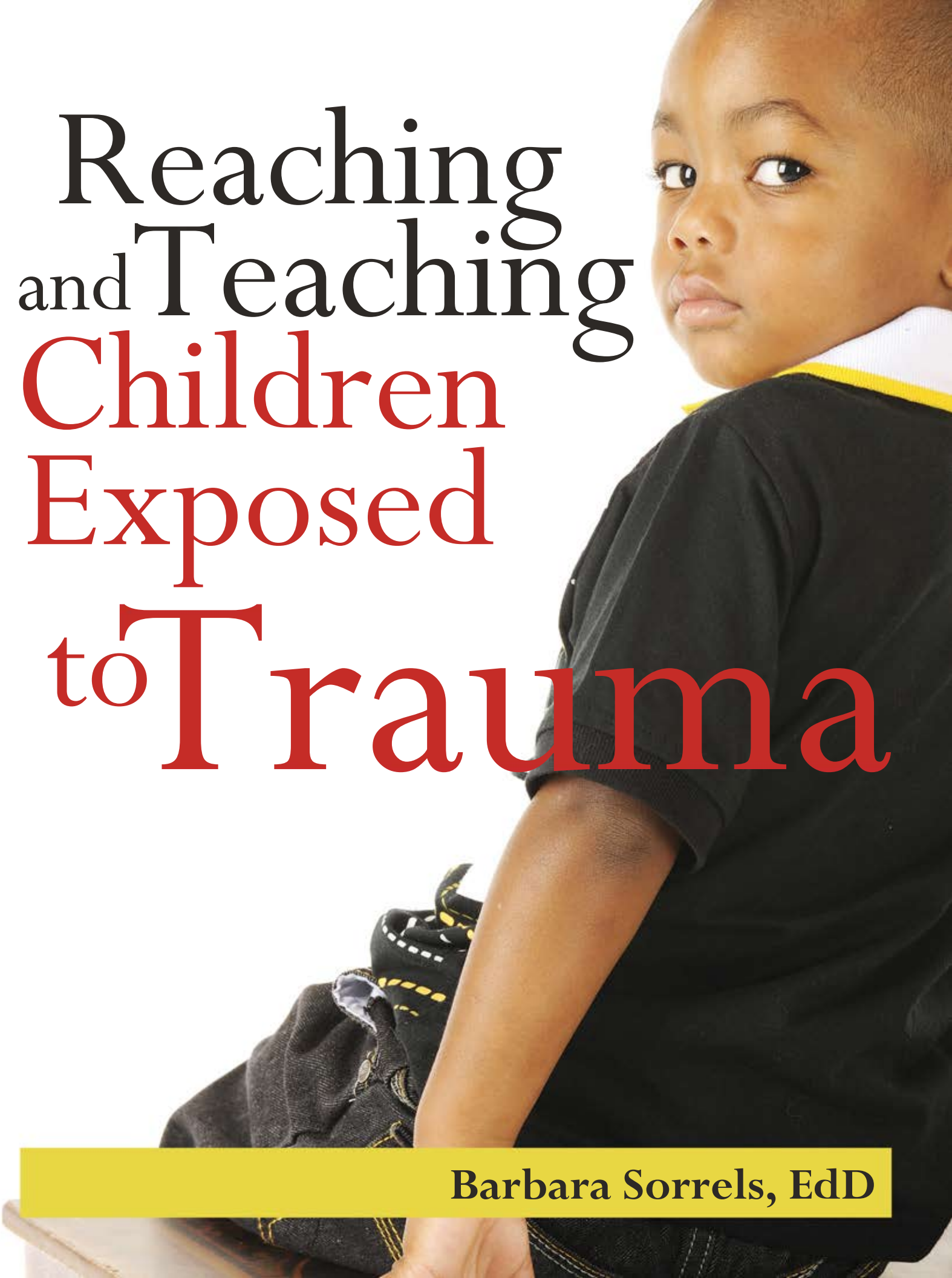
Reaching and Teaching Children Exposed to Trauma



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Introduction

Four-year-old Katie sat under the table barking like a dog. This was not a child enjoying dramatic play; this was one of the unpredictable and more bizarre behaviors that Katie displayed in child care. I invited her to join us in group time and offered to let her pass out the rhythm sticks. She responded with an exaggerated laugh that unnerved me and then crawled further under the table, out of my reach. I sat on the floor to make eye contact with her and presented some alternative choices of activities that she could do while the rest of the class had group time, but she shook her head and continued to laugh and bark like a dog. Not wanting to disrupt the routine of the other eleven children, I struggled to carry on with our normal routine. We made it through group time, and I breathed a sigh of relief as she came out from under the table when I announced it was time to go outside to play.*

