

# National Child Traumatic Stress Network (NCTSN) Resources

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

The Network is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services through a congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative. As of November 2009 the Network comprises 60 members. Affiliate members—sites that were formerly funded—and individuals currently or previously associated with those sites continue to be active in the Network as affiliates.



A screenshot of the NCTSN website homepage. The header includes the NCTSN logo, navigation tabs (Home, Trauma Types, Resources, About Us, Products, Login / Register), a search bar, and social media icons for Twitter (3.5k likes) and Facebook. The main content area is divided into several sections: a large blue box for "Access Information on Early Childhood Trauma" with an image of a woman and child; a "Terrorism &amp; Disasters" section; a "Learning Center" for child and adolescent trauma; an "Information Resource Tools" section with links to Knowledge Bank, Measures Review Database, and Military Families Knowledge Bank; a "What's New?" section with a list of recent updates; a "Public Awareness" section with a link to "Holiday Stress"; and an "Upcoming Events" section for "Trauma-Focused Cognitive Behavioral Therapy for Traumatized Children and Their Families (March 7-8, 2013)". A "Looking for help? click here" button is also present. At the bottom, there are icons and links for "For Parents &amp; Caregivers", "For Professionals", "Military Children &amp; Families", "For Educators", "For the Media", and "Información en Español". A footer section provides "For more information" with links to Trauma Topics, Treatment &amp; Services, Sustainability &amp; Policy, and The Network.

<http://www.nctsn.org/>

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The logo for NCTSN (The National Child Traumatic Stress Network) features the acronym "NCTSN" in a bold, blue, sans-serif font.The logo for The National Child Traumatic Stress Network features a yellow arc above the text "The National Child Traumatic Stress Network" in a blue, sans-serif font.

The National Child  
Traumatic Stress Network

# Early Childhood Trauma

(Print version of

[http://nctsn.org/nccts/nav.do?pid=typ\\_early1](http://nctsn.org/nccts/nav.do?pid=typ_early1))

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*Zero to Six Collaborative Group*

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## Overview

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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?

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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

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

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particularly vulnerable to the effects of exposure to trauma. 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/](http://developingchild.harvard.edu/library/reports_and_working_papers/wp3/).

## Scope of the Problem

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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.<sup>1</sup>

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.<sup>2</sup>
- One in three children under the age of six has injuries severe enough to warrant medical attention.<sup>3</sup>

### 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.<sup>4</sup>
- Infants are the fastest growing category of children entering foster care in the United States.<sup>5</sup>
- 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.<sup>6</sup>

### 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.<sup>7</sup>
- Nearly two-thirds of young children attending a Head Start program had either witnessed or been victimized by community violence, according to parent reports.<sup>8</sup>
- 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.<sup>9</sup>

### 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.<sup>10</sup> 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.<sup>11</sup>

## 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
<b>Cognitive</b>		
Demonstrate poor verbal skills	✓	
Exhibit memory problems	✓	
Have difficulties focusing or learning in school		✓
Develop learning disabilities		✓
Show poor skill development		✓
<b>Behavioral</b>		
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		✓
<b>Physiological</b>		
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		✓
<b>Physiological</b>		
Have a poor appetite, low weight, and/or digestive problems	✓	
Experience stomachaches and headaches		✓
Have poor sleep habits	✓	✓
Experience nightmares or sleep difficulties	✓	✓

## Protective Factors: Enhancing Resilience in Young Children and Families

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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.<sup>12</sup>

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### 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.<sup>13</sup>

#### 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

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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 through 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)<sup>14</sup>—aged 1½–5
- Posttraumatic Stress Disorder Semi-Structured Interview and Observation Record<sup>15</sup>—aged 0–4 years of age
- Posttraumatic Symptom Inventory for Children (PT-SIC)<sup>16</sup>—aged 4–8 years
- Preschool Age Psychiatric Assessment (PAPA)<sup>17</sup>—aged 2–5
- PTSD Symptoms in Preschool Aged Children (PTSD-PAC)<sup>18</sup>—aged 3–5<sup>18</sup>
- Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR)<sup>19</sup>—aged 0–6
- Trauma Symptom Checklist for Young Children (TSCYC)<sup>20</sup>—aged 3–12
- Violence Exposure Scale for Children-Preschool Version (VEX-PV)<sup>8</sup>—aged 4–10

- Violence Exposure Scale for Children-Revised Parent Report (VEX-RPR)<sup>8</sup>—for parents of preschool-aged children aged 4–10<sup>8</sup>

#### *Instruments for Assessing Parenting Stress and Strengths*

- Life Stressor Checklist–Revised (LSC-R)<sup>21</sup>
- Parenting Stress Index (PSI)<sup>22</sup>
- Davidson Trauma Scale (DTS)<sup>23</sup>

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.

<b>Resources for Identifying Traumatic Stressors in Young Children</b>
<b>Online resources</b>
<b>The Child Trauma Academy</b> ( <a href="http://www.childtrauma.org">http://www.childtrauma.org</a> ) Articles for professionals ( <a href="http://www.childtrauma.org/index.php/articles/articles-for-professionals">http://www.childtrauma.org/index.php/articles/articles-for-professionals</a> )
<b>The Health Care Toolbox</b> ( <a href="http://www.healthcaretoolbox.org/index.php">http://www.healthcaretoolbox.org/index.php</a> ) Center for Pediatric Traumatic Stress at The Children’s Hospital of Philadelphia
<b>Centers for Disease Control and Prevention</b> ( <a href="http://www.cdc.gov">http://www.cdc.gov</a> ) <i>Injury—A Risk at Any Stage of Life</i> ( <a href="http://www.cdc.gov/ncipc/fact_book/Injury%20-%20Risk%20at%20Any%20Stage%20of%20Life-2006.pdf">http://www.cdc.gov/ncipc/fact_book/Injury%20-%20Risk%20at%20Any%20Stage%20of%20Life-2006.pdf</a> )
<b>Journal Articles</b>
Cohen, J. A., Kelleher, K. J., & Mannarino, A. P. (2008). Identifying, treating, and referring traumatized children: The role of pediatric providers. <i>Archives of Pediatrics and Adolescent Medicine</i> , 162(5), 447–452.
Dehon, C., & Scheeringa, M. S. (2006). Screening for preschool posttraumatic stress disorder with the Child Behavior Checklist. <i>Journal of Pediatric Psychology</i> , 31(4), 431–435.
Groves, B. M., & Augustyn, M. (2009). Pediatric care. Moving From Evidence to Action: <i>The Safe Start Series on Children Exposed to Violence, Issue Brief #2</i> . 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 <a href="http://www.safestartcenter.org/pdf/IssueBrief2_PEDIATRIC.pdf">http://www.safestartcenter.org/pdf/IssueBrief2_PEDIATRIC.pdf</a>

