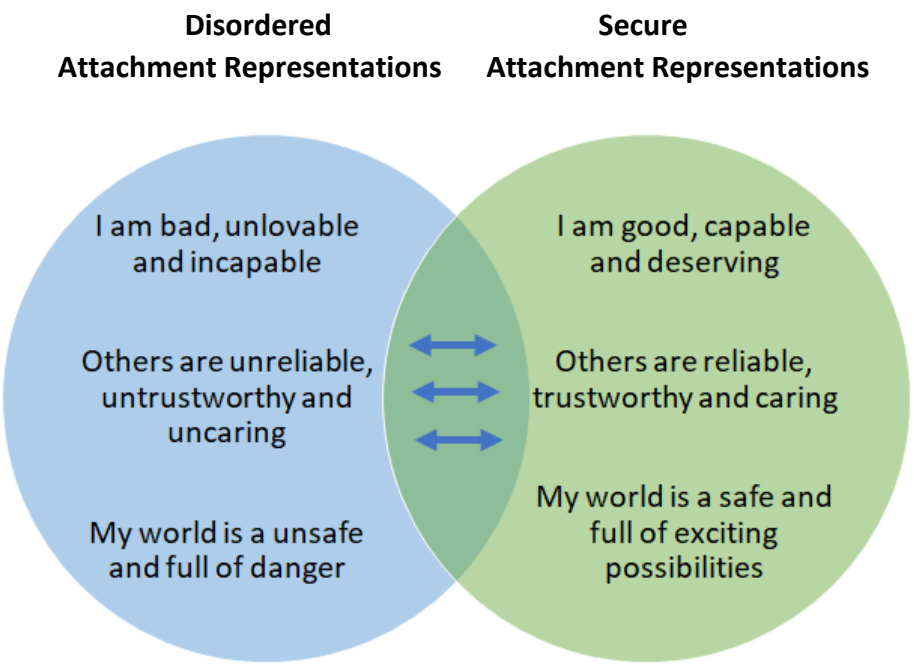
A *Secure* attachment style is recognised in those children who use attachment figures as a safe base and source of feelings of wellbeing from which to launch into the world and explore without undue anxiety. When these children are distressed during the early developmental period, they are easily soothed 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 do not readily orient to their primary attachment figures for comfort. Their exploration of, and interaction with, their environment/world is limited by the restricting and debilitating effects of unresolved distress. Though they may appear to be resilient, they are in-fact highly anxious.

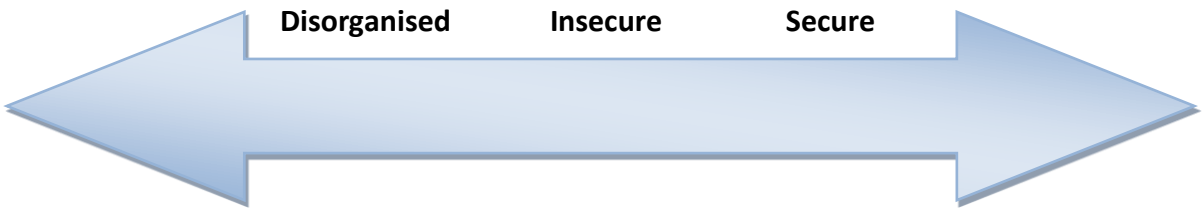
An *Insecure Ambivalent* attachment style is recognised during the early developmental period in those children for whom closeness to or reunion with their primary attachment figures is not sufficiently comforting or reassuring for them to launch out into their world and tolerate separations. As a result, 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 who interact with them in care and management roles. 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 to 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.

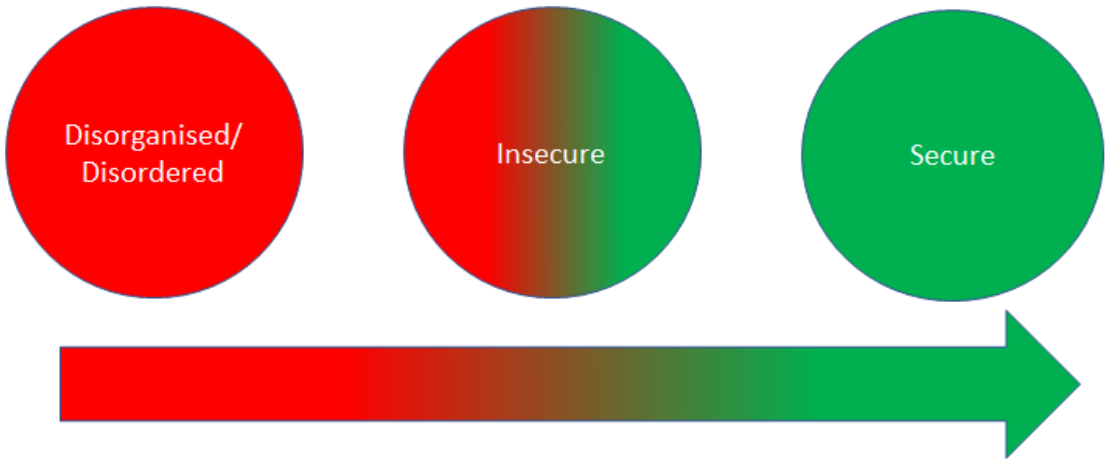


Children who have a secure attachment style approach life and relationships predominantly under the influence of secure attachment representations. Though they sometimes think in a disordered way (as we all do) depending on their contemporary experiences (hence the bi-directional arrows), their predominant 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 early adversity 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 early adversity do so in a manner that promotes and strengthens time spent under the influence of secure attachment representations*.



Arousal

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, 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 development[1].

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.

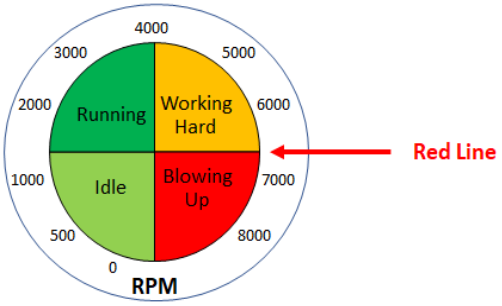
The instinctive behaviour response system that is initiated when a human is anxious is referred to as the fight-flight-freeze response. In children, this presents as:

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

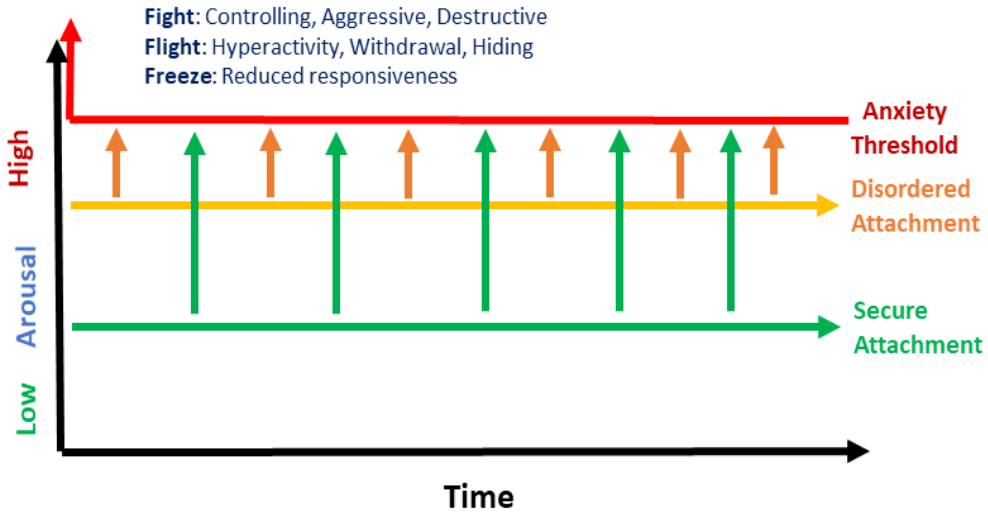
[1] A child's understanding of their world and development of skills are supported by exploration. Hence, any restriction to exploration will likely have a corresponding impact on the child's developing understanding of their world and skills to negotiate it.

