Early Childhood Trauma

(Print version of
http://nctsn.org/nccts/nav.do?pid=typ_early1)

August 2010

Zero to Six Collaborative Group

Overview

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0–6. Because infants' and young children's reactions may be different from older children's, and because they may not be able to verbalize their reactions to threatening or dangerous events, many people assume that young age protects children from the impact of traumatic experiences. When young children experience or witness a traumatic event, sometimes adults say, "They're too young to understand, so it's probably better if we don't talk to them about it." However, young children are affected by traumatic events, even though they may not understand what happened.

A growing body of research has established that young children—even infants—may be affected by events that threaten their safety or the safety of their parents/caregivers, and their symptoms have been well documented. These traumas can be the result of intentional violence—such as child physical or sexual abuse, or domestic violence—or the result of natural disaster, accidents, or war. Young children also may experience traumatic stress in response to painful medical procedures or the sudden loss of a parent/caregiver.

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How Is Early Childhood Trauma Unique?

Traumatic events have a profound sensory impact on young children. Their sense of safety may be shattered by frightening visual stimuli, loud noises, violent movements, and other sensations associated with an unpredictable frightening event. The frightening images tend to recur in the form of nightmares, new fears, and actions or play that reenact the event. Lacking an accurate understanding of the relationship between cause and effect, young children believe that their thoughts, wishes, and fears have the power to become real and can make things happen. Young children are less able to anticipate danger or to know how to keep themselves safe, and so are particularly vulnerable to the effects of exposure to trauma.

Children may blame themselves or their parents for not preventing a frightening event or for not being able to change its outcome.

A 2-year-old who witnesses a traumatic event like his mother being battered may interpret it quite differently from the way a 5-year-old or an 11-year-old would. Children may blame themselves or their parents for not preventing a frightening event or for not being able to change its outcome. These misconceptions of reality compound the negative impact of traumatic effects on children's development.

As with older children, young children experience both behavioral and physiological symptoms associated with trauma. Unlike older children, young children cannot express in words whether they feel afraid, overwhelmed, or helpless. However, their behaviors provide us with important clues about how they are affected.

Young children who experience trauma are at particular risk because their rapidly developing brains are very vulnerable. Early childhood trauma has been associated with reduced size of the brain cortex. This area is responsible for many complex functions including memory, attention, perceptual awareness, thinking, language, and consciousness. These changes may affect IQ and the ability to regulate emotions, and the child may become more fearful and may not feel as safe or as protected.

Young children depend exclusively on parents/caregivers for survival and protection—both physical and emotional. When trauma also impacts the parent/caregiver, the relationship between that person and the child may be strongly affected. Without the support of a trusted parent/caregiver to help them regulate their strong emotions, children may experience overwhelming stress, with little ability to effectively communicate what they feel or need. They often develop symptoms that parents/caregivers don't understand and may display uncharacteristic behaviors that adults may not know how to appropriately respond to.

Read More About It

For more on the impact of trauma on brain development, see *Excessive Stress Disrupts the Architecture of the Developing Brain*, a working paper from the National Scientific Council on the Developing Child, available at http://developingchild.harvard.edu/library/reports_and_working_papers/wp3/

Scope of the Problem

Young children are exposed to traumatic stressors at rates similar to those of older children. In one study of children aged 2–5, more than half (52.5%) had experienced a severe stressor in their lifetime.[1]

The most common traumatic stressors for young children include: accidents, physical trauma, abuse, neglect, and exposure to domestic and community violence.

Child Accidents and Physical Trauma

- Children aged five and under are hospitalized or die from drowning, burns, falls, choking, and poisoning more frequently than do children in any other age group.[2]

- One in three children under the age of six has injuries severe enough to warrant medical attention.[3]

Child Abuse and Neglect

- Young children have the highest rate of abuse and neglect, and are more likely to die because of their injuries.

