CHAPTER 26

Posttraumatic Stress Disorder in Young Children

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It has been well established over the past two decades that as early as the first year of life, children can develop symptoms of posttraumatic stress disorder (PTSD) following exposure to trauma. We begin by describing the core symptoms and clinical presentation of PTSD in young children. We follow with a brief overview of changes in diagnostic criteria for the disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) from the fourth to the fifth editions, including the introduction of a new developmental subtype of the disorder for children under age 6 years. Reviews have documented a number of studies that form an empirical justification for this subtype. In this chapter, we update and expand on these reviews and consider the disorder's symptom presentation, prevalence, course, associated impairments, and comorbidities. Some studies we review used DSM-IV (American Psychiatric Association, 1994) PTSD criteria; others used an alternative algorithm for determining PTSD in young children (PTSD-AA) that is similar to DSM-5 (American Psychiatric Association, 2013) criteria. We then present best practices for and challenges to assessing and intervening with young children who have PTSD, with an emphasis on caregiver involvement, and we conclude with a discussion of common clinical dilemmas in the treatment of young children with PTSD.

Core Symptoms and Clinical Presentation

PTSD occurs following exposure to one or more traumatic events. "Trauma" is defined as the experience of "actual or threatened death, serious injury, or sexual violence" either directly, as a witness, learning that the event occurred to a close family member or friend, or being exposed repeatedly or in an extreme manner to aversive details about a traumatic event (American Psychiatric Association, 2013). Symptom presentation varies and may include fear-based reexperiencing of the event and other emotional and behavioral reactions following the event. Some individuals present predominantly with negative mood and cognitions following the event. Other individuals may experience hyperarousal, and still others may dissociate. Many individuals with PTSD present with a combination of these symptoms.

The emphasis in the assessment of children under age 6 years is on observable behavioral expression of symptoms rather than on internal experiences given young children's limitations in their ability to report such experiences. For infants, reexperiencing of the traumatic event may be more often expressed by behavioral reactions, such as crying, around stimuli in the environment that serve as reminders of the event, such as exposure to an abusive adult. Toddlers and preschool-age children may en-

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gage in play reenactments or may report nightmares rather than describe intrusive thoughts of a trauma. A toddler may repeatedly drive a toy car over a doll figure following being hit by a car. Avoidance, or attempts at avoidance, does occur, but is limited by young children's lack of control over their exposure to frightening reminders. For example, children who develop PTSD following an invasive medical procedure may have no choice about whether to attend follow-up medical appointments, despite their protests and fear expression. Furthermore, what may occur is that the parent begins to accommodate the child's wishes to avoid certain places; therefore, care must be taken to ask the parent about any accommodations being made to minimize symptoms. Negative thoughts and emotions may manifest in young children as increased irritability, temper tantrums, emotional withdrawal, or detachment.

Associated features supporting a PTSD diagnosis in young children are described in DC:0–5 (Zero to Three, 2016), and include new onset of fears not related to the trauma (e.g., fear of the dark) or new separation anxiety. New onset of angry, aggressive, and oppositional behavior since the traumatic event is common. Loss of previously acquired skills, such as regression in communication skills or toileting, also may be evident.

Diagnosis

With DSM-5 came substantive changes for diagnosing PTSD. First, a new category of trauma- and stressor-related disorders was created, and PTSD is no longer classified as an anxiety disorder. Second, the revision of DSM criteria was based on a substantial literature base (see Friedman, 2013, for a review of the literature). As in DSM-IV, exposure to a traumatic event, such as exposure to or actual threatened death, serious injury, sexual violence, directly or indirectly (Criterion A), remains as the primary requirement to consider a PTSD diagnosis. However, the DSM-IV A2 criterion regarding the emotional response at the time of the event was eliminated. In DSM-5, the symptom clusters have been reconceptualized as intrusion (Criterion B; at least one symptom is required), avoidance (Criterion C; at least one symptom is required), negative alterations in cognitions in mood (Criterion D; two or more symptoms are required), and marked alterations in arousal or reactivity (Criterion E; two or more symptoms are required). Some symptoms were removed from the criteria, such as the sense of a foreshortened future. Symptoms must be associated with the traumatic event(s), and the onset or worsening of the symptoms must occur after the traumatic event(s) for PTSD to be considered. Duration of the disturbance is longer than 1 month. Symptoms must not be attributable to the physiological effects of a substance or other medical condition.

Most relevant to the field of infant mental health, DSM-5 is the first edition of the manual to specify a developmental subtype of a mental disorder, basing its criteria for PTSD in children age 6 years and under on over two decades of research primarily by Scheeringa and colleagues (Scheeringa, Myers, Putnam, & Zeanah, 2012; Scheeringa, Peebles, Cook, & Zeanah, 2001; Scheeringa, Wright, Hunt, & Zeanah, 2006; Scheeringa, Zeanah, Myers, & Putnam, 2003, 2005). This research evaluated an alternative algorithm for diagnosing PTSD in young children. The criteria for this age group are similar to those for individuals older than 6 years except for the following modifications: (1) Only one symptom is required from either the avoidance *or* negative alterations in cognitions or mood, and (2) it is recognized that children this young may express symptoms differently than do older individuals. Examples are that intrusive memories may be expressed through play reenactments, and altered reactivity may manifest as temper tantrums.

