

# Young Children and Trauma: Research and Clinical Perspectives on Assessment

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NCTSN

The National Child  
Traumatic Stress Network

# Early Trauma Treatment Network National Child Traumatic Stress Network

## Mission

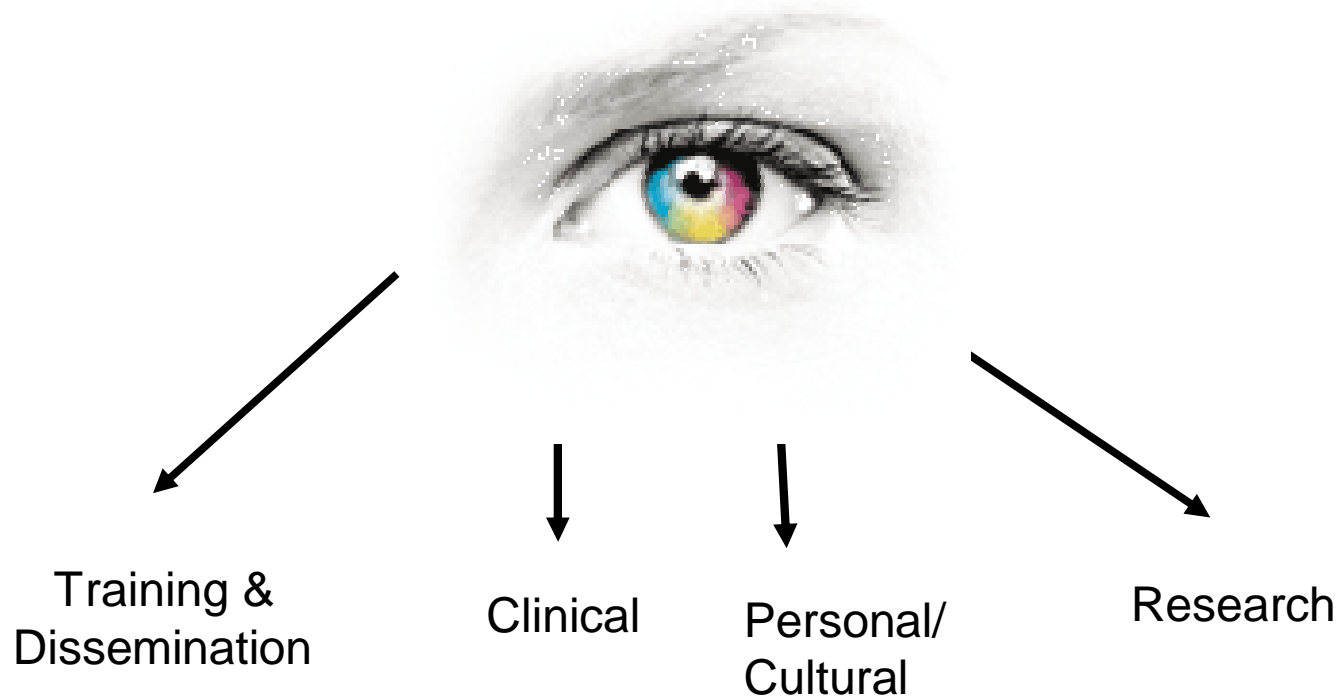
To raise the standard of care and improve access to services for traumatized children aged 0-5, their families, and communities throughout the United States.

[nctsn.org](http://nctsn.org)

# NCTSN Measure Review Database

- [Nctsn.org/measures](https://nctsn.org/measures)
- Searchable database containing reviews of measures important to the field of child traumatic stress
- All measures reviewed using a uniform assessment template and a standardized procedure
- It's free

# My Perspective



NCTSN

The National Child  
Traumatic Stress Network



# Michael's Story



# Overview

- Prevalence of early childhood trauma (need for assessment)
- Domains of assessment
- Assessment tools
- Challenges
- Ways to manage challenges