## 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	
<b>Online resources</b>	
<b>Center on the Social and Emotional Foundations for Early Learning</b> ( <a href="http://csefel.vanderbilt.edu/about.html">http://csefel.vanderbilt.edu/about.html</a> )	<i>Practical Strategies for Teachers/Caregivers</i> ( <a href="http://csefel.vanderbilt.edu/resources/strategies.html">http://csefel.vanderbilt.edu/resources/strategies.html</a> )
<b>Head Start</b> ( <a href="http://www.headstart.org/">http://www.headstart.org/</a> )	<i>Head Start Bulletin #73: Child Mental Health</i> ( <a href="http://eclkc.ohs.acf.hhs.gov/hslc/resources/ECLKC_Bookstore/PDFs/A6E18891317C94E72DD233C75C4DBD7D.pdf">http://eclkc.ohs.acf.hhs.gov/hslc/resources/ECLKC_Bookstore/PDFs/A6E18891317C94E72DD233C75C4DBD7D.pdf</a> )  <i>Head Start Bulletin #80: Mental Health</i> ( <a href="http://www.headstartresourcecenter.org/assets/file/Publications/Bulletin-Mental%20Health%202009v3.pdf">http://www.headstartresourcecenter.org/assets/file/Publications/Bulletin-Mental%20Health%202009v3.pdf</a> )
<b>National Child Traumatic Stress Network</b> ( <a href="http://www.nctsn.org">http://www.nctsn.org</a> )	<i>Child Trauma Toolkit for Educators</i> ( <a href="http://www.nctsn.org/nctsn_assets/pdfs/Child_Trauma_Toolkit_Final.pdf">http://www.nctsn.org/nctsn_assets/pdfs/Child_Trauma_Toolkit_Final.pdf</a> )  <i>Caja de Herramientas Para Educadores Para el Manejo de Trauma Infantil</i> ( <a href="http://www.nctsn.org/nctsn_assets/pdfs/SP_Child_Trauma_Toolkit_111009_FINAL.pdf">http://www.nctsn.org/nctsn_assets/pdfs/SP_Child_Trauma_Toolkit_111009_FINAL.pdf</a> )
<b>Scholastic for Teachers</b> ( <a href="http://www2.scholastic.com/">http://www2.scholastic.com/</a> )	Library of articles by trauma expert Bruce D. Perry, MD, PhD ( <a href="http://teacher.scholastic.com/professional/bruceperry/index.htm">http://teacher.scholastic.com/professional/bruceperry/index.htm</a> )  Greenspan, S. I. (2002). Meeting learning challenges: Working with the child who has PTSD. <i>Scholastic Early Childhood Today</i> .  Perry, B. D. (2006). Death and loss: Helping children manage their grief. <i>Scholastic Early Childhood Today</i> .
<b>Print Resource</b>	
Rice, K. F., & Groves, B. M. (2005). <i>Hope and healing: A caregiver's guide to helping young children affected by trauma</i> . 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

<b>National Child Traumatic Stress Network</b> ( <a href="http://www.nctsn.org">http://www.nctsn.org</a> )	<i>Helping Traumatized Children: Tips for Judges</i> ( <a href="http://www.nctsn.org/nctsn_assets/pdfs/JudgesFactSheet.pdf">http://www.nctsn.org/nctsn_assets/pdfs/JudgesFactSheet.pdf</a> ) <i>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</i> ( <a href="http://www.nctsn.org/nctsn_assets/pdfs/judicialbrief.pdf">http://www.nctsn.org/nctsn_assets/pdfs/judicialbrief.pdf</a> )
<b>Safe Start Center</b> ( <a href="http://www.safestartcenter.org/">http://www.safestartcenter.org/</a> )	<i>A Judicial Checklist For Children And Youth Exposed To Violence</i> ( <a href="http://www.safestartcenter.org/pdf/childandyouth_checklist.pdf">http://www.safestartcenter.org/pdf/childandyouth_checklist.pdf</a> ) .
<b>Zero to Three</b> ( <a href="http://www.zerotothree.org/">http://www.zerotothree.org/</a> )	<i>Helping Babies from the Bench: Using the Science of Early Childhood Development in Court</i> (DVD) Order form available at <a href="http://www.zerotothree.org/about-us/funded-projects/court-teams/dvd_order_form_2009.pdf">http://www.zerotothree.org/about-us/funded-projects/court-teams/dvd_order_form_2009.pdf</a>