The criteria for PTSD in DC:0–5 are similar to those in DSM-5, including the descriptions, clusters, and number of symptoms required within each cluster. There are a few additions and emphases not found in DSM-5, reflecting the developmental sensitivity of DC:0–5. First, DC:0–5 notes that children may become preoccupied with the traumatic event, as conveyed by repeated statements or questions about some aspect of the event(s). In addition, symptoms may interfere with the young child's participation in everyday activities or routines, impede the child's developmental progress, or impact family functioning.

Prevalence

Although experiencing trauma and other adverse events is relatively common in the general population, it is important to note that the

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majority of infants and young children who experience a traumatic event do not experience lasting adverse outcomes and do not develop PTSD. In one study, the prevalence of exposure to potentially traumatic events in 24- to 48-month-olds with healthy birth histories was 26.3% (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). However, prevalence rates of PTSD in young children in the general population are estimated at less than 1%. Egger and Angold (2006) assessed PTSD using PTSD-AA criteria in a sample of 307 children, ages 24–71 months, recruited from a large primary care pediatric clinic and found a prevalence rate of 0.6%. Prevalence is significantly higher (26–50%) in help-seeking populations (Scheeringa et al., 2003; Scheeringa & Zeanah, 2008). Due to the lack of sensitivity of previous diagnostic criteria as illustrated by Scheeringa and colleagues (2012), further research is greatly needed to assess the prevalence, course, and sequelae of PTSD experienced in early childhood.

To our knowledge, only a few longitudinal studies have tracked the prevalence and course of PTSD using the DSM-IV alternative algorithm for young children. Scheeringa and colleagues (2005) studied 62 children, ages 20 months–6 years following various types of traumas, including motor vehicle accidents, exposure to domestic violence, and invasive medical procedures. The length of time between the trauma and the first assessment ranged widely, from 2–52 months. Second and third assessments occurred, on average, 1 and 2 years, respectively, following the initial assessment. The rates of PTSD based on PTSD-AA criteria were 25.8% (16 of 62 children) at visit 1, 23.4% (11 of 47) at visit 2, and 22.9% (8 of 35) at visit 3. A PTSD diagnosis at visit 1 significantly predicted a PTSD diagnosis 2 years later, but not 1 year later. Nevertheless, diagnosis was stable from visit 1 to visit 3. This study was limited by the wide variability of length of time from the traumatic incident to the first assessment, as well as the time period between follow-up assessments. Furthermore, there was no comparison group, retention was poor, and some children had received treatment at some point during the study period, possibly affecting the diagnosis.

Meiser-Stedman, Smith, Glucksman, Yule, and Dalgleish (2008) studied 114 children, ages 2–10 years, who had experienced a motor vehicle accident. Just over half of the children were between ages 2 and 6 years. Children were assessed at 2–4 weeks and again at 6–10 months postaccident. At the initial assessment, four children (6.5%) were diagnosed, based on PTSD-AA criteria. At the follow-up assessment, six children (10%) were diagnosed with PTSD. The diagnosis of PTSD was stable from the acute phase onward.

De Young, Kenardy, Cobham, and Kimble (2012) assessed 130 young children (80% under age 3) who had been unintentionally burned at 1 month and at 6 months postincident. At 1 month, 33 children (25%) had PTSD, and at 6 months, 13 children (10%) had PTSD based on the DSM-IV alternative algorithm. Interestingly, three children (2.3%) had new-onset PTSD at the 6-month assessment.

These studies suggest that the prevalence of PTSD in young children exposed to different traumatic events varies and may depend on external factors such as the length of time between the incident and assessment or exposure to subsequent traumatic events, intrinsic child factors, or parent response factors.

Comorbidities

Regarding comorbid diagnoses, three studies have identified psychiatric disorders that may co-occur with PTSD in young children, especially in convenience samples: oppositional defiant disorder (ODD), separation anxiety disorder (SAD), attention-deficit/hyperactivity disorder (ADHD), and major depressive disorder (MDD) (De Young et al., 2012; Scheeringa et al., 2003; Scheeringa & Zeanah, 2008). Scheeringa and Zeanah (2008) found that no child developed a new non-PTSD diagnosis in the absence of new PTSD symptoms following exposure to a natural disaster, which suggests that PTSD could be a gatekeeper to developing other disorders following a traumatic event. To this point, a treatment study found that children who received cognitive-behavioral therapy (CBT) targeting PTSD displayed a reduction in PTSD, ODD, and ADHD symptoms compared to children in the waiting-list condition. Furthermore, MDD and SAD were reduced in both the CBT and waiting-list condition, which suggests that these symptoms can improve with the passage of time following a traumatic event (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). Scheeringa (2009) suggests that it is important to ascertain whether the onset of comorbid disorders and symptoms fol-

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lowed a traumatic event, and if so, to prioritize the assessment and treatment of PTSD.

