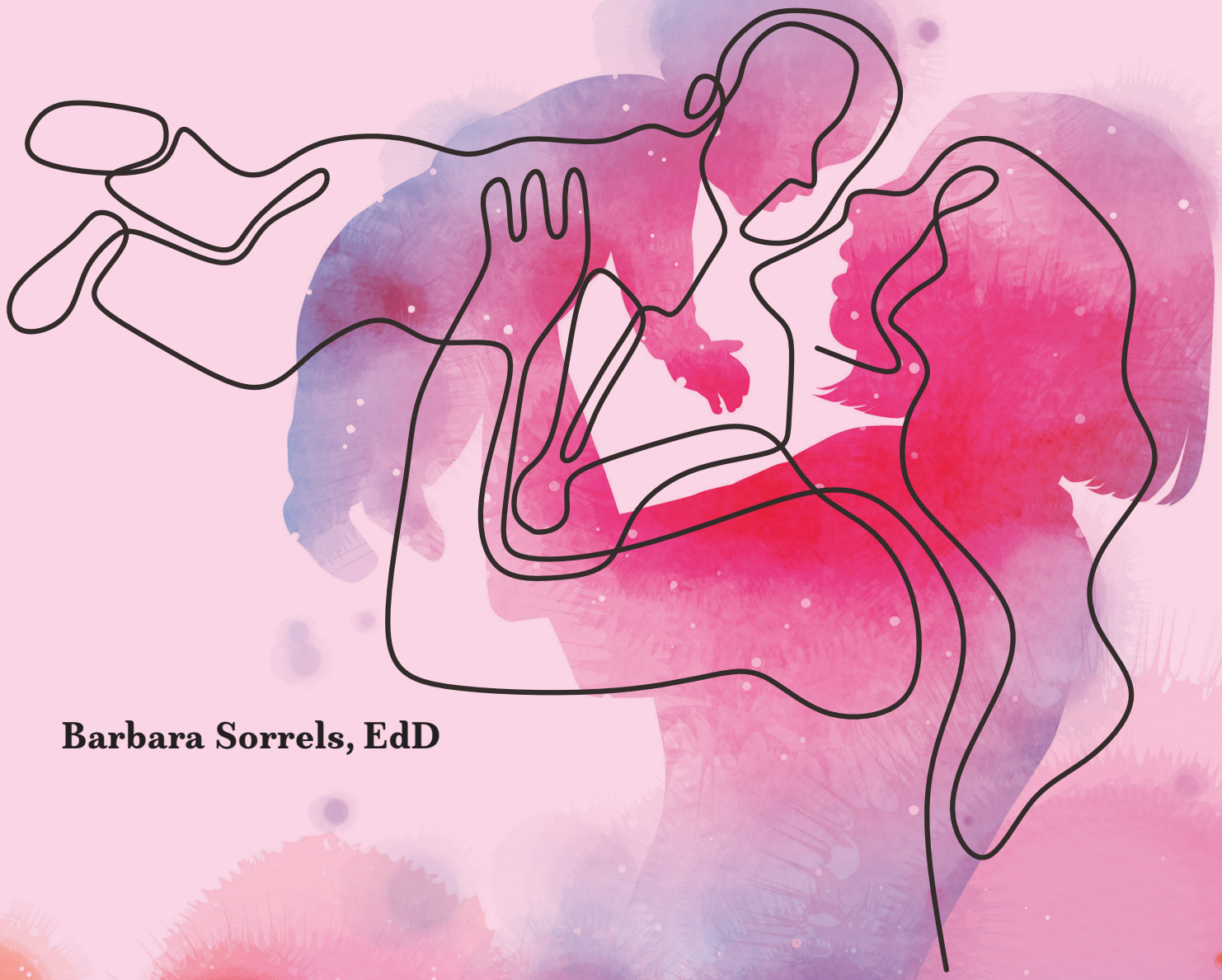
Trauma-Sensitive Care

for Infants, Toddlers, and Two-Year-Olds



Barbara Sorrels, EdD

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INTRODUCTION

I receive a call from a child-care licensing specialist who has recently returned from making a regularly scheduled visit to a licensed family child-care home. The specialist reports that the child-care provider needs support for an eleven-month-old infant who has been in her care for the last two months. The child was removed from the biological mother at birth due to a positive drug test. The infant was placed into a foster home at three weeks of age after being in the neonatal intensive-care unit (NICU) for withdrawal from drugs. The current family with whom the child is living is the infant's fifth placement.

