The Tip of the Iceberg: Looking Beyond Behavior in Helping Behaviorally Challenged Kids

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Neurodevelopmental Approaches-
DIR (Greenspan and Wieder)
2006

• **Developmental**: A child’s development is not solely about milestones, but how these work together with the environment to shape development.

• **Individual**: Children have unique physiological, neurological, psychological, communication, motor and sensory processing differences.

• **Relationship**: Parent/caregiver relationships play a vital role in shaping all aspects of development, including social emotional growth.
ASD & Special Needs

• Participated in multi-disciplinary groups in hospital and educational settings
• Each child from the perspective of the different brain areas represented by our different professions:
  • OT, PT, Speech-language, Pediatrics, Neurology, MH, Education.
• Where we were taught that behaviors had meaning in the child’s body or development

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MH and DD are Connected yet Divided

- Body up – Development--- is how mental health is formed.

- Yet Mental health Clinicians are trained from the top-down!

- And what’s the difference??
To Understand Development…

• Context Matters!

• Some behaviors, particularly in toddlerhood and the second toddlerhood, adolescence are expected.

• And for those behaviors, loving logical limits (and a sense of humor) is needed. Brain is under construction. EF hasn’t developed!
But Many Behaviors signal Vulnerability..

• And many who work with children don’t understand the developmental roadmap that leads to the ability to control one’s emotions and behaviors.

• In the field of EI & ASD Tx I have found children whose volitional control is still developing being “taught” with reinforcement schedules and punishing techniques that assume this capacity.
When do children have the impulse control to resist the desire to do something forbidden?

56% of parents believe children have the impulse control to resist the desire to do something forbidden before age 3.

Within that group, 36% of parents believe that children under age 2 have this kind of self-control.

However, brain research shows that these skills start developing between 3.5 and 4 years, and take many more years to be fully developed.
Expecting more from children than they are capable of can lead to lots of frustration for both parents and children. Parents agree:

45% of parents tell ZERO TO THREE they want to know how and when children develop self-control...

44% of parents want to know what skills to expect at different ages.

To learn about how and when children develop self-control, and what you can do to nurture this skill, visit www.werotothree.org/DevelopingSelfControl
The Expectation Gap

- Between what we expect children to do and what they can actually do.

- Ross Greene: “Children do well if they can” Philosophy
- We *think* kids can do things when in reality they can’t…yet
- The central myth “kids do well if they wanna”
- Ross, you shifted the paradigm worldwide

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Expulsion from Preschool and Child Care

- 2016 National Survey of Children’s Health (NSCH) reported 50,000 preschoolers were **suspended** from school; 17,000 expelled. [http://childhealthdata.org/learn/NSCH](http://childhealthdata.org/learn/NSCH)
- Children of Color/boys disproportionately represented
- **Implicit bias** refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.
Treatment falls short for our Most Vulnerable

- Abuse-school-Prison Pipeline—
- More than one in five **FOSTER** children will become homeless after age 18.
- At the age of 24, only half are employed.
- Fewer than 3 percent will earn a college degree by age 25 (compared to 28 percent of all 25-year-olds).
- One in four will be involved in the justice system within two years of leaving the foster care system.
- [http://www.aecf.org/m/resourcedoc/aecf-JimCaseyInitiativeToolkit.pdf](http://www.aecf.org/m/resourcedoc/aecf-JimCaseyInitiativeToolkit.pdf)
Three Reasons Treatment Falls Short

• I believe that our current conceptualization, evaluation and treatment of behavioral challenges falls short for three main reasons: we fail to find the correct etiology of the behaviors; we use one size fits-all approaches; and we don’t utilize a developmental roadmap to understand when to use the right approach at the right time.
The Moment

- Sergio hadn’t begun speaking yet at two-and-a-half. He had challenges in communication, attention, peer-relationships, and learning. Sergio’s brain-wiring differences made it difficult for him to speak and to let others know what he was thinking. I was asked to help with his behavioral challenges, habitually wandering around his small special-education classroom, touching the walls incessantly—and often his classmates as well.
During my first observation, I watched Sergio in a group-learning session, trying to get the attention of his aide, seated beside him. When the aide didn’t look his way, Sergio moved his arm until it glanced hers. She then followed his (IEP), which called for adults to ignore behaviors deemed as “non-preferred.” So instead of acknowledging him, she slid her chair sideways, out of Sergio’s reach. He began to move his arms and torso more vigorously, leaning over and grabbing his aide’s arm, who then quietly asked him to pay attention to the teacher, and moved behind him, out of his view.
The Moment