Two weeks later I noticed bruises on Katie's legs. Because she was a very active child, I first assumed they were the result of normal childhood activity. But when she came in with a bruise on her cheek, my emotional radar signaled alarm. I asked her how she got the bruise, and very matter-of-factly she replied, "My mommy hit me." What shocked me was that this was a highly educated, professional, churchgoing family that, from outward appearances, seemed to have it together. After numerous phone calls, meetings, and a visit from child protective services, I found out there were secrets behind those closed doors.

*Not her real name.

For many children, childhood is not the idyllic, carefree time that adults typically envision. There are many children like Katie in child care centers, Head Start programs, and public and private schools across America who have experienced various forms of maltreatment and trauma. Statistics from the U. S. Department of Health and Human Services indicate that in 2012, child protective services in the United States received 3.4 million reports of abuse or neglect involving 6.3 million children. Of those referrals, 62 percent were substantiated; 78 percent involved neglect, 18 percent involved abuse, and 9.3 percent involved sexual abuse. Infants suffered the highest rates of maltreatment with 26 percent of the reports involving children under three years of age; 20 percent of the victims were three to five years old.

Early childhood professionals are typically the first people to see a child on a regular basis outside of the home and, therefore, play a key role in early identification of maltreatment and unhealthy patterns of development. That makes it crucial for those in early education to be trained and informed about the maltreatment of children.

According to Howard Bath, author of the 2008 article "The Three Pillars of Trauma-Informed Care," it is a fact that many, if not most, of the children who are in the child welfare system, the juvenile justice system, and mental health programs have been exposed to trauma in their early years. Many children exposed to trauma are identified as having special needs because most eventually receive the diagnosis of at least one of the following: attention-deficit disorder (ADD), attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder, bipolar disorder, obsessive compulsive disorder, or depression. It is important to recognize that, in these cases, disorders are but a symptom of the underlying trauma. If we only address the symptoms and do not address the trauma that caused the neurochemical changes in the brain, we are only putting a bandage on the problem. The neurochemical changes resulting from the trauma of living in chronic fear and unmanageable stress cause profound changes in behavior. Early childhood professionals are typically the first people to see a child on a regular basis outside of the home and, therefore, play a key role in early identification of maltreatment and unhealthy patterns of development. That makes it crucial for the child care work force and those in early education to be trained and informed about the maltreatment of children.

It has been generally assumed that only those with advanced education and clinical skills can help traumatized children, but as Ricky Greenwald asserts in *Child Trauma Handbook*, a great deal of healing can take place in nonclinical settings with teachers, caregivers, coaches, and family members who are informed in trauma-based care. Bath also asserts that evidence indicates that trauma-informed environments in the home, child care center, and at school are a necessary ingredient in the healing process.

Dr. Bruce Perry is internationally recognized as one of the leading experts in child trauma. He and his team led the therapeutic recovery effort for children who escaped from the horrific fire in the Branch Davidian compound in Waco, Texas, in 1993. He comments in his book *The Boy Who Was Raised as a Dog* that

the most important thing he learned from that experience is that it doesn't take trained therapists to heal a child. It is the ongoing, daily interactions with loving, emotionally responsive and caring adults—be they a teacher, a caregiver, an aunt, or a grandfather—that bring about healing. Therapists and psychiatrists can certainly provide insight, determine the need for medication, and offer advice, but children find healing in the daily acts of love and nurture experienced in ordinary relationships. Because child care providers and teachers often spend more waking hours with a child than any other adult, they are key players in the path to healing. Therefore, it is imperative to train teachers and caregivers so they can effectively serve in our child care centers and schools.

It is the ongoing, daily interactions with loving, emotionally responsive and caring adults—be they a teacher, a caregiver, an aunt, or a grandfather—that bring about healing.

Trauma-informed care and education means that caregivers and teachers understand how trauma changes the brain and affects relationships, self-regulation, sensory processing, learning, and behavior. Informed adults recognize the behavioral signs of trauma and know how to create environments that provide a sense of emotional safety and healing. They are able to look at children's behavioral challenges with compassion rather than anger and frustration. Trauma-informed caregivers know how to respond to maladaptive behavior in ways that maintain respect for children and help them learn new ways of being in the world.

