

# Trauma and Treatment in Early Childhood: A Review of the Historical and Emerging Literature for Counselors



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**Young children are especially susceptible to exposure to trauma. Rates of abuse and neglect among this population are staggering. This article presents a review of relevant literature, including research findings specific to early childhood vulnerability to trauma, symptoms associated with traumatic events, diagnostic validity of early childhood trauma, and treatments for young children. In the past, misconceptions about the mental health of young children have hindered accurate diagnosis and treatment of trauma-related mental illness. Due to the prevalence of trauma exposure in early childhood, counselors are encouraged to become familiar with ways that clients and families are impacted and methods for treatment. Implications for future research also are presented.**

***Keywords:* early childhood, trauma, treatment, mental health, mental illness**

Children from birth to age 5 are at a particularly high risk for exposure to potentially traumatic events due to their dependence on parents and caregivers (Lieberman & Van Horn, 2009; National Child Traumatic Stress Network, 2010). Traumatic events are incidents that involve the threat of bodily injury, death or harm to the physical integrity of self or others and often lead to feelings of terror or helplessness (National Library of Medicine, 2013). The American Psychological Association (APA) Presidential Task Force on Posttraumatic Stress Disorder (PTSD) and Trauma in Children and Adolescents (2008) indicated that traumatic events include suicides and other deaths or losses, domestic or sexual violence, community violence, medical trauma, vehicle accidents, war experiences, and natural and manmade disasters. With more than half of young children experiencing a severe stressor, they are especially susceptible to accidents, physical trauma, abuse and neglect, as well as exposure to domestic or community violence (National Child Traumatic Stress Network, 2010).

Over 20 years ago, Straus & Gelles (1990) estimated that three million couples per year engage in severe in-home violence toward each other in the presence of young children. The Administration on Children, Youth, and Families (2003) reported that in 2001, 85% of abuse fatalities occurred among children younger than 6 years of age, and half of all child victims of maltreatment are younger than 7. More recently, the Child Welfare Information Gateway (2014) indicated that 88% of child abuse and neglect fatalities occurred among children 7 years of age and younger. Often, there is an overlap between domestic violence and child physical and sexual abuse (Osofsky, 2003). In addition to domestic violence, young children also are vulnerable to community violence.

A study conducted by Shahinfar, Fox, and Leavitt (2000) suggested that the majority of young children enrolled in Head Start experienced violence in their communities. Young children also are exposed to traumatic

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stressors such as accidental burns or falls resulting in hospitalization or death (Grossman, 2000). It is common for children to experience more than one traumatic event (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008).

Young children birth to age 5 are especially vulnerable to adverse effects of trauma due to rapid developmental growth, dependence on caregivers and limited coping skills. However, despite decades of statistical data, counselors generally have limited knowledge of the impact of traumatic events on younger children in comparison to older children and adolescents (De Young, Kenardy, & Cobham, 2011). Reasons for this disparity in knowledge include a historical resistance to the notion that early childhood mental health is important and concerns about diagnosing young children with mental disorders.

Research in early childhood mental health has developed rapidly over the past 20 years. Practitioners and researchers who work with this population continue to contribute to the understanding of trauma and early childhood mental health. However, the broader counselor population seems less informed which hinders referrals for this vulnerable population of young children. For example, a counselor may work with a victim of domestic violence who has young children. However, due to the counselor's limited knowledge of early childhood trauma and the impact of domestic violence, the counselor may not consider support services for the children. The present article examines the history and diagnostic validity of trauma-related mental illnesses in young children, the symptoms of trauma in early childhood, the longitudinal impact of early childhood trauma, the protective and risk factors associated with trauma in early childhood, and current and emerging treatments for this vulnerable population.

## **Mental Health, Trauma and Young Children: A Historical Perspective**

Historically, researchers have spent little time and energy researching the effects of trauma exposure in early childhood. A widely held misconception has been that infants and young children lack the perception, cognition and social maturity to remember or understand traumatic events (Zeanah & Zeanah, 2009). Additionally, mental health counselors have been hesitant to diagnose trauma-related mental illness as a result of the associated stigmas that plague young children. In some cases when a child is diagnosed with mental illness, society focuses on the diagnosis and not the child.

Today it is widely accepted that children have the capacity to perceive and remember traumatic events. From birth, the tactile and auditory senses of a child are similar to those of an adult, which suggests that a child can experience stressful events (De Young et al., 2011). At 3 months of age, a child's visual sensory development increases exponentially. A study by Gaensbauer (2002) suggested that infants as young as 7 months of age can remember and reenact traumatic events for up to 7 years. By 18 months of age, children begin to develop autobiographical memory; however, it is unlikely that memories from before that age can be recalled verbally (Howe, Toth, & Cicchetti, 2006). Researchers have demonstrated that infants and young children have the perceptual ability and memory to be impacted by traumatic events (De Young et al., 2011; Howe et al., 2006).