The child-care provider believes she is not equipped to care for the child. The baby is very difficult to console and cries constantly. The caregiver attributes this to her own inadequacy and expressed her anxiety to the specialist. She feels that the baby needs to go somewhere else that is more equipped to deal with her needs. The specialist tries to reassure the caregiver that it isn't a matter of her own inadequacy but the result of the child's early life exposure to adverse circumstances. The specialist calls for advice and expresses her concern over the devastating loss that the child would experience should the caregiver ask the family to find another caregiver. She wants to know how to help this caregiver understand this infant's needs and behavior.

The home can be a dangerous place for children in the United States. In 2019, the U.S. Department of Health and Human Services reported that child welfare agencies received 4.4 million reports of child maltreatment that involved 7.9 million children. Of this number, 91.4 percent of the victims, or 7.2 million children, were harmed by one or both parents. Children under age three have the highest rates of child maltreatment, representing 28 percent of all victims (Bartlett, 2021). It is estimated that five children die every day in the United States from child abuse. Of these children, 70.3 percent are younger than three years. The rate of victimization decreases with age.

A child-care center is often the young child's first contact with people outside of the home (Bartlett, 2021). Infant and toddler child-care providers are, in a sense, "first responders," as they are often the first to recognize that something is amiss and bring it to the attention of the child welfare system. Early identification of children who are affected by severe stress and trauma is critical because the earlier appropriate interventions can be put in place, the greater the likelihood of changing the trajectory of development in a more positive direction.

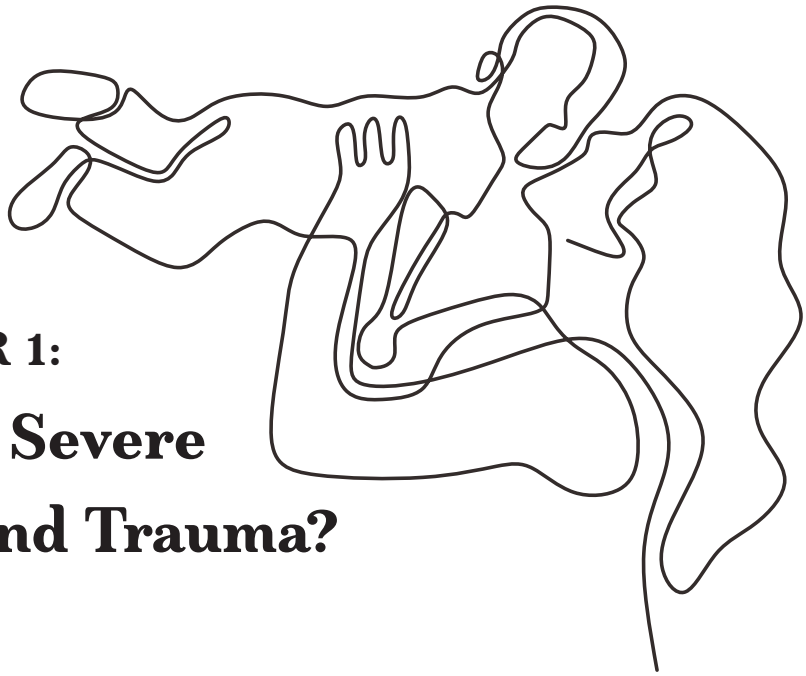
Important Details to Keep in Mind

A common theme throughout this book will be serve-and-return interactions. Warm, responsive, and nurturing interactions with a consistent caregiver who is fully present and attuned is the foundation of mental health and the essence of trauma-sensitive care. Adults are the mediators of children's experiences, and the quality of the serve-and-return interactions affects all developmental domains and sets the trajectory of children's lives.