- Children younger than three years of age constituted 31.9 percent of all maltreatment victims reported to authorities in 2007.[4]

- Infants are the fastest growing category of children entering foster care in the United States.[5]

- Infants removed from their homes and placed in foster care are more likely than are older children to experience further maltreatment and to be in out-of-home care longer.[6]

Child Exposure to Domestic or Community Violence

- In a survey of parents in three SAMHSA-funded community mental health partnerships, 23 percent of parents reported that their children had seen or heard a family member bring threatened with physical harm.[7]

- Nearly two-thirds of young children attending a Head Start program had either witnessed or been victimized by community violence, according to parent reports.[8]

- In a survey of parents of children aged six and under in an outpatient pediatric setting, it was found that one in ten children had witnessed a knifing or shooting; half the reported violence occurred in the home.[9]

Data from National Child Traumatic Stress Network (NCTSN) Sites

In 2002 the NCTSN Complex Trauma Task Force conducted a clinician survey on trauma exposure for children who were receiving assessment and/or intervention services. Among the findings —published in a white paper, *Complex Trauma in Children and Adolescents*—was that 78 percent of children had experienced more than one trauma type and that the initial exposure on average occurred at age five.[10] Additional data from more than 10,000 cases of children receiving trauma-focused services from sites in the NCTSN reveal that in this cohort, one-fifth of children are aged zero to six. The traumas these children most often received services for were exposure to domestic violence, sexual abuse, neglect, and traumatic loss/bereavement.[11]

Symptoms and Behaviors Associated with Exposure to Trauma

Children suffering from traumatic stress symptoms generally have difficulty regulating their behaviors and emotions. They may be clingy and fearful of new situations, easily frightened, difficult to console, and/or aggressive and impulsive. They may also have difficulty sleeping, lose recently acquired developmental skills, and show regression in functioning and behavior.

Possible Reactions of Children Aged Zero to Six Exposed to Traumatic Stress		
Behavior Type	**Children aged 0–2**	**Children aged 3–6**
Cognitive		
Demonstrate poor verbal skills	✓	
Exhibit memory problems	✓	
Have difficulties focusing or learning in school		✓
Develop learning disabilities		✓
Show poor skill development		✓
Behavioral		
Display excessive temper	✓	✓
Demand attention through both positive and negative behaviors	✓	✓
Exhibit regressive behaviors	✓	✓
Exhibit aggressive behaviors	✓	✓
Act out in social situations		✓
Imitate the abusive/traumatic event		✓
Are verbally abusive		✓
Scream or cry excessively	✓	
Startle easily	✓	✓
Are unable to trust others or make friends		✓
Believe they are to blame for the traumatic experience		✓
Fear adults who remind them of the traumatic event	✓	✓
Fear being separated from parent/caregiver	✓	✓
Are anxious and fearful and avoidant		✓

Possible Reactions of Children Aged Zero to Six Exposed to Traumatic Stress		
Behavior Type	Children aged 0–2	Children aged 3–6
Show irritability, sadness, and anxiety	✓	✓
Act withdrawn	✓	✓
Lack self-confidence		✓
Physiological		
Have a poor appetite, low weight, and/or digestive problems	✓	
Experience stomachaches and headaches		✓
Have poor sleep habits	✓	✓
Experience nightmares or sleep difficulties	✓	✓
Wet the bed or self after being toilet trained or exhibit other regressive behaviors		✓
Physiological		
Have a poor appetite, low weight, and/or digestive problems	✓	
Experience stomachaches and headaches		✓
Have poor sleep habits	✓	✓
Experience nightmares or sleep difficulties	✓	✓

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Protective Factors: Enhancing Resilience in Young Children and Families

The effects of traumatic experiences on young children are sobering, but not all children are affected in the same way, or to the same degree. Children and families possess competencies, psychological resources, and resilience—often even in the face of significant trauma—that can protect them against long-term harm.

How Communities Can Help

Communities can do much to mobilize on behalf of children, and the larger society can make it a priority to make sure basic services are provided to children to help keep them safe. Additional information on enhancing children's resilience through community intervention is available in *Building Community Resilience for Children and Families*, a guidebook developed by the Terrorism and Disaster Center of in the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center and the National Child Traumatic Stress Network.[12]

> Children and families possess psychological resources and resilience that can protect them against long-term harm.