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.

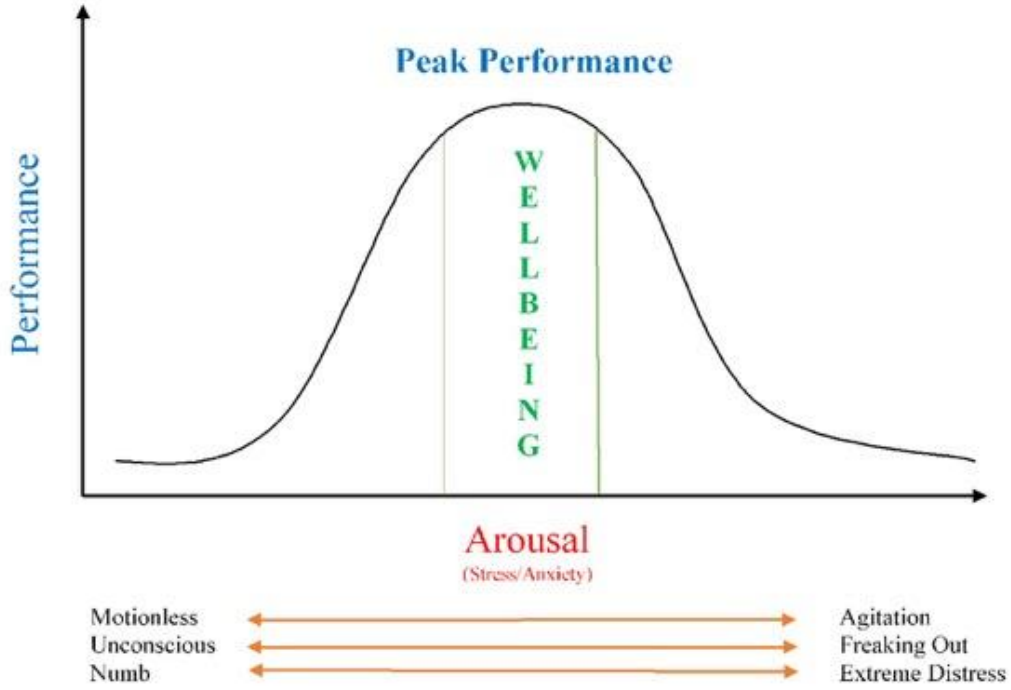
The anxiety response is tied to high levels of physiological *arousal*. Arousal refers to the level of activation of a person's nervous system. Each person's nervous system can be likened to the motor in a car. As with the motor in a car, a person's 'motor' has a speed at which it idles, a typical running 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.



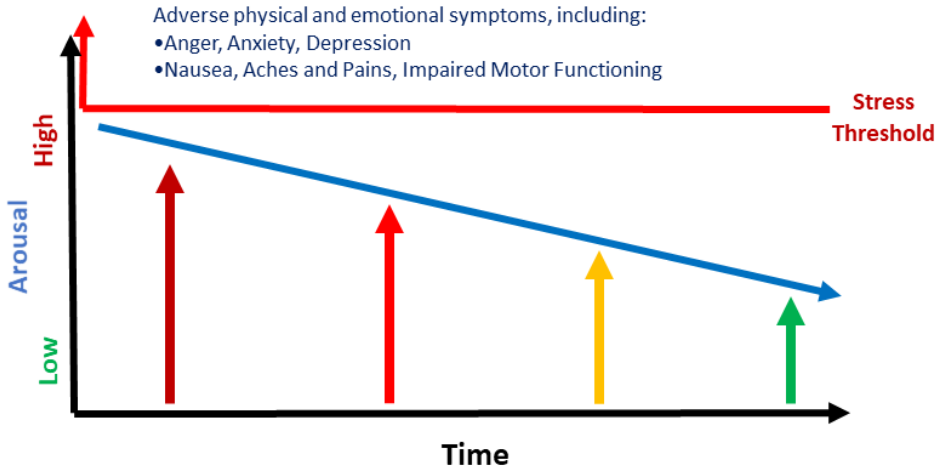
The difference between one person and another is how close to the 'red line' their idle is set and, therefore, how much they can tolerate increases in arousal when they perceive a threat. The 'motor' of children who have experienced early adversity typically idles faster than those who have not. This 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 early adversity 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 Law[7], 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 early adversity and slow their idle!



Accessibility to Needs Provision

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 do not, 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 home 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.

In this context, 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 early adversity; 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 early adversity 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 early adversity 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 to be accessible and responsive for needs provision*.

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

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

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Part 2 – Addressing the impact of early adversity on functioning and performance at school

Enrichment

Across a career spanning more than 30 years I have spent much of my time engaging with caregivers of children who are recovering from early adversity.

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 early adversity 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 early adversity 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 into old habits and ways in which we have always done things. This is a big problem for children who have experienced early adversity 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 early adversity 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.

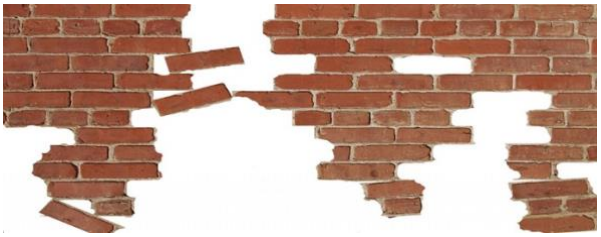
Let's have a go. In the table below, write in the space available what experiences of care infants need to grow up happy and healthy and to achieve their potential. Next, do the same for children and teens. Finally, make a list of the experiences of care adults need to be happy and healthy and perform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

Infant	Child	Teen	Adult

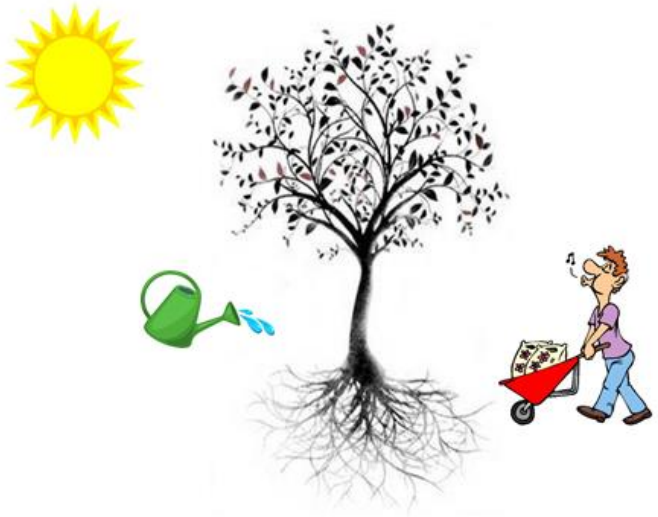
I expect that your lists are pretty similar, whether we are talking about an infant or an adult or all the ages in between. We all need certain experiences of care. It can just look a bit different in how it is put into practice for an infant versus a teen, and so on

Children who have experienced early adversity have often missed out on important experiences of caregiving and relating that support optimal development and wellbeing. They have not had enough of these experiences, or they have not had them consistently enough. This can occur when the child's needs overwhelm the capacity of adults in a caregiving role to meet them consistently, or where the home environment is problematic. Consistency is important, as I explained in the previous section about what children learn about accessibility to needs provision. 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' then. Remember your list above. Our care needs 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 early adversity, 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 person you have never met _____
2. An employer _____
3. A friend _____
4. A sibling _____
5. Your life partner _____
6. Your parent _____
7. Your child _____

When I ask people to do this task, I sometimes get asked questions like how old the stranger is or whether there is some other issue that impacts their vulnerability (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, for example. 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 I am advised that it is how the person would be perceived by those close to them that is their biggest concern (and regulating influence).

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 . . .

