

Introduction: Recognizing the Impact of Trauma Exposure on Young Children

Research evidence, in addition to anecdotal information, indicates that children are exposed to a wide range of traumatic experiences during infancy and early childhood, a sensitive period for development (Osofsky, 2011). Indeed, in a representative sample of approximately 1,000 young children, Briggs-Gowan and colleagues (2010) found that by 2 to 3 years of age, approximately 26% of children had been exposed to trauma and 14% exposed to violence. Highlighting the vulnerability of particular groups, exposure was even more pronounced in children with additional risk factors. For example, 49% of children living in poverty had been exposed to trauma and were 2 to 5 times more likely to be exposed to violence. Researchers have documented a dose–response effect of childhood exposure to trauma, such that cumulative trauma places children at higher risk for long-term problems. Specifically, findings from the landmark Adverse Childhood Experiences Study (Felitti & Anda, 2010), which we describe

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Treating Infants and Young Children Impacted by Trauma: Interventions That Promote Healthy Development, by J. D. Osofsky, P. T. Stepka, and L. S. King

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in more detail later, indicate that greater numbers of adverse experiences (e.g., domestic violence, abuse, neglect) are associated with greater risk of physical and mental problems in adulthood (e.g., depression, anxiety, heart disease). The study demonstrated the enormous societal cost of exposure to trauma in early life. Those individuals with greater numbers of adverse childhood experiences were also more likely to experience social problems, such as unemployment, family violence, parenting problems, and criminal behavior, with a higher use of health and social services.

These findings highlight the critical need for psychology and other health disciplines to devote greater attention to the effects of trauma on infant and early childhood mental health. Trauma, either recognized or unrecognized, is a major factor contributing to mental health symptoms in young children. I (Joy D. Osofsky) was instrumental in the development of the Harris Center for Infant Mental Health in 1996, an early effort to draw greater attention to the effects of early childhood trauma. With a grant from the Irving Harris Foundation, the Harris Center was established in the Department of Psychiatry at Louisiana State University Health Sciences Center to improve training in infant mental health and the implementation of evidence-based practices and services (Osofsky, Drell, Osofsky, Hansel, & Williams, 2016).

One of the first referrals to the Harris Center was twin boys aged 2 years and 11 months who had witnessed their mother's shooting death by their father 7 months earlier (Osofsky, Cohen, & Drell, 1995). We received the referral of these young children when they came from another state to live with their maternal grandparents. Other agencies stated they did not know how they could help these very young children with extreme symptoms. Although they were cute, their behavior was extremely dysregulated, and they only spoke a few words, which were difficult to understand. In our work with them, we learned firsthand about how extreme trauma exposure can lead to "freezing," "dissociation," and the inability to focus in young children. Although at that time questions were raised about whether it was possible to diagnose posttraumatic stress disorder in such young children, the two boys demonstrated diagnostic features, including repetitive, driven play, reexperiencing of the trauma set off by

“trauma triggers” such as the color red (in Play-Doh), and avoidance and dissociation when they encountered play objects and subjects related to their mother. We were able to help these little boys and their grandparents with intensive treatment, assisting them to “get back on track” and return to a normal developmental trajectory. In turn, these little boys helped us in defining efforts to assist traumatized young children and their families. That experience 2 decades ago has profoundly influenced our efforts and commitment to helping very young children exposed to trauma and to making a difference in their lives.

We have used our experience over the years to help dispel the myth that infants and toddlers are not affected by trauma and to help promote understanding that early intervention and treatment can make a difference. An important part of our efforts has been the education of psychologists, psychiatrists, pediatricians, social workers, and other health professionals about the impact of trauma on young children and the evidence-based treatments that work. Clinicians have to learn about ways to understand young children, including their ways of telling us how they feel, especially when they are too young to communicate using language. Play has always been an important means by which young children communicate, with some authors even saying that “play is the language of children” (Landreth, 1983, p. 202). Further, clinicians must learn the importance of behavioral observations, through which we can learn how young children feel. Young children affected by trauma commonly show strong emotions; their reactions are most often expressed in dysregulated, typically aggressive or withdrawn behaviors.