How Parents/Caregivers Can Help

Research on resilience in children demonstrates that an essential protective factor for children is the reliable presence of a positive, caring, and protective parent/caregiver, who can help shield their children against adverse experiences. They can be a consistent resource for their children, encouraging them to talk about the experiences. And they can provide reassurance to their children that the adults in their life are working to keep them safe. [13]

Read More About It

For more on building resilience at the family and community level, visit the Child Welfare Information Gateway's Web page on enhancing protective factors, at http://www.childwelfare.gov/preventing/promoting/protectfactors/.

Identifying and Providing Services to Young Children Who Have Been Exposed to Trauma: For Professionals

Due to the particular developmental risks associated with young children's traumatic experiences, it is essential that vulnerable children be identified as early as possible after the trauma. Many community resources—including health systems, Early Intervention programs, child welfare agencies, Head Start, child care programs, and early education systems—play an important role in identifying children, and in linking them and their families with services.

Some of these systems now try to address possible traumatic experiences by including questions about specific traumas into their intake and/or assessment protocols. For example, both Head Start and Early Intervention intake protocols include questions about domestic violence in families. Other protocols may include targeted questions about accidents, loss of family members, and/or significant medical history.

For Mental Health Professionals

Behavioral Health Assessment

Assessment of trauma in young children must focus on the presenting problem in the context of the child's overall development. This information can be gathered though interviews with the parents/significant caregivers in the child's life, observation of the parent/caregiver-child interaction, and standardized assessment tools. Clinical assessment should include review of the specifics of the traumatic experience(s) including:

- Reactions of the child and parents/caregivers

- Changes in the child's behavior

- Resources in the environment to stabilize the child and family

- Quality of the child's primary attachment relationships

- Ability of parents/caregivers to facilitate the child's healthy socioemotional, psychological, and cognitive development

Instruments for Assessing Traumatic Stress in Young Children

Below is a list of some of the standardized instruments used within the NCTSN to assess traumatic stress in young children.

- Child Behavior Checklist (CBCL)[14]—aged 1½–5

- Posttraumatic Stress Disorder Semi-Structured Interview and Observation Record[15]—aged 0–4 years of age

- Posttraumatic Symptom Inventory for Children (PT-SIC) [16]—aged 4–8 years

- Preschool Age Psychiatric Assessment (PAPA) [17]—aged 2–5

- PTSD Symptoms in Preschool Aged Children (PTSD-PAC) [18]—aged 3–5[18]

- Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR) [19]—aged 0–6

- Trauma Symptom Checklist for Young Children (TSCYC) [20]—aged 3–12

- Violence Exposure Scale for Children-Preschool Version (VEX-PV) [8]—aged 4–10

- Violence Exposure Scale for Children-Revised Parent Report (VEX-RPR) [8]—for parents of preschool-aged children aged 4–10[8]

Instruments for Assessing Parenting Stress and Strengths

- Life Stressor Checklist—Revised (LSC-R) [21]
- Parenting Stress Index (PSI) [22]
- Davidson Trauma Scale (DTS) [23]

When conducting an assessment of a young child, it is also important to assess developmental delays (e.g., gross/fine motor, speech/language, sensory processing), which may indicate that the child could benefit from evaluation and/or services from another professional (e.g., occupational therapist, speech/language therapist, physical therapist). And it is often helpful to consult and/or to work collaboratively with these professionals to conduct a multidisciplinary evaluation.

For Medical Professionals

Screening/Assessment in Health Settings

Most young children are seen at regular intervals by providers in the pediatric health care system, enabling repeated opportunities for identifying early childhood trauma.

Medical providers can also play an important role in diminishing risks and in maximizing protective factors associated with young children's exposure to trauma. They can supply information to prevent accidents and can incorporate questions about stressful and traumatic experiences into their interviews with families.