# Is Michael's Story Unique? Prevalence of Early Childhood Trauma

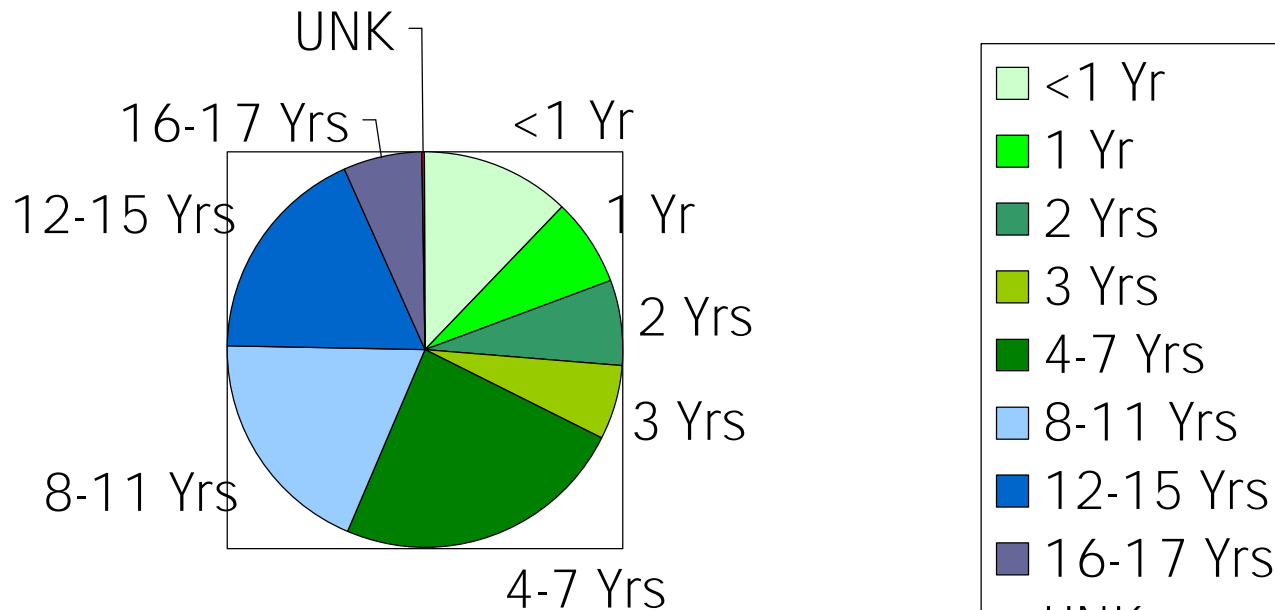


# Domestic Violence Exposure

- 15.5 million children live in families with partner violence (McDonald, Jouriles, Ramisetty-Mikler, Caetano & Green, 2006)
- Police reports of domestic violence show children under age 5 are more likely to be exposed (Fantuzzo & Fusco, 2007)
- Minnesota Parent-Child Project, 25 year longitudinal study of mothers and children in poverty: 12% of mothers reported mild partner violence, 25% reported severe partner violence when children were 18-64 months old (Yates, Dodds, Sroufe, & Egeland, 2003)

# Maltreatment Exposure

- 2008: 3.7 million children received a CPS investigation
- 772,000 considered victims of maltreatment.
- 32.6% age 3 or younger
- 56.2% under age 7
- 78% of child fatalities younger than age 3; 90% younger than 7