To address these problems, the overall goals of this volume are two-fold. First, we provide the reader with a comprehensive understanding of the effects of different types of trauma on young children’s development. Second, we use this understanding as a foundation for describing evaluations and “treatments that work” to address the effects of trauma on young children. Coordinated trauma-informed systems of care are needed to address the significant public health issue of early life stress and trauma. A trauma-informed system not only recognizes the effects of trauma on children and families but also works to establish policies and procedures

that do not inadvertently retraumatize children at the same time as efforts are instituted to keep children safe (Howard & Tener, 2008; Ko et al., 2008).

The National Child Traumatic Stress Network (NCTSN), which has placed much emphasis on creating and supporting trauma-informed child and adult service systems, describes the importance of providing knowledge to help service providers and other individuals recognize and respond to the impact of traumatic exposure on young children and families whom they care for and serve. Within these systems, trauma awareness, knowledge, and skills can become part of the organizational culture, practices, and policies affecting all individuals who are involved with the child. Being trauma-informed also means using the best available science to support the recovery and resilience of the child.

NCTSN has proposed guidelines for mental health providers and child-serving services systems when incorporating trauma-informed practices that include (a) routine screening for trauma exposure and related symptoms; (b) using culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (c) making resources available to children, families, and providers on trauma exposure, its impact, and treatment; (d) engaging in efforts to strengthen the resilience and protective factors of children and families affected by and vulnerable to trauma; (e) addressing parent and caregiver trauma and its impact on the family system; (f) emphasizing continuity of care and collaboration across child-service systems; and (g) maintaining an environment of care for staff that both addresses, minimizes, and treats secondary traumatic stress and also increases staff resilience. It is important for child service systems to receive training and consultation to develop and adhere to these important trauma-informed guidelines.

THE IMPORTANCE OF THE PARENT–CHILD RELATIONSHIP

Readers of this book will gain an understanding of the importance of the parent–child relationship in supporting infants and young children who are exposed to traumatic events. Because young children have a more lim-

ited understanding and ability to cope with trauma than do older children, their sense of security comes from experiences in trusting, nurturing relationships with parents or adult caregivers who are available to understand their behavior and protect them, providing physical and emotional safety (Bowlby, 1988).

When young children experience trauma, their developing ability to maintain trust in relationships is threatened; if they are the target of or witness to violence by those whom they depend on for protection, it can not only dysregulate emotions and behaviors but also affect their view of themselves and others. For example, it is not unusual for a young child with a father who is a perpetrator of domestic violence and is in jail to react by becoming more active and anxious while also expressing that he misses his daddy. If adults describe his father as “bad,” with the child’s experience of his father as being important in his life, it can be confusing. With exposure to trauma and chronic stress, young children may begin to anticipate that they will have repeated negative experiences and may even think they are at fault. For children in the child welfare system, these negative perceptions can accompany them even when they are placed in a home that provides loving, nurturing relationships. For these reasons, sensitive relationship-based therapy can be helpful in working to modify these negative perceptions.

Parents can also be traumatized by similar violence exposure, such as domestic violence, which may make it more difficult for them to be emotionally available and supportive of their children. Common reactions in infants and toddlers include regression to earlier behaviors with more crying, clinging and fears of separation, aggression, and sleep or feeding problems. Preschool children exposed to trauma may lack self-confidence and be aggressive, anxious, and fearful. They may act out in social situations, have difficulty separating, imitate the behavior they have experienced or witnessed, complain of stomachaches or headaches, and show increased fear when an adult perpetrator is present. Exposure to trauma can also interfere with development, particularly social and emotional development. For all of these reasons, it is important to work together with both the young child and the parent to address the ongoing and sometimes shared

traumatic experiences of both members of the dyad, including the past experiences of the parent that may be contributing to current difficulties.

THE IMPORTANCE OF UNDERSTANDING CUMULATIVE TRAUMATIC EXPERIENCES

The Adverse Childhood Experiences Study

The Adverse Childhood Experiences (ACE) Study carried out at Kaiser Permanente, with approximately 18,000 participants, is the largest study of its kind ever done to examine the effects of stress and trauma on well-being over the lifespan (Felitti et al., 1998). Although the ACE Study was retrospective (i.e., adults were interviewed about their past experiences), the findings provided foundational support for a cumulative risk model of the impact of early stress and trauma on well-being.