Unfortunately, the burgeoning body of research regarding trauma-informed care and education is often unknown or ignored by professionals in the field. In fact, in the Child Trauma Academy 2013 winter webinar series, Dr. Perry described our educational culture as "child-illiterate." We currently have amassed more information and scientific research regarding the development of children than any other time in human history, but this body of information sleeps in university libraries. The current educational culture focuses on accountability and assessment, largely ignoring even basic principles of child development. Child care providers and teachers often feel that they are not qualified to address the social-emotional issues of maltreated children or that they will need to add one more thing to the complex demands currently placed upon them. One of the interesting findings, however, is that many aspects of developmentally appropriate practice (DAP) are parts of a supportive and healing environment to children who have been harmed. What early childhood educators have long known at an intuitive level has scientific evidence to explain and understand the benefits of DAP.

My own interest in trauma began in 1967 as a fourteen-year-old. On Sunday afternoons you would find me at DC General Hospital in Washington, DC, rocking babies on the abandoned-baby ward. The jail was across the street, and this was the ward where babies born to incarcerated moms were taken shortly after birth. Other infants were left on doorsteps, in city parks, or in trash cans. They remained in the hospital until they turned six months old and could be taken to the city orphanage.

These babies were not like those I saw in the church nursery, nor were they like my younger brother at home. They never cried, laughed, made eye contact, or tried to engage in play. I would sometimes spend hours just trying to get a baby to make eye contact. I wondered how and why this happened. A seed was planted in my soul to understand the behavior of children who were at risk. Throughout my high school and college years, I stayed involved in inner-city programs for children.

I began my teaching career caring for four-year-olds in the inner city in one of the most violent areas of DC. I cried on my way to work many mornings because I felt incompetent to meet the needs of the eighteen children in my care. Although I had some significant experience with children, I found this group to be exceptionally challenging. When they didn't want to clean up, they threw paint, blocks, or anything in front of them. They cursed, bit, hit, and seemed to bounce off the walls. In my heart, I knew these were not "bad" children: They were children who had seen more violence and trauma in their short lives than many others would see in a lifetime.

I moved on in my career and started two early childhood programs. Although I was no longer working in an inner city, I still encountered children across socioeconomic groups who struggled with behavioral challenges. In the 1980s, children started showing up at school with bottles of Ritalin and a label of ADD or ADHD. As I saw more and more children being diagnosed with this previously unheard-of condition, I began to notice a pattern. The vast majority of the children being medicated had experienced some sort of significant loss in their short lives—divorce, abandonment by a parent, violence in the home, or adoption. I had no idea how adoption could play into ADHD, but I just knew that I saw a pattern. It was also during this time that I encountered Katie and others who carried a diagnosis of reactive attachment disorder (RAD).

I read everything I could get my hands on to try to explain what I was seeing. The literature was scarce and bleak, mostly geared to mental-health professionals. It offered little hope other than medication for children with severe behavioral disorders. I had a hard time believing this could be true.

In the late 1990s, while working on my doctorate in early childhood education, I attended a conference where I heard Dr. Perry speak on brain development. I sat riveted as he confirmed what I somehow already knew: Trauma and loss profoundly change children. This discovery launched me into a passionate search to learn more. My motivation was both personal and professional: I had a drive to know, but I also had a desire to help the students I served as an early childhood education professor.

As students went out into the field, their number one struggle was classroom guidance and management. I began consulting with programs around the state, and I learned that the behavior of children is the biggest concern. Teachers and caregivers were increasingly seeing children with significant behavior challenges.

Recently, I "accidently" fell into the foster-care world in our state. A friend asked me to share what I knew about trauma with a group of foster parents. Their desperation and hunger to know how to help the children in their care were heartrending. Since that encounter, I have been immersed in the adoptive and foster-care world, training professionals, families, and clergy on the impact of trauma on healthy child development.

I am indebted to the work of Dr. Bruce Perry, Dr. Karyn Purvis and Dr. David Cross of Texas Christian University, Dr. Alicia Lieberman, Dr. Charles Zeanah, Dr. Vincent Fellitti, and the many others who are dedicated to helping children heal. Their wisdom and insight have informed my thinking, deepened my understanding, and changed my view of the world and of children. The extensive reading and education I have received through professional development have opened my eyes to the vast amount of knowledge that I have yet to learn. It continues to fuel my passion to understand more so I can help those on the front lines who live and work with children on a daily basis.

The purposes of this book are to help early childhood professionals understand how maltreatment and trauma impact healthy growth and development, to help caregivers know how to identify maltreated and traumatized children, and to teach practical strategies to create environments that bring about hope and healing for maltreated children.