### 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.nctsn.org/nctsn/nav.do?pid=typ\\_terr\\_resources\\_pfa](http://www.nctsn.org/nctsn/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	
<b>Online resources</b>	
<b>After the Injury</b> ( <a href="http://aftertheinjury.org/">http://aftertheinjury.org/</a> )	<i>Find Ways to Help Your Child Recover</i> ( <a href="http://aftertheinjury.org/findWhat.html">http://aftertheinjury.org/findWhat.html</a> )
<b>Center on the Social and Emotional Foundations for Early Learning</b> ( <a href="http://csefel.vanderbilt.edu/about.html">http://csefel.vanderbilt.edu/about.html</a> )	<i>Family Tools</i> ( <a href="http://csefel.vanderbilt.edu/resources/family.html">http://csefel.vanderbilt.edu/resources/family.html</a> )
<b>National Child Traumatic Stress Network</b> ( <a href="http://www.nctsn.org">http://www.nctsn.org</a> )	<i>After the Hurricane: Helping Young Children Heal</i> ( <a href="http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/Helping_Young_Children_Heal.pdf">http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/Helping_Young_Children_Heal.pdf</a> )  <i>Helping Young Children and Families Cope with Trauma</i> ( <a href="http://www.nctsn.org/nctsn_assets/pdfs/Helping_Young_Children_and_Families_Cope_with_Trauma.pdf">http://www.nctsn.org/nctsn_assets/pdfs/Helping_Young_Children_and_Families_Cope_with_Trauma.pdf</a> )
<b>Scholastic.com</b> ( <a href="http://www2.scholastic.com/browse/home.jsp">http://www2.scholastic.com/browse/home.jsp</a> )	Brodtkin A. M. (2005). Talking with children about natural disasters. <i>Scholastic Early Childhood Today</i>

### 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

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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.nctsn.org/nctsn/assets/pdfs/promising\\_practices/afcbt\\_general.pdf](http://www.nctsn.org/nctsn/assets/pdfs/promising_practices/afcbt_general.pdf).

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://www.nctsn.org/nctsn/assets/pdfs/promising\\_practices/afcbt\\_general.pdf](http://www.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.<sup>24,25</sup>

### **Attachment, Self-Regulation and Competency (ARC)**

([http://www.nctsn.org/nctsn/assets/pdfs/promising\\_practices/arc\\_general.pdf](http://www.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/scot.php>.

### **Child-Parent Psychotherapy (CPP)**

([http://www.nctsn.org/nctsn/assets/pdfs/promising\\_practices/cpp\\_general.pdf](http://www.nctsn.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.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/pcit\\_general.pdf](http://www.nctsn.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](mailto:mscheer@tulane.edu).

### Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

([http://www.nctsn.org/nctsn\\_assets/pdfs/promising\\_practices/TF-CBT\\_fact\\_sheet\\_3-20-07.pdf](http://www.nctsn.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.nctsn.org/nctsn\\_assets/pdfs/TF-CBT\\_Implementation\\_Manual.pdf](http://www.nctsn.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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# Child Trauma Toolkit for Educators

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This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

# Child Trauma Toolkit for Educators

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October 2008

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Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

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**FACT: One out of every 4 children attending school has been exposed to a traumatic event that can affect learning and/or behavior.**

**FACT: Trauma can impact school performance.**

- Lower GPA
- Higher rate of school absences
- Increased drop-out
- More suspensions and expulsions
- Decreased reading ability

**FACT: Trauma can impair learning.**

Single exposure to traumatic events may cause jumpiness, intrusive thoughts, interrupted sleep and nightmares, anger and moodiness, and/or social withdrawal—any of which can interfere with concentration and memory.

Chronic exposure to traumatic events, especially during a child's early years, can:

- Adversely affect attention, memory, and cognition
- Reduce a child's ability to focus, organize, and process information
- Interfere with effective problem solving and/or planning
- Result in overwhelming feelings of frustration and anxiety

**FACT: Traumatized children may experience physical and emotional distress.**

- Physical symptoms like headaches and stomachaches
- Poor control of emotions
- Inconsistent academic performance
- Unpredictable and/or impulsive behavior
- Over or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Intense reactions to reminders of their traumatic event:
  - Thinking others are violating their personal space, i.e., "What are you looking at?"
  - Blowing up when being corrected or told what to do by an authority figure
  - Fighting when criticized or teased by others
  - Resisting transition and/or change

**FACT: You can help a child who has been traumatized.**

- Follow your school's reporting procedures if you suspect abuse
- Work with the child's caregiver(s) to share and address school problems
- Refer to community resources when a child shows signs of being unable to cope with traumatic stress
- Share Trauma Facts for Educators with other teachers and school personnel

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## What can be done at school to help a traumatized child?

- Maintain usual routines. A return to “normalcy” will communicate the message that the child is safe and life will go on.
- Give children choices. Often traumatic events involve loss of control and/or chaos, so you can help children feel safe by providing them with some choices or control when appropriate.
- Increase the level of support and encouragement given to the traumatized child. Designate an adult who can provide additional support if needed.
- Set clear, firm limits for inappropriate behavior and develop logical—rather than punitive—consequences.
- Recognize that behavioral problems may be transient and related to trauma. Remember that even the most disruptive behaviors can be driven by trauma-related anxiety.
- Provide a safe place for the child to talk about what happened. Set aside a designated time and place for sharing to help the child know it is okay to talk about what happened.
- Give simple and realistic answers to the child’s questions about traumatic events. Clarify distortions and misconceptions. If it isn’t an appropriate time, be sure to give the child a time and place to talk and ask questions.
- Be sensitive to the cues in the environment that may cause a reaction in the traumatized child. For example, victims of natural storm-related disasters might react very badly to threatening weather or storm warnings. Children may increase problem behaviors near an anniversary of a traumatic event.
- Anticipate difficult times and provide additional support. Many kinds of situations may be reminders. If you are able to identify reminders, you can help by preparing the child for the situation. For instance, for the child who doesn’t like being alone, provide a partner to accompany him or her to the restroom.
- Warn children if you will be doing something out of the ordinary, such as turning off the lights or making a sudden loud noise.
- Be aware of other children’s reactions to the traumatized child and to the information they share. Protect the traumatized child from peers’ curiosity and protect classmates from the details of a child’s trauma.
- Understand that children cope by re-enacting trauma through play or through their interactions with others. Resist their efforts to draw you into a negative repetition of the trauma. For instance, some children will provoke teachers in order to replay abusive situations at home.
- Although not all children have religious beliefs, be attentive if the child experiences severe feelings of anger, guilt, shame, or punishment attributed to a higher power. Do not engage in theological discussion. Rather, refer the child to appropriate support.