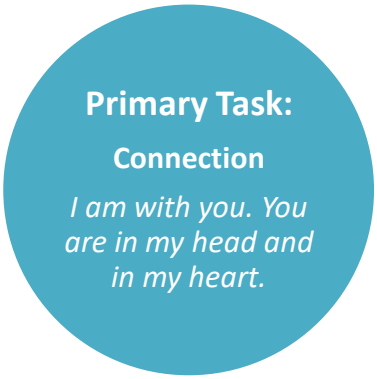
. . . than those young people who reported having at least one adult that they can depend on[8]. *Connection matters*!

Sadly, many troubled children who have experienced early adversity 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. As Megan Corcoran said on an episode of The Secure Start Podcast, *you don't need to be a therapist to provide a therapeutic experience[9].*

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 early adversity 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.



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.

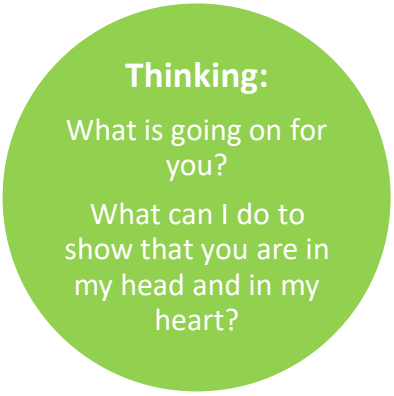
Consider the child who boasts compulsively of their physical prowess.
The child feels unsafe.
Behaviour is a form of communication.

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 early adversity lies in part one of this resource; that is, their behaviour is likely to be under the influence of one or more of:

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

In terms of what to do to address the performance and adjustment at school of children who have experienced early adversity, I recommend that you are mindful of your AURA, and implement a plan to enrich the experience of others of it:

- Accessibility
- Understanding
- Responsiveness
- Attunement.

Consistency

Before I go through the AURA dimensions, I just want to say something about the importance of consistency in your approach to the care and management of children in your home.

Remember the operant conditioning experiments I referred to earlier? These experiments highlight the importance of consistency and the impact of inconsistency. Whatever you endeavour to do for and behalf of children who have experienced early adversity, the consistency with which you do it is important. Similarly, it is important that children who have experienced early adversity observe you to be consistent in your approach to all children in the home; including them. This means that any strategy you implement for and on behalf of children who have experienced early adversity, you need to also be doing it for the other children. This is why the strategies that I recommend as part of the AURA model 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 contrast, consistency is, ultimately, soothing. We all need

consistency. Some children who have experienced early adversity can be uncomfortable, initially, in a consistent and consistently responding environment; as it is *inconsistent* with their experience and learning. 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 of caregiving.

Consistency does not only 'slow the idle' (and therefore, the general running speed of the 'motor'). Consistency ensures that the child who has experienced early adversity perceives the home as a predictable environment and, in turn, safe. Consistency of approach to the child who has experienced early adversity reassures the child that they are just as worthy as the next child and, so long as you implement the AURA 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 early adversity.

In order to enrich consistency, I would first ask you to download the AURA by Secure Start App from the Apple App Store or Google Play Store. This app provides daily reminders to stop and reflect on your delivery of the strategies that make up the AURA model, and by extension, your personal aura and the aura of your home. It also supports your reflection on how the day went. You can respond to the app in relation to individual children, or the home as a whole. You can review your responses for the past week and past month and share your responses with others via the 'export' provision.

Accessibility

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

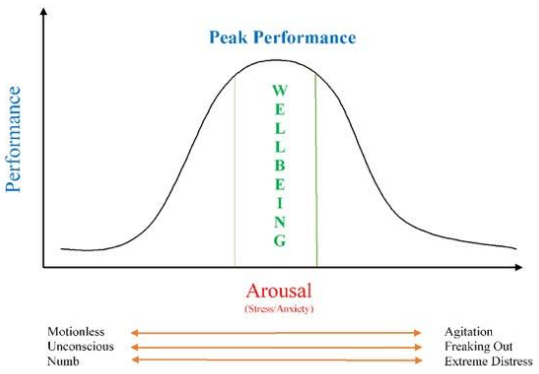
- one of these friends rarely initiates contact with you, and
- the other friend initiates contact with you on a regular, non-intrusive basis.

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.



I am good, capable and deserving

Others are reliable, trustworthy and caring

My world is a safe and full of exciting possibilities

In non-adverse circumstances, children typically experience their parents as being accessible to them. From infancy, their parents attend to them *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 caregiving role are available and attentive without them having to go to any great lengths to make it so. The process by which they have learnt this is that their caregivers have attended to them *proactively*.

I am bad, unlovable and incapable

Others are unreliable, untrustworthy and uncaring

My world is a unsafe and full of danger

In contrast, children who have experienced early adversity too often experience their parents as inconsistently accessible; whether this be due to the child's needs overwhelming the capacity of their parents to meet them consistently, or where some aspect or other of the home environment is problematic. These children have learnt that they cannot always rely on adults in a caregiving 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. As Richard Rollinson said on an episode of The Secure Start Podcast, *when children fear that they are not in your mind they produce behaviours in order to be on your mind*[11].

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 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 is typically learnt by children who were raised in non-adverse circumstances. 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 (be 'on' your mind), you need to attend to them *proactively*.

Your Task:

In order to enrich their experience of your *accessibility* to them, first make a list of the times you already attend to the children in your home 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 children in your home seek your attention and closeness to them 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 a child before they do anything to make it so; or

2. Choose one of the times that you respond to a 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 early adversity 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 early adversity 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.

Understanding

In conventional nurturing care environments, adults in a caregiving role typically 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. They do this because baby cannot tell them what is going on for them and what they want, in words. Rather, the adult who is caring for them must work it out, generally through observation and reflection on the cues the baby gives, and the circumstances at the time. In non-adverse circumstances, the adult is usually successful in answering the question '*What's going on for baby?',* and the 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.

For children who have experienced early adversity, their adult caregivers may have asked and answered the question *what's going on for baby,* but due to the circumstances that existed they may have done so inconsistently, or insufficiently, or relied on a limited understanding and got it wrong too much of the time. As a result, the child who has experienced early adversity 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.

We can enrich a child's experience that their inner world is understood and important in our words, our actions, and our projected emotion. In terms of the AURA model, the first and, perhaps, most influential step in enriching the child's experience of being understood, is through words.

Your task:

Record some of the *statements* you typically make about the experience of children in your care (you may wish to do this over a couple of days):

_____

_____

_____

_____

Describe an activity or situation involving a child or children in your care:

_____

_____

_____

_____

What do you think is likely to be the experience (thoughts, feelings, needs) of the child or children in your care of the activity or situation?

_____ _____

_____ _____

_____ _____

What are some short (less than 10 words) statements you could say that communicate understanding of each child's experience (thoughts, feelings, needs) 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.

Responsiveness

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 caregivers to make it so. They no longer worry about the responsiveness of their adult caregivers. They develop optimistic beliefs about the responsiveness of adult caregivers 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 caregivers, to make it so.

Sadly, this is not always the case for children who have experienced early adversity. In order to support more optimistic ideas about their worth and deservedness, the responsiveness of adult caregivers, 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.

<u>Your task:</u>

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

_____ _____

_____ _____

_____ _____

_____ _____

Next, I want you to think about each child 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. Address this aspect of their experience or need proactively!

Verbalising understanding and addressing their needs proactively supports experiences for the child who has experienced a tough start to life that they are cared for and cared about, thereby supporting secure attachment representations, optimal arousal for wellbeing and success, and trust in adult caretakers for needs provision.

Attunement

Attunement 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 caregiver 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 caregivers assist the infant to regulate their emotions (co-regulation) until the infant can do so themselves (self-regulation). Through adult caregivers tuning in to the emotions of the infant and helping them to return to calm, the adult caregiver supports the infant's safe exploration of emotions and a broad emotional repertoire. Further, within this emotional connection the adult caregiver 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 caregiver can be relied upon, including for needs provision.