I will use the term "children from hard places" to refer to infants and toddlers with a history of trauma. This designation was coined by the late Dr. Karyn Purvis, and I prefer this term because it attributes the child's struggles to the place from which they come rather than implying that there is something wrong with the child. I will also use the terms "parents and caregivers" to refer to both the guardians with whom children live and the child-care providers who care for them outside the home. I recognize that there are many kinds of parents—foster, adoptive, step, biological, and kinship. Parents may be LBGTQ, grandparents, extended family, or friends of the family. So, for simplicity's sake, I will use "parents and caregivers."

The vignettes are compilations of real situations and children that I have encountered over the years as a teacher, child-care director, university professor, expert witness, consultant, and trainer. Names and identifying details have been changed to prevent identification. The issues have remained true to reality. The stories are sometimes raw and painful to read, but as advocates and caregivers of young children it is important to understand the world in which some of them live. If you find the vignettes to be triggering and evocative of painful memories of your own story, seek out a trusted friend, spouse, clergy, or counselor to share your memory. Facing and resolving our own pain is one of the healthiest things we can do for ourselves and the children in our care.

My hope is that this book will help early childhood professionals understand more deeply the nuances of nurturing environments and sensitive interactions. This is why I emphasize the nature of healthy developmental processes and relationships. It is necessary to first know what is "normal" before being able to recognize what is abnormal. There is often a very fine line between the two, making the difference hard to distinguish. I also hope that infant-toddler teachers will come away with a new appreciation for the importance of the job that they do and the importance of the role they play in the lives of children.



CHAPTER 1:
What Is Severe Stress and Trauma?

Definition of Stress

There is often the misguided myth that positive mental health means that we are free from stress and anxiety. In her book *Good Anxiety* (2021), Wendy Suzuki explains that not all stress is bad—it is how we grow. Resilience grows when we successfully face manageable stressors in our lives. It is much like muscle building. We would not get stronger if we went to the gym every day and lifted one-pound weights for an hour. On the other hand, we are likely to damage our bodies if we go to the gym and attempt to lift one-hundred-pound weights. Just the right amount of resistance is needed to grow strong muscles.

Likewise, children grow psychologically and become more resilient when they face manageable stress with sufficient support. Our goal is not to prevent them from ever being sad or disappointed or experiencing failure. Our goal as caregivers is to provide support to children when they face stress to act as buffers and help them successfully navigate the challenge. Let's take a look at different kinds of stress.

- Positive
- Tolerable
- Toxic
- Traumatic

Positive Stress

Eighteen-month-old Katrina gets frustrated while trying to put wooden shapes into the correct holes in the shape sorter. After several failed attempts, she throws a block to the floor and looks at her mom, who then

points to the rectangular hole and says, "Try putting it there." Katrina looks at her mom but does not move. Her mother urges, "Go ahead and give it a try." Katrina finally picks up the block and successfully places it into the shape sorter, then gives a satisfied sigh. Later in the day, she gets frustrated when she tries to put her jacket on by herself and she can't quite get her arm in the sleeve. After a few moments of struggle, she manages to get it on. Outside, she sits atop the slide poised to come down but looks frightened and begins to whimper. Her mom stands at the bottom and promises to catch her. Katrina lets go and slides into the arms of her mom. Her frightened face instantly turns to glee, and she says, "Again!"

These are normal events in the life of a child that create *positive stress* (Center on the Developing Child, 2016). Positive stress creates short moments during which the heart rate increases and the body produces mild elevations of stress hormones. But these moments are short-lived and present the child with manageable challenges that promote growth and resilience. It is much like going to the gym to strengthen your muscles. Muscles will never grow stronger if they are not appropriately stressed. Too little stress will make children weak and unable to deal with ordinary life challenges. Too much stress will have a negative impact on brain architecture and psychological development.

When Katrina is encouraged to persevere and figure things out on her own or is given the right amount of support from caregivers, she learns to self-regulate and manage strong emotions. The capacity to self-regulate will eventually allow her to manage her own behavior (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). She will be increasingly able to calm herself in stressful situations, wait patiently for her teachers to serve a snack, participate in story time, and adjust to new situations calmly and confidently. Successfully navigating manageable challenges also helps children gain a sense of self-efficacy or an "I can do it" approach to life.