Chapter 1

Defining Trauma

Betsy Groves, author of *Children Who See Too Much*, defines trauma as, "any event that undermines a child's sense of physical or emotional safety or poses a threat to the safety of the child's parents or caregivers." There are different levels of trauma, including acute and complex forms.

Floods, tornados, motor-vehicle accidents, or acts of terrorism such as the Boston Marathon bombing are examples of *acute trauma*, a single exposure to an overwhelming event. These events undermine a child's sense of physical and/or emotional safety and may cause nightmares and avoidance of anything that reminds the child of the trauma. A child who has had the experience of a tornado hitting his home can become panicked by merely hearing the local weather station mention a storm somewhere in the country. Certain triggers will evoke fear, but the child typically will not live life in a chronic state of being afraid.

Bessel van der Kolk, a psychiatrist who specializes in working with people who experience post-traumatic stress, defines *complex trauma* as, "the experiences of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature . . . and early life exposure." In other words, complex trauma usually happens in the context of a relationship with a family member or caregiver who is in some way responsible for the

well-being of a child. It is the experience of being harmed or neglected at the hands of another person. It is chronic and ongoing, not a one-time event. This is the most toxic form of trauma and is the primary focus of this book.

Before looking at the impact of trauma, it helps to understand the ways relational trauma can manifest in the life of a child:

- **Physical Abuse:** The most obvious form of trauma is bodily harm from hitting, kicking, slapping, beating, burning, or punching. In 2009, the National Child Traumatic Stress Network Physical Abuse Collaborative Group published the *Child Physical Abuse Fact Sheet*. It states that approximately 149,000 cases of child physical abuse were reported in the United States, but the number is very likely much greater because not all abuse is reported. In many states, child protective service agencies are underfunded and overwhelmed with heavy caseloads, which means they can only respond to situations that are imminently life threatening. Many children fall through the cracks and never come to the attention of the authorities, or the circumstances of their lives are regarded as non–life threatening and remain unaddressed.

  Abuse at the hands of a family member or caregiver is psychological poison. As Alicia Lieberman and Patricia Van Horn assert in their book *Psychotherapy with Infants and Young Children*, when the person who is supposed to protect the child is the one who willfully and intentionally harms the child, the child is put into an impossible psychological dilemma. The natural instinct of a child is to run to a parent for protection, yet at the same time, the stress response of the brain tells the child to run from the source of threat. The child has nowhere to turn, and the psychological impact is long lasting and severe. Children who experience abuse in the early years of life are often diagnosed with ADD/ADHD because they live in a chronic state of alarm, hypervigilant to any possibility of threat. They have difficulty forming lasting relationships because they are unable to trust others and typically resort to aggression to solve conflict. Later substance abuse is a common issue as it is a way of assuaging their emotional pain. They often carry within themselves a deep sense of worthlessness and the false belief that they somehow deserve the abuse, which often leads to risky behaviors. Some develop manipulative strategies to deal with their abuser, and manipulation becomes a way of handling all relationships.

  Research has found that invasive medical procedures in the first three years of life are often processed in a child's psyche as abuse. An infant does not have the capacity to understand that the tubes, needles, and pain he endures are necessary to save his life. He only knows that the people around him cause pain. Early medical trauma can cause a pervasive sense

of anxiety across the lifespan because the development of the regulatory system may be affected, which can interfere with the attachment process.

- **Neglect:** The definition of neglect, or deprivation, is inadequate responsiveness to the needs of a child. Neglect can happen in both subtle and profound ways. Gross neglect of the basic survival needs of food, water, sleep, medical attention, or shelter can literally threaten a child's life. Poverty of experience, having a chronically depressed parent or caregiver, and lack of sensory stimulation also are forms of neglect and can have serious emotional and cognitive repercussions. Though more subtle, these forms are, nevertheless, profoundly harmful. Decades of research have l ed experts to agree that the effects of neglect are far more destructive and profound than outright abuse. Significant language delay, learning deficits, a pervasive sense of anxiety, mental health issues, an inability to form lasting relationships, and an inability to cope with stress are some of the common outcomes.

- **Sexual Abuse:** Sexual abuse involves a wide range of behaviors, from the obvious forms of bodily contact, such as fondling, kissing, and intercourse to others that don't involve contact. Sexual exploitation for pornographic purposes, witnessing sexual activity between adults, and exposure to pornography and flashing are also destructive forms of sexual abuse. Children exposed to sexual abuse often have no personal boundaries and initiate and accept inappropriate forms of physical contact. They often act in a provocative manner later in life, making them a prime target for sexual predators and abusive partners. Some, but not all, grow up to be perpetrators of sexual abuse because this is their "normal." Many will struggle with intimacy and have difficulty sustaining lasting relationships.

