Chapter ONE

Why Relationships Matter

> *People don't care how much you know until they know how much you care.*
>
> THEODORE ROOSEVELT

Shawna sat on my office couch and let out a sigh. "We need help," she said, barely getting the words out before she began to cry. Her face was gaunt and she had dark circles under her eyes. Over the next hour, she explained what had led her to seek my help.

She and her husband had recently moved across the country with their son David, now two. His new pediatrician had expressed concern about David's ability to communicate, eventually referring him to a state-sponsored evaluation center for testing. That meeting proved challenging, as David clung to his mother, unwilling to interact with the evaluator despite Shawna's encouragement. Watching her son struggle with the simple, fun activities the evaluator presented over several visits was painful to the young mother. She was still reeling from the idea that something was amiss in his development.

Ultimately, the examiner offered an opinion: David had a delay in language and communication, "at the very least." She recommended semiweekly speech therapy and enrolling David in an early intervention program in the mornings. Immediately securing these services, Shawna still struggled emotionally. Unable to sleep, she lost her appetite and felt paralyzed at the prospect that a mysterious developmental disorder threatened her child's future. When I met her, six months into David's treatment, she reported that the carefree, joyful times she had once shared with her family were now distant memories. Now, worrying about her child's well-being caused her intense and constant stress.

Every day, parents of young children with suspected delays or disorders seek help in our systems of care. We evaluate skills and create treatment plans. But the process, so essential to providing early services to children, falls short in a significant way. Many of the professionals in our early intervention systems lack training in how to support the emotional well-being of parents and children. When a child is struggling or not developing as expected, parents experience a wide range of emotions. If we understand the nature of parents' emotional experiences, we can help them and their children if the stress of a diagnosis or atypical development arises.

Because parents and caregivers are essential to their children's development, knowing how to support them is a vital first step toward building young people's emotional resilience. Neuroscientists are increasingly reaching a consensus that emotions are among "the bioregulatory devices with which we come equipped to survive" (Damasio, 1999, p 53). Joseph LeDoux (2015) describes emotions as related to"survival circuits" that "manage interactions with the environment as part of the daily quest to survive" (p. 44).

In this daily quest to survive and thrive, all humans benefit from the brain and body's constant subconscious monitoring of threat and safety. Stephen Porges (2011) calls this surveillance process "neuroception." Neuroception is the brain's ability to detect danger. It's how we distinguish whether situations or people are safe or threatening. *For many vulnerable children, neuroception is biased toward detecting danger when there is no real danger.* This can result from a host of causes including (but not limited to) developmental differences; constitutional or brain wiring differences; environmental and/or relational stress; biomedical issues; or sensory processing challenges, which cause a child to perceive ordinary sensations as threatening.

Consider two toddlers in their first experiences at preschool:

Miguel

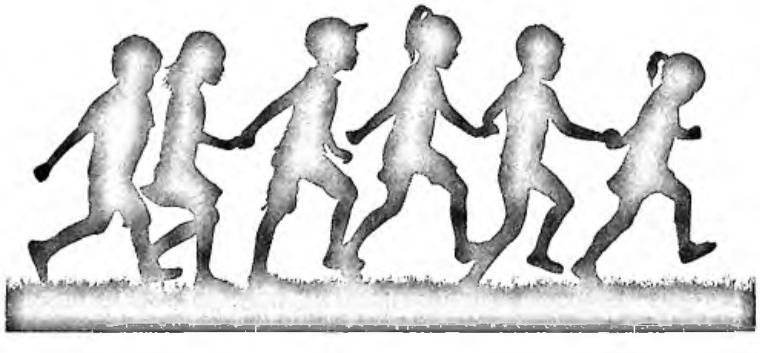
Miguel, age 3, was enrolled in a local Head Start preschool. His parents were excited to have their child start school in a program with a good reputation and lots of fun activities. On the first day, Miguel's mother stayed for an hour and watched her son explore the new environment. Before long, he was sitting next to another little boy, playing with some brightly colored blocks, occasionally looking at his mom and smiling broadly.