Biology, temperament, and degree of support play a role in children's capacity to navigate positive stress. As we explore in chapter 2, the biological makeup of a child can predispose them to be more reactive, and some children are born with a temperament that makes it more difficult to soothe them. The availability of an attentive and attuned caregiver is essential. As discussed in a 2012 report by SAMHSA, when children have the confidence that they can rely upon others to support them, these ordinary stressful moments serve to enhance their development (SAMHSA, 2012). One of the challenges for caregivers is to give the right amount of support at the right time. For example, if her mom had swooped in while Katrina was struggling with the shape sorter and completed the task for her with the intention of protecting Katrina from undue frustration, the child would have missed an opportunity for growth. Providing the least amount of support necessary for the child to successfully complete a task is important to growth and resilience.

Tolerable Stress

Tolerable stress is an event that has the potential for lasting harm but is buffered by the presence of a supportive adult. Just like positive stress, tolerable stress can actually serve to help the child become more resilient and self-regulated. Let's consider another scenario.

> Lucian's mom was in a serious car accident and hospitalized for a week to treat her injuries. The accident occurred as she was on her way to pick up Lucian from child care. He became anxious when his mother did not show up at the usual time. As other children left with their parents, he grew increasingly agitated. His caregiver responded to his stress with comfort and reassurance. Lucian's grandmother finally appeared to pick him up, and he rushed into her arms. His grandmother explained what had happened and took Lucian home. Over the course of the next week, Lucian's grandparents remained in the home to help care for him and his two siblings. Though they couldn't visit their mom, the children had video chats with her, allowing them small moments of connection. His grandparents were very attentive and attuned to Lucian's anxiety over his mom's absence and provided comfort and support.

Infants and toddlers will inevitably encounter life situations and experiences that present a significant challenge for them to navigate. These more challenging situations produce a stress response that is stronger and longer lasting than the ordinary daily stressors of life. A child's state of arousal may be intense and lasting enough to alter the structure and neural architecture of the child's brain (Perry and Winfrey, 2021), if the child is left to manage the situation on his own.

The good news, however, is that, with appropriate adult support, the risk of lasting harm can be mitigated. The presence of Lucian's grandparents and their attuned and loving care can prevent him from being overwhelmed and lower the stress response of the brain. The mere presence of a supportive adult can help a potentially harmful event become tolerable (Center on the Developing Child, 2007).

Toxic Stress

Let's consider a very different scenario.

> Alyona was born to nineteen-year-old Eva, who had aged out of the foster-care system. Eva had nowhere to go after being told she could no longer stay in her foster home once she turned eighteen. Between living on the streets with others in her same situation and couch surfing with friends, Eva managed to survive. She met thirty-two-year-old Frank, a drug dealer, who promised her the world if she would come live with him. Soon after, Eva became pregnant. Once Frank found out, he was irate and began to beat her. To endure the resulting despair, Eva began taking drugs. She was quite sure they would take her baby from her, but somehow Eva flew below the

radar and was able to keep Alyona. Having nowhere else to go, she returned to Frank's house. The beatings continued, and Eva's depression worsened. It seemed like the more depressed she became, the more Alyona cried. Sometimes Eva couldn't stand to listen to the crying and would leave the house and just walk the streets for hours. She loved her baby and wanted to be a good mom, but she had no idea what to do. Finally, one of the neighbors became suspicious when people were seen coming and going in and out of the house at all hours. The police conducted a drug raid when Eva happened to be gone and found Alyona alone in the house. Alyona was taken into custody, and the police were waiting for Eva when she returned home. She was charged with child abandonment, and Frank was eventually arrested for dealing drugs.

Alyona is experiencing toxic stress, which means that the stress response is continually activated, never allowing her brain and body to return to a regulated state of calm. Chronic activation can damage the developing architecture and neural circuitry of the brain (SAMHSA, 2012; Perry, 2016). She has not had access to the support of a warm, responsive caregiver who can provide a sense of comfort and safety (Gerhardt, 2015). The presence of a loving caregiver is the key factor in the life of an infant or toddler that prevents a potentially tolerable situation from becoming toxic.