It is crucial to recognize that risk of negative outcomes increases markedly depending on the number of adverse early childhood experiences. Young children exposed to psychological, physical, or sexual maltreatment and those who come from dysfunctional households with domestic violence, substance abuse, or mental illness are more likely to experience negative outcomes because of exposure to significant, often multiple, adverse experiences with little support to buffer them from the effects. Young children with multiple adverse early experiences are more likely to demonstrate neurobiological effects, including brain abnormalities and dysregulation of biological stress response systems, as well as psychosocial effects. These effects may change in manifestation and intensity over time. In the school-age years, social problems and poor self-efficacy may become evident. As trauma-exposed children enter the adolescent years, they are more likely to participate in increasingly risky behaviors that affect their health and social environment, including smoking, overeating, lack of exercise, substance abuse, and promiscuity. Evidence-based prevention strategies, interventions, and treatments are critical for mitigating these negative outcomes. Such evidence-based treatments are described in Chapters 2, 3, and 4.

Since the original ACE Study, the ACE survey has been implemented with modifications for specific populations. The additional studies are helpful in broadening our understanding of the effects of early adverse experiences. The Philadelphia Urban ACE Study used the nine original ACE indicators—physical, sexual, or emotional abuse; physical or emotional neglect; witnessing domestic violence; living with someone who abused substances, was mentally ill, or imprisoned—and added five urban ACE indicators (Health Federation of Philadelphia, 2016)—experiencing racism, witnessing violence, living in an unsafe neighborhood, living in foster care, or experiencing bullying. The investigators included 1,784 Philadelphia residents throughout the city who were aged 18 years or older, representing a diverse range of socioeconomic, ethnic, and racial status. They were interviewed by telephone with a 67% response rate. When the authors compared their data with those of the Kaiser Permanente study, they found that the Philadelphia sample reported experiencing more emotional, physical, and sexual abuse and physical neglect. The authors concluded that individuals living in higher risk urban environments are likely to experience even more adverse childhood experiences that can have a negative impact on both their physical development and mental health.

In another relevant study, the San Francisco-based Center for Youth Wellness published *A Hidden Crisis* (C. Chen, 2014), which focused on 4 years (2008, 2009, 2011, 2013) of data collected from 27,745 adult residents of California. Health surveillance of these residents once again revealed physical, mental, and emotional health effects of traumatic childhood experiences. The authors concluded that to develop trauma-informed systems that can prevent early adversity and intervene more effectively among those exposed, it is important to screen young children for ACEs. Their data also suggested that instead of assuming there is “something wrong” with a young child who shows challenging behaviors and emotional dysregulation, it is also important to ask the child or caregivers “What happened to you?” The findings from these studies indicate an important direction for work related to trauma, which we further elaborate later in relation to developing trauma-informed child-serving systems.

Research on Polyvictimization

Exposure to interpersonal trauma, or trauma caused by other individuals, may have particularly detrimental effects. Finkelhor and colleagues (Finkelhor, Ormrod, & Turner, 2007; Finkelhor, Turner, Hamby, & Ormrod, 2011) conducted a series of population-based studies of children experiencing cumulative interpersonal trauma or, as they described it, *polyvictimization*. This research was conducted with a sample of over 2,000 children aged 2 to 17 years through telephone interviews with children or caregivers of the younger children. Surveys asked about child exposure to violence in the home and community—for example, physical assault, sexual assault, and burglary; child welfare violations such as child abuse, neglect, or family abduction; experience of warfare or civil disturbance; and bullying. The researchers found that a large proportion of the children who reported one type of victimization, such as sexual assault or bullying, reported a large number of additional types of victimization experienced during the prior year. In other words, multiple experiences of victimization are common when exposure to a single type is reported. Importantly, polyvictimization predicted trauma symptoms and had a greater influence on mental health than did single-type victimization. On the basis of these findings, Finkelhor and colleagues (2007, 2011) emphasized that to better understand negative experiences that lead to trauma symptoms, it is important to systematically study cumulative and interactive effects among different types of child victimization. Not only were victimized children more likely to experience additional victimization, they also had a higher level of additional lifetime adversities, including illnesses, accidents, family unemployment, parental substance abuse, and mental illness. The authors suggested that a more holistic approach to child victimization is needed to identify children who are at greatest risk of negative outcomes, with implications for treatment and public policy (Finkelhor et al., 2007, 2011).

