Early Intervention as Prevention: Addressing Trauma in Young Children

Two and one-half-year-old David was in his mother's arms as his father stabbed her. David was not injured physically, but he saw the entire event. After David's mother was stabbed, she ran into the street and hailed a passerby, who called the police. As his mother collapsed, the passerby picked up David and held him. When the police arrived, his mother was taken to the hospital. David was taken to a neighbor's home where he stayed for three hours until his grandmother could pick him up. He did not see his mother for 5 days, until she returned home from the hospital.

According to his mother, David seemed subdued when she returned home. He refused to go to his daycare program. He had trouble sleeping at night. He asked repeatedly about his mother's "boo-boos." His mother worried about the changes in his behavior, and wondered if what he saw could have a lasting effect on David. She decided to call her pediatrician, who suggested that she might talk to a therapist about her concerns. She was referred to a program that offered specialized services to preschoolers.

The story of David raises important questions about the impact of trauma on very young children. How does David understand what happened? How do we make sense of David's response to this event? How might this event affect his behavior and his relationship with his mother? How do we effectively help this mother and child? For the past five years, the Early Trauma Treatment Network, a consortium of four specialized early childhood mental health programs around the country, has provided counseling and support to parents and children affected by domestic violence who are similar to David and his mother. This article will present an overview of the research on early childhood trauma, and what we have learned about effective intervention.

Babies, Toddlers, and Trauma

Young children bear a disproportionate share of violence and abuse in the home. Infants and toddlers experience the highest rates of child maltreatment of any age group. Of the 1400 children who died from child abuse in 2004, 76% were under the age of four.[9] Domestic violence (defined here as abuse or threats of abuse between adult partners in the home) also affects many young children. A survey of American households revealed that nearly 30% of children in this country live in homes where there is some form of intimate partner violence.[7] A study on police responses to domestic violence calls in five large metropolitan areas found that children under the age of six were disproportionately represented in the homes that police responded to.[2] Some were directly injured; others, like David, were the helpless bystanders to the violence.

Young Age and Vulnerability

In the past 15 years, tremendous strides have been made in recognizing the vulnerability of our youngest children to trauma in the environment. Previously, it was commonly thought that young age somehow protected children: they were too young to understand, and therefore, they could not be seriously affected. However, research has shown that babies take in much more of their world than we previously thought, and the developing brain is highly responsive to the caregiving environment. This knowledge of the sensitivity of very young children to their environment and the malleability of the developing brain in the neonatal and early childhood developmental periods has increased the importance of early identification of significant childhood stressors.

The meaning of a traumatic event in the life of a child is based on the child's stage of cognitive and emo-

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

tional development. Two-year-old David may witness his mother being battered, and construct a meaning of the event that will be quite different from the explanation that a five- or eleven-year-old would develop. In one study of young victims of child abuse, researchers found that the most powerful predictor of the development of traumatic symptoms was not the direct abuse, but the child's perceptions of the physical safety of a caregiver.[10] Given this finding, David's reactions to his mother's abuse become more comprehensible. In general, young children lack the cognitive capacities to understand cause and effect; they are less able to anticipate danger or to know how to keep themselves safe, thus being particularly vulnerable to the effects of violence exposure. A study by Davidson and Smith[1] reported results consistent with this view, finding that traumatic events experienced prior to age twelve are three times more likely to result in Post Traumatic Stress Disorder than such events experienced after age twelve.

Young Children and Exposure to Violence

Child stressors fall on a continuum, ranging from short-term, tolerable or even beneficial stress, to prolonged, uncontrollable stress that is traumatic or toxic to child development. Chronic exposure to traumatic stress can produce dramatic changes in the stress response system and in extreme cases may result in the development of a smaller brain.[8]

In our work with young children and families, we have learned that when children are exposed to family violence, their expectations for a safe and predictable world are shattered. [3] Young children depend on the attachment relationship with the primary caregiver to organize what is safe and dangerous in the environment, and when this fails, children lose their basic trust that a parent can emotionally and physically protect them. This disruption of the attachment relationship is at the core of risk for children. The strains on the attachment relationship are further exacerbated if the parent is also traumatized. Consider David and his mother: she is a victim of abuse. Her ability to be physically and emotionally available to David may be compromised. For example, she was physically separated from him immediately after the traumatic experience, at the time when he most needed the comfort and security of his mother.

Children respond to trauma-related feelings of fear and vulnerability in a variety of ways. Often, the child is aggressive. In fact, the most frequent referral complaint voiced by parents is concern about their child's aggression, short temper, or impulsive behavior. Other children respond with increased anxiety about any separation from a parent, and with irregular sleeping and eating patterns. Children also learn early and powerful lessons about the use of violence in interpersonal relationships. Violence is an acceptable way to relieve stress and exert one's will. It can also be confused with expressions of love and intimacy.