Trauma

Toxic stress can become traumatic when it is particularly severe or prolonged. The National Child Traumatic Stress Network (2022b) defines *trauma* as an event that is "frightening, dangerous, or violent and poses a threat to the child's life or body integrity." A traumatic event overwhelms a child's senses or regulatory capacities and communicates that the world is uncontrollable and unpredictable (Melville, 2017). Witnessing an event that is threatening to the child's caregiver can also be traumatic. Infants and toddlers are astute observers of adult behavior, exquisitely attuned to body language, facial expressions, and tone of voice. When young children observe a family member being threatened or harmed, the child attunes to the emotional state of the adult and innately knows whether the adult is still available for comfort and protection (Lieberman and Van Horn, 2011).

Complex developmental trauma is defined by Bessel van der Kolk (2014) as "the experiences of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature . . . and early life exposure." When children feel

threatened, their instinct is to turn to attachment figures for safety and support. But when the person who is supposed to protect is the source of harm, the child is placed into an impossible psychological dilemma. Ongoing physical and emotional abuse, physical and emotional neglect, and sexual abuse are examples of complex developmental trauma.

The Adverse Childhood Experiences Study

Our awareness of trauma can largely be attributed to the Adverse Childhood Experiences (ACE) study conducted by Kaiser Permanente in San Diego. What began as a study on morbid obesity in the 1980s soon became a seminal study on trauma that has launched the topic to the forefront of the American education system and child-care industry. As researcher Vincent Felitti explored the underlying causes of morbid obesity, he uncovered the powerful effects of traumatic events in the first five years of life and their long-lasting implications for health and well-being. The ACE study identified ten risk factors or *adverse experiences* in a child's life that can have lifelong implications (CDC, 2021a).

- **Abuse and Neglect:**
  - Physical abuse
  - Emotional abuse
  - Physical neglect
  - Emotional neglect
  - Sexual abuse
- **Household Dysfunction:**
  - Substance abuse in the home
  - Parental separation or divorce
  - Mental illness in the home
  - Battered mother
  - Criminal behavior

The ten adverse experiences listed are the indicators used to determine an individual's ACE score. For example, if you experienced three out of the ten adversities, your ACE score would be a 3. An individual's score has implications for health and well-being across the life span.

The number of adverse experiences a child is exposed to in the first five years of life has a direct correlation to both the physical and mental health of the individual, meaning that the more adversity one experiences in the first five years of life, the greater the likelihood of more frequent health issues and unhealthy behaviors (Harris, 2019). For example, a child with an ACE score of 2 is more likely to be diagnosed with asthma, type two diabetes, and skin rashes. A child with an ACE score of 4 is 32.2 percent more likely to demonstrate behavioral issues and challenges. Some of the physical conditions manifest in childhood; others such as lung cancer and COPD may not manifest until the fifth decade of life (Harris, 2019).

The ACE study challenges earlier assumptions that illness is determined by genetic factors. Scientists now know that illness is a dynamic interaction between genes and environment. Trauma expert Bruce Perry (Perry and Winfrey, 2021) compares our genetic makeup to a piano keyboard. The piano has the potential of manifesting an exponential number of tunes depending on what keys are played by the "environment" (pianist) at any given time. Likewise, our genes are activated by the environment. We may carry the genetic potential for certain diseases, but for most conditions, an environmental trigger is necessary to cause the gene to turn on (Lucero, 2018).

Over the past three decades, the ACE study has helped bring the issue of trauma into mainstream conversation. It has confirmed what many early childhood educators have intuitively believed for decades: early experiences matter. The roots of our children's health, behavior, and psychological functioning are found in the earliest years of life.

Although the ACE study has played a major role in bringing the issue of trauma into the spotlight, the study has its limitations in that it does not account for many other forms of trauma and severe stress that touch the lives of our youngest children. Prenatal alcohol, drug and nicotine exposure, toxic stress in pregnancy, prematurity, difficult birth, early medical trauma, adoption, immigration, terrorism, community violence, homelessness, medical neglect, food scarcity, racism, epidemics, surrogacy, and relational poverty are other forms of trauma that touch the lives of children.