- **Emotional Abuse:** This form of trauma often flies under the radar and can remain undetected for years—even throughout childhood. Emotional abuse occurs when an adult intentionally subjects the child to terrifying events, taunts, humiliation, or chronic shame. Examples include parents telling children they are stupid, they will never amount to anything, or they can't do anything right, or stepchildren rejected by a stepparent and treated like outsiders. Emotional abuse instills within the child a deep sense of shame and humiliation that paralyzes and prevents her from living up to her potential. The child may go through life viewing herself as somehow defective, unworthy of love and affection. The child may live in the shadows and try to go through life unnoticed and invisible.

- **Domestic Violence:** Domestic violence includes actual or threatened physical and/or emotional abuse between family members or intimate partners. A 2009 survey by the National Child Trauma and Stress Network indicates that between fifteen million and seventeen million children in the United States—30 percent—live in homes where they are exposed to intimate-partner violence. A review of court records reveals that children younger than six are disproportionately represented in this population.

  Living in the context of domestic violence gives a child a distorted sense of love and relationships. Abuse at the hands of a spouse or partner is their "normal," and they often repeat the cycle and end up marrying or living with an abusive partner or becoming an abuser themselves. Because of the egocentric nature of children, they often believe they are somehow the cause of the violence at home. They may grow up to view themselves as ineffective and helpless as they are powerless to stop the violence. To them, conflict is handled by aggression rather than words and negotiation.

- **Abandonment:** Being abandoned by a primary caretaker is a traumatic event. Even children who are given up for adoption at birth and placed into loving and nurturing families can experience a traumatic stress response. Abandonment may happen through death, divorce, or incarceration. Divorce is so commonplace in our culture that it goes unrecognized as a source of trauma. But the breakup of a family typically results in a rupture of an attachment relationship to one degree or another, and this is painful to a child of any age. They often grow into adulthood cynical about marriage or live in fear that any relationship they have will inevitably come to an end. Trust issues are very common.

In 1998, I attended the annual conference of the National Association for the Education of Young Children (NAEYC) in Toronto, Canada. There I heard Dr. Bruce Perry speak on the most recent findings about the brain. Research allows us to understand how a child's brain develops and gives us insight into the needs and conditions that support healthy growth and development.

Basic Principles of Healthy Brain Development

The brain begins to develop just days after conception with the first cells rapidly dividing and prolifically producing millions and millions of neurons. Many different types of neurons are produced in the brain, each designed with specific capabilities. In the next step of brain development, the cells migrate to specific locations where they will do their work. Once in their assigned locations, they begin to connect with other neurons to fulfill their functions. The brain is at its most vulnerable during this period of cell division, migration, and differentiation. It is highly susceptible to the destructive effects of substance abuse, smoking, and toxic stress. When mothers live in the context of domestic violence during pregnancy or experience some sort of significant loss or threat, the resulting stress crosses the placenta and affects brain development. (We will take a deeper look at how trauma affects the developing brain in Chapter 3.)

The development of a baby is an interactive project and not the result of a simple unfolding of nature. It is a dynamic process that involves both nature and the environment. Genes provide the basic blueprint for development, but experience fine-tunes or customizes the brain to function and adapt to a particular environment. Small differences in the beginning have a disproportionate effect on the trajectory of a child's life and leave their mark in significant ways.

The architecture of the brain is developed through two kinds of experiences: *experience expectant* and *experience dependent*. When a child is born, there are certain kinds of experiences that are expected to be common to all members of our species. As Charles Nelson, Nathan Fox, and

Charles Zeanah point out in their book *Romania's Abandoned Children: Deprivation, Brain Development, and the Struggle for Recovery*, it is assumed that all children will have opportunities to see patterned light, listen to language, and gaze at faces because these are some of the most basic life experiences common to all mankind. Experience-dependent development, on the other hand, is unique to the individual. For example, not all children have the opportunity to learn to play a musical instrument or learn gymnastics, which establish certain patterns of connection in the brain. The resulting brain development that occurs from these experiences will only happen for those exposed to these opportunities. The brain develops as a result of the quantity and quality of life experiences. The number of connections and the complexity of the connections in the brain are determined by the richness of life experiences.

There is nothing easy about caring for a group of infants when it is done well.