Child Maltreatment 2008, US Dept of Health and Human Services

<http://www.acf.hhs.gov/programs/cb/pubs/cm08/cm08.pdf>

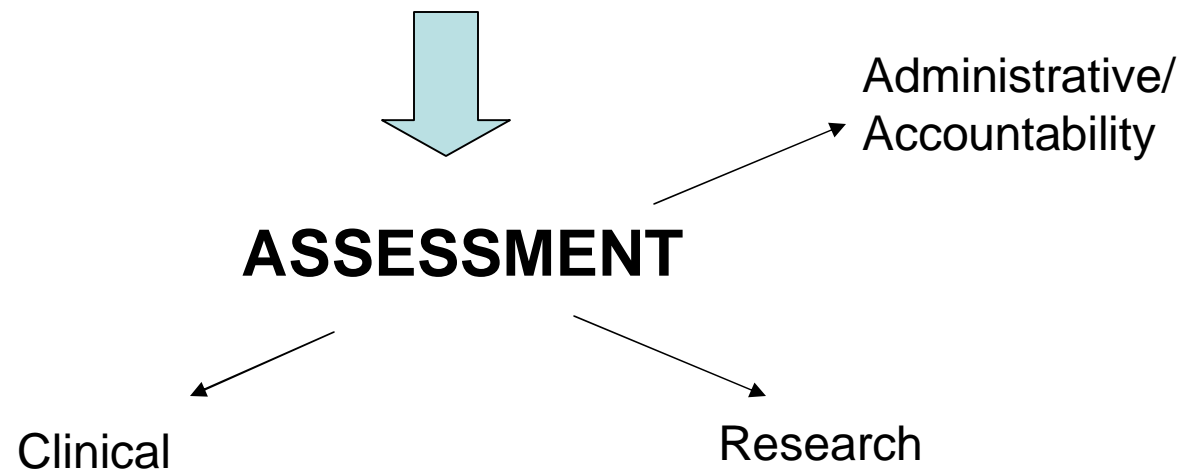
<http://www.childwelfare.gov/pubs/factsheets/fatality.pdf>

# Community Violence Exposure

- Boston non-referred pediatric sample of 3-5 year old children (Linares et al., 2001).
  - 42% had seen at least one violent event
  - 21% experienced 3+ violent events
  - 12% witnessed 8+ events
- Washington, DC Head Start: 67% of parents and 78% of children reported child had witnessed or been victim to at least one incidence of violence (Shanifar, Fox, & Leavitt, 2000)
- Boston urban pediatric setting: 1 in 10 children had witnessed a knifing or shooting by age 6 (Taylor et al, 1995)

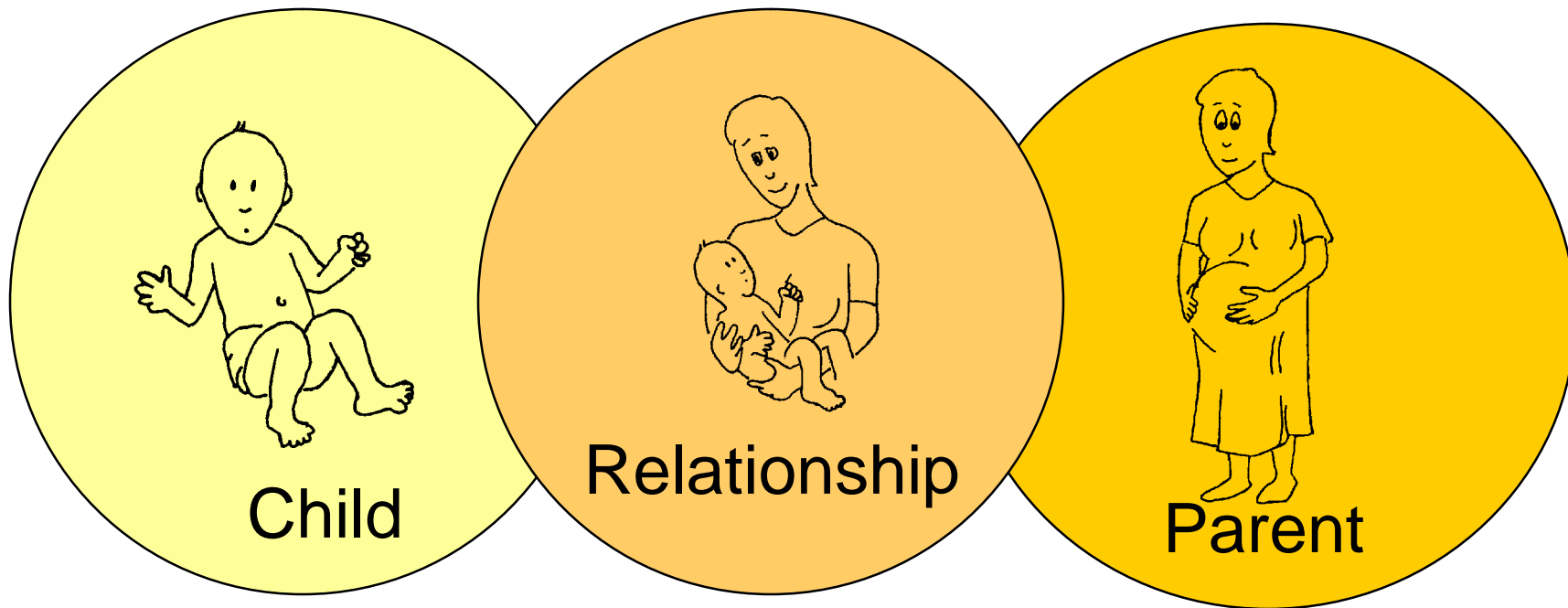
## Where do we go from here?