- While a traumatized child might not meet eligibility criteria for special education, consider making accommodations and modifications to academic work for a short time, even including these in a 504 plan. You might:
  - Shorten assignments
  - Allow additional time to complete assignments
  - Give permission to leave class to go to a designated adult (such as a counselor or school nurse) if feelings become overwhelming
  - Provide additional support for organizing and remembering assignments

### When should a referral be made for additional help for a traumatized child?

When reactions are severe (such as intense hopelessness or fear) or go on for a long time (more than one month) and interfere with a child's functioning, give referrals for additional help. As severity can be difficult to determine—with some children becoming avoidant or appearing to be fine (e.g., a child who performs well academically no matter what)—don't feel you have to be certain before making a referral. Let a mental health professional evaluate the likelihood that the child could benefit from some type of intervention.

### When to seek self care?

Seek support and consultation routinely for yourself in order to prevent "compassion fatigue," also referred to as "secondary traumatic stress." Be aware that you can develop compassion fatigue from exposure to trauma through the children with whom you work.



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## There are children in your preschool who have experienced trauma.

**Consider Ricky.** Ricky, a three-year-old boy, cries inconsolably when his mother drops him off at school in the morning. His teachers thought his crying would stop when he became more comfortable in the classroom; however, he continues to cry every day and does not interact with his teachers or play with his peers. Ricky also has a speech delay and gets very upset when the other students are loud or when his daily routine is interrupted. One day the teacher asked Ricky to talk about his drawing, and he said, "Daddy hurt mommy." Ricky's mother was later observed to have a black eye and bruises that were consistent with assault.

**Another example is Alexa.** Alexa, a four-year-old girl, has been kicked out of two other preschools and is about to be expelled from her current school. She curses at teachers, hits, kicks, and scratches other students, and bangs her head on the table when she is frustrated. Alexa's behaviors are most difficult when transitioning from one activity to another. When the teacher meets with Alexa's father, the father reports that Alexa's mother uses drugs, that Alexa has seen her mother arrested by the police, and that Alexa's mother often does not come home at night.

What do these children have in common? They have both been exposed to trauma, defined as *an experience that threatens life or may cause physical injury and is so powerful and dangerous that it overwhelms the preschool child's capacity to regulate emotions*. Generally, traumatic events evoke feelings of extreme fear and helplessness. Reactions to traumatic events are determined by the subjective experience of the child, which could be impacted by developmental and cultural factors. What is extremely traumatic for one child may be less so for another.

Some traumatic experiences occur once in a lifetime, others are ongoing. Many children have experienced multiple traumas, and for too many children, trauma is a chronic part of their lives. (For examples, see sidebar, at right.)

Some children show signs of stress in the first few weeks after a trauma, but return to their usual state of physical and emotional health. Even children who do not exhibit serious symptoms may experience some degree of emotional distress, which may continue or even deepen over a long period of time. Children who have experienced traumatic events may experience problems that impair their day-to-day functioning.

### Children who have experienced traumatic events may have behavioral problems, or their suffering may not be apparent at all.

It is important to be aware of both the children who act out and the quiet children who don't appear to have behavioral problems. These children often "fly beneath the radar" and do not get help. In any situation where there is a possibility of abuse, as in the cases above, you may be legally required to report the information to social services or law enforcement.

Be alert to the possibility of misdiagnosis due to the many presentations of trauma-related anxiety. For instance, many behaviors seen in children who have experienced trauma are nearly identical to those of children with developmental delays, ADHD and other mental health conditions. Without recognition of the possibility that a child is experiencing childhood traumatic stress, adults may develop a treatment plan that does not fully address the specific needs of that child with regard to trauma.

### Situations that can be traumatic:

- Physical or sexual abuse
- Abandonment
- Neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations and/or painful medical procedures
- Witnessing or experiencing community violence (e.g., shootings, stabbings, robbery, or fighting at home, in the neighborhood, or at school)
- Witnessing police activity or having a close relative incarcerated
- Life-threatening natural disasters
- Acts or threats of terrorism (viewed in person or on television)
- Living in chronically chaotic environments in which housing and financial resources are not consistently available

## What you might observe in Preschool children:

Remember, young children do not always have the words to tell you what has happened to them or how they feel. Behavior is a better gauge and sudden changes in behavior can be a sign of trauma exposure.

- Separation anxiety or clinginess towards teachers or primary caregivers
- Regression in previously mastered stages of development (e.g., baby talk or bedwetting/toileting accidents)
- Lack of developmental progress (e.g., not progressing at same level as peers)
- Re-creating the traumatic event (e.g., repeatedly talking about, "playing" out, or drawing the event)
- Difficulty at naptime or bedtime (e.g., avoiding sleep, waking up, or nightmares)
- Increased somatic complaints (e.g., headaches, stomachaches, overreacting to minor bumps and bruises)
- Changes in behavior (e.g., appetite, unexplained absences, angry outbursts, decreased attention, withdrawal)
- Over- or under-reacting to physical contact, bright lighting, sudden movements, or loud sounds (e.g., bells, slamming doors, or sirens)
- Increased distress (unusually whiny, irritable, moody)
- Anxiety, fear, and worry about safety of self and others
- Worry about recurrence of the traumatic event
- New fears (e.g., fear of the dark, animals, or monsters)
- Statements and questions about death and dying



Some children, if given support, will recover within a few weeks or months from the fear and anxiety caused by a traumatic experience. However, some children will need more help over a longer period of time in order to heal and may need continuing support from family, teachers, or mental health professionals. Anniversaries of the events or media reports may act as reminders to the child, causing a recurrence of symptoms, feelings, and behaviors.