Understanding the Role of Neuroception in Emotional Development

***Neuroception** is:*

- ✓ A concept defined by Stephen Porges, Ph.D. that describes the subconscious detection of threat and safety
- ✓ A way of describing how neural circuits distinguish whether situations or people are safe, dangerous, or life threatening
- ✓ The ability to assess risk in the environment, and if the environment appears safe, inhibit defensive reactions (e.g. fight, flight, or freeze)
- ✓ The subconscious and immediate process of identifying familiar and trustworthy people and evaluating the intentions of others

The neuroception of safety is essential to a child's social and emotional development, ability to adapt and "take in" the environment, play, learn and engage in pro-social behaviors.



* From Neuroception: A Subconscious System for Detecting Threats and Safety (Porges, 2004)

Martin

Martin, age 3, began his first school experience at his family's church preschool. His parents were eager to see how he would do because they felt confused about his behaviors much of the time. On the first day of school, the teacher instructed them to say a quick good-bye and leave. Martin didn't seem to notice that his parents left, and as the staff later reported, he sat by himself for most of the morning. Whenever children approached him, he tried to grab toys out of their hands or hit them.

The two little boys were having very different reactions to the same experience of entering a group setting for the first time. Miguel was experiencing a *neuroception of safety*, as evident from the spontaneous play he enjoyed with a peer. Martin, on the other hand, was experiencing a *neuroception of threat* that supported defensive strategies (hitting and grabbing).

In short, emotions are what "move" humans to do what we do. The neuroception of safety is essential to a child's social and emotional development, ability to adapt and "take in" the environment, play, learn and engage in pro-social behaviors. This contemporary understanding provides a compelling lens through which to view emotional development and support.

When we view emotions as supporting our survival drive, it becomes clear how important it is to support parents and children alike. From my clinical experience, I know that many parents experience stress when they perceive that their child is developing atypically or experiencing challenges. Their own threat-detection systems become activated as they work hard to develop action plans to help their child.

Throughout this book, I will suggest ways that all early childhood practitioners, across disciplines and educational backgrounds, can present information to parents in ways that activate feelings of safety rather than threat. We do this by viewing our relationships with children and parents as helping to mediate their responses to stress.

Parents like Shawna, described earlier, are usually left to their own devices to find emotional support to cope with the diagnostic and intervention process. Those with children diagnosed with autism have been found to be particularly vulnerable to the complex process required to secure appropriate services and resources for their child (Moh & Magiati, 2012; Karst & Van Hecke, 2012).

Mothers and fathers experience a range of feelings and reactions when their child is identified as having developmental differences. For some, the relief that their child is identified and will receive help is accompanied by anxiety about the unknown. Others experience the news as traumatic, feeling grief and a sense of loss (Foley, 2006). Others handle the child's differences with acceptance, feeling that they are intrinsic to the child's identity. **Most parents wonder what the diagnosis means for the child's future, and whether they are opting for the appropriate therapies.**

When parents direct most of their energy and focus toward treatment and monitoring the child's progress, there is often less time for a key nutrient of developmental gains: spontaneous joyful interactions. Parents like Shawna grow fatigued under the strain and complexities of their child's care precisely when enjoyable interactions are needed most. Fortunately, as providers of services to children and families, we can help. We address this problem by viewing the child not in isolation, but rather in the context of his caregivers and family.

Supporting children begins with supporting relationships. As an infant mental health specialist, I have come to believe that support for parents needs to expand well beyond my subspecialty to all childhood professionals. We begin with the birthplace of emotional growth: relationships.

Relationships are like a tapestry, formed from the threads of interactions throughout one's life. When a young child is identified as having challenges, the tapestry is just beginning to form. All professionals who evaluate, treat, teach or otherwise support children and families become a part of it.