For reasons expressed earlier, the experience of attunement from their adult caregivers is often inadequate for the child who has experienced early adversity. As a result, 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 caregivers 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 attunement for children who have experienced early adversity and trauma.

Attunement 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 early adversity 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 hypervigilant child. 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 early adversity 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 early adversity and might be diagnosed with Reactive Attachment Disorder.

In order to enrich attunement for the child who has experienced early adversity I first suggest that you make a list of the emotions commonly presented by children in your home 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 home, and the emotional tone of the home as a whole.

Next, I recommend that for each child in your home you think about an activity or task you have engaged in with the child. 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 matched 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:

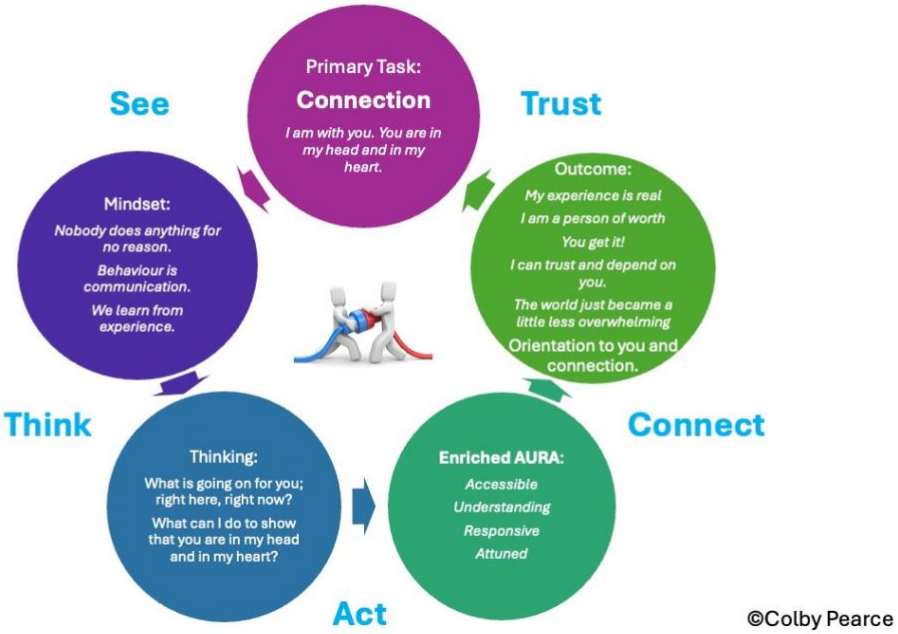
So now you have strategies for supporting the child's experience of connection from you. Anticipated outcomes for the child are thoughts that:

- 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 early adversity 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 early adversity created the problem, an enriched AURA will address it therapeutically!



[8] *My World Survey*; Dooley and Fitzgerald (2012)
[9] Corcoran, M. (2025), *How Supporting Adults creates the safety children need to learn, belong, and heal*. The Secure Start Podcast, Episode 25, 5/10/25.
[10] Kahn, W. A. (2005) *Holding Fast: The Struggle to Create Resilient Caregiving Organisations*, Hove and New York: Brunner-Routledge.
[11] Rollinson, R. (2025), *Learning to live with yourself and others: Insights from Therapeutic Residential Care*, Episode 14, 13/7/25

Part 3 Responding therapeutically to Behaviours of Concern Using your AURA

Before we get into this topic, I want to start with an explanation of why conventional behaviour management does not work when applied to children and young people recovering from early adversity.

Lessons in Learning: Some truths about behaviour management

Conventional behaviour management, as it is widely used in the care and management of children, incorporates three main techniques:

- Reinforcement of wanted or desired behaviours;
- Punishment of unwanted or undesirable behaviours; and
- Extinction of unwanted or undesirable behaviours by ignoring or otherwise removing the outcome desired by the child (reward/reinforcer) for such behaviours.

The psychological science behind these techniques comes from the Operant Conditioning Paradigm. Developed by academic psychologist B. F. Skinner in the 1930's, the Operant Conditioning Paradigm asserts that a behaviour becomes part of an individual's repertoire if in its action the individual receives some form of desired or desirable reward or achieves a desired outcome.

Think of a conventional school classroom. Children learn that in order to gain the attention and assistance of the teacher they must raise their hand. When they raise their hand, they are rewarded with the teacher's attention and assistance. Of course, during their early schooling children are told that this is the behaviour they must perform in order to gain the teacher's attention and assistance. They are reminded to do so when they call out or seek the teacher's attention and assistance by other, less desirable means. Children also see other children raise their hand and gain attention and assistance from the teacher (a.k.a. social learning). But what if the teacher did not respond to hands being raised or only responded sometimes? Would raising one's hand become part of a child's behavioural repertoire to gain the teacher's attention and assistance?

The answer to this questions lies in the three main conditions under which an action was reinforced (or not) in the original operant conditioning experiments. In those experiments rats and pigeons were placed in an experimental apparatus called a Skinner Box. The Skinner Box was a plain box with a lever or button and a chute. The chute was connected to a feed bottle located above the Skinner Box. The apparatus was set up to release a food reward (or not) via the chute in response to presses of the button or lever. The basic experiment involved seeing how well the animals learnt to press the button or lever under different reinforcement conditions. The reinforcement conditions were as follows:

1. Consistent (or Continuous) Reinforcement, whereby the animal received a food reward for every press of the button or lever;
2. Inconsistent Reinforcement, whereby the animal received a food reward sometimes when they pressed the button or lever; and
3. No Reinforcement, whereby the animal never received a food reward for presses of the button or lever.

Animals in condition 1 soon learnt to press the button or lever in order to access a food reward. Once they had learnt this, these animals appeared to only press the button or lever when food was required.

Animals in condition 2 were slow to learn to press the button or lever to access a food reward. Once learnt, these animals pressed the bar or lever at a higher rate and with greater persistence than the animals in condition 1.

Animals in condition 3 soon lost interest in the button or lever and never learnt that they might access food by pressing the button or lever.

What has all this got to do with human children? Apart from remembering that we too are animals, think of the infant's acquisition of spoken language. The infant babbles and occasionally makes a noise that approximates a word. Perhaps in imitation of what they hear from their mother-figure, that noise is "mu" or "ma". The response of the mother-figure typically is delight and the bestowing of attention on the infant. The infant is rewarded for uttering "mu" or "ma" and repeated consistently enough, the infant learns to secure their mother-figure's attention and delight by saying "mu" or "ma". Such is the beginning of language acquisition.

Rewarding desired behaviour

So, in terms of behaviour management, children learn new, wanted and desired behaviours most quickly, and only perform such behaviours when required or it is desirable to do so, when the behaviour is consistently reinforced/rewarded. Where the behaviour is reinforced inconsistently, the children are slow to learn and, when they do, they are prone to engaging in the behaviour with high rate and great persistence, which can be a problem. If it is never rewarded/reinforced, they never learn.

Punishment

Punishment works differently. Punishment involves substituting the desirable reinforcer/reward for something undesirable for a behaviour that has already gone through an operant conditioning process. In later experiments, Skinner introduced aversive consequences into the operant chamber. When lever presses were followed by mild electric shock, response rates declined[12]. Subsequent behavioural research has shown that punishment may also produce undesirable side effects, including fear, anxiety, avoidance and aggression[13,14]. In humans, fear impairs learning and can precipitate fight, flight or freeze responses, thereby undermining the intended benefits of punishment.

Extinction

Ignoring the unwanted or undesirable behaviour that has already gone through a conditioning process, also called extinction, is the third behaviour management technique referred to above. In operant conditioning terms, it involves taking away the reward/reinforcer. In further research involving rats and pigeons that had learnt to press the button or lever under conditions of either consistent or inconsistent reinforcement, the food reward was taken away. What happened next is, from my perspective, one of the most interesting and least widely known aspects of the operant

conditioning paradigm. As you might expect, the rats and pigeons who originally received a food reward for each and every press of the button or lever were quick to learn that conditions had changed and soon stopped pressing the button or lever when the behaviour was no longer reinforced. In contrast, the rats and pigeons whose behaviour developed under inconsistent reinforcement conditions were slow to learn that conditions had changed and continued to press the button or lever with a high rate and great persistence.