Course and Developmental Challenges

The extant literature about the course of PTSD includes case studies describing clinical presentations of the course of PTSD from infancy through adulthood (e.g., Terr, 2003, 2004), studies following children after acute traumatic exposure for 6 months to 2 years (e.g., De Young et al., 2012; Meiser-Stedman et al., 2008; Scheeringa et al., 2005), and studies assessing PTSD symptoms in young children exposed to intimate partner violence (e.g., Levendosky, Bogat, & Martinez-Torteya, 2013). These studies suggest that preschool children with PTSD do not always experience natural recovery and may retain the diagnosis for up to 2 years (Scheeringa et al., 2005); however, the profile of symptoms may look different across different ages. Levendosky and colleagues (2013) assessed PTSD symptoms in children each year at ages 1 through 7 years and found different rates of symptom clusters associated with witnessing intimate partner violence at different ages. Affective dysregulation (e.g., hyperarousal) was most common in children ages 1–5 years, and children ages 5 and 7 years experienced more cognitive and behavioral dysregulation (e.g., avoidance and reexperiencing).

Based on research with older children (Le Brocque, Hendrikz, & Kenardy, 2010), De Young and colleagues (2012) classified the trajectory of PTSD symptoms in 1- to 6-year-old burn victims into four categories: "resilient" (no PTSD at either time point studied), "recovery" (PTSD at 1 month but not at 6 months), "chronic" (PTSD at 1 month and at 6 months), and "late onset" (PTSD at 6 months but not at 1 month). The majority of the children (72%) were classified as "resilient," followed by 18% in the "recovery" trajectory group. The chronic group comprised 8%, and 2% were in the delayed-onset group, representing the children most in need of clinical attention. Children in the chronic group had significantly more posttraumatic stress symptoms than the children in the recovery and the resilient groups. Children in the recovery group had significantly more posttraumatic stress symptoms than children in the resilient group. Furthermore, children in the chronic group did not experience any significant reductions in symptoms across time and had significantly more symptoms than children in the other groups at 6 months postincident.

The long-term course of untreated PTSD experienced in early childhood into middle childhood, adolescence, and adulthood is unknown. Diagnosis of PTSD notwithstanding, studies have consistently demonstrated a significant association between trauma and other adversities experienced in infancy and early childhood, and the onset of parent–child relationship disturbances (e.g., Lieberman & Knorr, 2007), later diagnosis of psychiatric and substance abuse disorders (Green et al., 2010), health risk behaviors (e.g., smoking, physical inactivity, and suicide attempts), and a range of physical health conditions (e.g., diabetes, cancer, heart disease, and stroke) in adulthood (Felitti et al., 1998). Although the pathways to these problems are complex and only beginning to be delineated (Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016; Widom, White, Czaja, & Marmorstein, 2007), together these findings indicate that young traumatized children may be particularly vulnerable to long-term adverse outcomes. Untreated PTSD places infants and young children at risk of adverse psychological and physiological outcomes as they are undergoing a rapid period of brain development, have limited emotion regulation skills, and are dependent on their primary caregiver to protect them physically and emotionally (for reviews, see De Young, Kenardy, & Cobham, 2011; Lieberman, 2004; Lieberman & Knorr, 2007).

Assessment

The "gold standard" for assessing infants and young children includes a comprehensive review of the child's history through interviews with significant adults and reviews of medical, school/child care center, and child protective service records as available and relevant. In addition, it is important to observe the child in a number of settings and circumstances with the primary caregiver (e.g., home, clinic), and with other caregivers in various settings (e.g., child care). Finally, interviewing the caregiver and/or child directly is necessary for gaining information about history and current symptoms and functioning. This comprehensive approach, which should consider the cultural and other relevant contexts of the child and family, allows providers to gain a thorough understanding of the child's life experiences, the medical con-

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cerns that may or may not contribute to current behaviors, along with the child's relationships with various caregivers, providing information about the child's functioning and behavior within specific relationships. Although there are limits to the utility of each individual method for identifying PTSD specifically in young children, using multiple methods and sources leads to confidence in the diagnosis of PTSD and can aid in treatment planning.

Even with a comprehensive assessment approach, a number of challenges to identifying PTSD in young children include establishing the occurrence of a traumatic event, identifying PTSD symptoms, and considering the impact of caregiver functioning and caregiver–child relationships on the development and/or exacerbation of PTSD symptoms. In this section, we discuss each of these challenges and potential ways to address them.

Identifying the Traumatic Event

Establishment of the occurrence of a traumatic event necessary for the diagnosis of PTSD can be challenging with young children due to the subjective nature of a traumatic event, in which the child experiences a perceived threat of danger. Although it has been well established that children as young as 8 or 9 months may have some sensory or cognitive memory of a traumatic event, infants and young children are limited in their ability to report and describe events due to their developmental status with regard to expressive language (for review, see Scheeringa, 2009). Traumatic events may go unreported for some time unless a caregiver of the child is aware of the event. Still, caregivers may not readily identify an event as traumatic for the child, and they are likely to underestimate the impact of the event on the child (Richters & Martinez, 1993). Caregivers may underestimate the child's ability to attend to, remember, and/or be impacted by traumatic experiences such as exposure to intimate partner violence (Levendosky et al., 2013; Lieberman, Van Horn, & Ghosh Ippen, 2005).