Acute Trauma

In addition to these significant life stressors are other forms of acute trauma that are most often acts of nature, such as floods, hurricanes, earthquakes, and tornadoes. These events are relatively short in duration, but the effects of such disasters are ongoing. Rebuilding homes and communities can take years, displacing families and children for prolonged periods of time. Infants' and toddlers' capacity to endure acute events without significant negative repercussions is largely determined by the emotional state of the children's caregivers and the strength of the emotional connections between caregivers and children.

The child's individual history of trauma also plays a part. Children who have experienced prenatal and postnatal trauma are far more vulnerable to acute trauma because they already view the world as unsafe. Natural disasters can reaffirm this conviction.

Intergenerational Trauma

Intergenerational or historical trauma is an emerging topic of interest, yet many unknowns and unanswered questions remain. The University of Minnesota Extension (2020) describes *historical trauma* as shared experiences by a given community that results in "cumulative emotional and psychological wounds that are carried across generations." For example, it was first noted in 1966 when therapists found that grandchildren of Holocaust victims were 300 percent more likely to suffer with mental-health issues than grandchildren of people who had not directly experienced the Holocaust (Sigal, Dinicola, and Buonvino, 1988).

Historical trauma has been found among Native Americans and among descendants of enslaved people, people who experienced the Irish potato famine, and Japanese-Americans who experienced internment camps during World War II. Common problems found among those who experience historical trauma are poor overall physical health, low self-esteem, depression, self-destructive behavior, propensity for violent and aggressive behavior, substance abuse and addiction, cardiovascular disease, and suicide (Sigal, Dinicola, and Buonvino, 1988).

Present-day family dysfunction, poor health, community violence, early death, and mental-health issues can be symptoms of the past as much as they are experiences of the present (Atkinson, 2013). The mechanism by which historical trauma is passed down

from generation to generation is not clearly understood and can occur in a variety of ways. Unresolved trauma of the past can be internalized as shame and guilt (Aboriginal Torres Strait Islander Healing Foundation Development Team, 2009). People begin to believe that they are somehow deserving of the maltreatment and come to expect this is just the way life is. They lose hope and stop imagining a different future for themselves and their children.

Adversity, trauma, and depression interfere with a parent's capacity to be attentive and responsive to the needs of their children (SAMHSA, 2012; Perry, 2014; Perry and Winfrey, 2021). Biological, psychological, behavioral, and cognitive changes in children are inevitable. The real tragedy of early maltreatment and trauma is not just the frightening and often painful event that happens in the moment; it is the disruption of healthy developmental processes that compromises ongoing future development. A healthy foundation is essential for a positive developmental trajectory.

Another mechanism by which intergenerational trauma can be passed down is through changes in gene expression. The genes themselves don't change, but what gets turned on and what gets turned off is affected by the circumstances of life (Perry and Winfrey, 2021). Remember Perry's metaphor of the piano keyboard? It is believed that the environment in which we live determines which genes are activated and which genes remain silent. In other words, an individual may possess the gene for a certain characteristic or disease but never manifest the condition because the environment did not trigger the expression of the gene. Growth and development is an interaction between biology and nurture.

The Role of Memory in Infant and Toddler Trauma

> Anna, a foster parent of a two-year-old, called me to seek advice. The child-care center was threatening to expel the child because she was "violent" and aggressive, throwing temper tantrums every time she was told no, and hitting the caregivers. Anna denied that the child had experienced any trauma: "Of course, she has no trauma. She came to live with me when she was two months old. She couldn't possibly remember anything that happened to her before that."

This is a common misunderstanding of infant-toddler trauma. Many people believe that because our youngest children can't remember, they are untouched by trauma. Nothing could be further from the truth. The psychiatric community now recognizes that babies talk through their eyes, facial expressions, gestures, and body (Keren, Hopp, and Tyano, 2018). One of the mechanisms by which infant-toddler trauma impacts children is through implicit and explicit memory. Bessel van der Kolk's book *The Body Keeps the Score* (2014) is an eloquent discussion of the human body's capacity to encode all of life's experiences. Our

body can carry information across time, from one moment in time to another (Perry, 2000). When certain neural pathways are activated repeatedly, each pathway becomes encoded in the brain as a memory.

