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Review Article

IDENTIFYING AND HEALING CHILDHOOD TRAUMA

Prerna Singh* and Anu Dandona

AIBAS, Amity University Lucknow

A R T I C L E I N F O

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A B S T R A C T

As children and adolescents grow up, they continually learn about different types of problems. However, terrible things sometimes happen within and outside the family. They can happen suddenly without warning. Children may experience different types of traumas during their stages of development. Some traumas, such as child abuse or witnessing domestic violence, may happen repeatedly over a long period of time. Dangers can become "traumatic" when they threaten serious injury or death. In traumatic situations, we experience immediate threat to ourselves or to others, often followed by serious injury or harm. These powerful, distressing emotions go along with strong, even frightening physical reactions. Experiencing a prior traumatic event does not toughen up a child. Instead, the effects can add up, with each successive experience leading to more severe and chronic posttraumatic stress reactions and other developmental consequences. In fact, a child who has suffered from prior traumatic experiences may be apt to have more intense reactions to another trauma. Experiencing any type of trauma will inevitably leave a lasting impact on a person's life. When children experience a traumatic event, it can impact various stages of their development. Because of their young age and lack of life experience, children often do not possess the appropriate coping skills needed to deal with trauma in a healthy way. For this reason, receiving treatment can be extremely beneficial in helping youth overcome the symptoms that may arise as a result of traumatic experiences. The present paper deals with identifying and healing childhood trauma.

INTRODUCTION

Trauma is often the result of an overwhelming amount of stress that exceeds one's ability to cope, or integrate the emotions involved with that experience. A traumatic event involves one's experience, or repeating events of being overwhelmed that can be precipitated in weeks, years, or even decades as the person struggles to cope with the immediate circumstances, eventually leading to serious, long-term negative consequences.

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."

Corresponding author:* **Prerna Singh
AIBAS, Amity University Lucknow

However, young children are affected by traumatic events, even though they may not understand what happened.

Child may experience trauma as a result of a number of different circumstances, such as:

- Abuse, including sexual, physical, emotional
- Exposure to domestic violence
- Severe natural disaster, such as flood, fire, earthquake or tornado
- War or other military actions
- Abandonment
- Witness to violence in the neighborhood or school setting, including fights, drive by shootings, and law enforcement actions
- Personal attack by another person or an animal
- Kidnapping
- Severe bullying
- Medical procedure, surgery, accident or serious illness

Psychological trauma may occur during a single traumatic event or as a result of repeated exposure to overwhelming stress (Terr, 1992). In addition, the failure of caregivers to sufficiently protect a child may be experienced as betrayal and further contribute to the adversity of the experience and effects of trauma.

In the United States alone from 1996 to 1998 there were more than 5 million children exposed to some form of severe traumatic event such as physical abuse, domestic and community violence, motor vehicle accidents, chronic painful medical procedures and natural disasters. These experiences can have a devastating impact on children.

Beginning with Lenore Terr's landmark work, investigators over the last twenty years have determined that more than thirty percent of children exposed to these kinds of traumatic events will develop serious and chronic neuropsychiatric problems. The most common are Post-Traumatic Stress Disorders (PTSD).

Terr (2003) distinguishes four characteristics that are common to most cases of childhood trauma. These are (a) strongly visualized or repeatedly perceived memories, (b) repetitive behaviors, (c) trauma specific fears, and (d) changed attitudes about people, life, and future. Children are exposed to various forms of traumatic stress i.e.Community Violence, Complex Trauma, Domestic Violence, Medical Trauma, Natural Disasters, Neglect, Physical abuse, Refugee Trauma, School Violence, Sexual Abuse, Terrorism, and Traumatic Grief.

Symptoms and Behaviours 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 in sleeping, lose recently acquired developmental skills, and show regression in functioning and behaviour.

Children often re-experience traumas. Triggers may remind children of the traumatic event and a preoccupation may develop (Lieberman & Knorr, 2007). For example, a child may continuously re-enact themes from a traumatic event through play. Nightmares, flashbacks and dissociative episodes also are symptoms of trauma in young children (De Young *et al*., 2011; Scheeringa, Zeanah, Myers, & Putnam, 2003).