Fundamental to the assessment of PTSD is inquiring about the child's exposure to all possible traumatic experiences. This can be done by reviewing available medical and child protection records, as well as interviewing the caregiver. While a caregiver may assume that the child cannot remember an event, especially if the exposure was indirect (i.e., domestic violence between adults) or for the child's well-being (i.e., invasive medical procedures), the assessor should attempt to gather a full picture of all possible traumatic events the child has experienced.

Both the Traumatic Events Screening Inventory—Child Report Form Revised (Ghosh Ippen et al., 2002a) and the Traumatic Events Screening Inventory—Parent Report Revised (Ghosh Ippen et al., 2002b) are 24-item measures, with a focus on children under age 6 years, and include traumatic events with special significance in early childhood (i.e., caregiver separation). Follow-up probes inquire about the relationship to the child if the child witnessed the event happening to another person, as well as the age of the child when the event occurred, and whether the caregiver believes this child was affected emotionally by the experience. If an item is endorsed, follow-up questions are asked about the age of the first experience, the age of the last experience, and the total number of times an event was experienced.

Identifying Symptoms

The fact that young children are developmentally less capable of understanding and expressing their own internal experiences in the form of language also makes the identification of internalizing PTSD symptoms (e.g., avoidance and/or numbing) challenging. Furthermore, young children are developmentally less capable of connecting the memory of a traumatic event to their emotions, and this may contribute to underreporting of internalizing symptoms (Scheeringa et al., 2006) and overreporting of externalizing symptoms by caregivers.

There are a few semistructured diagnostic interviews and checklists that are useful for assessing PTSD symptoms in young children, although none based on DSM-5 criteria for PTSD have been disseminated to date. The Preschool Age Psychiatric Assessment (PAPA; Egger, Ascher, & Angold, 1999) is a semistructured caregiver interview with adequate test–retest reliability for PTSD symptoms in children ages 2–5 years. The Posttraumatic Stress Disorder Semi-Structured Interview (Scheeringa & Zeanah, 1994) is based on DSM-IV criteria, as well as other studied developmental behaviors associated with trauma (i.e., loss of previously learned skills, new separation anxiety behaviors) and may be used for infants and children up to age 7 years. It includes an interview with

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the caregiver, as well as an observation of the child with the caregiver. The instrument demands a high level of clinical skill, as it requires the interviewer to observe the child's behaviors, while simultaneously conducting the interview with the caregiver and making in-the-moment decisions about follow-up questions based on the caregiver's responses (Stover & Berkowitz, 2005). Since developing this measure, Scheeringa and colleagues (2001; Scheeringa, 2009) have suggested that a PTSD diagnosis is primarily based on a careful interview with the caregiver. Only a small number of signs of PTSD are actually made in office observations (Scheeringa et al., 2001), though these are important for the diagnostic algorithm and increase confidence in diagnostic accuracy.

We have found that the most useful interview for assessing PTSD in young children is the Diagnostic Infant and Preschool Assessment (DIPA; Scheeringa & Haslett, 2010). The DIPA, a semistructured interview administered to caregivers of children ages 9–60 months, covers a range of disorders based on the criteria for symptoms in DSM-IV-TR (American Psychiatric Association, 2000), including PTSD. Furthermore, the instrument includes an algorithm for diagnosing PTSD that closely aligns with DSM-5 criteria for children age 6 years and younger.

Other measures for assessing PTSD symptoms in children ages 1–6 years include the Young Child PTSD Checklist (YCPC; Scheeringa, 2012). In addition to items assessing 11 possible traumatic events and a space to fill in an event that is not listed, this measure includes 22 items assessing PTSD symptoms and six functional impairment items. The measure is intended to be administered to the caregiver via interview but may be completed by the caregiver independently.

Finally, the PTSD Symptoms in Preschool Children (Levendosky, Huth-Bocks, Semel, & Shapiro, 2002) is a caregiver interview designed to assess Criteria B, C, and D of DSM-IV-TR symptoms in children ages 3–5 years.

Although not designed to target PTSD specifically, procedures such as the MacArthur Story Stem Battery (Emde, Wolf, & Oppenheim, 2003) may be useful for assessing young children. This assessment, normed with children ages 3–6 years, directly engages and interviews the child and is recommended by some as adjunctive to the PAPA or Semi-Structured Interview for PTSD (Stover & Berkowitz, 2005). Certainly, procedures such as these should not be used solely for diagnostic purposes, but they can provide insight into the child's internal experience and how he or she views the world, relationships and roles within it, as well as other areas of social development, which may be useful for developing intervention goals.

