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What Our Children Need: A Bill of Rights[1]

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We can not solve our problems with the same level of thinking that created them. ~Albert Einstein

One of the campers who attended our summer camp, The Hope Connection, in the early 2000s was a lovely thirteen-year-old who had been adopted from an institution in Eastern Europe. She had been a sexual pet for the workers there and bore the deep emotional scars of chronic maltreatment. During the fall school term following this young adoptee's summer camp experience, her mother called us and told us how her daughter refused to walk to school alone. Frustrated, her mother explained how the walk to school was just a few blocks and was clearly safe. Lots of children in the neighborhood walked to school alone or with friends, but her daughter wouldn't do it. This mother had concluded that her daughter was being willfully disobedient, and the mother was ready to turn her out.

Dr. Purvis and I explained to the mother that it did not matter that *she* knew her daughter was safe, what mattered was whether or not her daughter *felt safe*. We suggested that she start walking her daughter to school, and when her daughter did in fact begin to feel safe, she would ask to walk alone. After a few weeks of walking together, this is exactly what happened. Once her daughter began to feel safe—a feeling cultivated by shared experience with a caring adult—her natural thirteen-year-old need for independence asserted itself, and she was able to join her peers on the trek to school. Of course, this was just one episode in this young teen's healing journey, but it was a telling episode.

This story helps us see the vital importance of *felt-safety* in human affairs. Felt-safety is the most basic of human needs, and in humans the deep need for felt-safety can *only* be met by other humans.[2] Further, felt-safety is the great *unmet* need of children "who come from hard places," and the system's failure to meet this need is the root cause of nearly all the misery that surrounds their care. The Australian psychologist Howard Bath suggests that there are three pillars of trauma-informed care,[3] one of which is felt-safety (see Figure 1). In the story, the mother was able to nurture and support her adopted daughter's emerging autonomy by meeting her daughter's need for felt-safety.

This story also helps us see the vital role of *connection* in promoting felt-safety and autonomy. In what seems like a paradox, it is the mother's recognition of the connection—her daughter's *dependence*—that enables the emergence of autonomy—her daughter's *independence*.[4] Indeed, the second of Howard Bath's pillars for trauma-informed care is *connection,* which we at the Institute of Child Development (ICD) see as the most fundamental

Figure 1
Three Pillars of Trauma-Informed Care

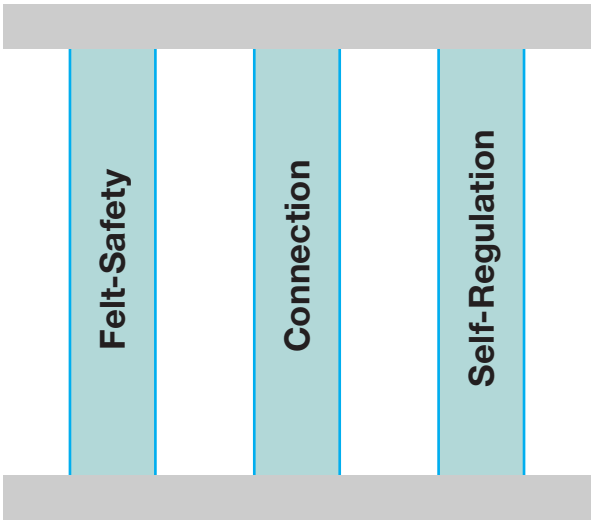

Figure 1: Based on extensive experience with children "who come from hard places," as well as the work of child trauma experts such as Dr. Bruce Perry and Dr. Bessel van der Kolk, Howard Bath has identified "Three Pillars of Trauma-Informed Care."

of the three pillars, for connection is the ultimate source of felt-safety and self-regulation in humans. The teen's connection with her mother not only helped create a sense of felt-safety, but it enabled her to regulate (manage) her fear and anxiety, so she could walk to school on her own. In this way, her mother was *scaffolding* her emerging ability to self-regulate emotional and behavioral states.[5]

This story also illustrates common mental models that can guide the responses of adults in difficult situations.[6] The mother's initial response illustrates one such paradigm, which might be called the *Willful Disobedience* paradigm ("She could if she wanted to!"). This paradigm typically leads to power struggles, frustration, escalation, rejection, anger, and an ongoing cycle of conflict and resistance. Unfortunately, this is the default paradigm for most parents and professionals when faced with challenging behavior, and it is far too characteristic of what many children and adolescents encounter in the child welfare system. It goes without saying that adult responses within the Willful Disobedience paradigm will fail to promote connection, felt-safety, and self-regulation.