The brain stem is the only part of the brain that is fully developed at birth, and its primary purpose is to ensure survival. The limbic or emotional brain functions only partially at birth, and the cortex, or the thinking part of the brain, is relatively undeveloped. In other words, the brain develops from the bottom up: It moves from more primitive, reflexive types of functioning to complex thinking.

The brain stem controls most of our vital life functions, such as breathing, heart rate, and blood pressure. It organizes in utero around the consistent, predictable rhythm of the mother's heartbeat, and, because it develops prenatally, it is the hardest part of the brain to change. All sensory input—whether received through the eyes, ears, skin, nose, or mouth—enters through the brain stem and is sorted, processed, and disseminated to other parts of the brain to be acted upon. The effects of early trauma are primarily rooted in the brain stem.

The first three years of life lay the foundation for future mental health. Our most emotionally stable and competent child care providers need to be caring for our youngest children. There exists the mistaken notion that infant child care is just about rocking babies. I've heard people comment that they just want to rock babies and not work with older children in child care because the older ones are too hard to handle. There is nothing easy about caring for a group of infants when it is done well. Infant care providers need a great deal of knowledge and understanding to facilitate the growth of a stable foundation for mental health.

Exposure to relational trauma transcends socioeconomic class, race, and ethnicity. Neglect and abuse happen behind the closed doors of the rich and educated as well as the poor and unschooled. They are often more difficult to detect among the affluent because outward appearances are carefully guarded.

The true rates at which young children are subject to trauma is difficult to assess because the private nature of many forms of trauma can fly under the radar and not come to the attention of the community. It is suspected that the true rates of abuse and neglect are far greater than those reported.

Children who experience trauma are often unable to communicate their distress through words. Some fear retribution from their abusers, and some develop defense mechanisms against even remembering the experience. But as van der Kolk asserts, the body is an historical organ, and it keeps score. Even though the child may not consciously be able to recall the event, the trauma is literally encoded in the psyche and in the cells of the body, and its effects are felt throughout the biological system.

Traumatized children often communicate their distress through behaviors that frustrate caregivers and teachers who do not understand the negative effects of maltreatment on children's growth and development. These hurting children are often reprimanded, punished, sent to time out, and have privileges taken away by well-meaning but misinformed adults who aren't able to "hear" the messages being communicated. Labels such as "challenging," "defiant," "uncooperative," and even "bad" are attached to these children, and the labels often follow them throughout their school careers. This underscores the importance of caregivers and teachers recognizing the signs of trauma.

Characteristics of Traumatized Children

Young children communicate more through their behavior than they do through words. Different children will display different characteristics depending on the timing, intensity, and nature of the abuse or neglect. Some children will exhibit many—if not all—of the characteristics described below, and some will intensely demonstrate just a few.

Infants

- **Difficult to soothe:** Infants who were exposed to substances or toxic stress in utero may be chronically fussy and hard to comfort.
- **Resistant to touch:** Babies who suffered prenatal insult, early medical trauma, prematurity, early neglect, or abuse may resist being held. They may arch their backs and refuse to mold to the caregiver's body. Some will forcefully throw themselves backward to the point that they are upside down. They will often try to wiggle out of the arms of the adult and may loudly protest.
- **Sleep dysregulation:** Some infants will have difficulty falling asleep, while others will violently startle, scream, or cry out. Some will appear awake, with eyes wide open, but seem unaware of what is going on.
- **Feeding issues:** The brain and the "gut" are intertwined, and stress has a profound impact on digestive issues. Infants may chronically spit up or have gas or constipation issues.
- **Dull, listless appearance:** Babies who have suffered neglect often have expressionless faces. They will lay listless in their cribs and stare into space. They rarely respond to initiations from the caregiver to interact or play.
- **Lack of eye contact:** Infants will avert their eyes or look past the caregiver, seemingly staring at something behind them. Others may look at their caregiver as if they are looking through them and not at them.
- **Rocking:** Infants may incessantly rock back and forth in their cribs or while sitting on the floor. All babies may occasionally rock, but when the behavior is persistent and intense, it is cause for concern.
- **Head banging:** Children may hit themselves on the head with their hands or bang their heads on the wall or floor.
- **Sudden lack of motor control:** When infants experience a lack of safety, they may suddenly be unable to perform motor activities that they have previously demonstrated a capacity to do. For example, a baby may suddenly lose the ability to crawl. The child may collapse in spread-eagle fashion and just lie on the floor. Or, if you are holding a baby and he becomes overwhelmed, he may start yawning and lurch forward, losing postural control.