For Shawna, discovering that her child had developmental delays was so stressful that it affected her mental health and her relationship with her son. Unfortunately, evaluation and treatment methods (outside of relationship-based approaches) rarely take into account how atypical development affects the *parents'* mental health or the parent-child relationship. This oversight stems from our current culture of sub-specialization and the demarcation between early intervention and mental health.

Worksheet

Variations in Reactions to Developmental Differences

Parents and caregivers experience a wide range of variability in their reactions to their child's differences. As providers of service, it is important not to assume we know what parents are experiencing, but to understand each caregiver's unique perspective.

- O Fear or anxiety
- O Values the differences
- O Confusion
- O Acceptance
- O Sense of loss
- O Protectiveness
- O Relief
  - O For gateway to funding services
  - O For answers as to child's behaviors or challenges
- O Skepticism
- O Sadness
- O Hope
- O Optimism
- O Empathy
- O Anger
- O Guilt
- O Energy

For each parent and caregiver, consider a wide range of reactions to a child's diagnosis, and add your own observations.

Brene Brown, Ph.D. (2012), the social worker and researcher, has written that "we are hardwired to connect with others: it's what gives purpose and meaning to our lives, and without it, there is suffering"(p. 8). Let's begin by considering our own impact on the emotional support of children and caregivers, and the ways we can connect with parents to help promote resilience.

The Therapeutic Use of Self

Regardless of our role in a child's life—as a therapist, teacher, evaluator, interventionist, or paraprofessional—we all have impact on relationships. The *way* we interact with children and families matters. As Jeree Pawl and Maria St. John (1998), leaders in the infant mental health field, put it in the title of their training monograph, "How You Are Is as Important as What You Do."

While knowledge of one's specific discipline is important, it's not everything. In fact, it's not even the most important thing. **If we do not have a solid, trusting relationship with a child, our developmental interventions will be less successful.** Likewise, if we do not have a solid, trusting relationship with parents, they will be less likely to incorporate our suggestions and advice at home, and more vulnerable to stress.

The "therapeutic use of self" has different meanings for different disciplines. In the field of infant mental health, the use of self includes an *awareness of one's own reactions* to the work with infants, toddlers, and their families. According to Heffron and Murch (2010), "the use of self can be thought of as an internal ability to reflect upon and examine one's own internal responses, thoughts, and feelings, and then simultaneously to imagine the thoughts, feelings and perspective of others" (p. 98). In other words, professionals benefit when we become aware of our own thoughts and feelings in our work with children and families. This is because our feelings guide our interactions with others.

In occupational therapy, the use of self has been defined as a therapist's "planned use of his or her personality and perceptions as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). In nursing, Freshwater (2003) describes it as "the formation of a meaningful relationship through the development of an effective interpersonal process" (p. 47).

Worksheet

The Wide Reach of the Therapeutic Relationship

Every single interaction we have with caregivers can influence the therapeutic relationship. Use the following list and add your own observations of the various opportunities providers and clinic staff members have to interact with parents and caregivers.

Provider and all clinic/school/office staff members

- O Initial phone call
- O Initial greeting to parent/caregiver
- O Initial greeting to child
- O Email communications
- O Scheduling
- O Managing clerical and financial issues
- O Ongoing interactions with parents

Social & emotional aspects of interactions with parents

- O Body posture
- O Affective or emotional tone
- O Prosody/tone of voice
- O Level of empathy and understanding
- O Pacing of session
- O Ability to follow parent's lead
- O Ability to follow child's lead

Even though it is defined in clinical training, in actual practice, many professionals are not comfortable or familiar with the concept of the use of oneself as a therapeutic tool. In a study of one thousand occupational therapists, Taylor (2009) revealed that most felt inadequately trained in the area and that only four percent had taken a class about the therapeutic use of oneself, though a majority reported that they had some exposure to the topic in occupational therapy graduate school.

The Therapeutic Use of Self in Direct Work with Children

If you are a teacher or center-based provider or work in settings without parents present, it is beneficial to establish a relationship of trust with each child, beginning with forming a relationship with the child's parents or caregivers. The details of relationship-building with parents are unique to the setting in which one works. (If you are a teacher, for example, you will not have the same access to parents as a speech therapist in private practice.) Regardless, the following basic principles apply to all settings and providers.