In behaviour management terms, extinction works best when the unwanted or undesirable behaviour was originally rewarded/reinforced on a consistent basis and when the reward/reinforcer is taken away *completely*. Extinction is less successful when the unwanted or undesirable behaviour was rewarded/reinforced on an inconsistent basis. The child is slow to learn that conditions have changed and will continue to display the unwanted or undesirable behaviour at a high rate and great persistence, giving the impression that extinction is not working.

What is worse, if you cannot ignore (or remove the reinforcer) or punish the unwanted or undesirable behaviour consistently, the child and their behaviour is on an *inconsistent reinforcement* paradigm; meaning that they will continue to perform the unwanted or undesirable behaviour in anticipation of it being rewarded/reinforced at least some of the time.

Behaviour management is further complicated by the fact that, for many children, their unwanted/undesirable behaviours developed under conditions of inconsistent reinforcement; as is the case in children raised in chaotic households or where abuse and neglect are a feature. These latter children might view punishment and extinction as *desired* outcomes of their behaviour, though abused and neglected children are also more likely to exhibit undesirable behaviours associated with activation of the fight-flight-freeze response when they are punished or denied access to a desired outcome.

Adults in a caregiving role with children cannot rely solely on conventional behaviour management to address all unwanted or undesirable behaviours. Fortunately, there are other, effective ways to promote positive behaviour in children. These are the subject of much of my written work and programmes.

Another Way

I would like for you to re-read this section after you have been an AURA Plan for a minimum of four weeks. When you do so, I anticipate that you will have experienced a positive change in the way you think and feel as an caregiver, and that you have noticed positive changes among children in your home who have experienced early adversity. You may even have noticed positive changes in other children, and the home as a whole.

Though I consider that, most often, the frequency, intensity, and duration of behaviours of concern will decrease as a result of using the AURA app daily, it would be unrealistic to expect that simply by doing so there will be no more behaviours of concern in the home.

So, what do I suggest for addressing behaviours of concern, as they arise, and following regular implementation of an AURA Plan? In this next section I present a process for reflecting on behaviours of concern exhibited in the home, and how to respond therapeutically to them through enriching experiences of your AURA.

Step 1: Review implementation of AURA

In the first instance, I recommend that you review your use of the AURA app to ensure that you are consistently enriching your AURA. You can access this information using the "Export" function in the app menu.

Step 2: Remember your Primary Task –*Connection*

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 the Triple A Model of Therapeutic Care, the primary task is to achieve a stable and meaningful *connection* with the child who has experienced early adversity. 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.

Remember your AURA

- Accessible
- Understanding
- Responsive
- Attuned

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 AURA, 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*;
- *Behaviours of concern are simply behaviours that are not yet understood*;
- *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 the experience of the child?
- What can I do, right now, to show that you (the child) are in my head and in my heart?

Step 3: Responding therapeutically to behaviours of concern

What follows is a reflective process that is intended to support problem solving about behaviours of concern, and the generation of strategies to respond therapeutically to them, based on the Triple-A Model and your AURA.

1: What is the name of the child you are reflecting about: _____

2: What behaviour(s) are you concerned about.

_____

_____

_____

3: In relation to this, consider the following questions:

1. If they could or would, how would the child truthfully describe themself, others, and their world?

   _____

   _____

   _____

2. How fast does their internal motor run? That is, how activated is their nervous system?

   (If you are not sure, consider the following : Are they typically restless? Are they anxious? Do they tantrum easily? These can be signs of a nervous system running too fast, for example?)

   _____

   _____

   _____

3. What does the child appear to have learnt about how to get their needs met?

   (If you are not sure, are they more or less trusting and accepting of adult care? Are they particularly demanding of your accessibility and responsiveness, or do they appear to accept that you are there for them and will respond to their needs as they arise? Are they overly self-reliant?).

   _____

   _____

   _____

4: Returning to the behaviour of concern, and your answers to the previous three questions, what do you consider might be the real reasons for the behaviour?.

(If you are still not sure, consider the following:

- What purpose does the behaviour serve?
- What is the child or teen's intention when engaged in the behaviour?
- What need does the behaviour meet?)

_____

_____

_____

Further still, you may wish to refer to the following table, which presents some of the real reasons for behaviours of concern, and how they relate to both the Triple-A Model and AURA. In consideration of regular use of the AURA app being a strategy to respond therapeutically to the children's need for enriched consistency of caregiving and relational behaviours, I have included a section on Consistency.

Insufficient AURA	**Behaviours of concern**	**Reason(s) for the behaviour (Based on AAA Model)**	**Responding Therapeutically**
Insufficient Consistency	Controlling Manipulative Demanding Charming/ Seductive Asking lots of questions about arrangements Tantrums and Meltdowns	Negativity in relation to self, others, and world. Chronic hyperarousal or proneness to hyperarousal. Anxiety proneness due to combination of high arousal and negative thinking. Problematic learning about the reliability and responsiveness of adults for needs provision.	Turn a "sometimes" thing into a consistent thing Use a calendar Use controlled choices Provide explanations Allocate roles (class monitor)
Insufficient AURA	**Behaviours of concern**	**Reason(s) for the behaviour (Based on AAA Model)**	**Responding Therapeutically**
Insufficient Accessibility	Indiscriminate sociability (any adult is a potential carer) Exaggerated dependency Clingy	Low self-worth. Fear of abandonment. Pervasive feelings of vulnerability. Anxiety proneness.	Check-in proactively Allocate one-to-one time Teach a new game/skill

	Demanding Separation Anxiety	Preoccupied with needs provision[2].	
Insufficient Understanding and Responsiveness	Poor Self-Care Bodily Function Disturbances (e.g. wetting, soiling) Lying Defiance Stealing Hoarding food Acting out, as opposed to speaking out	Low Self-Worth Low expectations of deservedness Feels unlovable Anticipates rejection Chronic feeling of emptiness Anticipates neglect Poor inner-state language Worries excessively about needs provision Craves acceptance	Verbalise understanding Respond to needs and preferences proactively Support engagement in activities of interest Support mastery experiences
Insufficient Emotional Connectedness	Restricted range of affect Inconsistent affect Reduced empathy Emotionality (poor self-regulation)	Impaired emotional development Low expectations of being loved, adequate, worthy Hyperarousal Chronic feelings of inadequacy	Model emotion expression Support diverse affective experiences Enrich empathy Co-regulate

Step 5: Now, in consideration of all of your previous responses, how do you think the behaviour should be responded to?

_____

_____

_____

[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 6: What, do you think, will be the outcome of responding in this way?

_____

_____

_____

Step 8: How might the child or young person approach life and relationships differently when you respond in this way? Write down your answer.

_____

_____

_____

The CARE Curriculum

Evidence of progress – Primary School Aged

Arousal	Attachment	Accessibility (to needs provision)
Calmness	Giving things a go	Accepting separations
Restful sleep	Confident exploration	Sharing
A range of natural emotion	Joining in	Seeking help when needed
Easily soothed	(Appropriate) Independence	Independent play
Cooperation	Readily soothed by adult	Exploration
Sustained attention (focus)	Seeking help when needed	Feeding self
Bladder and bowel control	Having fun	Independence
Attaining milestones	Making friends	
Academic success	Accepting Challenges	
	Grooming	
	Using words to communicate	
	Positive self-esteem	

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The CARE Curriculum

Evidence of progress – Teenagers

Arousal	Attachment	Accessibility (to needs provision)
Calmness	Joining in	Accepting separations
Restful sleep	Independence	Sharing
A range of natural emotion	Seeking help when needed	Seeking help when needed
Self-regulation	Having fun	Independence
Cooperation	Making friends	Ambition
Sustained attention (focus)	Accepting Challenges	Communication about experiences/needs
Academic success	Self-care (Grooming)	Self-reliance
Adult-like thinking	Empathy	
	Hopefulness	
	Dreams and Aspirations	
	Self-worth/worthiness	

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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 AURA that relate to the reason.