Relationship between Caregiver Symptoms and Child Symptoms

The parent–child relationship is fundamental to the well-being of infants and young children, and caregivers' own PTSD symptoms have been found to be positively correlated with the symptoms of their young children. Scheeringa and Zeanah (2001) summarize the empirical support for a relational theory of PTSD or "the co-occurrence of posttraumatic symptomatology in an adult caregiver and a young child when the symptomatology of one partner, usually the adult, exacerbates the symptomatology of the other" (p. 809). This exacerbation can occur especially when the dyad is exposed to the same threat (Laor, Wolmer, & Cohen, 2001; Scheeringa & Zeanah, 2001; Wolmer, Laor, Gershon, Mayes, & Cohen, 2000). Furthermore, parental report of PTSD in young children may be influenced by parents' own experience of having PTSD, even when the source of the PTSD was not the same (Briggs-Gowan, Carter, & Schwab-Stone, 1996; Richters, 1992; Stover & Berkowitz, 2005). Since infants depend on their primary caregiver (in most cases, the mother) for physical and emotional well-being, a mother's own trauma symptoms can impact the relationship by intensifying the infant's trauma symptoms (Scheeringa & Zeanah, 2001).

Levendosky and colleagues (2013) studied mothers and young children, ages 1–7 years, exposed to intimate partner violence (IPV), and they found a significant co-occurrence of PTSD symptoms between them. They suggested, "Young children who are likely to be in close physical and emotional proximity to their mothers are likely to influence and be influenced by her [*sic*] traumatic response to the IPV" (p. 196), supporting a relational theory of PTSD as proposed by Scheeringa and Zeanah (2001). In particular, the results of the study indicated a significant association between the mother's arousal symptoms and the child's arousal symptoms, implying that the child was directly re-

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sponding to the mother's affective dysregulation and also exhibiting his or her own affective dysregulation.

A related issue is the impact of caregivers' trauma symptoms on relationships with their children. One study focused on the role of trauma symptoms in a group of refugee fathers and the relationships with their children, ages 18–42 months, who had not been exposed to a traumatic event (van Ee, Sleijpen, Kleber, & Jongmans, 2013). The researchers assessed for trauma symptoms in the fathers (86% of whom met full criteria for PTSD), as well as mothers, observed the quantity and quality of caregiving tasks and play between the dyads, and interviewed fathers only about their perceptions of their relationships with their children. Parents of both genders reported that fathers had less involvement in caregiving of the child, which may have been typical and culturally related. No gender differences were found in the quality of interactions between parents and their children. Of significance, trauma symptoms were negatively related to the quality of the parent–child interaction for both mothers and fathers. Furthermore, symptoms of traumatic stress negatively affected fathers' perceptions of parent–child interaction. The study did not include an assessment of PTSD in the young children themselves, but the results suggested that the parental PTSD symptoms were interfering with the quality of the parent–child relationship.

Taken together, the existing research indicates that when assessing for posttraumatic stress in young children, clinicians should consider the impact of the caregivers' trauma symptoms on the child, especially when the child and caregiver experienced the same traumatic event. As child and caregiver symptoms can be transferred from one to the other, it is important to understand the caregiver's own traumatic experiences and symptoms. Useful assessment measures for assessing trauma in caregivers include the Life Stressors Checklist (Wolfe & Kimerling, 1997) and the Davidson PTSD Scale (Davidson et al., 1997).

Impact of the Caregiver–Child Relationship

Obtaining comprehensive information regarding the caregiver–child relationship is imperative for supplementing caregiver interviews for the assessment of PTSD and developing goals for intervention. While direct observation of the child individually is not efficient or useful for the assessment of PTSD typically, observation of the parent–child dyad is essential for assessing and conceptualizing the functioning of young children. The use of dyadic observation schedules provides the assessor with an opportunity to observe children's interactions with their caregivers, as well as with other significant adults in their lives. An assessment of the caregiving relationship may provide evidence of symptoms, especially if they occur in the presence of specific caregivers. Dyadic assessments can be helpful, especially in determining strengths and weaknesses in the relationship that may be useful when developing a treatment plan for PTSD in young children, and in identifying traumatic experiences or symptoms the caregivers and children may share, such as PTSD-related avoidance.

The Parent–Child Structured Play Interaction ("Crowell Procedure"; Crowell, Feldman, & Ginsberg, 1988) is used to assess children, ages 12–60 months, with a caregiver and includes a period of unstructured play, a cleanup activity, problem-solving tasks, and a separation and reunion period. The separation and reunion period is especially useful for gathering information about how the child uses the caregiver to regulate following the activation of the attachment system. This and other useful methods are discussed by Miron, Lewis, and Zeanah (2009).

When assessing for PTSD in the child, as well as the impact of the caregiving relationship on the child's functioning, it is important to consider the cultural context of the dyad and the child, including the culture in which the traumatic event occurred, the culture with which the child interacts regularly, and how culture may impact symptom manifestation. Knowledge of one's own biases and cultural expectations, and the expectations of clients with regard to response to trauma, are important. Additionally, families should receive assessments in their native languages. Resources to assist in responding to trauma are available in languages other than English and may be accessed through databases such as that maintained by the National Child Traumatic Stress Network (*www.nctsn.org*). Other recommendations for culturally responsive practice with young children and their caregivers are found within the "Diversity-In-

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formed Infant Mental Health Tenets" (St. John, Thomas, & Noroña, 2012).