- Seconds later, Sergio leaned back in his chair to see her—so far that he toppled over, landing on his back. That prompted the teacher to instruct the aide to take Sergio to the “calm down room,” a plain closet-like space in the back of the classroom with padded walls and floor. Looking in through the one-way window, I watched Sergio, a flat and sad expression on his face, kicking the wall while the aide sat to the side avoiding any interaction.
What happened:

- Survival-based responses were being interpreted as misbehavior.
- We don’t distinguish between top-down and body or bottom-up behaviors.
- Sergio’s behavior was treated as volitional and managed with punishment.
- 3 populations: Autism and neurodivergence and Kids diagnosed with ODD, DMDD, kids in the foster system with trauma histories.
*Top-down thinking* develops over time with particular activity in the prefrontal cortex, the region known as the brain’s “executive center”. Even though most children begin to have “effortful control” of their behaviors, attention and impulses at 3.5 – 4 years old, it takes many more years for these abilities to fully develop.
Siegel and Bryson describe the area of the brain associated with bottom-up reactions the **Downstairs** brain, with activation in the area of the brain known as the limbic system, including the amygdala. **Upstairs Brain** associated with conscious thought and executive function.
Iatrogenesis and how to Address these Shortcomings?

• Appreciate Individual Differences & value Relationships
• Distinguish Top-down from Bottom-up behaviors
• Understand a bit about how the ANS works

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Developmental Iceberg
Attributions of Behavior

The child or environment's "fault"

- Purposely misbehaving
- Attention-seeking
- Oppositional
- Defiant
- Testing limits
- Lazy
- Avoidant
- Poor parenting
- Inconsistent discipline
- Intellectual disability

Adaptation to one's unique differences

- Physiological State
- Faulty neuroception
- Emotional responses (e.g. shame or embarrassment)
- Stress responses (flight, flight, or freeze)
- Adaptations to sensorimotor processing or preferences
- Physical pain or discomfort
- Thoughts or ideas

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What we saw

• Preschool child having difficulty settling body down, so his body is trying to regulate adaptively (move).

• Tell Miss Leslie what you want. --assumes he can. Top-down

• He can’t (not won’t) comply and they help his body (restrain him)

• Sends his ANS into increasing amounts of stress, he fights more.
Ain’t Misbehaving

• 1. Was the child’s behavior intentional misbehavior?
• 2. Was the child’s behavior a stress response?
Joshua

- In the video was showing signs of developmental immaturity (vulnerability) in his ability to self-soothe, the first developmental milestone.

- His behavior wasn’t intentional misbehavior when he was reprimanded, he had a stress response, **induced by the teachers.**
Foundation of the House

• The foundation of Children’s social-emotional and mental health is emotional and physiological state co-regulation with attuned, loving care-sharers.

• Relational Safety forms the foundation of Brain development, Social-Emotional development and Mental Health
Polyvagal Theory

• Through a compassionate new lens informed by neuroscience, we begin to view our role in new light- leading to a better treatment techniques.

• We need to develop an appreciation of the **Autonomic Nervous System**

• Not yet integrated into IMH, Social Work, or MH

• Porges’ PVT, three states of the ANS guide us: Ventral Vagal Parasympathetic (calm and receptive to learning), the Sympathetic (fight or flight) and the phylogenetically older branch of the parasympathetic, the Dorsal vagal.

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Awake States with Stress Responses

**Green Zone — Just Right/Alert**

**EYES**
- Bright, shiny eyes
- Looks directly at people, objects
- Looks away for breaks, then returns to eye contact
- Seems alert, takes in information

**FACE**
- Smiles, shows joy
- Neutral
- Can express all emotions

**BODY**
- Relaxed with good muscle tone
- Stable, balanced and coordinated movements
- Infant moves arms and legs toward center of the body
- Infant molds body into a caregiver when held
- Moves faster or slower depending on environment