Mental health counseling that has been demonstrated to be effective in helping children deal with traumatic stress reactions typically includes the following elements:

- Helping children and caregivers reestablish a safe environment and a sense of safety
- Helping parents and children return to normal routines
- An opportunity to talk about and make sense of the traumatic experience in a safe, accepting environment
- Explaining the trauma and answering questions in an honest but simple and age-appropriate manner
- Teaching techniques for dealing with overwhelming emotional reactions
- Helping the child verbalize feelings rather than engage in inappropriate behavior
- Involving primary caregivers in the healing process
- Connecting caregivers to resources to address their needs—young children's level of distress often mirrors their caregiver's level of distress

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

This information sheet summarizes material found in the “In-Depth General Information Guide to Childhood Traumatic Grief” and “In-Depth Information on Childhood Traumatic Grief for School Personnel,” available at [www.NCTSN.org](http://www.NCTSN.org).

Childhood traumatic grief is a condition that some children develop after the death of a close friend or family member. Children who develop childhood traumatic grief reactions experience the cause of that death as horrifying or terrifying, whether the death was unexpected or due to natural causes. Even if the manner of death is not objectively sudden, shocking, or frightening to others, children who perceive the death this way may develop childhood traumatic grief.

For some children and adolescents, responses to traumatic events can have a profound effect on the way they see themselves and their world. They may experience important and long-lasting changes in their ability to trust others, their sense of personal safety, their effectiveness in navigating life challenges, and their belief that there is justice or fairness in life.

It's important to keep in mind that many children who encounter a shocking or horrific death of another person will recover naturally and not develop ongoing difficulties, while other children may experience such difficulties. Every child is different in his or her reactions to a traumatic loss.

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## Identifying Traumatic Grief in Students

Children at different developmental levels may react differently to a loved one's traumatic death. But there are some common signs and symptoms of traumatic grief that children might show at school. Teachers may observe the following in the student:

- Being overly preoccupied with how the loved one died
- Reliving or re-enacting the traumatic death through play, activities, and/or artwork
- Showing signs of emotional and/or behavioral distress when reminded of the loss
- Attempting to avoid physical reminders of the traumatic death, such as activities, places, or people related to the death
- Withdrawing from important aspects of their environment
- Showing signs of emotional constriction or “numbing”
- Being excessively jumpy or being easily startled
- Showing signs of a lack of purpose and meaning to one's life

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## How School Personnel Can Help a Student with Traumatic Grief

### **Inform others and coordinate services**

Inform school administration and school counselors/psychologists about your concerns regarding the student. Your school district or state may have specific policies or laws about dealing with emotional issues with children. If you feel a student could benefit from the help of a mental health professional, work within your school's guidelines and with your administration to suggest a referral.

### **Answer a child's questions**

Let the child know that you are available to talk about the death if he or she wants to. When talking to these children, accept their feelings (even anger), listen carefully, and remind them that it is normal to experience emotional and behavioral difficulties following the death of a loved one. Do not force a child to talk about the death if he or she doesn't want to. This may be more harmful than helpful for the child.

### **Create a supportive school environment**

Maintain normal school routines as much as possible. A child with traumatic grief can feel that life is chaotic and out of his or her control. It's beneficial for the child to have a predictable class schedule and format. The child may also need extra reassurance and explanation if there is a change. Staff should look for opportunities to help classmates who are struggling with how best to help and understand a student with traumatic grief.

### **Raise the awareness of school staff and personnel**

Teachers and school staff may misinterpret changes in children's behaviors and school performance when they are experiencing childhood traumatic grief. Although it is always a priority to protect and respect a child's privacy, whenever possible it may be helpful to work with school staff who have contact with the child to make sure they know that the child has suffered a loss and may be experiencing difficulties or changes in school performance as a result. In this way, the school staff can work together to ensure that children get the support and understanding they need.

### **Modify teaching strategies**

Balance normal school expectations with flexibility. You might avoid or postpone large tests or projects that require extensive energy and concentration for a while following the death. Be sensitive when the student is experiencing difficult times—for example, on the anniversary of a death—so that you can be supportive and perhaps rearrange or modify class assignments or work. Use teaching strategies that promote concentration, retention, and recall and that increase a sense of predictability, control, and performance.

### **Support families**

Build a relationship of trust with the student's family. On a personal level, be reliable, friendly, consistently caring, and predictable in your actions. Keep your word, and never betray the family's trust. It can be helpful for the school or district to designate a liaison who can coordinate the relationship among teachers, the principal, the guidance counselor, other appropriate school personnel, the family, and the child.

### **Make referrals**

Consider referral to a mental health professional. Traumatic grief can be very difficult to resolve, and professional help is often needed. If possible, the student and him or her family should be referred to a professional who has considerable experience in working with children and adolescents and with the issues of grief and trauma.

## **For more Information**

Additional information about childhood traumatic grief and where to turn for help is available from the National Child Traumatic Stress Network at (310) 235-2633 and (919) 682-1552 or at [www.NCTSN.org](http://www.NCTSN.org).

**“There is a cost to caring.” - Charles Figley**

Trauma takes a toll on children, families, schools, and communities. Trauma can also take a toll on school professionals. **Any educator who works directly with traumatized children and adolescents is vulnerable to the effects of trauma**—referred to as *compassion fatigue* or *secondary traumatic stress*—being physically, mentally, or emotionally worn out, or feeling overwhelmed by students’ traumas. The best way to deal with compassion fatigue is early recognition.