Resources for Identifying Traumatic Stressors in Young Children
Online resources
The Child Trauma Academy (http://www.childtrauma.org)   Articles for professionals (http://www.childtrauma.org/index.php/articles/articles-for-professionals)
The Health Care Toolbox (http://www.healthcaretoolbox.org/index.php)   Center for Pediatric Traumatic Stress at The Children's Hospital of Philadelphia

Centers for Disease Control and Prevention (http://www.cdc.gov)
   Injury—A Risk at Any Stage of Life
   (http://www.cdc.gov/ncipc/fact_book/Injury%E2%80%94A%20Risk%20at%20Any%20Stage%20of%20Life-2006.pdf)

Journal Articles
Cohen, J. A., Kelleher, K. J., & Mannarino, A. P. (2008). Identifying, treating, and referring traumatized children: The role of pediatric providers. *Archives of Pediatrics and Adolescent Medicine*, *162(5)*, 447–452.
Dehon, C., & Scheeringa, M. S. (2006). Screening for preschool posttraumatic stress disorder with the Child Behavior Checklist. *Journal of Pediatric Psychology*, *31(4)*, 431–435.
Groves, B. M., & Augustyn, M. (2009), Pediatric care. Moving From Evidence to Action: *The Safe Start Series on Children Exposed to Violence, Issue Brief #2*. North Bethesda, MD: Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Program, U.S. Department of Justice. Retrieved August 5, 2010 from http://www.safestartcenter.org/pdf/IssueBrief2_PEDIATRIC.pdf

For Early Educators and Childcare Providers

Educators and childcare providers may inquire about children's safety; offer resources to reestablish safety for families; and, most importantly, support young children's learning through nurturing relationships, and through predictable expectations and routines in the classroom.

Resources for Early Educators and Childcare Providers	
Online resources	
Center on the Social and Emotional Foundations for Early Learning (http://csefel.vanderbilt.edu/about.html)	*Practical Strategies for Teachers/Caregivers* (http://csefel.vanderbilt.edu/resources/strategies.html)
Head Start (http://www.headstart.org/)	*Head Start Bulletin #73: Child Mental Health* (http://eclkc.ohs.acf.hhs.gov/hslc/resources/ECLKC_Bookstore/PDFs/A6E18B91317C94E72DD233C75C4DBD7D.pdf)
	Head Start Bulletin #80: Mental Health (http://www.headstartresourcecenter.org/assets/file/Publications/Bulletin-Mental%20Health%202009v3.pdf)
National Child Traumatic Stress Network (http://www.nctsn.org)	*Child Trauma Toolkit for Educators* (http://www.nctsnet.org/nctsn_assets/pdfs/Child_Trauma_Toolkit_Final.pdf)
	Caja de Herramientas Para Educadores Para el Manejo de Trauma Infantil (http://www.nctsnet.org/nctsn_assets/pdfs/SP_Child_Trauma_Toolkit_111009_FINAL.pdf))
Scholastic for Teachers (http://www2.scholastic.com/)	Library of articles by trauma expert Bruce D. Perry, MD, PhD (http://teacher.scholastic.com/professional/bruceperry/index.htm)
	Greenspan, S. I. (2002). Meeting learning challenges: Working with the child who has PTSD. *Scholastic Early Childhood Today.*
	Perry, B. D. (2006). Death and loss: Helping children manage their grief. *Scholastic Early Childhood Today.*
Print Resource	
Rice, K. F., & Groves, B. M. (2005). *Hope and healing: A caregiver's guide to helping young children affected by trauma.* Washington, D.C.: Zero to Three Press.	

For Family Court Judges and Staff

The more that family court judges know about child development and the effects of child trauma, the better equipped they are to make decisions regarding permanency planning for abused and neglected children, to improve the lives of children who have witnessed domestic violence, and to adjudicate custody and visitation cases.

Resources for Family Court Judges and Staff	
Online resources	
National Child Traumatic Stress Network (http://www.nctsn.org)	*Helping Traumatized Children: Tips for Judges* (http://www.nctsnet.org/nctsn_assets/pdfs/JudgesFactSheet.pdf) *NCTSN Service Systems Brief: Judges and Child Trauma: Findings from the National Child Traumatic Stress Network/National Council of Juvenile and Family Court Judges Focus Groups* (http://www.nctsnet.org/nctsn_assets/pdfs/judicialbrief.pdf)
Safe Start Center (http://www.safestartcenter.org/)	*A Judicial Checklist For Children And Youth Exposed To Violence* (http://www.safestartcenter.org/pdf/childandyouth_checklist.pdf) .
Zero to Three (http://www.zerotothree.org/)	*Helping Babies from the Bench: Using the Science of Early Childhood Development in Court* (DVD) Order form available at http://www.zerotothree.org/about-us/funded-projects/court-teams/dvd_order_form_2009.pdf

For Faith-Based, Community, and Mentoring Organizations

Community and faith-based organizations have in-depth knowledge of the resources and challenges in their communities. They play a vital role in linking families to resources that help stabilize and support them in the aftermath of trauma events. Advocating for families and increasing access to care can help families begin their recovery process. NCTSN offers the following excellent resources for such organizations.