OUTLINE OF THIS BOOK

In Chapter 1, we review research findings related to the effects of early trauma on psychobiological development, including the developing brain and physiology, cognitive and linguistic capacities, and emotions and rela-

tionships. Further, we highlight the effects of different types of trauma to which young children are exposed, with particular emphasis on maltreatment (abuse and neglect) and domestic violence.

In Chapters 2, 3, and 4, we describe three evidence-based treatments—child–parent psychotherapy, attachment and biobehavioral catch-up intervention, and parent–child interaction therapy—that are used in evaluating and providing services for young children affected by traumatic events. Each of these chapters describes the theoretical base, goals and evaluations, evidence base, and implementation strategies for these treatments. What is perhaps most important is for the reader to recognize that there are effective ways to intervene early, before a problem becomes increasingly difficult as the child grows older. All of the treatments are designed to support and restore not only the child, but also the caregiver–child relationship. An important message is that the caregiver and caregiving environment, as well as the child, are affected by trauma exposure.

Chapter 5 focuses on different treatment possibilities but also takes the reader a step further toward understanding what treatment works for whom (Fonagy et al., 2014). Here, we provide a road map to guide the reader through the criteria included in the evaluation process and the decision about which treatment might be most helpful for an individual child and caregiver. It is important that readers understand that the three treatments described in this book incorporate a developmental understanding of expected behavior in young children and integrate a socio-cultural perspective related to background and beliefs in working with children and families. The Afterword provides a perspective on the fields of infant mental health and trauma and offers suggestions about directions for the future in these areas.

The overall goal of this volume is to help clinicians learn more about how to recognize and understand the effects of trauma exposure on young children, and evidence-based treatments that can make a difference in both the child’s developmental trajectory and mental health. To raise awareness and increase knowledge in this area, infant mental health theory, research, and treatments should be included in training programs for all mental health professionals. Although infant mental health has recently been integrated into a number of training programs and clinical care settings, there

are at present still a limited number that include infant mental health in their curriculum or have an infant and child track for psychology predoctoral internships, postdoctoral fellowships, or child psychiatry (Osofsky et al., 2016). Most programs still give little attention to training on evaluation and treatment of infants and young children. However, there is now abundant evidence not only about the need for, but also information about, evidence-based treatments that are effective for very young children, as indicated in a chapter in the *APA Handbook of Clinical Psychology* (Osofsky, 2016). Although other evidence-based treatments are helpful with older children exposed to trauma, such as trauma-focused cognitive behavioral therapy, the three treatments presented in this volume are specifically designed for use with children under the age of 6 years.

Early identification and treatment benefits from specialized training because the traumatic responses of infants and young children often are misinterpreted or misdiagnosed as developmental delays, difficult temperament, or behavior problems (ZERO TO THREE, 2005). Further, many clinicians who work with children have learned individual treatment approaches that focus on the child and parent separately. Although certainly appropriate in some cases, this treatment approach may not be optimal for infants and young children for whom the problems are best addressed within the context of the relationship. Because the burgeoning knowledge about brain development and the immediate and long-term impact of trauma in early life is rapidly advancing, this is an important time for psychologists and other mental health professionals to be trained in evidence-based treatments for young children affected by trauma. Further, the service gap is larger for minorities and families living in poverty, with significant disparities in care, and stress and trauma are also higher in these groups (Briggs-Gowan, Carter, & Ford, 2012; Shonkoff et al., 2012); therefore, training and technical assistance at all services levels are needed to close that gap. Psychologists have the opportunity to take the lead in increasing access to expert mental health care for children, including young children, exposed to trauma across developmental stages.

It has become clear in recent years that young children are often understood best in the context of their relationships. The quality of early development is important for later outcomes and, therefore, an under-

standing of early development is essential for addressing mental health issues and psychopathology in adults. Because we describe and elaborate on the problems that can develop early in life, readers will learn that early traumatic exposure can set a child on a path of developmental, behavioral, emotional, and mental health challenges. These challenges can be addressed or moderated by appropriate interventions, support, and treatment. Further, there is significant economic evidence that an educational and public health investment in prevention, intervention, and treatment will show large returns related to learning, productivity, and contributions to society (Knudsen, Heckman, Cameron, & Shonkoff, 2006).

We hope that readers of this book learn that early implementation of evidence-based treatments can prevent the negative effects of exposure to trauma, and significantly improve developmental outcomes for children.