**TIPS FOR EDUCATORS:**

1. **Be aware of the signs.** Educators with compassion fatigue may exhibit some of the following signs:
  - Increased irritability or impatience with students
  - Difficulty planning classroom activities and lessons
  - Decreased concentration
  - Denying that traumatic events impact students or feeling numb or detached
  - Intense feelings and intrusive thoughts, that don’t lessen over time, about a student’s trauma
  - Dreams about students’ traumas
  
2. **Don’t go it alone.** Anyone who knows about stories of trauma needs to guard against isolation. While respecting the confidentiality of your students, get support by working in teams, talking to others in your school, and asking for support from administrators or colleagues.
  
3. **Recognize compassion fatigue as an occupational hazard.** When an educator approaches students with an open heart and a listening ear, *compassion fatigue* can develop. All too often educators judge themselves as weak or incompetent for having strong reactions to a student’s trauma. Compassion fatigue is not a sign of weakness or incompetence; rather, it is the cost of caring.
  
4. **Seek help with your own traumas.** Any adult helping children with trauma, who also has his or her own unresolved traumatic experiences, is more at risk for compassion fatigue.
  
5. **If you see signs in yourself, talk to a professional.** If you are experiencing signs of compassion fatigue for more than two to three weeks, seek counseling with a professional who is knowledgeable about trauma.
  
6. **Attend to self care.** Guard against your work becoming the only activity that defines who you are. Keep perspective by spending time with children and adolescents who are not experiencing traumatic stress. Take care of yourself by eating well and exercising, engaging in fun activities, taking a break during the workday, finding time to self-reflect, allowing yourself to cry, and finding things to laugh about.

Resource: Figley, C.R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel, Inc.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

## What Is Child Traumatic Stress?

Child traumatic stress is when children and adolescents are exposed to traumatic events or traumatic situations, and when this exposure overwhelms their ability to cope.

When children have been exposed to situations where they feared for their lives, believed they could have been injured, witnessed violence, or tragically lost a loved one, they may show signs of traumatic stress. The impact on any given child depends partly on the objective danger, partly on his or her subjective reaction to the events, and partly on his or her age and developmental level.



**If your child is experiencing traumatic stress you might notice the following signs:**

- Difficulty sleeping and nightmares
- Refusing to go to school
- Lack of appetite
- Bed-wetting or other regression in behavior
- Interference with developmental milestones
- Anger
- Getting into fights at school or fighting more with siblings
- Difficulty paying attention to teachers at school and to parents at home
- Avoidance of scary situations
- Withdrawal from friends or activities
- Nervousness or jumpiness
- Intrusive memories of what happened
- Play that includes recreating the event

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## What Is the best way to treat child traumatic stress?

There are effective ways to treat child traumatic stress.

**Many treatments include cognitive behavioral principles:**

- Education about the impact of trauma
- Helping children and their parents establish or re-establish a sense of safety
- Techniques for dealing with overwhelming emotional reactions
- An opportunity to talk about the traumatic experience in a safe, accepting environment
- Involvement, when possible, of primary caregivers in the healing process

For more information see the NCTSN website: [www.nctsn.org](http://www.nctsn.org).

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## What can I do for my child at home?

Parents never want their child to go through trauma or suffer its after effects.

**Having someone you can talk to about your own feelings will help you to better help your child.**

**Follow these steps to help your child at home:**

1. Learn about the common reactions that children have to traumatic events.
2. Consult a qualified mental health professional if your child's distress continues for several weeks. Ask your child's school for an appropriate referral.
3. Assure your child of his or her safety at home and at school. Talk with him or her about what you've done to make him or her safe at home and what the school is doing to keep students safe.
4. Reassure your child that he or she is not responsible. Children may blame themselves for events, even those completely out of their control.
5. Allow your child to express his or her fears and fantasies verbally or through play. That is a normal part of the recovery process.
6. Maintain regular home and school routines to support the process of recovery, but make sure your child continues going to school and stays in school.
7. Be patient. **There is no correct timetable for healing. Some children will recover quickly. Other children recover more slowly.** Try not to push him or her to "just get over it," and let him or her know that he or she should not feel guilty or bad about any of his or her feelings.



**How can I make sure my child receives help at school?**

If your child is staying home from school, depressed, angry, acting out in class, having difficulty concentrating, not completing homework, or failing tests, there are several ways to get help at school. Talk with your child's school counselor, social worker, or psychologist. Usually, these professionals understand child traumatic stress and should be able to assist you to obtain help.

**Ask at school about services through Federal legislation including:**

1. Special Education—the Individuals with Disabilities Education Act (IDEA) which, in some schools, includes trauma services; and
2. Section 504—which protects people from discrimination based on disabilities and may include provisions for services that will help your child in the classroom.

Check with your school's psychologist, school counselor, principal, or special education director for information about whether your child might be eligible for help with trauma under IDEA.

**The good news is that there are services that can help your child get better. Knowing who to ask and where to look is the first step.**

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

## What Is Childhood Traumatic Grief?

This brief information guide to Childhood Traumatic Grief summarizes some of the material from the “In-Depth General Information Guide to Childhood Traumatic Grief,” which can be found at [www.NCTSN.org](http://www.NCTSN.org).

- Childhood traumatic grief is a condition that some children develop after the death of a close friend or family member.
- Children with childhood traumatic grief experience the cause of that death as horrifying or terrifying, whether the death was sudden and unexpected or due to natural causes.
- The distinguishing feature of childhood traumatic grief is that trauma symptoms interfere with the child’s ability to work through the typical bereavement process.
- In this condition, even happy thoughts and memories of the deceased person remind children of the traumatic way in which they perceive the death of the person close to them.
- The child may have intrusive memories about the death that are shown by nightmares, feeling guilty, self-blame, or thoughts about the horrible way the person died.
- These children may show signs of avoidance and numbing such as withdrawal, acting as if they are not upset, and avoiding reminders of the person, the way the person died, or the event that led to the death.
- They may show physical or emotional symptoms of increased arousal such as irritability, anger, trouble sleeping, decreased concentration, drop in grades, stomachaches, headaches, increased vigilance, and fears about safety for themselves or others.
- These symptoms may be more or less common at different developmental stages.
- Left unresolved, this condition could lead to more serious difficulties over time.
- Not all children who lose a loved one in traumatic circumstances develop childhood traumatic grief; many experience normal grief reactions.