Implicit Memories

Throughout the fetal period and across the first eighteen months of life, the infant's experiences are being recorded and encoded in the brain through *implicit* or unconscious memory (Keren, Hopp, and Tyano, 2018). Memories are being recorded and assimilated, yet the child doesn't have the capacity to consciously recall these memories and tell a story about them (Perry and Winfrey, 2021; Vöhringer et al., 2017). If an individual can remember something from this period of time, it is likely a "flashbulb" memory—an image with a strong emotion attached, either something happy or exceedingly scary or sad. It is possible that implicit memories can remain dormant and symptoms of trauma not be manifested for many years down the road (Keren, Hopp, and Tyano, 2018). Implicit memories fall into three categories:

- Emotional
- Procedural
- State

Emotional Memory

An emotional memory is the memory of how you felt during a particular experience (National Institute for the Clinical Application of Behavioral Medicine [NICABM], 2017). It can be triggered by an object, a person, a smell, or any other sensory stimuli present during the event. Emotional memories can intrude upon a child without any context. For example, a child raised in a home with an abusive father who happens to have a beard may become flooded with fear when he encounters a bearded stranger. The child will likely have no idea why he suddenly feels overwhelmed by fear. He just suddenly is overcome by a fight, flight, or freeze response.

Procedural Memory

Procedural memory is sometimes referred to as *motor-vestibular memory* (NICABM, 2017). For example, ice skaters and gymnasts talk about practicing certain moves repeatedly until they can perform them without thinking about what they are doing. Once they initiate the first movement in the sequence, body memory takes over and they complete the sequence. We have all probably experienced body memory when we curl up in a fetal position with severe pain or illness. Our body hearkens back to the calmest, safest time of prenatal development when the fetal position evokes a sense of soothing, calm, and safety (Perry, 2000).

State Memory

When a certain event happens repeatedly, the bodily responses associated with that event become encoded as a state memory. It is common in the child-welfare system for an infant

to experience a profound state memory when he meets a biological parent who was present during the pregnancy but has been absent since birth. For example, Jason's father disappeared shortly before he was born. His father was physically and verbally abusive toward Jason's mother throughout the pregnancy. Later, when Jason is around nine months of age, his father petitions the court for joint custody. A supervised visit is arranged, and when dad walks into the room and speaks, Jason becomes hysterical and screams inconsolably. The sound of his voice triggers a biological state of fear, similar to what Jason experienced in utero.

Explicit Memory

Conscious memory or *explicit* memory begins to function somewhere between two and three years of age. This is the kind of memory that can be intentionally recalled, and a narrative can be created about the memory (NICABM, 2017). For example, a child may tell you a story about his birthday over the weekend or the family's purchase of a new dog. There are two basic types of explicit memory: declarative and autobiographical.

Declarative Memory

Declarative memory is the kind that we employ when we memorize math facts, the Declaration of Independence, or information for a test. It is information that we can intentionally recall (NICABM, 2017).

Autobiographical Memory

Autobiographical or episodic memory refers to the ability to recall a particular event of your life and create a narrative (NICABM). Autobiographical memory allows us to remember events and put them in sequential order so that we might be able to make meaning of our lives.

These different forms of memory are not rigid categories but overlap and intersect with one another; however, all play a part in how trauma impacts the lives of children. The toddler's resistance to being held by a particular child-care provider may have nothing to do with the individual. Instead, the caregiver's appearance, perfume, or voice may evoke an implicit memory of a negative experience with someone in the past. We can unwittingly bump up against a child's past and never really know what happened.

The Effects of Trauma

Ms. Kay, a toddler teacher, is focusing on the identification of color. She plays lots of games involving color, includes color-related vocabulary words in her daily conversation, but little Susie isn't making the connection. Ms. Kay knows that Susie is in the child-welfare system due to failure to thrive. She was left alone in a crib for long periods during her first year of life. She was found by a custodian in a hotel room, lying in feces and suffering from a horrible diaper rash. In the six months that she has been in custody, she has already had four placements. Ms. Kay recognizes that Susie's history of maltreatment and trauma may delay her basic milestones in language and other cognitive skills.