Furthermore, young children exposed to traumatic events may avoid conversations, people, objects, places or situations that remind them of the trauma (Coates & Gaensbauer, 2009). They frequently have diminished interest in play or other activities, essentially withdrawing from relationships. Other common symptoms include hyper arousal (e.g., temper tantrums), increased irritability, disturbed sleep, a constant state of alertness, difficulty concentrating, exaggerated startle responses, increased physical aggression and increased activity levels (De Young *et al*., 2011).

Traumatized young children may exhibit changes in eating and sleeping patterns, become easily frustrated, experience increased separation anxiety, or develop enuresis or encopresis, thus losing acquired developmental skills **(**Zindler, Hogan, & Graham, 2010). There is evidence that traumas can prevent children from reaching developmental milestones and lead to poor academic performance (Lieberman & Knorr, 2007).

If sexual trauma is experienced, a child may exhibit sexualized behaviors inappropriate for his or her age (Goodman, Miller, & West-Olatunji, 2012; Pynoos *et al*., 2009; Scheeringa *et al*., 2003; Zero to Three, 2005).

The symptoms that young children experience as a result of exposure to a traumatic event are common to many other childhood issues. Many symptoms of trauma exposure can be attributed to depression, separation anxiety, attention-deficit/hyperactivity disorder, oppositional defiant disorder or other developmental crises. It is important for counselors to consider trauma as a potential cause of symptomology among young children.

Effects of Psychological Trauma on Child

Severe psychological trauma causes impairment of the neuroendocrine systems in the body. Extreme stress triggers the fight or flight survival response, which activates the sympathetic and suppresses the parasympathetic nervous system fight or flight responses increase cortisol level in the central nervous system, which enables the individual to take action to survive (either dissociation, hyper arousal or both), but which at extreme levels can cause alterations in brain development and destruction of brain cells.

Trauma affects basic regulatory processes in the brain stem, the limbic brain (emotion, memory, regulation of arousal and affect), the neocortex (perception of self and the world) as well as integrative functioning across various systems in the central nervous system. Traumatic experiences are stored in the child's body/mind, and fear, arousal and dissociation associated with the original trauma may continue after the threat of danger and arousal has subsided.

Development of the capacity to regulate affect may be undermined or disrupted by trauma, and children exposed to acute or chronic trauma may show symptoms of mood swings, impulsivity, emotional irritability, anger and aggression, anxiety, depression and dissociation. Early trauma, particularly trauma at the hands of a caregiver, can markedly alter a child's perception of self, trust in others and perception of the world. Children who experience severe early trauma often develop a foreshortened sense of the future. They come to expect that life will be dangerous, that they may not survive, and as a result, they give up hope and expectations for themselves that reach into the future (Terr, 1992).

Among the most devastating effects of early trauma is the disruption of the child's individuation and differentiation of a separate sense of self. Survival becomes the focus of the child's interactions and activities and adapting to the demands of their environment takes priority. Traumatized children lose themselves in the process of coping with ongoing threats to their survival; they cannot afford to trust, relax or fully explore their own feelings, ideas or interests.young trauma victims often come to believe there is something inherently wrong with them, that they are at fault, unlovable, hateful, helpless and unworthy of protection and love. Such feelings lead to poor self-image, self-abandonment and self-destructiveness. Ultimately, these feelings may create a victim state of body-mind-spirit that leaves the child vulnerable to subsequent trauma and re-victimization.

The lack or loss of self-regulation is possibly the most far-reaching effect of psychological trauma in both children and adults. The younger the age at which the trauma occurred, and the longer its duration, the more likely people were to have long-term problems with the regulation of anger, anxiety and sexual impulses (Van der Kolk, Roth, Pelcovitz & Mandel, 1993).

In additions, children exposed to trauma have been shown consistently to have increased vulnerability to infections, including the common cold virus, respiratory infections, hepatitis B, Herpes simplex and cytomegalovirus.