Troubleshooting

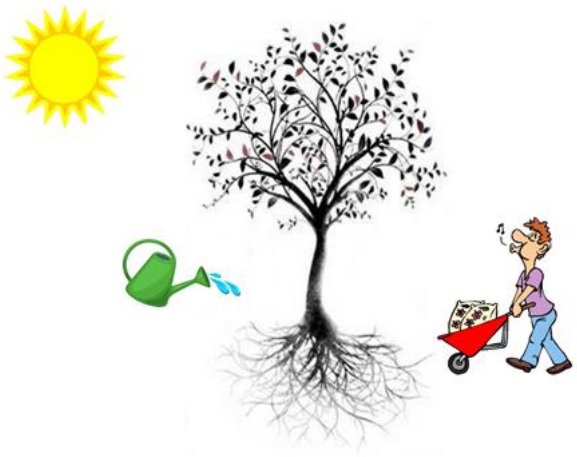
The main thing I would have you remember is that you do not have to be right all the time when attempting to answer *what is going on here*(?). Enriching the child's experience of any of the AURA dimensions recommended above will not cause them harm. If you do not see a reduction in the frequency, intensity 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 early adversity.

[12] Skinner, B. F. (1938). *The behavior of organisms: An experimental analysis*. Appleton-Century.
[13] Sidman, M. (1989). *Coercion and its fallout*. Authors Cooperative.
[14] Fontes, R. M., & Shahan, T. A. (2021). *Punishment and its putative fallout: A reappraisal*. *Perspectives on Behavior Science, 44*, 7–41.

Part 4: Adopting a balanced view

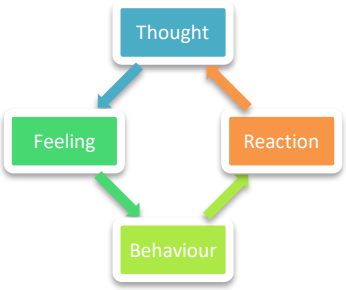
I was born in January, which is the height of summer in Adelaide, South Australia. As such, I have always thought of myself as a "summer baby" and considered that this is why I enjoy the warmer months as opposed to the cooler months. I have a lifelong aversion to feeling cold and for many, many years 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.

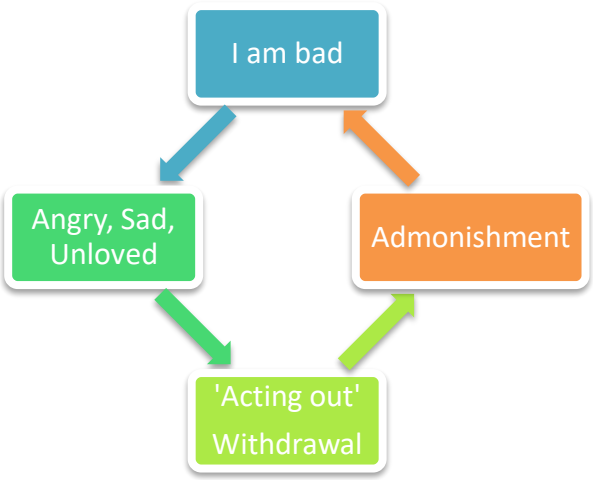


What has all this got to do with the care and management of children who have experienced early adversity? Well, it has to do with how we perceive them and the effects of this; both in terms of our own experience of interacting with them and their experience of us.

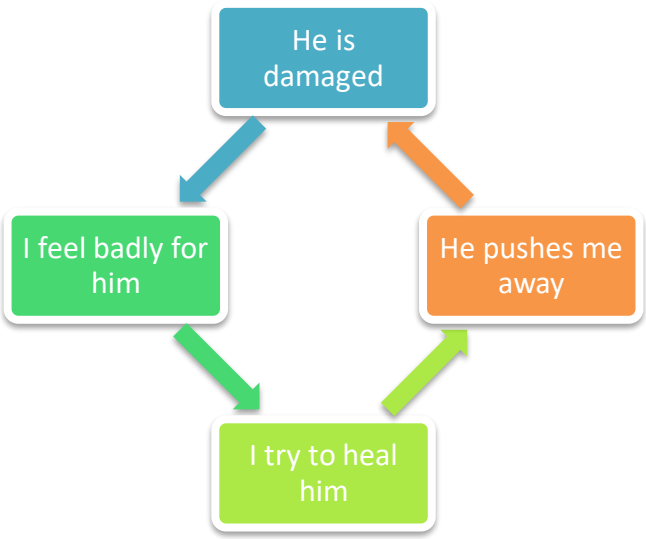
I am particularly interested in the idea of "self-fulfilling-prophecies". In Psychology, these take the following form. I have a thought. My thought induces an emotion. My emotion activates a behavioural response. My behavioural response precipitates a reaction in others. The reaction of others often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



Let's try one. Thought: ***I am bad***. Common feeling associated with this thought: ***anger***, ***sadness, unloved***. Common behavioural response to feeling sad, angry, or unloved: '***acting out'***, or ***withdrawal***. An all-to-common reaction from others to 'acting out' and/or withdrawal: ***admonishment***. An (almost) inevitable result: confirmation of the original thought – ***I am bad***.

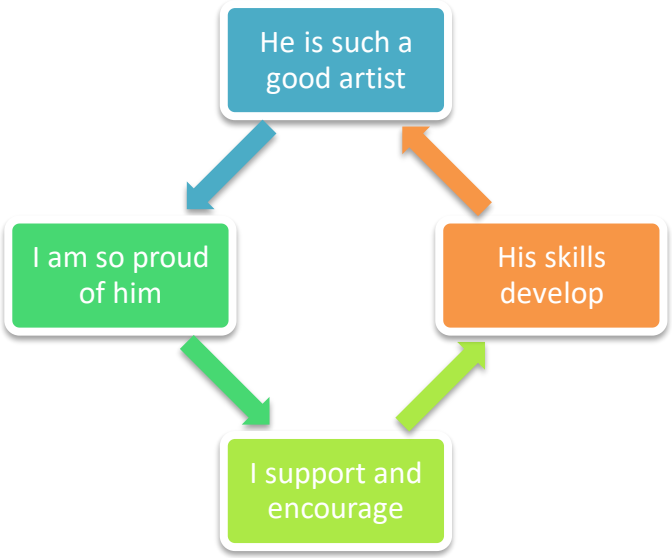


Let's try another. *He is damaged by his early experiences*. I feel badly for him. I try to heal him. He keeps pushing me away[3]. He is obviously damaged.



[3] Children who have experienced early adversity, especially as a result of adverse experiences in the home, can be 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.

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!



Children who have experienced early adversity, especially as a result of adverse experiences in the home, are commonly referred to as "traumatised". There is much literature about how early adverse experiences in the home impact 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 adverse experiences in the home 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*[15]. Coelho tells the story of two fire-fighters who take a break from firefighting. 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)[16], 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 early adversity and encouraging a more helpful focus among those who interact with 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 children and their caregivers daily, I strive to find a balance between acknowledging and addressing the ill-effects of early adversity 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 has been 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?

[15] Coelho, P (2005), *The Zahir*. London. Harper Collins
[16] Cooley, C.H. (1902). *Human Nature and the Social Order*. New York. NY: Scribner Publishers

Part 5: Take care of yourself too!