Intervention

Best practice with young children involves including caregivers in the treatment; thus, our focus is on two evidence-based interventions: one targets the parent–child dyad and the other is an individual child intervention that relies heavily on caregiver involvement. We conclude with a discussion of clinical dilemmas that often arise when treating young children with PTSD.

Child–Parent Psychotherapy

Child–parent psychotherapy (CPP; Lieberman & Van Horn, 2005, 2008) is a dyadic intervention for children age 5 years and under and their caregivers, who have experienced traumatic or other stressful events. In CPP, the focus is on the relationship at every level of intervention. One of the aims of CPP is to foster child mental health by enhancing the parent's capacity to provide safety and developmentally appropriate caregiving to the child (Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011; Lieberman et al., 2005; Lieberman & Van Horn, 2008).

Three randomized controlled trials support CPP's efficacy with infants and young children who have been exposed to trauma, including maltreatment (Cicchetti, Rogosch, & Toth, 2006; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002) and exposure to domestic violence (Lieberman et al., 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006; see also Lieberman, Dimmler, & Ghosh Ippen, Chapter 29, this volume).

In a study involving 75 children, ages 3–5 years, from diverse ethnic and socioeconomic backgrounds who had been exposed to domestic violence, and their mothers, dyads were randomly assigned to receive CPP or monthly case management plus referrals to community-based individual services (Lieberman et al., 2005). Parents completed the Child Behavior Checklist and participated in the Structured Clinical Interview for DC:0–3 (Zero to Three, 1994) to assess children's emotional and behavioral problems and PTSD symptoms. Mothers completed the Symptom Checklist-90 and the Clinician-Administered PTSD Scale interview to assess their general psychiatric and PTSD symptoms. Weekly CPP sessions lasted 60 minutes and occurred for 50 weeks (the mean number of sessions attended was 32.09, SD = 15.20). The majority of the children (65%) in the treatment-as-usual group completed more than 20 individual sessions.

Children who completed CPP demonstrated a significant reduction in their PTSD symptoms and behavior problems compared with those who completed case management plus treatment as usual. Following treatment, there was a statistically significant group difference, with only 6% of the CPP group compared with 36% of the comparison group meeting criteria for PTSD. Furthermore, the mothers who completed CPP showed significantly fewer PTSD avoidance symptoms compared with mothers in the treatment-as-usual group. The authors noted that many mothers did not speak openly about the violence the children had witnessed prior to participating in CPP because they believed it would be harmful to the child or that the children were too young to notice the violence. CPP's focus on dispelling myths about the impact of domestic violence on young children and the joint sessions enabled the children and mothers to communicate more openly and construct a joint trauma narrative.

In a 6-month follow-up study, the behavior problems of the children who participated in CPP continued to show significant reductions, whereas children in the comparison group did not (Lieberman et al., 2006). Unfortunately, PTSD symptoms were not assessed in the follow-up study due to limited resources; thus, the long-term impact of CPP on these symptoms was not determined. Of significance, the parents who participated in CPP continued to display improvement in psychiatric functioning compared with the mothers in the comparison group, which suggests that CPP had a lasting effect on the mother's well-being 6 months postintervention.

In a reanalysis of the data, Ghosh Ippen and colleagues (2011) examined the effectiveness of CPP on children with a high number of traumatic and stressful events (TSEs), including physical and sexual abuse, witnessing domestic violence, neglect, separation from a caregiver, caregiver criminal history, substance abuse, and mental illness. The results were that children at all levels of TSEs who completed CPP showed significant reductions in PTSD symptoms compared with children in the comparison

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group. These findings support the efficacy of CPP for children with a history of multiple traumatic events who are at highest risk for negative outcomes.

Cognitive-Behavioral Therapy

Over the past two decades, there has been much discussion about the feasibility and effectiveness of conducting CBT with young children (Doherr, Reynolds, Wetherly, & Edwards, 2005; for reviews, see Grave & Blissett, 2004; Miron & Scheeringa, 2017). Given the effectiveness of CBT for older children and adolescents with PTSD, clinicians and researchers have sought ways to modify CBT for younger children, for example, by incorporating play-based techniques within structured protocols (for discussion, see Cavett & Drewes, 2012; Drewes & Cavett, 2012). To date, three groups have demonstrated the effectiveness of CBT techniques in young traumatized children: Cohen and Mannarino (1996) and Deblinger, Stauffer, and Steer (2001) showed superiority in treatment outcome of CBT techniques in randomized trials. Their groups were limited to sexually abused children, and they did not have to have PTSD to be included in the trial. Scheeringa and colleagues (2011) demonstrated effectiveness of CBT techniques for young children with a diagnosis of PTSD following a variety of types of traumatic events.