- *Psychological First Aid: Field Operations Guide, 2nd Edition* and *Psychological First Aid Field Operations Guide for Community/Religious Professionals*. Available from NCTSN at http://www.nctsnet.org/nccts/nav.do?pid=typ_terr_resources_pfa

Helping Young Children Exposed to Trauma:
For Families and Caregivers

When young children experience a traumatic stressor, their first response is usually to look for reassurance from the adults who care for them. The most important adults in a young child's life are his/her caregivers and relatives. These adults can help reestablish security and stability for children who have experienced trauma by:

- Answering children's questions in language they can understand, so that they can develop an understanding of the events and changes in their life

- Developing family safety plans

- Engaging in age-appropriate activities that stimulate the mind and body

- Finding ways to have fun and relax together

- Helping children expand their "feelings" vocabulary

- Honoring family traditions that bring them close to the people they love, e.g., storytelling, holiday celebrations, reunions, trips

- Looking for changes in behaviors

- Helping children to get back on track

- Setting and adhering to routines and schedules

- Setting boundaries and limits with consistency and patience

- Showing love and affection

> Caregivers and relatives are the most important adults in children's lives. They can help reestablish security and stability for children who have experienced trauma.

Resources for Family and Caregivers	
Online resources	
After the Injury (http://aftertheinjury.org/)	*Find Ways to Help Your Child Recover* (http://aftertheinjury.org/findWhat.html)
Center on the Social and Emotional Foundations for Early Learning (http://csefel.vanderbilt.edu/about.html)	*Family Tools* (http://csefel.vanderbilt.edu/resources/family.html)
National Child Traumatic Stress Network (http://www.nctsn.org)	*After the Hurricane: Helping Young Children Heal* (http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/Helping_Young_Children_Heal.pdf) *Helping Young Children and Families Cope with Trauma* (http://www.nctsnet.org/nctsn_assets/pdfs/Helping_Young_Children_and_Families_Cope_with_Trauma.pdf)
Scholastic.com (http://www2.scholastic.com/browse/home.jsp)	Brodkin A. M. (2005). Talking with children about natural disasters. *Scholastic Early Childhood Today*

When to Seek Help for Your Child

For many young children who have been affected by a traumatic experience, the most effective help is the reassurance and comfort provided by parents and trusted caregivers. However, if the trauma is severe or chronic, if it affects those close to the child, and/or if the child continues to be upset or have symptoms after a month or so has elapsed, it is advisable to seek help for the child.

Parents/caregivers may wish to consult their pediatrician, their child's teacher, and/or their childcare provider for suggestions of professionals who specialize in early childhood mental health. Because of the young age of the child and the importance of the parents/caregivers in the child's life, treatment for the child should actively include those adults. See the section below for a summary of treatments designed especially for young children.

Treatments for Children and Families

As recognition has grown about the prevalence and impact of trauma on young children, more age-appropriate treatment approaches have been developed and tested for this population. These interventions share many of the same core components. For example, they are generally relationship-based, and focus on healing and supporting the child-parent relationship.

NCTSN has developed a series of fact sheets on the clinical treatment and trauma-informed service approaches being implemented by Network centers. The complete fact sheets are available on the NCTSN Web site at http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom#q3.

The treatment approaches discussed below have all been developed and evaluated for the treatment of young children and have significant empirical support for efficacy.

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) for Preschoolers
(http://nctsn.org/nctsn_assets/pdfs/promising_practices/afcbt_general.pdf)

AF-CBT treatment is designed to help physically abused children and their offending parents by addressing underlying contributors to maltreatment including changing parental hostility, anger, maladaptive coercive family interactions, negative perceptions of children, and harsh parenting.