Exposure to extreme traumatic stress affects people at many levels of functioning: somatic, emotional, cognitive, behavioral, and characterological. Childhood trauma sets the stage for variety psychiatric disorders such as borderline personality disorder, dissociative disorders, self-mutilation, eating disorders and substance abuse.

Trauma leads to a variety of problems with the regulation of affective states, such as anger, anxiety, and sexuality. Extreme arousal is accompanied by dissociation and the loss of capacity to put feelings into words. Failure to establish a sense of safety and security leads to characterological adaptations that include problems with self-efficacy, shame self-hatred, as well as problems in working through interpersonal conflicts. Such problems are expressed either in excessive dependence or social isolation, lack of trust, and a failure to establish mutually satisfying relationships (van der Kolk, *et al*., 1996).
Traumatic experiences are inherently complex. Every traumatic event is made up of different traumatic moments. Trauma-exposed children experience subjective reactions to these different moments that include changes in feelings, thoughts, and physiological responses; and concerns for the safety of others.

Children may consider a range of possible protective actions during different moments, not all of which they can or do act on. Children's thoughts and actions during various moments may lead to feelings of conflict at the time, and to feelings of confusion, guilt, regret, or anger afterwards. Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances. Childhood trauma occurs within the broad ecology of a child's life that is composed of both child-intrinsic and child-extrinsic factors. Child-intrinsic factors include temperament, prior exposure to trauma, and prior history of psychopathology. Child-extrinsic factors include the surrounding physical, familiar, community, and cultural environments. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.

Traumatic experiences affect the family and broader care giving systems. Children are embedded within broader care giving systems including their families, schools, and communities. Traumatic experiences, losses, and ongoing danger can significantly impact these care giving systems, leading to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers' own distress and concerns may impair their ability to support traumatized children. In turn, children's reduced sense of protection and security may interfere with their ability to respond positively to their parents' and other caregivers' efforts to provide support. Assessing and enhancing the level of functioning of caregivers and care giving systems are essential to effective intervention with traumatized youths, families, and communities.

Culture is closely interwoven with traumatic experiences, response, and recovery. Culture can profoundly affect the meaning that a child or family attributes to specific types of traumatic events such as sexual abuse, physical abuse, and suicide. Culture may also powerfully influence the ways in which children and their families respond to traumatic events including the ways in which they experience and express distress, disclose personal information to others, exchange support, and seek help.

Importance of Early Identification and Early Intervention

"It is well established that significant trauma disrupts normal development in ways that are detrimental to many areas of adult functioning and often leads to costly emotional and physical problems that could be avoided or minimized by much earlier intervention"(Harris, *et al*.,2006). Fundamental to primary prevention efforts is the provision of safe, nurturing relationships for all children. Secondary prevention requires early identification of young children and youth who are exposed to traumatic events and timely potent intervention to create or re-establish safety and self-regulation and to promote optimal development for each individual.

Screening has played a critical role in public health administration and has become a routine standard part of health care in this and other countries. The cost of screening is justified when the incidence of a health problem is high, when the costs of its occurrence are great and when prevention or remediation is possible.

More cost effective would be screening for vulnerable groups of children who are known to have high rates of trauma.

Early detection may be accomplished by screening for symptoms of trauma in children and families as a part of regular, routine pediatric care, early prevention, screening, diagnosis and treatment, emergency medical care, child protection and juvenile corrections intake.

Early intervention and treatment can minimize the social and emotional impact of a child's exposure to a traumatic event. Professional counselors should consider making referrals to counselors trained in providing early childhood mental health support. If the professional counselor has difficulties finding a referral source, the counselor's basic counseling skills can provide the foundation for a safe, secure and trusting relationship between the counselor, family and child. Demonstrating empathy, genuine care and acceptance also fosters rapport among stakeholders (Corey, 2009). Mental health counselors can emphasize strengths and resources for the child and family.

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.

People are usually surprised that reactions to trauma can last longer than they expected. It may take weeks, months, and in some cases, many years to fully regain equilibrium. Many people will get through this period with the help and support of family and friends. But sometimes friends and family may push people to 'get over it' before they're ready. They should know that such responses are not helpful for them right now.