- **Temper tantrums:** All babies have meltdowns now and then, but traumatized infants have them on a regular basis. They have very little frustration tolerance.
- **Lack of play:** Around four months of age, babies typically become very playful and begin to issue invitations for interactions with caregivers. Traumatized and neglected infants show little interest and ability to engage in playful interactions.

Toddlers

In addition to the characteristics mentioned above, toddlers may also display the following:

- **Language delay:** One of the hallmarks of trauma and neglect is a significant delay in language development. Children from hard places lack rich verbal interactions with caring and sensitive adults. Babies learn to communicate out of an innate drive to connect with those who love and care for them. They imitate the sounds and nonverbal expressions of communication of those around them. Maltreated infants and toddlers typically have little experience with reading, singing, nursery rhymes, chants, and games.
- **Alternately fearful and aggressive:** Their actions can be highly contradictory and extreme. Temper tantrums are frequent. They hit and bite other children even without provocation.
- **Excessively negative and oppositional:** Though it is the nature of children between eighteen and thirty-six months to demonstrate some level of opposition and defiance, traumatized children may demonstrate this to an extreme. They will have temper tantrums throughout the day, particularly during times of transition.
- **Withdrawal:** While some children demonstrate their dysregulation through aggression, others withdraw and become pulled into self. They rarely interact with others or respond to initiations to interact and play. They may sit quietly and stare into space. There are children who are simply slow to warm up by nature, but after an initial reticence, they wholeheartedly engage in play. Maltreated children never warm up and consistently remain withdrawn or actively resist interaction.
- **Random and erratic play:** Though toddlers are known for their perpetual motion and relatively short attention spans, children who experience trauma may demonstrate a frenetic level of activity. They randomly roam around the room, picking up toys, only to throw them down after a few seconds. Their behavior almost seems like a wind-up toy, with little purposeful engagement of any sort.
- **Difficulty with separation:** Entry into child care and leaving a family member or guardian is difficult and triggers meltdowns. Because people

have inconsistently come and gone in these children's lives, they struggle with separation. They are very fearful of letting someone go because, in their world, that person is likely to not come back.

- **Refuse to be comforted when hurt:** Maltreated children will often resist efforts by adults to comfort them when they fall and often turn to things rather than people for solace.

Three- to Five-Year-Olds

In addition to the behaviors described above, the following may also appear:

- **Precocious self-care:** Children from hard places have often had to shoulder responsibility for their own daily survival needs and demonstrate the capacity to do things that typically developing children don't do yet. At the same time, they are unable to do things that are typical for their age. For example, a four-year-old may be able to prepare a bottle for her baby sister yet not be able to use scissors.
- **Indiscriminate attachment:** Some children are not able to distinguish the differences among an attachment figure, an acquaintance, and a stranger. Sometimes people mistake their behavior as just being very outgoing and friendly. They will initiate not only conversation but physical contact with a total stranger. If a visitor comes into the room, they may run over and hug the person and strike up a very animated conversation.
- **Inability to play:** For several different reasons, maltreated children often do not know how to play. Mom is typically a child's first play partner, but when she is abusive or neglectful, playful interactions are few and far between. In other instances, young children are forced to deal with inappropriate psychological stress or responsibilities that rob them of the time and energy to play. Some children are so overwhelmed that all of their inner resources are spent merely trying to cope and survive.
  Maltreated children find it very difficult to engage in any kind of play that involves the use of symbols. Dramatic play, blocks, and play that depends on language are very difficult for them for reasons that will be discussed in a later chapter.
- **Unusually controlling:** Chaos typically characterizes the lives of children who have experienced abuse and neglect. To compensate, they spend an enormous amount of energy trying to manipulate and control everything and everyone in the child care or school environment. Sometimes their efforts seem helpful and appropriate, but there is an intensity and pervasiveness that is extraordinary. For example, I had a severely maltreated and neglected five-year-old who assumed the role of caretaker. She noticed every detail regarding the needs and activity of all the children in the group. If someone needed glue, she jumped to get it for him. If someone needed a cotton ball for an art project, she frantically scrambled

to find one. She relayed messages to adults in the room regarding the needs of other children. She made individualized lists reminding others of what they were supposed to be doing. At first glance, her behavior might be construed as helpful, but in reality, this child had a high need to control her environment to feel safe. A child with a high need to control finds it very difficult to relax and just be a child.