Meet with Parents First

If possible, meet the child's caregivers *before* you meet the child for the first time. This allows time for the parent or caregiver to get to know you, and for you to set the tone of a respectful and compassionate relationship. Additionally, caregivers often speak more freely without their child present. When children repeatedly hear themselves talked about in the third person, they can find it confusing, and it influences their self-perception. If it is impossible to first meet with the caregiver(s) in person, then a phone call or Skype conversation is a good alternative.

Observe in the Comfort of a Natural Setting

Additionally, if possible, it is beneficial to observe a child in one of her natural settings before you meet her privately. Logical locations for the observation are the home, daycare or school settings, in order to see the child's typical interactions with her most trusted caregivers. The relational clues gleaned from speaking with parents combined with a naturalistic observation are well worth the effort. **Our primary aim is to discover how the child uses relationships to feel safe, engage in play, and experience connection with others.**

Worksheet

Developing an Awareness of the Use of Self

Our interactions with children and caregivers set the tone for all treatment and support of the family. In this exercise, reflect on the following:

List the strategies that you typically use to help caregivers feel comfortable as you get to know them.

_____

_____

List the strategies that you typically use to help children feel comfortable as you get to know them.

_____

_____

Recall and record a situation where a caregiver or child experienced stress in an initial meeting or ongoing session with you.

_____

_____

Reflect about how you felt when a caregiver or child experienced stress in an initial meeting or ongoing session with you.

_____

_____

Reflect on anything you may have done differently to counteract the stress for the child or caregiver.

_____

_____

Worksheet

Meeting with Parents or Caregivers

Conversing with a parent or caregiver before meeting the child provides valuable clues about the type of emotional support you will need to provide to the caregiver and child, known as a *dyad.*

The following questions for caregivers can assist in understanding the child's relationship preferences:

1. How does your child typically react when meeting new people?

   _____

   _____

2. How long does it take for your child to warm up to a new person or setting?

   _____

   _____

3. What advice can you give me to help your child feel safe and relaxed?

   _____

   _____

4. How does your child fare without your presence at school, daycare or other activities?

   _____

   _____

5. What are the favorite activities that you and your child enjoy together?

   _____

   _____

Worksheet

Observing in Natural Settings

Consider the following as you observe and record observations of how the child utilizes adult and peer relationships:

1. Is the child tracking or otherwise noticing where her caregiver is in a room?

   _____

2. Is the child tracking or otherwise noticing where her caregiver is in their house or apartment?

   _____

3. Does the child access her caregiver directly (e.g., sitting on the lap, or moving close to her physically)?

   _____

4. Does the child access his caregiver indirectly (e.g., catching sideways glances and using peripheral vision to make sure she is available, making verbal contact with caregiver)?

   _____

5. What is the quality of the child's emotional relationships with adults?
   - Is there distance, closeness, engagement, pleasure?
   - With familiar adults?
   - With unfamiliar adults?
   - With peers?

6. Is the child observing peer interactions? Describe.

   _____

7. If you are observing in a school setting, is the child actively playing with peers? Describe.

   _____

8. Is the child *moving away* from peers and avoiding them? Describe.

   _____

Meeting a Child for the First Time

The following steps are useful when meeting a young child for the first time:

1. Approach the child and caregiver slowly, respectful of their interactions.
2. Kneel or sit down at the child's level.
3. Begin with indirect eye contact, moving to full eye contact if the child appears comfortable and is returning your gaze.
4. If the child's body language or facial expression indicates that she is uncomfortable, move away slightly and slowly.
5. Begin with a quiet tone of voice, and casually speak with the caregiver about a neutral topic to give the child time to adjust.
6. Allow the child to warm up and explore the environment at his own pace.
7. Provide a variety of toys for the child and caregiver to explore together.