The randomized clinical trial involving CBT for 3- to 6-year-old children with diagnosed PTSD conducted by Scheeringa and colleagues (2011) was the first to systematically collect data on the feasibility of young children to accomplish CBT techniques. Sixty-four children (59.5% African American and 35.1% European American) and their caregivers were randomly assigned to a 12-week CBT individual intervention or a delayed treatment waiting list. The children had experienced an acute single-blow trauma, repeated exposure to domestic violence, or Hurricane Katrina. Waiting-list children whose symptoms did not fully remit during after 12 weeks were allowed to enroll in CBT. Children were reassessed at 6 months posttreatment.

The Preschool PTSD Treatment protocol (PPT; Scheeringa, Amaya-Jackson, & Cohen, 2002) included the following components: psychoeducation about PTSD, behavior management, recognition of emotions, development of coping skills (progressive muscle relaxation, controlled breathing, and positive imagery), graduated exposures to trauma-related reminders using drawings, imaginal and *in vivo* modalities, and safety planning. The mothers of the children were present with the child and therapist for all of the first (psychoeducation) and second (behavioral management) sessions, and the 12th and final session (review/graduation). In addition, during Sessions 3–11, the mothers observed the children's work with the therapists for the first half of the session via monitor in a separate room, so that they could learn about the child's experience and reactions simultaneously. Mothers spent the second half of Sessions 3–11 alone with the therapists, assisting with the interpretation of the young children's body language and discussing and troubleshooting homework.

Children in the CBT group showed significant improvement in PTSD symptoms compared with children in the waiting-list group. Time effects for children in the CBT group were significant for MDD, SAD, and ODD. However, time × group interactions were not significant, suggesting no effect of participating in CBT above and beyond that of the passage of time on these comorbid disorders. There was no improvement for ADHD in either group. The effect size for treatment completers for PTSD was 1.48; compared with 1.20 for MDD, 0.89 for SAD, and 1.03 for ODD. There was an 82.4% reduction in PTSD diagnosis for the 25 treatment completers. At the 6-month follow-up, the effect size for PTSD increased to 1.88, while remaining fairly constant for the comorbid disorders.

Regarding feasibility of CBT techniques with young children, the 46 children who completed at least one treatment session and were rated on feasibility were judged to understand and complete 83.5% of the treatment tasks. The authors reported that in general, the 3-year-old children had difficulty with some tasks, such as the initial graduated exposure sessions. The younger children seemed to have the most difficulty with imaginal exposures (as compared with drawing-based or *in vivo* exposures). However, they completed nearly all tasks, including exposures, with time and practice. Participants also had difficulty rating their gradations of emotions and understanding new homework assignments, even though they were able to successfully complete homework assignments with their caregivers. Using pictorial aids to educate about PTSD symptoms seemed to assist the majority of the children in understanding the concepts.

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PPT (Scheeringa, 2015) is being disseminated across the United States, and its effectiveness has been demonstrated in case studies (e.g., Puff & Renk, 2015) and in a trial comparing the effectiveness and cost of PPT and stepped care trauma-focused CBT for young children, an innovative service delivery method designed to address treatment barriers with young children who are experiencing posttraumatic stress symptoms (Salloum et al., 2014, 2016; Salloum, Scheeringa, Cohen, & Storch, 2015). Based on evidence to date, CBT is a feasible and effective intervention with young children with PTSD.

Considerations for Intervening with PTSD in Early Childhood

The Caregiver–Child Relationship

Given the significance of the caregiver–child relationship in early childhood, it is essential that the child have a supportive and reliable caregiver before he or she will be able to recover from PTSD. The caregiver must fully understand the need to create a sense of psychological safety in order for the child to "tell his or her story" and recover from trauma. This consideration is particularly significant when the child has been placed in out-of-home care (e.g., foster care) due to maltreatment. In such cases, it is important to assess and, if warranted, intervene with the primary caregiving relationship. Given that young children have a biological need for attachment security, this should be the focus of attention prior to, or simultaneous with, intervening with PTSD because in order to recover from trauma, children need to feel physically and psychologically safe and that is that there is no longer a threat to them or their caregivers. Young children feel this security in the context of the caregiving relationship. There are a few research-supported interventions targeting the caregiver–child relationship that may be effective prior to intervening with PTSD symptoms, such as PCIT. Some evidence suggests that PCIT addresses not only the caregiving relationship but also emotion regulation skills, and this in turn assists children with managing distressing emotions such as those provoked by upsetting reminders and helps them cope with PTSD symptoms in general (Allen, Timmer, & Urquiza, 2016; Blacker & Urquiza, 2014). In addition, CPP simultaneously targets the caregiving relationship and PTSD.

When the Perpetrator of Trauma Is the Caregiver. Experts in the field are often asked how to address PTSD when the biological parent is the perpetrator of the trauma (for discussion, see Dorsey & Deblinger, 2012). There are a number of situational factors to consider here. If the young child is residing in foster care, particularly due to trauma inflicted by the biological parent, the parent may have issues to address (e.g., substance abuse) prior to being able to assist the child in recovering from trauma. In such cases, the nonoffending parent or the foster parent may serve as an appropriate partner in PTSD intervention with a skilled therapist. The foster parent must understand the need to provide both instrumental and emotional care to the child, and should be provided with psychoeducation about trauma and PTSD symptoms in order to assist in the child's healing.