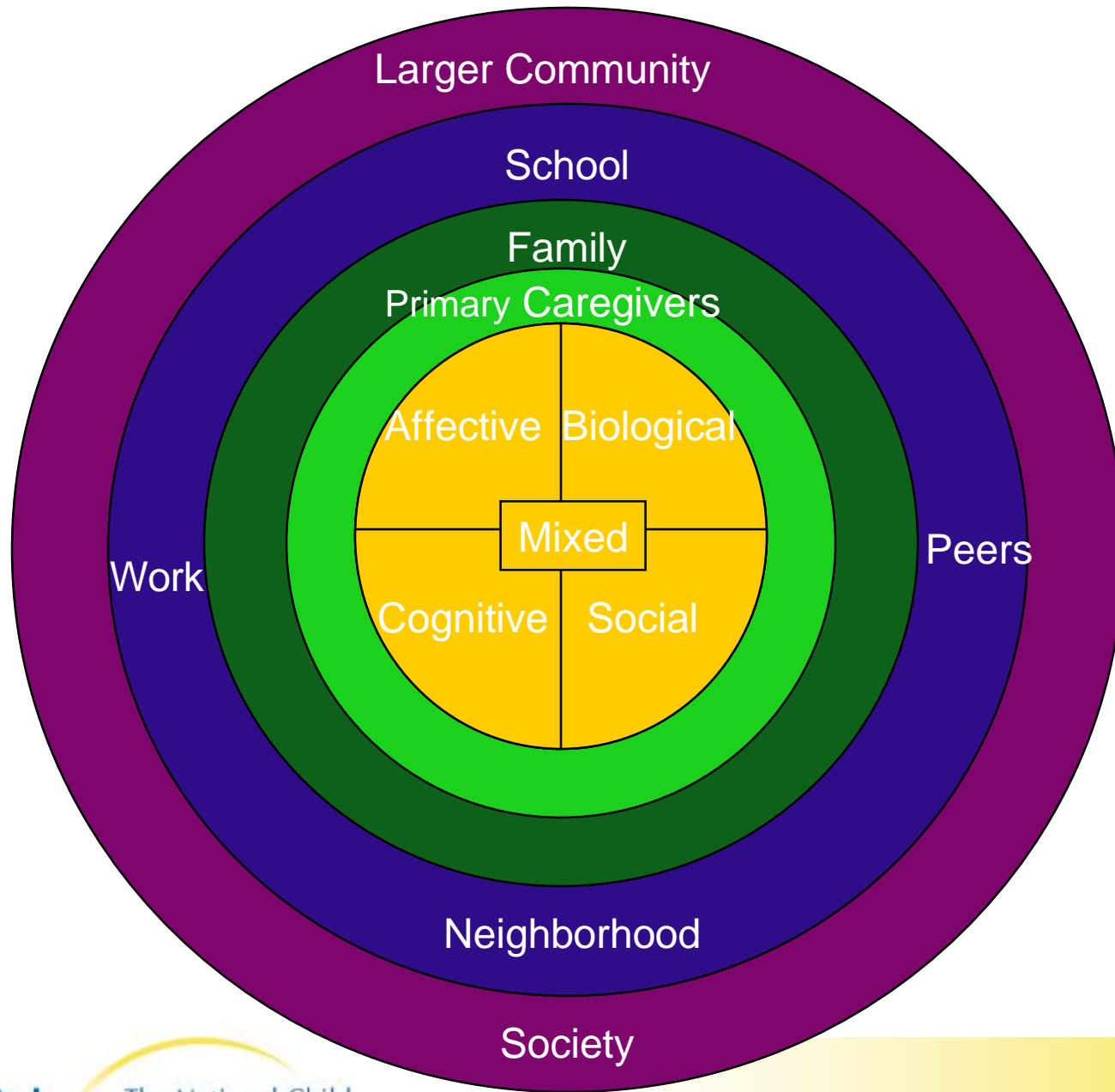
- Trauma/violence is an epidemic
- Young children are often victims in this epidemic
- We need to address this problem
- To address it we need to understand it