The mother's second response, achieved through coaching from Dr. Purvis and me, illustrates a second paradigm, which might be called the *Survival Behavior* paradigm ("Her freeze response is a survival strategy."). This paradigm can lead to reduced frustration, development of skills, growth of self-awareness, appropriate use of language, and a

diminished cycle of conflict and resistance. This paradigm involves *compassionate understanding* of how the child's traumatic history impacts their behavior. This perspective is consistent with contemporary neurodevelopmental models of stress and trauma, which suggest that children's difficult behaviors—their "fight, flight, or freeze" response—are in fact optimal strategies for the toxic rearing environments they have endured.[7]

How can we meet children's needs for connection, felt-safety, and self-regulation? We have come to believe that in order to meet the needs of children in care (residential care, foster care, etc.), the significant adults in their lives (caregivers, caseworkers, teachers, therapists, CASAs, lawyers, judges, etc.) must be well-versed and practiced in the essential components of trauma-informed care and service, including the following:

1. These adults must understand the impact of relational trauma (abuse, neglect, domestic violence, etc.) on children's *brains, behavior, bodies, and beliefs*. Relational trauma wires children's brains so that these children are fearful and hypervigilant, emotionally and behaviorally dysregulated, lacking in self-esteem and self-worth, and have difficulty forming relationships and learning new skills.[8]

2. These adults must understand the complex needs of children who have experienced relational trauma, emphasizing children's needs for *felt-safety, connection,* and *guided self-regulation*.[9]

3. These adults must understand the central role of *connection* (relationship) in bringing healing to children who have experienced relational trauma.[10] In other words, they must recognize that *relationship-based traumas demand relationship-based interventions*.

4. These adults must cultivate a compassionate and trauma-informed framework for understanding traumatized children and their behavior. They must be able to interpret the challenging and perplexing behavior of traumatized children—not as *willful disobedience,* but as *survival strategies* acquired through adaptation to toxic social environments.[11]

5. These adults must combine a compassionate and trauma-informed outlook with a rich and honest self-evaluation about how their own relationship histories might impact their caregiving behaviors—taken together, a compassionate understanding coupled with an honest and growing self-awareness form the *core aptitudes* of trauma-informed care and service.[12]

6. These adults must understand and practice a core set of intervention strategies including the following:[13]

   (a) *Engagement strategies,* which emphasize playfulness, healthy touch, and nonverbal modes of communication.

   (b) *Ecological strategies,* which emphasize the importance of transitions and rituals in promoting children's well-being.

   (c) *Physiological strategies,* which emphasize bodily needs including hydration, blood sugar, sensory processing, and physical activity.

   (d) *Proactive strategies* for teaching social skills and building character; nurture groups provide an excellent framework for breaking cycles of socially inappropriate behavior and building prosocial skills and beliefs.

   (e) *Responsive strategies* that help structure positive, nurturing adult-child interactions, especially in challenging situations; the best strategies are action-based, interactive, and mutually respectful including such strategies as "Redos," "Choices," and "Compromises."

7. Finally, these adults must use *systems thinking*[14] to create trauma-informed *systems* (organizations, communities, etc.), so that caregivers and professionals are not isolated, and children experience consistent and synergistic trauma-informed care and service across all areas of their lives.

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(Endnotes)

1. This essay is written in memory of Dr. Karyn Purvis on behalf of the children she served—all those children "who come from hard places." Dr. Cross is Rees-Jones Director, Institute of Child Development, Texas Christian University.

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