People who fully engage in recovery from trauma discover unexpected benefits. As they gradually heal their wounds, survivors find that they are also developing inner strength, compassion for others, increasing self-awareness, and often the

most surprising- a greater ability to experience joy and serenity than ever before.

Many people find that individual, group, or family counseling is helpful, and in particular, EMDR (Eye Movement Desensitization and Reprocessing) is a phenomenally rapid and wonderful therapeutic method. Another superior therapeutic method is IFS (Internal Family Systems). Either way, the key-word is CONNECTION- asks for help, support, understanding, and opportunities to talk

Listed below are some of the treatments that have been developed and evaluated for young children, each of which has significant support for efficacy.

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) for Preschoolers

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, mal-adaptive 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 (Chalk and King, 1998; Kolko and Swenson, 2002).

Child-Parent Psychotherapy (CPP)

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 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.

Trauma focused Cognitive Behavioral Therapy (TF-CBT)

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 post-traumatic symptoms as a result of sexual abuse.

Treatment generally consists of twelve treatment sessions. Maltreated children and their non-abusing family members learn stress-management skills; and they practice these techniques during graduated exposure to abuse-constructed trauma. The parents/caregivers learn how to address their own emotional reactions. Several joint parent/caregiver-child sessions are also 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.

Skills for Psychological Recovery (SPR)

The *Skills for Psychological Recovery* (SPR) manual, formally completed in 2010, was designed to be an evidence-informed intervention that is intended to foster short- and long-term adaptive coping in disaster survivors who are exhibiting moderate levels of distress, by offering simplified, brief application of skills that are commonly related to improved recovery in post-disaster/emergency settings. These skills include problem solving, positive activity scheduling, managing reactions, helpful thinking, and building healthy social connections. SPR is intended to help survivors identify their most pressing current needs and concerns and teach and support them as they develop skills to address those needs. Each skill can be covered in one helping contact, and then reinforced in continuingcontacts. The actions all include task assignments to practice the skills learned.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

CBITS is an ideal trauma intervention for underserved ethnic minority students who frequently do not receive services due to a whole host of barriers to traditional mental health services. This school-based program is designed to be delivered in school settings, whether it is in an urban or mid western public school serving a diverse student body or a religious private school providing outreach to an immigrant community. CBITS has been successfully used in a wide variety of communities because it can be flexibly implemented and addresses barriers such as transportation, language, and stigma. In addition, CBITS has also addressed the barrier of parent and family involvement that can be so common in many communities. CBITS is appropriate for a wide range of traumas including: physical abuse, disasters, accidents, witnessing death, assault, war, terrorism, and immigration related trauma, and traumatic loss.

Child and Family Traumatic Stress Intervention

CFTSI focuses on two key risk factors (poor social or familial support, and poor coping skills in the aftermath of potentially traumatic events) with the primary goal of preventing the development of PTSD. CFTSI seeks to reduce these risks in two ways: (1) by increasing communication between the affected child and his caregivers about feelings, symptoms, and behaviors, with the aim of increasing the caregivers' support of the child; and (2) by teaching specific behavioral skills to both the caregiver and the child to enhance their ability to cope with traumatic stress reactions.

Combined Parent-Child Cognitive Behavioral Therapy (CPCCBT)

CPC-CBT is a short-term, strength-based therapy program for children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies. These families can include those who have been substantiated for physical abuse, those who have had multiple unsubstantiated referrals, and those who fear they may lose control with their child. Children may present with PTSD symptoms, depression, externalizing behaviors and a host of difficulties that are targeted within CPC-CBT. Goals of CPC-CBT are to help the child heal from the trauma of the physical abuse, empower and motivates parents to modulate their emotions and use effective non-coercive parenting strategies,

and strengthens parent-child relationships while helping families stop the cycle of violence.

Role of Parents and Caregivers in Helping Children who have Experienced Trauma

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

Implications

While the prevention of child abuse is almost universally proclaimed to be an important social policy, surprisingly little work has been done to investigate the effectiveness of preventive measures.