# The Assessment Context







# Treatment Outcome Framework

- Primary Risk Factors (trauma history)
- Pre-existing Mediators and Moderators (Risk and Protective Factors)
- Mediators targeted during treatment (1er Change Agents)
- Outcome Variables



# Sample Domains

- Trauma Exposure
- Symptomatology (PTSD, depression, anxiety, behavior problems)
- Developmental Functioning
- Affect Regulation
- Basic Demographics
- Quality of the Child-Caregiver Relationship
- Risk and Protective Factors

## Treatment Outcome Framework: Key Domains

Level of Influence	1er Risk Factors	Risk/Protective Factors	1er Change Agents	Outcomes
Child Intrinsic	Trauma Hx.	Affect Regulation Demographics	→	Symptoms
Primary Caregiver	Trauma Hx.	Affect Regulation P-C Relationship Demographics	→ →	Symptoms
School/Peers Neighborhood				
Society				

# Experience of Trauma

- Type of events
- Age at trauma
- Severity of trauma
- Acute or chronic/multiple instances of trauma
- Relationship of victim to perpetrator
- Appraisal of danger
- Trauma reminders
- Protective factors

## Clinical Focus

How does the caregiver talk about the experience?

- Does the caregiver feel the child remembers what happened?
- What is the caregiver's affect like?

# Symptoms

- PTSD symptoms (DC: 0-3) – thinking about how the context of development affects the expression of symptoms
- Comorbid symptoms
  - Oppositional defiant disorder
  - Separation anxiety disorder
  - ADHD
  - Depression
  - Anxiety



## Clinical Focus

- Why does the caregiver think the child has these symptoms?
- What is the caregivers' response to these symptoms?

# Relationship

Examples of traditional constructs

- Warmth
- Responsiveness
- Affect (anger, frustration)
- Limit setting
- Level of stress in relationship

# Relationship

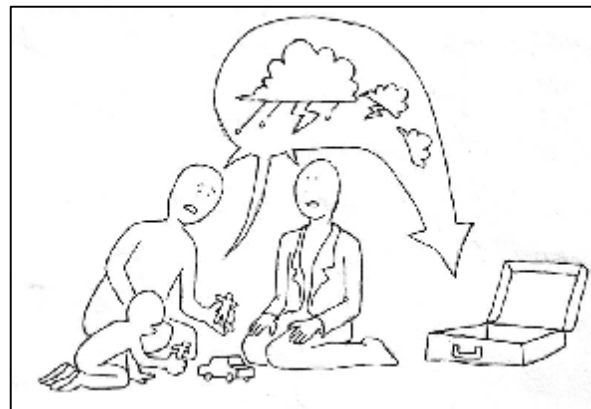
Examples of newer, clinically based constructs



Caregiver as protective shield



Dyadic affect regulation



Ability to jointly make meaning about what happened

# Trauma History

## Child

- Traumatic Events Screening Inventory Parent Report Revised (TESI-PRR; Ghosh Ippen et al., 2002)

## Parent

- Life Stressors Checklist Revised (LSC-R; Wolfe & Kimerling, 1997)  
<http://www.ptsd.va.gov/professional/pages/assessments/lsc-r.asp>