- **Seemingly random acts of aggression:** For maltreated children, feeling vulnerable is extremely unnerving and causes a great deal of anxiety. Emotional closeness and intimacy can be very threatening and feel unsafe; feelings of vulnerability can be more frightening and uncomfortable than feelings of aggression. Moments of emotional closeness may trigger a sudden and unprovoked act of aggression. For example, reading a book or telling a story with a group of children is often a special and intimate time. It is a common occurrence in an early childhood setting for the "holy hush" to settle over a group of children who are fully engaged in a story. That magical moment may be disrupted by a sudden outburst from a child with a trauma history. She may suddenly reach over and pinch another child, hit him with a stuffed animal, or sling a blanket at him. This aggressive behavior catches adults off guard because it seems so unprovoked and random.
- **Visceral reactions to frustration:** Children who experience trauma often struggle with strong emotion. Because they frequently lack the ability to use words to identify what they feel, they express emotion through their bodies. They have very little tolerance for frustration, and their reactions to anger and frustration often look like those of a toddler.
- **Gorges or hoards food:** Starvation in utero or in the first years of life touches the psyche of children at the most primitive level. Substance abuse and malnutrition in a pregnant mom can rob the developing baby of necessary nutrients and can result in prenatal starvation. According to Dr. Karyn Purvis, a child who experienced starvation in utero will act like a child who was starved after birth (Purvis, e-mail correspondence, 2010). Children may gorge to the point of throwing up. Some take food out of other children's lunches or backpacks. This is often perceived as "stealing," but it should be recognized as a survival mechanism. This behavior will be addressed in later chapters.
- **Difficulty with transitions:** Maltreated children tend to be rigid and inflexible in their behavior, and transitions often trigger defiance, aggression, and anxiety.
- **Memory problems:** Living in a state of chronic fear damages the physical architecture of the brain and can impair a child's short-term memory. Maltreated children may not remember what they are supposed to do next, and their behavior is often mistaken as noncompliance.

- **Hypervigilant:** Maltreated children are hypersensitive to any indication of a threat to their physical or emotional well-being. They notice every sound, movement, or change in the environment, making it very difficult for them to settle down and focus. It isn't that they aren't paying attention at all; on the contrary, they are paying attention to everything and cannot screen out what isn't important.
- **Misinterpret facial expressions and body language:** Traumatized children stay highly attuned to facial expressions and body language; however, they are prone to misinterpreting nonverbal cues. Their profound sense of shame and worthlessness causes them to filter everything through the lens of "She doesn't like me," or "There's something wrong with me." The frown on your face may be because of a headache, but the child with a trauma history will believe it is directed at him.
- **Developmental delay:** Children with a trauma history often seem significantly younger than their age. (Though a developmental delay may be apparent at younger ages, it usually becomes obvious to caregivers by age three.) Their behavior and responses to everyday events may appear more like a young toddler than a three-year-old. Generally speaking, according to *Understanding the Effects of Maltreatment on Brain Development* by the U. S. Department of Health and Human Services, children exposed to chronic violence, abuse, neglect, and trauma are developmentally about half of their chronological age.

I'm sure by now that you recognize these characteristics in some of the children you work with. The burning question is, "What do I do to help them?" We will address these behaviors and offer practical strategies in later chapters of the book, but first, you need to understand the why before knowing what to do. When teachers and caregivers understand the science or the rationale behind a particular teaching strategy, they are more likely to do it.

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What does a harmed child look like?

It's the little girl on the playground who has mysterious bruises on her legs. It's the three-month-old baby boy who arches his back when you try to hold him. It's the four-year-old who bites and hits when asked to clean up. These are the faces of traumatized children. Nearly half of the reports that national Child Protective Services receives annually are for victims under five years old.

As an early childhood professional, you play a key role in the early identification of maltreatment and unhealthy patterns of development. You are also the gateway to healing. In **Reaching and Teaching Children Exposed to Trauma**, you will find the tools and strategies to connect with harmed children and start them on the path to healing.

Sorrels offers practical strategies that caregivers need to help these littlest victims:

- Connecting with a harmed child using games, music, gentle touch, and play
- Meeting children's sensory needs throughout the day: morning arrival, group time, meal times, outdoor play, and naptime
- Creating a sensory-rich classroom environment with easy, simple ideas
- Teaching a traumatized child self-regulation skills and impulse control using visual cues, rehearsal and role play, games, and scripted stories
- Coaching and supporting social skills: turn taking, sharing, joining in play, empathy, and conflict resolution
- Communicating unconditional love and acceptance to children from hard places

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