The majority of programmes initiated by the government and Non-Government Organizations focus on victims or perpetrators of child abuse and neglect. Very few emphasize primary prevention approaches aimed at preventing child abuse and neglect from occurring in the first place. The literature provided by the present paper can be used to formulate interventions and measures to identify, prevent and heal childhood trauma. Additionally, awareness can be created among individuals to support any sufferer of childhood trauma.

A number of approaches have been implemented recently which can be used as a reference for further research in the area and also for formulating new interventions to provide relief to victims of trauma.

Family Support Approaches

Training in parenting

A number of interventions for improving parenting practices and providing family support have been developed. These types of programmes generally educate parents on child development and help them improve their skills in managing their children's behaviour. While most of these programmes are intended for use with high-risk families or those families in which abuse has already occurred, it is increasingly considered that providing education and training in this area for all parents or prospective parents can be beneficial. For families in which child abuse has already occurred, the principal aim is to prevent further abuse, as well as other negative outcomes for the child, such as emotional problems or delayed development.

Home visitation and other family support programmes

Home visitation programmes bring community resources to families in their homes. This type of intervention has been identified as one of the most promising for preventing multiple negative outcomes. During such home visits, information, support and other services to improve the functioning of the family are offered.

Intensive family preservation services

This type of service is developed to keep the family together and to prevent children from being placed in substitute care. Targeted towards families in which child maltreatment has been confirmed, the intervention is short and intense, with generally 10-30 hours a week devoted to a particular family.

An example of such a programme in the United States is Homebuilders, an intensive in-home family crisis intervention and education programmes. Families who have one or more children in impending danger of being placed in care are referred to this programme by state workers. Over a period of 4 months, the families receive intensive services from therapists who are on call 24 hours a day.

Health Service Approaches

Screening by health care professionals

Health care professionals have a key part to play in identifying, treating and referring cases of abuse and neglect and in reporting suspected cases of maltreatment to the concerned authorities.

Screening is the identification of a health problem before signs and symptoms appear.

Training for health care professionals

A number of health care organizations have developed training programmes so as to improve both the detection and reporting of abuse and neglect, and the knowledge among health care workers of available community services. In New York, for example, health care professionals are required to take a 2-hour course on identifying and reporting child abuse and neglect as a prerequisite to gain a license.

Therapeutic Approaches

Responses to child abuse and neglect depend on many factors, including the age and developmental level of the child and the presence of environmental stress factors. For this reason, a broad range of therapeutic services have been designed for use with individuals.

Services for victims

Therapeutic day care has been advocated for a range of conditions related to abuse, such as emotional, behavioral or attachment related problems and cognitive or developmental delays. The approach incorporates therapy and specific treatment methods in the course of the child's daily activities at a child care facility.

As with physical abuse, the manifestations of sexual abuse can vary considerably, depending on a number of factors, such as the individual characteristics of the victim, the relationship of

the perpetrator to the victim and the circumstances of the abuse. Eventually, a wide variety of intervention approaches and treatment methods have been adopted to treat child victims of sexual abuse, including individual, group and family therapy.

Services for children who witness violence

Children who witness violence may exhibit a range of symptoms, including behavioral, emotional or social problems and delays in cognitive or physical development. Given this inconsistency, different intervention strategies and treatment methods have been developed, taking into account the developmental age of the child.

Community Based Efforts

Community-based efforts often focus on a selected population group or are implemented in a specific setting, such as in schools. They may also be conducted on a wider scale-over a number of population segments or even the entire community.

School programmes

These programs are generally designed to teach children how to recognize threatening situations and to provide them with skills to protect themselves against abuse. The concepts underlying the programmes are that children own and can control access to their bodies and that there are different types of physical contacts. Children are taught how to tell an adult if they are asked to do something they find uncomfortable.

Prevention and educational campaigns

These programmes stem from the belief that increasing awareness and understanding of the phenomenon among the general population will result in lower level of abuse. This could occur directly-with perpetrators recognizing their own behaviors as abusive and wrong and seeking treatment-or indirectly, with increased recognition and reporting of abuse either by victims or third parties.

