Frequently Asked Questions (FAQs) on Complex Trauma in Infancy and Early Childhood

1. What is complex trauma and what is its impact in infancy and early childhood?

   A distinguishing feature of complex trauma is the exposure to multiple or recurring events over a period of time and usually in the context of a specific interpersonal relationship. It is often associated with severe and complex reactions and multiple diagnoses. There is currently no specific diagnostic code in the Diagnostic and Statistical Manual of Mental Disorders (DSM) for complex trauma; however, a child experiencing complex trauma may have multiple DSM diagnoses. For a child presenting with multiple diagnostic conditions, it would be important to determine if there is an underlying complex trauma that requires treatment, rather than treating each separate diagnostic condition independently. Complex trauma may have a serious and disabling impact on many dimensions of a child's functioning, including: attachments and relationships, emotional responses, dissociation, behavioral and cognitive responses, impairments in self-concept and future orientation, and long-term physical health consequences.

   Early identification and intervention are of critical importance in complex trauma since efforts to prevent the number of exposures and thus reduce the impact of complex trauma need to begin in infancy and early childhood when appropriate. Therefore, effective and validated screening and assessment tools for infants and young children need to be widely used across various sectors such as primary care providers, educational settings, home visitors, child welfare agencies, and mental health providers.

   For more information, please refer to Addendum #1–Research Findings on Impact of Complex Trauma in Infancy and Early Childhood.

2. What are Core Assessment Domains for assessing complex trauma in infancy and early childhood?

   - Child history of trauma exposure and assessment of any ongoing risks to safety
   - Child developmental functioning
   - Child trauma-related symptoms
   - Child behavioral symptoms
   - Quality of the child-caregiver relationship
   - Caregiver functioning
   - Socio-cultural context (e.g. social and community supports)

   For more information, please refer to Addendum #2–Description of Core Assessment Domains for Assessing Complex Trauma in Infancy and Early Childhood.

3. What is the best approach/method for assessing complex trauma in infancy and early childhood?

The gold standard approach for assessing infants and young children includes two essential components: 1) a thorough history consisting of interviews with significant adults in the child's life, as well as a comprehensive review of records (medical, legal, etc.) and 2) direct behavioral observation of the child under a variety of circumstances, including with the caregiver and in alternate settings, or with alternate caregivers (as this provides objective assessment of child, caregiver, and relational functioning). Given that attachment is relationship-specific, observation of the child in interaction with alternate caregivers also provides the evaluator with 1) a point of comparison and 2) critical information about relationship-specific functioning and behaviors that the child may be exhibiting.

4. What is meant by a "thorough" history?

   The child's history should be gathered from multiple sources. Much of the time it will come from a review of any existing records. Interviews with significant adults in the child's life are also helpful but can be problematic, especially when used in isolation from collateral sources, and as such should not be the primary or exclusive method used for gathering information. Interviews with the primary caregiver may not be reliable (particularly if they are the perpetrator or if they actively or passively colluded with the abuser). However, even in these cases, such interviews can provide important information regarding the quality of the relationship and beliefs or projections the caregiver may have regarding the child. Additionally, in combination with direct observation of the child in interaction with the caregiver, it can highlight inconsistencies between the caregiver's perception of the child's personality/behavior and what is directly observed by the evaluator. If the child is in foster care and the caregiver is not available, then symptoms reported by the foster parents can also be helpful; however, the information may be limited particularly if the child has not been with the foster parents for very long and therefore, do not know the child very well. <u>This is why it is important to review all available records *and* do a direct behavioral observation</u>. Additionally, collateral interviews with any available relatives may be helpful in providing historical context for current behaviors. The history should be gathered from social summaries, police reports, court records, medical records, etc. As far as the paper-pencil assessments, the Psychosocial and Environmental Stressor Checklist may be one example that can be useful to assess exposure; however, there may not be an available caregiver familiar enough with the child to complete it. It is a comprehensive list of over 75 traumatic (e.g., physical abuse) or stressful (e.g., multiple changes in caregivers) events that infants and young children may be exposed to.

5. What are some specific methods for assessing infants and young children through direct behavioral observation?

   The caregiver-child relationship is typically best assessed through direct behavioral observation. There are different approaches for observing interactions between the caregiver and child. Common components include: free play, clean-up, problem-solving tasks, and a separation and reunion from the caregiver. The separation-and-reunion component allows the clinician to assess; 1) if and how well the caregiver prepares the

child for the separation, 2) how the child responds to stress and separation, 3) how the caregiver responds to any cues of distress by the child and supports the child on reunion if needed, and 4) how the child receives the caregiver and is comforted upon return. Not all observations include the separation-and-reunion component, which is an important factor to consider when selecting an assessment approach. As behavioral observation in assessing infants and young children for complex trauma is a growing area, there are Infant Mental Health specialists nationwide that are specifically being trained in doing assessments such as the Parent-Child Structured Play Interaction ("the Crowell Procedure"). Accordingly, many child welfare organizations have made a commitment to training clinicians to conduct this type of assessment. Specific parent-child observational approaches are listed in Table 1, under Quality of Caregiver-Child Relationship domain.

6. What is the role of standardized instruments in assessing complex trauma in infants and young children?

   Parent/caregiver reports, as provided on standardized instruments, can supplement the assessment but should not be the primary tool/component, with this population. There is general consensus in the field that caregivers are frequently not adequate reporters with regard to complex trauma for a variety of reasons, including the caregivers' own trauma histories/intergenerational transmission of trauma that may lead them to either normalize certain behaviors or be triggered by behaviors that might be typical given the child's age. Also, given that one of the most persistent and prevalent responses to trauma is avoidance of triggers and reminders, caregivers with trauma histories could be very likely to avoid thinking about the impact of trauma on their child. Thus, specific examples are provided of caregiver report assessment tools that may be useful. However, as stated previously, these should be used to supplement the information gathered, and should not be used in lieu of a behavioral observation and a full biopsychosocial interview.