Abused children are helped to view abuse as wrong and illegal; and are taught emotional comprehension, expression, and regulation as well as social skills. Parents learn proper emotion regulation skills, how to avoid potentially abusive situations, and healthy child management and disciplinary techniques. Dyadic work gives families an opportunity to measure progress, to help identify and clarify family miscommunication, and to establish a family no-violence agreement.[24,25]

Attachment, Self-Regulation and Competency (ARC)
(http://nctsn.org/nctsn_assets/pdfs/promising_practices/arc_general.pdf)

ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that impact traumatized youth and that are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their parents/caregivers, while recognizing that a one-size model does not fit all.

Within the three core domains, ten building blocks of trauma-informed treatment and service are identified. For each principle, the ARC manual provides key concepts and guiding theoretical structure, educational information for providers and parents/caregivers, tools for clinicians, and developmental issues to consider. ARC is designed for youth from early childhood to adolescence and their parents/caregivers or caregiving systems.

> **Read More About It**
> The Trauma Center at Justice Resource Institute provides an excellent overview of ARC on their Web site, at http://www.traumacenter.org/research/ascot.php.

Child-Parent Psychotherapy (CPP)
(http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/cpp_general.pdf)

CPP integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach designed to restore both the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of family violence. Child-parent interactions are the focus of the intervention.

The goals of CPP are to address issues of safety, improve affect regulation, improve the child-parent relationship, normalize trauma-related response, allow the parent and child to jointly construct a trauma narrative, and return the child to a normal developmental trajectory. The intervention runs for fifty weeks and can be conducted in the office or in the home.

Parent-Child Interaction Therapy (PCIT)
(http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/pcit_general.pdf)

PCIT is a parent training intervention that teaches parents/caregivers targeted behavior management techniques as they play with their child. PCIT focuses on improving the parent/caregiver-child relationship and on increasing children's positive behaviors. It has been adapted for children who have experienced trauma.

Parents/caregivers are coached live by the therapist while engaging in specific play therapy and discipline skills with their child. PCIT is a short-term, mastery-based treatment that typically runs for sixteen to twenty weeks, based on the needs of the family.

Preschool PTSD Intervention

The Preschool PTSD Intervention is a protocol-specific cognitive-behavioral treatment that is combined with parent/caregiver involvement in every session. Treatment is for twelve weeks, and it can be focused on PTSD symptoms from any type of trauma. The cognitive-behavioral components include relaxation training, graded systematic exposure, and homework. The protocol also encourages coverage of parental and parent-child relational issues.

The manual for this intervention, the *Preschool PTSD Treatment Manual*, was developed by Michael Scheeringa, MD, Judith Cohen, MD, and Lisa Amaya-Jackson, MD, and is available free by contacting Dr. Scheeringa at mscheer@tulane.edu.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
(http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/TF-CBT_fact_sheet_3-20-07.pdf)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) uses cognitive-behavioral theory and principles, and was developed by Judith Cohen, MD, Anthony Mannarino, PhD , and Esther Deblinger, PhD. TF-CBT was originally designed for children with posttraumatic symptoms as a result of sexual abuse.

Treatment generally consists of twelve treatment sessions. Maltreated children and their nonabusing family members learn stress-management skills and practice these techniques during graduated exposure to abuse-constructed trauma. Parents/caregivers learn how to address their own emotional reactions. Several joint parent/caregiver-child sessions are included to enhance family communication about sexual abuse and other issues. Children who participate in TF-CBT show significant improvement in their fear reactions, depressive symptoms, inappropriate sexualized behaviors, and self-worth.

> **Read More About It**
>
> NCTSN offers guidelines on the use of TF-CBT in the *manual How to Implement Trauma-Focused Cognitive Behavioral Therapy*, available at http://www.nctsnet.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf
>
> Web-based training in TF-CBT is available from the National Crime Victims Research and Treatment Center at the Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, at http://tfcbt.musc.edu/.

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%2BCome%2BFrom%253f%26Ntk%3DSCHL30_SI%26Ntx%3Dmode%2Bmatchallpartial%26y%3D0%26N%3D0%26x%3D0%26_N%3Dfff%22+class%3D%22endecaAll%22%3EAll+Results%3C/a%3E

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