# Functioning: Child

## PTSD

- Trauma Symptom Checklist for Young Children (TSCYC; age 3-12)
- Posttraumatic Stress Disorder Semi-Structured Interview (PTSDSSI; age 0-7; [http://nctsn.org/nccts/nav.do?pid=msr\\_detail&id=34](http://nctsn.org/nccts/nav.do?pid=msr_detail&id=34))
- MacArthur Story Stem Battery (MSSB; Emde, Wolfe, & Oppenheim, 2003)

## Behavior Problems

- Child Behavior Checklist (1.5-5)
- Infant Toddler Social-Emotional Questionnaire (ITSEA; 12-36 months)
- Devereaux Early Childhood Assessment-Clinical (DECA-C; age 2-5)
- Behavior Assessment Scale for Children-2 (BASC-2; age 2-5, 6-11, 12-21)
- Strengths and Difficulties Questionnaire (SDQ; 3-16)

# Relationships

- Parenting Stress Index – Short Form (Abidin, 1995)
- Crowell parent-child interaction procedure



# Challenges: Inaccurate Responding

- Engagement-Rapport-Safety-Validity
  - Can I trust you enough to talk about trauma?
  - Why am I seeing you – mandated?
  - This is my personal business
  - Is this something we talk to outsiders about?
  - Some of these items are offensive
- Caregiver with reduced capacity to see child's perspective (reflective functioning)
- Caregivers are the reporters
  - Multiple traumas
  - Multiple stressors
  - Charged affect
  - Lower education (sometimes)  
*Does s/he have intrusive memories of the trauma?*
  - Language-related issues



Affect validity

# Managing: Inaccurate Responding

- Validity scales
- Have clinicians code for it using a validity scale

0 no problems

1 minor over reporting

2 serious over reporting

-1 minor underreporting

-2 serious underreporting

V1: Inability to understand

V2: Misrepresentation

V3: Misperception/denial

## Challenges: Burden

- These questionnaires and interviews are long?
- They're not fun
- They repeat – A LOT (internal consistency versus threat to validity from burden)
- Caregivers may have trauma symptoms
  - There's a lot going on in my life that I need help with. Do I have time to do all this?
  - Trauma interferes with memory and concentration
  - Avoidance is a core aspect of PTSD, how does this affect my feelings about assessment?

# Managing Burden

In the future, we need to think about . . .

- Managing need for internal consistency with need for efficiency.
- Gating questions versus asking all questions
- Organizing items the way people think not according to diagnostic criteria
- Wording items colloquially (not taken directly from DSM)
- Thinking creatively about assessment – using manipulative, images)
- Ensuring that when we do research assessments, we think about clinical processes that affect their validity

# Developmental Challenges

- How do adults perceive young children and their behavior given their age, culture, context?
- Measures may not cut across the age range you need – need different measures for different developmental stages
- As the child develops, their capacity to process what happened and to communicate distress changes. How does this affect research?
- How do babies show distress? Toddlers? They will not meet criteria. Should they get treatment?
  - Sleep problems
  - Feeding problems
  - Soothing problems
  - Attachment problems

# Training and Dissemination Challenges

We do research so that it can affect clinical practice, but can and do clinicians use our assessment tools?

- Trauma screeners - structure for assessing trauma history
  - Give you the words to say
  - More procedural (this is what we do with everyone)
  - Allow for consistency in how trauma history is assessed and may wording that provides a more valid response
    - Have you experienced domestic violence vs. have you ever been hit, pushed, punched, or shoved

BUT

- Many clinicians are not comfortable talking about trauma
  - Reporting issues
  - Concern about how caregiver will feel
  - Worry about retraumatizing caregivers and children
  - Uncertainty about how to do this (competence)
  - There are too many tools to choose from (overwhelmed)
- Research instruments are often not clinically friendly
- If you find trauma (and this is likely), then what. . . . .

# Summary

- Trauma is an epidemic that affects young children
- We need to address this epidemic
- As we do this, we will need useful assessment tools
  - Measures, track, and dialogue about trauma exposure, functioning, risks, and strengths
- Our current tools need refinement (but when we refine, we will need to do research)
- We also need new tools (that need to be researched)
- We need tools that are informed by clinical practice and that think about the needs of clinicians and families along with the needs of research

Contextually informed scientist-practitioner assessment tools