7. Are there specific measures used to assess each of the Core Assessment Domains listed in Question 2?

   Yes, see Table 1 below for examples of measures for each domain.

8. What are some universal developmental screening tools for infants and young children that can be used to help identify concerns early on and target for early intervention?

   In addition to the measures described under Child Developmental Functioning domain (Table 1), there are universal developmental screening tools for young children that can be used during primary care visits and in educational settings to help identify concerns before they become problems and to open the door to early intervention. The following screening tools are high on accuracy and cultural relevancy and low on cost and time. Most importantly, they help providers, parents, and caregivers to communicate about the child's well-being and to support providers' efforts to adhere to the American Academy of Pediatrics' recommendations to screen children at the age of 9 months, 18 months and 30 months, as well as during the preschool years. The following tools cover multiple

domains of development including: communication, gross/fine motor, cognitive, social-emotional, self-help, social communication and behavior:

1) *PEDS (Parent's Evaluation of Developmental Status):* 10-item questionnaire completed by a parent and requires 2-10 minutes to complete.
2) *PEDS: DM (PEDS: Developmental Milestones):* 8-item questionnaire completed by a parent and requires 3-5 minutes to complete.
3) *ASQ: 3 (Ages and Stages Questionnaire-3):* 30-item questionnaire completed by a parent and requires 10-15 minutes to complete (ages 4-60 months).
4) *ASQ: SE (Ages and Stages Questionnaire –Social Emotional):* 22-item questionnaire completed by a parent and requires 8-10 minutes to complete. The kit offers targeted developmental guidance to support social emotional growth (ages 6-60 months).

Table 1. Core Assessment Domains for Assessing Complex Trauma in Infancy and Early Childhood

Core Assessment Domain	Name of Measure	Respondent	Targeted Age	Format
Child History of Trauma Exposure and Assessment of Any Ongoing Risks to Safety	*Child Trust Events Survey (CTES)*	Caregiver	0-8 years	26 items
	Traumatic Events Screening Inventory Parent Report Revised (TESI-PRR; Ghosh Ippen et al., 2002)	Parent	Typically for 0-6; but no upper age limit	24 items
	Young Child PTSD Checklist (YCPC; Scheeringa, 2013)	Caregiver	1-6 years	12 items trauma screen 29 additional items for trauma-related symptoms
Child Developmental Functioning	*Bayley Scales of Infant Development (BSI-III: Black & Matula, 1999)*	Professionals with advanced degrees with Caregiver report	1-42 months	
	Mullen Scales of Early Learning (MSEL; Mullen, 1995)	Professionals with Bachelor's degrees	0-5 years 8 months	
	Infant-Toddler Developmental Assessment (IDA; Provence, Erikson, Vater, & Palmeri, 1995)	Multidisciplinary team with caregiver report	0-3 years	
Child Trauma-Related Symptoms	*Young Child PTSD Screen (Scheeringa, 2010)*	Parent	0-5 years	6 items
	Young Child PTSD Checklist (YCPC; Scheeringa, 2013)	Caregiver	1-6 years	12 items trauma screen 29 additional items for trauma-related symptoms

	Pediatric Emotional Distress Scale (Saylor, 2002)	Caregiver	2-10 years	21 items
Child Behavioral Symptoms	*The Survey of Wellbeing of Young Children (SWYC)*	Parent	0-5 years	Varies for each age-specific form but about 40 items for each
	The Early Childhood Screening Assessment (Gleason et al., 2010)	Caregiver	18-60 months	40 items
	Infant-Toddler Social and Emotional Assessment (ITSEA; Carter & Briggs-Gowan, 2000)	Parent	12-36 months	166 items
	NICHQ Vanderbilt Assessment Scales (NICHQ)	Teacher Parent		22 items for teachers 55 items for parents
Quality of the Child-Caregiver Relationship	*Parent-Child Structured Play Interaction ("Crowell Procedure")*	Clinician's Observation of caregiver / child interaction	Typically 12-60 months but even younger as long as they can sit up independently	8 episodes of interactions: free play, clean-up, bubble blowing, 4 problem-solving tasks, separation / reunion episode
	The Massie-Campbell Attachment During Stress Scale (ADS)	One-page guide to clinician's structured observation	0-18 months	Infant / mother interactions to observe insecure attachment behaviors
	The NCAST Parent-Child Interaction Scales (PCI)	Certified NCAST instructor	0-36 months	Caregiver / child interaction on feeding (0-12 months) or teaching (0-36 months)
	The Parenting Stress Index, Fourth Edition (PSI-4) and the Parenting Stress Index, Fourth Edition Short Form (PSI-4-SF)	Parent self-report	0-12 years	120 items
	The "Still Face Paradigm"	Mostly Researchers and some clinicians		Experimental procedure to assess quality of caregiver-child relationship
Caregiver Functioning	*Center for Epidemiologic Studies: Depression Scale (CES-D; Radloff, 1977)*	Caregiver self-report	N/A	20 items
	MDE Screener (Muñoz, 1998)	Caregiver self-report	N/A	18 items

	PTSD Symptom Scale Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993)	Semi-structured interview of caregiver	N/A	17 items
Socio-cultural Context	It is important to have a comprehensive understanding of the environment in which a child experienced the trauma, as well as the child's current environment. While there is no specific measure being recommended for this domain, the culture/race/ethnicity of the child and family being assessed should be considered in the selection of assessment tools and interventions. Please refer to the website below for more information on the use of trauma-informed interventions with diverse cultural groups: http://www.nctsnet.org/nctsn_assets/pdfs/CCG_Book.pdf			