Damian, on the other hand, was found sleeping on a sidewalk in an apartment complex when he was nineteen months old. It was later discovered that the child was often seen wandering around the complex alone at all hours of the night. His parents were known drug addicts who were seen coming and going at all hours. Damian was placed in a very loving and stable foster home and was adopted into the family two years later. He is now four years old and meeting developmental milestones in all domains. His teachers often comment that no one would suspect his history based on his behavior and functioning.

So why is it that some children seem to be more resilient than others? Many variables determine how stress and adversity will impact a child. In 1975, researchers Arnold Sameroff and Michael Chandler introduced the notion that the impact is determined by the interplay between *protective* factors and *risk* factors. A child becomes resilient when the effect of protective factors outweighs that of the negative risk factors. This concept has been embraced by others in the field to explain why some children remain relatively unscathed and others are profoundly impacted. (Shonkoff and Phillips, 2000; Gilkerson and Klein, 2008; Keren, Hopp, and Tyano, 2018).

Protective and risk factors can originate from three different sources: the child, the parent, and the environment in which the parent and child live (Keren, Hopp, and Tyano, 2018). The child brings certain characteristics, biological traits, and competencies to the table, as

do parents and caregivers. The environment in which the family lives, including the child-care environment, contributes to the mix. Listed below are some of the protective and risk factors that come into play.

Sources	Protective Factors	Risk Factors
Within the Child	• High IQ • Genetic hardiness • Easygoing temperament • Race	• Low IQ • Developmental disabilities • Genetic propensity for illness and disease • Difficult temperament • Sensory-processing issues • Regulatory issues • Prematurity • Race
Parental Factors	• High education and IQ • Physical and mental health • Capacity for empathy • Healthy intimate-partner relationships • Capacity to manage emotions	• Low IQ and low education • Single parent • Divorce • Abuse, neglect, substance abuse • Mental or physical illness • Personality disorders • Family dysfunction • Domestic violence • Teen parents
Within the Environment	• Safe community • Socioeconomic class • Strong social supports • Faith community	• Violent community • Low socioeconomic status • Poverty • Lack of health care • Lack of family and social support • Racism

As illustrated in the vignette above, trauma can negatively affect infants' and toddlers' healthy growth and development and their ability to meet developmental milestones (Perry, 2014). It is common for infants and toddlers from hard places to have cognitive, language, motor, and social delays (Mitchell, Tucci, and Macnamara, 2020). Their development may be uneven or skewed, meaning that they may meet developmental milestones in one area but be significantly delayed in others. Children's development constricts around the period that the maltreatment and trauma was most intense (Mitchell, Tucci, and Macnamara, 2020). It is common for children from hard places to function at half their chronological age. In other words, an eighteen-month-old child may be more like a nine-month-old (Purvis, 2009; Perry, 2016).

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Immerse children who experience a rough start in life in the highest quality of care.

Maltreatment during the first three years of life is of utmost concern. Not only are the numbers of harmed infants and toddlers staggering, maltreatment during this vulnerable period alters children's development in such a way that it robs them of reaching their full human potential. As an infant-toddler child-care provider, you are a "first responder" to this national crisis, playing a key role in the early identification of maltreatment and unhealthy patterns of development. You can be a gateway to healing.

In *Trauma-Sensitive Care for Infants, Toddlers, and Two-Year Olds*, discover practical advice and strategies to nurture harmed children and start them on the path to healing.

- Create spaces that communicate safety.
- Provide predictable routines.
- Nurture connectedness and attachment.
- Use rhythm to support brain development.
- Nurture healthy social-emotional development.
- Use play to encourage self-regulation and self-confidence.
- Care for yourself so you can care for children.

To recover and develop resilience in the face of adversity, infants and toddlers need fully present, playfully engaged, calm, and invested caregivers. There is no margin for error.

Barbara Sorrels, EdD, is a child-development specialist, educator, and consultant with a heart for "children from hard places." She is the founder and CEO of Connected Kids, an organization providing training and consultation in trauma-responsive practices to school districts, schools, child-care centers, Head Start programs, churches, therapists, and community agencies. Dr. Sorrels spent more than 20 years as a classroom teacher, a founder and director of early childhood centers, and a professor in the early childhood education program at Oklahoma State University.

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