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## What Is Normal Grief?

In both normal childhood grief (also called uncomplicated bereavement) and childhood traumatic grief, children typically feel very sad and may have sleep problems, loss of appetite, and decreased interest in family and friends.

In both normal and traumatic grief, they may develop temporary physical complaints or they may regress, returning to behaviors they had previously outgrown, like bed-wetting, thumb-sucking, or clinging to parents.

Both groups of children may be irritable or withdrawn, have trouble concentrating, and be preoccupied with death.

Children experiencing normal grief reactions engage in activities that help them adapt to life.

### **Through the normal grief process children are typically able to:**

- Accept the reality and permanence of the death
- Experience and cope with painful reactions to the death, such as sadness, anger, resentment, confusion, and guilt
- Adjust to changes in their lives and identities that result from the death

- Develop new relationships or deepen existing relationships to help them cope with the difficulties and loneliness that may have resulted from the death
- Invest in new relationships and life-affirming activities as a means of moving forward without the person being physically present
- Maintain a continuing, appropriate attachment to the person who died through such activities as reminiscing, remembering, and memorializing
- Make meaning of the death, a process that can include coming to an understanding of why the person died
- Continue through the normal developmental stages of childhood and adolescence

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## **What Additional Challenges Increase the Risk of Childhood Traumatic Grief? (Secondary Adversities)**

Some evidence suggests that bereaved children who experience additional challenges related to the death—called secondary adversities—or who are already facing difficult life circumstances, are at risk for experiencing traumatic grief. For example, a child who must move after the death of a father must contend with both the absence of a parent and disruption of a social network. A child who witnessed the murder of her mother may face an array of severe additional adversities, such as participation in legal proceedings and facing intrusive questions from peers. Children whose lives are already very complicated and filled with challenges and adversities may be particularly susceptible to developing traumatic grief reactions.

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## **What to Do for Childhood Traumatic Grief**

Children with childhood traumatic grief often try to avoid talking about the deceased person or their feelings about the death, but talking about it may be important for resolving trauma symptoms that are interfering with the child's ability to grieve. If symptoms similar to those listed on this sheet persist, professional help may be needed. The professional should have experience in working with children and adolescents and specifically with issues of grief and trauma. Treatment itself should address both the trauma of the death and grief symptoms. Effective treatments are available, and children can return to their normal functioning. If you do not know where to turn, talking to your child's pediatrician or a mental health professional may be an important first step. They should be able to provide you with a referral to a mental health professional who specializes in working with children and adolescents experiencing traumatic grief reactions. Additional information is available from the National Child Traumatic Stress Network at (310) 235-2633 and (919) 682-1552 or [www.NCTSN.org](http://www.NCTSN.org).

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## Ready to Remember

# Ready to Remember

Jeremy's Journey  
of Hope and Healing



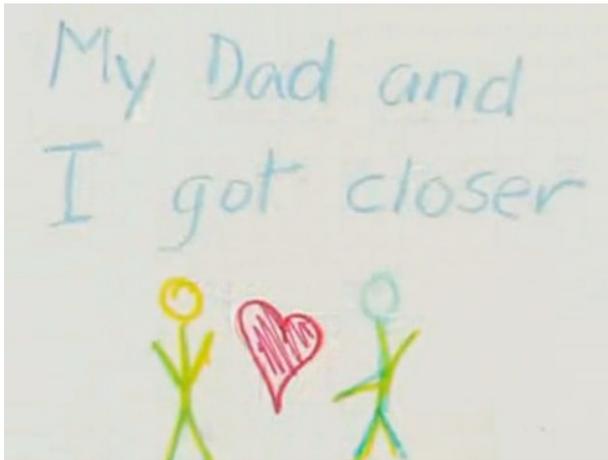
*Ready to Remember* tells the story of a 10-year-old boy's experience following the tragic death of his father. Jeremy is having a traumatic reaction and struggling at school and at home. Developed for the school age reader, with an additional caregiver guide, the illustrated book describes Jeremy's journey as he and his family get help and are able to enjoy happy memories together.

Although *Ready to Remember* is designed for children older than the 0-5 group, it is hoped that a version for younger children will soon be created.

Available at: [http://www.nctsn.org/sites/default/files/assets/pdfs/ctg\\_book\\_09\\_09\\_11a.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/ctg_book_09_09_11a.pdf)

## It's Okay to Remember: Video

A moving first-person narrative illustrating how a family can move through the pain of loss and go on to heal. The family shares their personal experiences of the traumatic grief experienced by one daughter after her sister's sudden death. Helps parents, educators, pediatricians, and others who care for children to understand childhood traumatic grief.



Available at: <http://www.nctsn.org/trauma-types/traumatic-grief/what-childhood-traumatic-grief/its-okay-remember>

# Trauma-Informed Interventions

A list of trauma interventions applicable to the 0-5 age group can be found through NCTSN at: [http://nctsn.org/nctsn\\_assets/pdfs/CCG\\_Book.pdf](http://nctsn.org/nctsn_assets/pdfs/CCG_Book.pdf).