Meeting the Child for the First Time

A warm and cordial greeting, first to the parent and then to the child, allows the parent to absorb the impact of the initial greeting. Each child is different. Some warm up in just a few minutes, while others may take weeks or even months. A "low and slow" approach gives the child control, allowing him to pace the introduction to the timing that feels best. It's best to kneel down to meet children at their level and use a soft voice, slow movements, few words, and a warm emotional tone. Monitor your facial expression, posture, tone of voice, and body position, in response to the child's reactions.

Starting "low and slow" is optimal. You can easily increase your emotional tone, proximity, rate of speech, etc. according to a child's needs, whereas it's difficult to recover trust if you startle the child with a physical approach that feels too loud, close or overwhelming. These first impressions form important memories as the child navigates a new situation and relationship. As a general rule, when in doubt, always err on the side of the child's feelings (and neuroception) of safety.

When Shawna (the mother who came to my office) had taken her son for evaluation, the assessment protocol and time constraints did not allow enough time for either of them to feel relaxed during the testing process. As a result, the evaluator did not

witness David's highest levels of skills or functioning. When we adopt a relationship-based perspective, we consider the assessment and treatment process as seamless and ongoing: every time we interact with children we are both *evaluating and supporting development at the same time* (Greenspan & Wieder, 1998; ICDL-DMIC, 2005). **While the initial evaluation can be considered a starting point, the most valuable information comes from interactions with children and caregivers over time.**

What We Do and Say Matters

During the initial weeks and months of establishing a relationship of trust with the child, what you *do* is as important as what you say. Your nonverbal communication with the child, including facial expressions and body language, sets the stage for a child to feel safe. This gives the child confidence to take risks and engage in learning. **Establishing trusting relationships is critical in early intervention,** but doing so requires patience and an attitude of reflection.

Davon: Struggling to Feel Safe

Davon, a quiet and loving eight-year-old boy diagnosed on the autism spectrum, was placed in a special education class with ten other classmates. Unable to use spoken language, he employed a picture-exchange system to communicate. His teacher worked hard to determine what he needed or wanted, yet often Davon would wail loudly and move about the classroom while touching the walls with his hands. His parents asked me to observe Davon and advise the teacher and staff on helping him with these behaviors and the difficult transition to his new classroom.

On the day I observed, Davon struggled to stay seated during a reading lesson. Lurching backward in his chair and making loud vocalizations, he finally stood up, ignoring his teacher's pleas to return to the table. The interaction was in stark contrast to what I had witnessed just minutes earlier on the playground. There, he had run up to the teacher and shown her a handful of leaves he had gathered. He smiled, appeared relaxed, and

was emotionally engaged—clearly connected to the teacher. Inside the classroom, though, Davon seemed disorganized and distant, seemingly miles away.

In a team meeting later in the day, we reflected on the stark contrast between Davon's emotional stability and availability outside and inside the classroom. We created a list of hypotheses to explain his behaviors and ways we might offer support. Was it possible that Davon was communicating that he wanted or didn't want something through his behavior? And how could the teacher help him use his relationship with her to let her know what he wanted? Most importantly, was it possible that the shifts in Davon's behaviors were due to his neuroception shifting from safety to threat once he entered into the classroom environment?

When the team applied a developmental and relationship-based approach to Davon's struggles, new strategies emerged. Now, his teachers viewed his body language (lurching and making noises) as his way of communicating his emotional state rather than "noncompliance." Why? We surmised that it was because his behaviors were, at times, his only form of communication. Inside the classroom, the sounds, lights, and a busy environment presented more challenges to Davon than on the playground where he could move around and feel more comfortable. Inside the classroom, it was more difficult for Davon to access the teacher and get help for his internal distress, so his *negative behaviors increased.* Emotions propel us to move, and all of Davon's behaviors were a clue to help us understand how to help him.

When challenging behaviors increase, we should ask if we are meeting and supporting the child's emotional needs and the neuroception of safety. If a child's behaviors are the only way he can signal the need for support, paying attention to the meanings underlying behaviors is critical to the child's