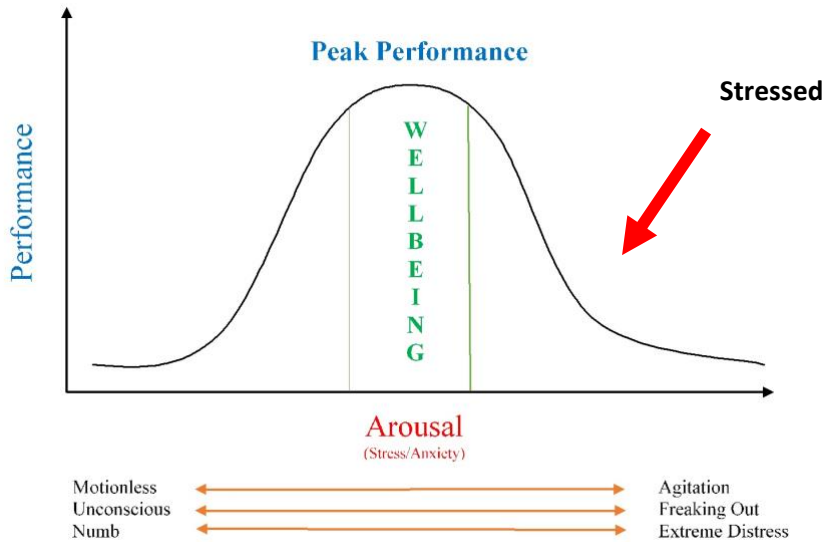
Eyes are Mirrors for a child's soul. What do children see in your eyes?

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*.

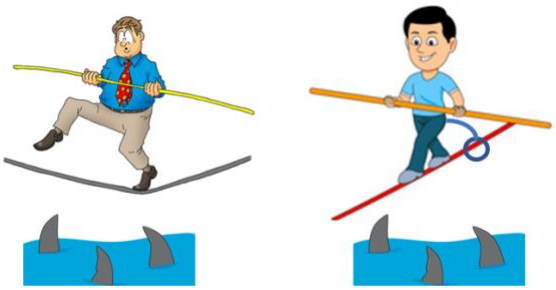
Have a look at the array of simple maths equations below. What stands out for you?

7+8=15		1+3=4
6-3=3		7-6=1
2x2=4	©Colby Pearce	4÷2=2
10+3=13		5x5=25
4+4=9		20÷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 tend to focus on the problem and not on what is right. When you are teaching a child who is recovering from early adversity, 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 below[17].



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 our role, and in the child or children in our care.

This is reflected in the two main aims of the self-care approach I favour:

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 (e.g. the delivery of AURA); and
2. To see evidence of the child or children breaking free of the effects of early adversity 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 early adversity, 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. I have included some suggestions, based on the Triple-A Model, below. 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?

[17] 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.

Self-Care	**Things I do to support the child**	**Signs the child is recovering and/or thriving**	**Observation of signs (Date or tick)**
Our thoughts are important! 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. Feeling successful supports wellbeing!	1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____	1. _____ _____ 2. _____ _____ 3. _____ _____	1. _____ _____ _____ _____ _____ _____ _____ _____ _____ 2. _____ _____ _____ _____ _____ _____ _____ _____ _____ 3. _____ _____ _____ _____ _____ _____ _____ _____ _____
Wellbeing Index (Rate from 0 – *poor* - to 10 – *great – week-by-week)*	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____		

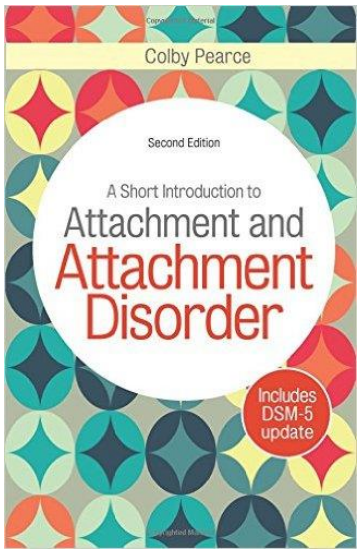
Anticipated outcomes of implementing the Triple-A Model of Therapeutic Care

Arousal	Attachment	Accessibility (to needs provision)
Calmness	Giving things a go	Accepting separations
Restful sleep	Confident exploration	Sharing
A range of natural emotion	Joining in	Seeking help when needed
Easily soothed	(Appropriate) Independence	Independent play
Cooperation	Readily soothed by adult	Exploration
Sustained attention (focus)	Seeking help when needed	Feeding self
Bladder and bowel control	Having fun	Independence
Attaining milestones	Making friends	
Academic success	Accepting Challenges	
	Grooming	
	Using words to communicate	
	Positive self-esteem	

Conclusion

Thank you for taking the time to read and consider this companion to the AURA App. I do hope that you will find it to be useful in your work with children who have experienced early adversity, 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!

Further Reading:



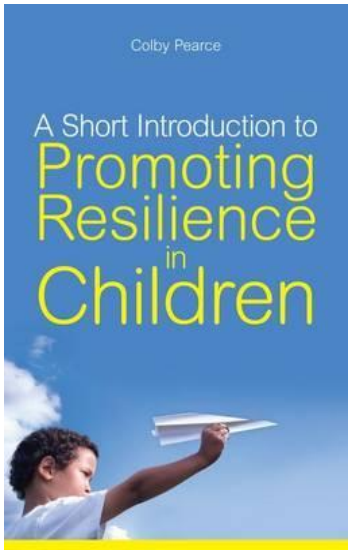
Accessible and jargon-free, after reading this book you will gain:

- 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**.

Appendix A: How long does it take therapeutic care strategies to work?

The 'failure' of a therapeutic care strategy to achieve the desired outcome on first administration does not necessarily mean that it will not or that it is a worthless strategy. Children and young people who are recovering from a tough start to life spend too much time approaching life and relationships under the influence of beliefs that caregivers are unresponsive and uncaring and they, themselves, are bad and undeserving. A therapeutic caregiving strategy takes time to exert it's influence over the attachment beliefs that influence responses to caregiving endeavours. At first, it may not be noticed by the child or young person who is selectively attending to behaviours that reflect their beliefs. If it is noticed, it may be experienced as inconsistent with their expectations of caregiver behaviour and responsiveness and difficult to trust. Further, as inconsistency is a central nervous system irritant, the implementation of a therapeutic care strategy may, in the first or early stages, give rise to a heightened response. Hence, the adage that *behaviour often gets worse before it gets better*

Notwithstanding the above, in my experience therapeutic care strategies can and do 'work', with some being quite powerful.

For a therapeutic care strategy to achieve a desired outcome, it must live up to its name. A *therapeutic* care strategy is a strategy that is intended to address some aspect of the way in which the child or young person approaches life and relationships that is maladaptive, in a therapeutic way. It must target something. In my view, a therapeutic care strategy addresses a maladaptive coping or survival strategy (and the beliefs that support them) that developed and was adaptive in an inadequate care environment, but which is no longer adaptive, such as when it precipitates exasperation and overwhelm in the contemporary caregiver. A therapeutic care strategy supports functional beliefs about life and relationships, and a functional approach to life and relationships.

This takes time; time to understand on some level that old ways of thinking and doing are no longer necessary or helpful, and to develop new ways of thinking and doing. Remember, I am talking about children and young people. This can be difficult for adults too.

A related factor that influences success in applying therapeutic care strategies is the nature of the strategy. Is it derived from psychological science and what we know about child development, or some other source? In my experience, the strategies most likely to achieve desired therapeutic outcomes are those that have a strong scientific and developmental basis to them.

Finally, in consideration of the earlier point that children and young people can be heightened by caregiver behaviours that are inconsistent with their beliefs and expectations, it is important to choose your strategy carefully and only implement it at a rate that you can sustain over time. It is better to not do anything than to start implementing a strategy, only to revert to previous caregiving practices. This only reinforces the belief that caregivers are unpredictable and cannot be relied upon. Rather, start with something simple, something that can easily be sustained over time and, inevitably, in the face of questions about whether the strategy is or will be successful. After a while, add another strategy. In my opinion, the simple things are not as foreign to children and young people who are recovering from a tough start to life as you might think. I am talking here about simple routines, checking in proactively with the child, communicating understanding of their experience and proactively responding to their needs, and being attuned to their emotional state. Most children and young people who are recovering from a tough start to life are familiar with, and have experienced some level of, these conventional aspects of care.