NCTSN The National Child Traumatic Stress Network <b>TAP: Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway</b>		
<b>Clinical &amp; Anecdotal Evidence continued</b>	<p>Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES, please include citation:</b> Every month satisfaction rates are reported in Chawick Center reports to team leaders. The Chawick Center Satisfaction Report, August 2006, reported satisfaction results for 14 therapists utilizing assessment-based treatment as described in the TAP model. Over 90% of parents reported being mostly to very satisfied in these surveys. In addition, satisfaction rates for clients triaged to TF-CBT were reported in the Breakthrough Series Collaborative monthly metrics (BSC Improvement Metrics, April 2006). One hundred percent of the caretakers triaged using techniques of the TAP model reported being satisfied with the treatment they received.</p> <p>Has this intervention been presented at scientific meetings? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES, please include citation(s) from last five presentations:</b> San Diego International Conference on Child and Family Maltreatment: Conradi &amp; Hazen, 2008; Gilbert &amp; Taylor, 2006 International Society for Traumatic Stress Studies (ISTSS); Gilbert &amp; Killen-Harvey, 2007</p> <p>Are there any general writings which describe the components of the intervention or how to administer it? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES, please include citation:</b> Taylor, Gilbert, Mann &amp; Ryan, 2006</p> <p>Has the intervention been replicated anywhere? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>The intervention has been tested within the Chawick Center and is being replicated at three other sites across the United States (Laredo, Texas; Tulsa, Oklahoma; Albany, Georgia and Houston, TX).</p> <p>Other countries? (please list) N/A</p> <p>Other clinical and/or anecdotal evidence (not included above): None</p>	
<b>Research Evidence</b>	Sample Size (N) and Breakdown (by gender, ethnicity, other cultural factors)	Citation
<b>Clinical Trial (w/ control groups)</b>	N=59 (quasi-experimental, non-randomized)	
<b>Randomized Controlled Trial</b>	N=55	Koike, 1996a; Koike, 1996b

NCTSN The National Child Traumatic Stress Network <b>ARC: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth</b>		
<b>Clinical &amp; Anecdotal Evidence</b>	<p>Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Uncertain</p> <p>Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time). 1</p> <p>This intervention is being used on the basis of anecdotes and personal communications only (no writings)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES, please include citation:</b> Subsite progress report, February 2005</p> <p>Has this intervention been presented at scientific meetings? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES, please include citation(s) from last five presentations:</b> AFSAC 2004, Boston Trauma Conference 2005, NCTSN All-Network Meeting 2005</p> <p>Are there any general writings which describe the components of the intervention or how to administer it? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES, please include citation:</b> Kinniburgh, Blaustein, Spinnazzola &amp; van der Kolk, 2005</p> <p>Has the intervention been replicated anywhere? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bothroy Christian Services, Grand Rapids, Michigan; Los Angeles Child Guidance Clinic, Los Angeles, California; Anchorage Community Mental Health Center, Anchorage, Alaska; La Rabida Children's Hospital, Chicago, Illinois.</p> <p>Other clinical and/or anecdotal evidence (not included above): pending</p>	
<b>Research Evidence</b>	Sample Size (N) and Breakdown (by gender, ethnicity, other cultural factors)	Citation
<b>Pilot Trial(s)/Feasibility Trial(s) (w/o control groups)</b>	N=estimated 300 children	In process at 8 locations as part of current SAMHSA NCTSN project cycle
	By gender: estimated even distribution	
	By ethnicity: estimated varied	

NCTSN The National Child Traumatic Stress Network <b>CARE: Child-Adult Relationship Enhancement</b>	
<b>Outcomes</b>	<p>What assessments or measures are used as part of the intervention or for research purposes, if any? Child-Adult Relationship Enhancement Evaluation</p> <p>If research studies have been conducted, what were the outcomes? None at this time</p>
<b>Implementation Requirements &amp; Readiness</b>	<p>Space, materials or equipment requirements? There are no material requirements in order to implement CARE.</p> <p>Supervision requirements (e.g., review of taped sessions)? Shelters who implement CARE are required to receive CARE training and are offered ongoing consultation.</p> <p>To ensure successful implementation, support should be obtained from: trainee CARE trainers (see below).</p>
<b>Training Materials &amp; Requirements</b>	<p>List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained. Child-Adult Relationship Enhancement Manual, Trauma Treatment Training Center, Cincinnati Children's Hospital</p> <p>How/where is training obtained? Training is being offered to Massachusetts family homeless shelters through the National Center on Family Homelessness and the Trauma Center at Justice Resource Institute.</p> <p>CARE training is offered on an agency-by-agency basis at the Trauma Treatment Training Center in Cincinnati. Trainers can train CARE onsite at local agencies, or agencies can bring staff to the Trauma Treatment Training Center.</p> <p>What is the cost of training? The Trauma Treatment Training Center in Cincinnati offers CARE trainings at their home offices in Ohio. Contact them directly for rates (per person rate in 2005 was approximately \$60). The National Center on Family Homelessness and the Trauma Center at JRI can provide trainings to homeless serving systems interested in adopting/adapting CARE. Please contact us directly (see below) for agency/individual rates.</p> <p>Are intervention materials (handouts) available in other languages? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES, what languages?</b> Currently being adapted in Spanish</p> <p>Other training materials &amp;/or requirements (not included above): Agency training for staff will vary depending on agency needs, but generally falls within 3-6 hours. Active skills-building practice in small groups may add additional time to the training, although extensive practice is not necessary to train the basic CARE program.</p>

Of the interventions listed, the following are applicable to this population:

- TAP:** Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway
- ARC :** Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- CARE:** Child-Adult Relationship Enhancement
- CPP:** Child-Parent Psychotherapy
- CM-TFT:** Culturally Modified Trauma-Focused Treatment
- IFACES:** International Family Adult and Child Enhancement Services, Heartland Health Outreach
- ITCT:** Integrative Treatment of Complex Trauma
- PCIT:** Parent-Child Interaction Therapy
- RLH :** Real Life Heroes
- Sanctuary Model**
- TF-CBT:** Trauma-Focused Cognitive Behavioral Therapy
- Trauma-Informed Organizational Self-Assessment.**