Interventions with Children and Parents

The Early Trauma Treatment Network uses a model of intervention, Child-Parent Psychotherapy.[5] Child-Parent Psychotherapy (CPP) is based on the premise that trauma-related problems in young children should be addressed within the context of the child's primary attachment relationships. For many children, this relationship is with their mothers or mothers and fathers. However, for children in foster or kinship care, there are other possibilities for an attachment relationship. The essential premise of this treatment is that the caregiver-child relationship is targeted and strengthened, thus enhancing supportive, protective and responsive parenting, and restoring the child's sense of safety and trust in adult caretakers. CPP interventions revolve around free play with the parent and child and the therapeutic use of developmental guidance and information. The intervention also guides the caretaker and child to create a joint narrative of the traumatic experience, so that each person has a greater understanding of the experience of the other, and what was unspeakable becomes tolerable to talk about. An evaluation of this intervention has substantiated CPP's effectiveness in decreasing children's behavior problems and trauma-related symptoms. The intervention also decreased mothers' trauma-related symptoms.[6]

Intervention with David and his Mother

David and his mother were seen together by a mental health clinician for 6 months. In the beginning, his mother had difficulty talking about what had happened. David also avoided all talk or reminders about what he had seen. The issue came up when David saw his mother's scars, and asked

Regional Research Institute for Human Services, Portland State University.
This article and others can be found at www.rtc.pdx.edu. For reprints or permission to reproduce articles at no charge, please contact the publications coordinator at 503.725.4175; fax 503.725.4180 or email rtcpubs@pdx.edu
FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

about the "boo-boos." The therapist had several sessions with David's mother, alone, to talk about what she observed with her son, to discuss her own trauma, and to inquire about the possibility of talking about what had happened with David. His mother felt uncomfortable with this idea. As the therapist explored her resistance, David's mother spoke of her remorse about what her son had witnessed. Once she explored these feelings with the therapist, she felt more able to talk about the incident with her son. The therapist facilitated this discussion with the use of puppets and dolls to act out what David had seen. As David played out his memories of the incident, it became clear that the most upsetting aspect of this event for him was the disappearance of his mother when she was taken to the hospital. David's mother learned important information about how he had perceived the event and she was able to speak directly to him about his fear and anger at her for leaving him. At the conclusion of this intervention, David's symptoms had decreased. Both mother and son had a deeper understanding of how this trauma affected them, and the mother was able to support David in sorting out his confused and frightened feelings.

This case provides an example of the impact of traumatic events for very young children and of the power of developmentally informed interventions that support both children and parents. With support, David's mother was able to respond to David's worries and fears, thereby helping him to feel protected. Both mother and child benefited from this treatment.

Identifying Young Children Affected by Trauma

Perhaps the greatest challenge that lies ahead is to develop systems that can provide early identification of children such as David and link them with appropriate intervention. The research on the adverse effects of early child exposure to violence creates a compelling case for developing more effective identification strategies. There are a variety of screening tools, both formal and informal, to assess for child abuse. However, tools for assessing exposure to domestic violence have not been as well developed, and screening for this type of exposure is not universally done.

Healthcare, early care/education settings, and Head Start are examples of agencies that see large numbers of young children and parents, and they offer important opportunities to screen for early trauma as well as other early childhood mental health risks. Some of these institutions have created tools for screening. For example, as part of the intake assessment at Head Start, families are asked about domestic violence and safety in the home. In pediatric and family healthcare settings, there is also a growing awareness of the importance of early identification of mental health issues in pre-schoolers. Recommendations for inquiring about family violence in pediatric and family health settings have been developed and are widely distributed.[4]

A greater capacity to identify young children who are affected by trauma must be met with greater resources for intervention. The first step toward increasing programmatic resources is to raise public awareness of the risks of trauma exposure for young children and the importance of investing in their early lives. We owe our youngest children this effort.

References

1 Davidson, J., & Smith, R. (1990). Traumatic experiences in psychiatric outpatients. *Journal of Traumatic Stress Studies, 3*, 459-475.

2 Fantuzzo, J., Boruch, R., & Beriama, C. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 116-122.

3 Groves, B. (2002). *Children who see too much: Lessons from the Child Witness to Violence Project.* Boston: Beacon Press.

4 Groves, B., Augustyn, M., Lee, D., & Sawires, P. (2002). *Consensus recommendations for pediatric and adolescent health settings.* San Francisco: Family Violence Prevention Fund.

5 Lieberman, A., & Van Horn, P. (2005). *Don't hit my mommy! A manual for child-parent psychotherapy with young witnesses of family violence.* Washington, DC: Zero to Three Press.

6 Lieberman, A. F., Van Horn, P., & Ghosh-Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44,* 1241-1248.

7 McDonald, R., Jouriles, E., Ramisetty-Mikler, S., Caetano, R., & Green, C. (2006). Estimating the number of American children living in partner violent households. *Journal of Family Psychology, 30,* 137-142.

8 National Scientific Council on the Developing Child. (2005). *Excessive stress disrupts the architecture of the brain.* Working Paper #3. www.developingchild.net/reports.shtml.

9 Palusci, V. J., Smith, E. G., & Paneth, N. (2005). Predicting and responding to physical abuse in young children using NCANDS. *Children and Youth Services Review, 27,* 667-682.

10 Scheeringa, M. S., & Zeanah, C. H. (1995). Symptom expression and trauma variables in children under 48 months of age. *Infant Mental Health Journal, 16,* 259-269.

Author

Betsy McAlister Groves is Director of the Child Witness to Violence Project at Boston Medical Center.

The Early Trauma Treatment Network (ETTN) operates under the auspices of the National Child Traumatic Stress Network, funded by the US Substance Abuse and Mental Health Services Administration. The agencies in the ETTN include the Child Trauma Research Project at the University of San Francisco Medical Center; the Child Witness to Violence Project at Boston Medical Center; the Child Violence Intervention Program at Louisiana State University Health Sciences Center, and the Infant Team at Jefferson Parish Human Services Authority/ Tulane University.