Appendix B: Five strategies for addressing issues with compliance in children

Children and young people who are recovering from a tough start to life are at-risk of experiencing their world as unpredictable and unsafe, and themselves as powerless and vulnerable. Often, they compensate for these experiences by seeking control and influence however they can. Too often, this can be self-defeating and result in sanctions for their behaviour, in turn perpetuating it.

Noncompliance is a strategy these children and young people use to feel as though they can influence what happens to them and feel safe. Any measure to address issues with compliance needs to recognise this and balance it with the need to support feelings of safety and potency (that is, feeling able to influence their world) for the child.

What follows are some gentle strategies that, when used in combination, help to restore adult authority and influence (which children need) while also supporting the child or young person's feelings of safety and potency. That is, they address the reason for the behaviour, as well as the behaviour.

1. Use 'controlled choices'

Also referred to as 'forced choices', this involves offering the child options that are determined by the adult. The child may be offered the choice of one shirt or another, or between brushing their teeth or their hair first, or between holding the left hand or the right hand before crossing the road. The most important thing here is that the child feels as though they have some say, which meets their need to feel in control and able to influence what happens to them. Nevertheless, adult authority and influence is reinforced as the adult determines what the options are. No choice is too trivial, though the adult must always be happy with whatever the child chooses.

2. Teach a new skill

Children often love to learn a new activity or skill in line with their needs and/or interests. When an adult supports this by teaching them a new activity or interest, the child is motivated to attend to and comply with adult directions. It is intended that the experience of complying is non-threatening, and that the child relinquishes control with no associated negative outcome that threatens their sense of safety and wellbeing. Examples of activities to teach the child include cooking, gardening, craftwork, or board and card games.

3. Don't ask; say!

Some children pay very close attention to the way we speak to them, including the language we use and tone of voice. When we ask them to do something, some children think we are offering them a choice. Rather, gently, but firmly, say what you require the child to do in a manner that projects an expectation of compliance. This strategy, though it may not always result in compliance, helps reduce the child's perception of being unfairly treated when, having been asked to do something and exercising their perceived choice to say no, the adult insists they comply anyway.

4. Help them be compliant

When you direct a child to do something, help them to be compliant. Do part of the task. The intent here is for the child to experience the adult as accessible, supportive, and safe when compliance is expected.

5. Catch them in the act

This is potentially the most helpful strategy of all. What is meant here is to observe the child and what they are doing, and gently direct them to do the *very same activity*. This is intended to help them get used to following directions, with nothing bad happening, and support a perception of adults being in control whilst avoiding challenging their own sense of choice. Again, nothing is too trivial to direct the child over. The only caveat is that it must be an activity that the adult is fine for the child to be engaging in. After a while, you may also be able to anticipate the child's next move and direct them to do this too.

Appendix C: Why does a child antagonise others then complain of being bullied?

Antagonizing others and then complaining of being bullied, though it is easily viewed as irrational and self-defeating, stems from very real (and justified) feelings of being poorly treated in life. Children and young people who have experienced relational trauma are prone to maintaining an exaggerated view of their vulnerability and the malintent of others towards them. Some compensate for this by adopting a persona of toughness and aggressiveness meant to warn others off 'messing with them'. Their intent is to maintain feelings of relational safety. Unfortunately, their aggressiveness can invite a retaliatory response from others that confirms their belief in their vulnerability and the threat posed by others. Though the attribution of bullying is made towards the contemporary (reciprocating) aggressor, the feeling of being vulnerable and bullied stems from past abuse and neglect.

Children and young people who approach the world and relationships in this way are often not amenable to endeavours to explain how they provoked aggression from others towards them. Such endeavours are incongruent with how they see the world and relationships, and their place in them. It is not a case of *they can give it but they can't take it*. These children and young people have been deeply hurt and until that hurt is healed, they are destined to maintain this maladaptive approach to life and relationships.

Another way to address this issue is to focus less on their behaviour and more on the feelings of relational vulnerability and insecurity that give rise to them. We need to intentionally, and in a sustained manner, facilitate experiences of their competency, worth, and of the sensitivity and responsiveness of others. This is conventionally learnt by the developing child in the home with adults who delight in spending time with them, anticipate and respond to their needs, share their highs and lows, and support their experience of mastery.

It is the relationships a child has with themselves and with the adults who care for them that is most influential in how they approach life and relationships. Where relationships have been inadequate, it is through enriched care that children and young people have the best chance to form more adaptive representations of themselves and others, and approach life and relationships in a more functional and self-promoting way.

Appendix D: **Why does a child lie?**

Lying is not necessarily evidence of a character flaw or lack of connection with reality. Children and young people who are recovering from a tough start to life due to abuse and neglect lie for self-protection. Such is their profound insecurity about their worth and the accessibility and responsiveness of adults in a caregiving role for needs provision, they lie to preserve connection (and access to needs provision) and avoid exacerbating pervasive feelings of shame.

Lying reflects the child or young person's desire to make and maintain relational connection with others and be viewed in a positive light. As such, lying is not evidence of antisocial tendencies. Nevertheless, lying is self-defeating as it can perpetuate the feeling of being beyond the genuine approval of others. As a result, the child or young person struggles to truly realise a positive sense of self.

For children and young people who are recovering from a tough start to life, lying comes from a place of shame and insecurity. As such, disapproval and sanctions for lying only exacerbate the reasons for lying and perpetuate the behaviour.

We need to be realistic. Most people lie, sometimes. However, if we wish to reduce this self-defeating behaviour we need to help the child or young person achieve and maintain a more positive sense of self and relational security.

When interacting with the child or young person who lies often, acknowledge their experience with your words and projected emotion, respond to their needs, and leave them feeling competent and worthy. The child or young person who has a healthy sense of their worth and feels secure about their relationships with others has less need of lying. They regulate their behaviour in consideration of their worth and relationships. You will know you are getting somewhere when they begin to take responsibility where previously they might have lied.

Appendix E: Why does a child smile when I am angry?

Smiling when you are angry is not necessarily a sign that the child or young person in your care is feeling self-satisfied and smug. Many children and young people who are recovering from a tough start to life due to abuse and neglect are unsettled by heightened emotion in adults. For them, it is associated with something bad happening.

From an early age infants smile to induce positive connection and emotion in others. The Still Face Experiments show that infants will smile to regulate connection and responsiveness from their caregivers. Viewed in this way, smiling may very well reflect an instinctive behaviour that serves to induce positive emotions and care from adults. Far from feeling self-satisfied, the child or young person is feeling unsafe and smiling is an instinctive reaction and strategy for relieving anxiety and restoring feelings of wellbeing by regulating you.

At other times (and, perhaps, at the same time), children and young people who are recovering from a tough start to life really are satisfied when you are angry at them. They crave the feeling of being understood in relation to their experience. If they are angry and successfully make you angry, they feel understood and acknowledged in their experience. They also feel able to influence the emotions (and, hence, behaviours) of others, which is profoundly reassuring.

It is important to understand and respond to the real reason for behaviours of concern. Only then will the child or young person feel heard and regulate their actions in consideration of their worth and their relationship with you.

If you accept what has been laid out above, you will see that smiling is the child or young person's way of feeling safe and understood; notwithstanding that their behaviour appears counter-intuitive and self-defeating.

N*eed trumps reason*. The child or young person may always smile when others are angry, but we should see this not as a sign of self-satisfaction or smugness, but as relating to a need to feel safe and heard in relation to their experience.

So, support them to feel competent through games and other activities and acknowledging their experience in your words, actions, and shared emotions. In time you might expect to see them as less preoccupied with controlling the emotions of others and more likely to facilitate understanding of their experience through the words that they use to communicate about themselves.