**VOICE**
- Laughing
- Tone changes

**RHYTHM / RATE OF MOVEMENT**
- Changes smoothly to respond to the environment
- Movements not too fast or too slow

From Infant/Child Mental Health, Early Intervention, and Relationship-Based Therapies: A Neurorelational Framework for Interdisciplinary Practice, by Connie Lillas and Janiece Turnbull.
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Awake States with Stress Responses

**Red Zone — Too Fast/Gas Pedal**

**EYES**
- Open, squinted or closed eyes
- May have direct, intense eye contact
- May avoid eye contact
- Eyes roll upward
- Eyes look quickly around the room

**FACE**
- Wide, open mouth
- Anger, disgust
- Frown, grimace
- Fake, forced smile
- Clenched jaw or teeth

**BODY**
- Fingers spread out
- Arched back; tense body position
- Constant motion
- Demands space by pushing, shoving, and getting into others’ space
- Biting, hitting, kicking, jumping, throwing
- Bumps into things, falls
- Threatening gestures (shakes finger or fist)

**VOICE**
- High-pitched crying, yelling or screaming
- Loud
- Hostile or grumpy
- Sarcastic
- Out of control laughing

**RHYTHM / RATE OF MOVEMENT**
- Fast movements
- Impulsive movements

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Awake States with Stress Responses

**Blue Zone — Too Slow/Brake**

**EYES**
- Glazed-glassy eyes (looks through rather than at)
- Looks away for a long time, looks down
- Seems drowsy/tired
- Does not look around the room for interesting items
- Looks at things more than people

**FACE**
- Flat/blank
- Mouth turned down, sad
- No smiles or hints of smiles
- Few emotions shown

**VOICE**
- Flat
- Makes few to no sounds
- Sounds cold, soft, sad, too quiet

**BODY**
- Slumped/slouching
- Low muscle tone
- Little or no exploring play or curiosity
- Wanders
- Frozen or slow-moving

**RHYTHM / RATE OF MOVEMENT**
- Slow movements
- Slow to start moving

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)*
Treatment Vignette

- Appreciation of Individual Differences
- Recognizing the Zones
- Relationships of Safety lead the therapeutic process
During Meltdown

1. Be Quiet & respect Individual differences in comfort
2. Be empathic-compassionate
3. Don’t ask questions until green zone
4. Don’t shame—they already feel bad about it.
5. Allow to use their own coping strategies—self determination is important
6. Wait, and wait some more— patience
7. Don’t use a neurotypical standard –
8. Encourage communication when ready including communication devices if used
Clinical Application

• What happens when we punish, ignore or negatively consequence a defensive physiological response?

• Increase the neuroception of threat and triggers additional defensive strategies (maladaptive behaviors increase)

• Kicked from 2 private schools.
Behavioral Paradox

• We “teach” kids social skills to not ignore people, yet we ignore behaviors we want to extinguish. We focus on Compliance.

• No wonder she says “it’s not nice to ignore people”.
Tx Dilemma

• Her school team was using a neurotypical lens to judge a behavior that had its basis in physiological state yet viewed as—maladaptive behavior

• She had unusual ways of communicating; her talking loud & close to people didn’t reflect a purposeful choice to misbehave, but *adaptive responses to her body, mind, emotions and movement differences.*
Mental Health Support

• No less important for neurodiverse persons

• Pathway to emotional resilience:

• 1. Relationships that provide Emotional Co-regulation, lead to the Neuroception of Safety

• 2. This bottom up process, by valuing rather than punishing individual differences (movement & behaviors)

• 3. Leads to top-down thinking in which the individual can share their internal world with others, connect relate, and form lasting relationships.
Relationships serve as the springboard for Learning

- Learning happens within a social context, within a dialogue with others. We acquire cognitive skills, knowledge and behavior regulation, not simply through memorization of facts or actions, or classroom rules but through our interactions in the social world where, when we feel safe and understood, this knowledge has function and meaning.

- Donnelan, et al 2010
What we saw:

• Through a compassionate relationship based on trust.
• Respecting the child’s physiological state and movement patterns & NEURODIVERSITY
• Following her lead, she is now happy, vigilant and her own unique self. Straight A’s and 8th grade valedictorian
Personalized Attunement

• 1. Determine if the child is experiencing the neuroception of safety
• 2. Determine the underlying causes/triggers of the behavior
• 3. Help the individual develop new ways to cope
Join me on

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