In some cases, such as when working toward reunification following out-of-home care, the perpetrator of the trauma may be considered for involvement in the child's PTSD intervention. We recommend the following in such cases: (1) that the parent perpetrator has taken responsibility and has expressed the desire to change the circumstances that led to the child's trauma and (2) that the parent has done the necessary work to improve these circumstances. In our experience working with young children in foster care, these two criteria are rarely met in a time frame appropriate for the young foster child with PTSD; thus, an alternative loving and supportive caregiver may be enlisted for involvement in the child's trauma treatment. We emphasize that trauma-focused intervention should not be delayed while the parent works on his or her individual issues, as research suggests that PTSD symptoms may not remit without targeted intervention.

In other cases, it may be that the parent working toward reunification is not the direct perpetrator of the trauma but he or she failed to protect the child from exposure to threat, such as in cases involving domestic violence. Similarly, this parent should be assessed for his or her ability to take responsibility for the circumstances, express the desire to assist the child in recovering from trauma, and have done the necessary work to provide a safe and stable context for recovery. This context for recovery may be the therapeutic environment, for example, the weekly 1-hour intervention session, and the child need not yet be returned to the par-

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ent's home in order to recover from trauma. As a case example, a 4-year-old boy who entered foster care subsequent to being kidnapped by his mother's violent partner participated with his current caregiver (maternal grandmother) in PPT for 12 sessions. After his mother had made progress in domestic violence intervention and was on track to reunify with her son, she began participating in PPT, along with the grandmother, during the ninth session. This allowed both the maternal grandmother and the mother to understand the child's PTSD symptoms and to assist in recovery, safety planning, and relapse prevention. The child was eventually safely reunified with his mother.

The Nature of the Trauma

Ongoing Trauma. If the exposure to threat is ongoing, such as in the case of continuous physical abuse, the child will be unable to recover from PTSD. Even in cases of ongoing emotional abuse, the child may perceive the threat of future trauma but may not be able to afford the psychological resources necessary to recover. In cases of domestic violence, the young child and the caregiver may be continuously threatened, and neither will be able to recover from past trauma with ongoing threats or the perception of future threat. Thus, in addition to a reliable caregiving relationship, stability and a trauma-free environment are necessary conditions for treatment of PTSD in young children.

When Trauma Is Suspected But Not Known. As described earlier, one of the predicaments of addressing PTSD in young children is that without the language skills necessary to describe past traumatic events, clinicians may observe some PTSD symptoms (startle response, hypervigilance, etc.) but not be able to identify an exact traumatic event. In these cases, a thorough assessment is needed to gain as much information as possible. Here, the focus of intervention again would be the caregiving relationship, and creating a sense of physical and psychological security for the child. Play-based intervention modalities (e.g., in CPP) are particularly useful, as they do not rely solely on the language-based techniques used in other modalities (e.g., CBT). It may be fruitful to complete a number of play sessions, during which details of the traumatic event may be revealed. It is important to consider that the child's perception of the traumatic event should be the target of intervention, which may or may not coincide precisely with details delineated in records.

When the Details of Trauma Are Not Known. Similarly, when all the details of a trauma are not known, nondirective, play-based intervention modalities may be more useful than others. At the same time, trauma details are often revealed across sessions of trauma-focused intervention and may be incorporated in future sessions. Thus, based on our professional experience, it is not necessary to know all of the details before beginning PTSD intervention, although some details are needed for most trauma-focused interventions to be effective for treating PTSD in young children.

When There Is a History of Trauma but Full Criteria for PTSD Are Not Met. Often, children and caregivers present for intervention, but careful assessment reveals that a full PTSD diagnosis is not warranted. In all cases, it is important to consider functional impairment of the presenting symptoms. Certainly, establishing that a traumatic event in fact occurred is the first essential step before proceeding to intervention. The next step is to ascertain the impairment caused by the child's PTSD symptoms and its effect on functioning. If the child's symptoms significantly interfere with the child's functioning (e.g., avoidance of school following a small school fire, in which the child felt his or her life was threatened), then it may be important and productive to proceed with trauma-focused intervention, even if full PTSD diagnostic criteria are not present.

Traumatic Grief. Trauma in which there is loss of a person of significance in the young child's life is worth mentioning here. In these cases, even if the child meets full criteria for PTSD, it may be necessary to incorporate, or focus fully, on the child's grief and sense of loss prior to or simultaneously with focusing on the PTSD symptoms. CPP offers a vehicle for addressing attachment, loss, and trauma issues simultaneously. In addition, the National Child Traumatic Stress Network (NCTSN) offers resources on addressing child traumatic separation (*www.nctsn.org*).

Conclusions

The existing studies involving young children who have been exposed to trauma suggest that

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the diagnosis of PTSD in children in the second year of life is reliable, valid, and stable, although there are a number of challenges to assessment. Trauma in the first years of life needs to be assessed and treated in the context of the child's primary attachment relationships. Young children's recovery from PTSD is possible with evidence-based, trauma-focused treatment with a reliable and supportive caregiver.

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