Societal Approaches

International treaties

In November 1989, the United Nations General Assembly adopted the Convention on the Rights of the Child. A guiding principle of the Convention is that children are individuals with equal rights to those of adults. Since children are dependent on adults, though, their views are rarely taken into account when governments set out policies. At the same time, children are often the most vulnerable group as regards government-sponsored activities relating to the environment, living conditions, health care and nutrition. The Convention on the Rights of the Child provides clear standards and obligations for all signatory nations for the protection of children.

National Child Traumatic Stress Network (NCTSN)

Established by Congress in 2000, the National Child Traumatic Stress Network 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.

NCTSN Mission*:* To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

NCTSN Vision*:* The NCTSN works to accomplish its mission of serving the nation's traumatized children and their families by-

- Raising public awareness of the scope and serious impact of child traumatic stress on the safety and healthy development of America's children and youth.
- Advancing a broad range of effective services and interventions by creating trauma-informed developmentally and culturally appropriate programs that improve the standard of care.
- Working with established systems of care including the health, mental health, education, law enforcement, child welfare, juvenile justice, and military family service systems to ensure that there is a comprehensive trauma-informed continuum of accessible care.
- Fostering a community dedicated to collaboration within and beyond the NCTSN to ensure that widely shared knowledge and skills become a sustainable national resource.

Clinical experience and research have revealed that many children and adolescents suffering from traumatic stress fail through the cracks never being identified as trauma victims and never receiving treatment or only receiving care years after first experiencing traumatic events. To address this problem, National Child Traumatic Stress Network programmes have developed easy-to-use screening tools that can be implemented by non-mental health professionals in the places where children and youth are found. NCTSN screening tools have been designed for use in schools and pediatrician's offices and by the institutions that come into contact with children in crisis.

Instruments and interventions disseminated by NCTSN reflect a developmental understanding of trauma and the direct toll it takes on a child's life. Effective intervention must not only address the trauma but it must also help a child get back his normal lifestyle and routine and the confidence that he has no reasons anymore to feel stressed.

Transforming Trauma Treatment: Since the launch of the NCTSN

- Hundreds of thousands of children have received effective, culturally sensitive, evidence-based assessment and treatment for child traumatic stress.
- Nearly a million providers have been trained in best practices.
- Family members and consumers have offered valuable input to ensure that treatment addresses the real needs of families and is responsive to their concerns.
- Data from more than 14,000 children treated by the NCTSN have provided an unprecedented portrait of

child trauma in America; this information is used to improve care and shape national child policies.

- Innovative and engaging new learning models, such as the NCTSN Learning Collaborative, ensure that changes in practice take hold and are sustained in service agencies across the country.
- The NCTSN Core Curriculum on Childhood Trauma has identified the most important principles of trauma treatment across theoretical models and disciplines. It has become a model in the field for innovative trauma education.

CONCLUSION

In recent years, many researches have been conducted to provide an understanding as to how trauma impacts infants and children. Researchers, child psychologists and clinicians know that infants and children are capable enough to perceive trauma and also have the capacity to experience post-traumatic stress following any traumatic event. Also, psychologists working with children must consider the residual impacts of traumatic events experienced in early childhood. School-aged children may experience behavioral problems and have difficulty learning and forming relationships as a result of early childhood trauma (Cole, Eisner, Gregory, & Ristuccia, 2013; Cole *et al*., 2005). A number of studies indicate that trauma is a strong predictor of academic failure (Blodgett, 2012). Therefore, school counselors serving as mediators between academics and wellness should explore ways to advocate for and support students with known or suspected exposure to traumatic events in early childhood.

Children and adolescents are building up confidence in the "social contract," a trust that the rules of a family, community, or society are fair and look after the best interests and welfare of its members. After family violence, young children may learn that feelings of love can be betrayed through abuse. If abuse occurs in the larger community, they may conclude that children can be taken advantage of by adults in positions of authority. It is more difficult to teach a school-age child that rules count when no one has been arrested for murdering a parent.

Mental healthcare providers must deal with many personal and professional challenges as they confront details of children's traumatic experiences and life adversities, witness children's and caregivers' distress, and attempt to strengthen children's and families' belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time. Building trauma-informed schools and communities will also aid a great deal (Walkley and Cox, 2013).

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