While research findings have confirmed that traumatic events can impact children, clinicians without proper training in early childhood mental health may have difficulty diagnosing trauma-related mental illness in childhood. Children younger than 5 years of age typically experience rapid developmental changes that often are misinterpreted or not fully accounted for which hinders proper diagnosis and intervention (Zero to Three, 2005). Given time and insurance reimbursement constraints, there can be difficulties observing children's behaviors across settings (Carter, Briggs-Gowan, & Davis, 2004). Although verbal skills develop rapidly in early childhood, children may lack the communication skills necessary to accurately express their thoughts,

emotions and experiences (Cohen, 2010). When conducting assessments, mental health professionals rely on parental feedback, inventories and reports from multiple sources, thus increasing the accuracy of the assessment (Carter, Briggs-Gowan, Jones, & Little, 2003).

There is a lack of psychometrically sound diagnostic tools for directly assessing trauma symptoms in children (Strand, Pasquale, & Sarmiento, 2011). Those tools currently available do not appropriately consider the developmental levels of young children (Carter et al., 2004; Egger & Angold, 2006; Strand et al., 2011). However, there are well-designed instruments for early childhood that utilize indirect assessments such as clinician observations and parent/teacher reports (Yates et al., 2008).

Diagnostic tools and assessments developed for children over age 5 are not suitable for assessing young children. For example, young children may not fully understand the directions or the vocabulary used in certain assessment tools. Furthermore, the diagnostic criteria for specific mental health issues (e.g., PTSD) are not developmentally appropriate for children younger than 5 (Scheeringa & Haslett, 2010). The APA Presidential Task Force on PTSD and Trauma in Children and Adolescents (2008) argues that children are not being appropriately identified or diagnosed as having trauma histories and do not receive adequate help.

From a historical perspective, mental health counselors as well as society as a whole have hesitated to acknowledge the plight that young children face in terms of trauma exposure. Several historical factors have contributed to counselors' general lack of knowledge and expertise regarding this population. However, recent advances in research and in the counseling profession, such as the new American Counseling Association division, the Association for Child and Adolescent Counseling, have begun to broaden counselor knowledge in this area.

## **Symptoms of Trauma in Early Childhood**

Trauma reactions can manifest in many different ways in young children with variance from child to child. Furthermore, children often reexperience traumas. Triggers may remind children of the traumatic event and a preoccupation may develop (Lieberman & Knorr, 2007). For example, a child may continuously reenact 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 hyperarousal (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 (see American Psychiatric Association, 2013). It is important for counselors to consider trauma as a potential cause of symptomology among young children.

## **Long-Term Consequences of Early Childhood Trauma**

Recently, researchers have focused on how trauma during early childhood impacts mental and physical health later in life. Symptoms of mental illness can manifest immediately after a trauma, but in some cases symptoms do not emerge until years later. PTSD, anxiety disorders, behavior disorders and substance abuse have all been linked to traumatic events experienced during early childhood (Kanel, 2015). The types and frequencies of traumatic events and whether they were directly or indirectly experienced also can have various effects on physical and mental health later in adulthood. In a review of literature, Read, Fosse, Moskowitz and Perry (2014) described support for the traumagenic neurodevelopmental model. This model proposes that brain functioning changes following exposure to trauma during childhood. These biological factors often lead to psychological issues and physical and mental health concerns in adulthood.

Mental health professionals are often challenged to accurately diagnose PTSD in early childhood, leading to inconclusive reports of the actual prevalence of post-traumatic stress (De Young et al., 2011). Still, there is a clear relationship between PTSD diagnoses and trauma experienced in childhood. For example, higher rates of PTSD are reported among children residing in urban populations where neighborhood violence is prevalent (Crusto et al., 2010; Goodman et al., 2012). Briggs-Gowan et al. (2010) found an association between family and neighborhood violence exposure and oppositional defiant disorder, attention-deficit/hyperactivity disorder, conduct disorder and substance abuse. Additionally, noninterpersonal traumatic events (e.g., car accidents, burns, animal attacks) are associated with PTSD as well as anxiety, phobias, seasonal affective disorder and major depressive disorder (Briggs-Gowan et al., 2010).

Violence exposure is associated with externalizing problems while nonpersonal traumatic events are associated with internalizing problems (Briggs-Gowan et al., 2010). In a more recent study, Briggs-Gowan, Carter, & Ford (2011) found that exposure to neighborhood and family violence in early childhood is associated with poor emotional health and poor performance in school. Low socioeconomic status and traumatic events in early childhood also are correlated with low academic achievement in school (Goodman et al., 2012). Similarly, De Bellis, Woolley, and Hooper (2013) found maltreated children demonstrated poorer neuropsychological functioning and aggregate trauma was negatively related to academic achievement.

According to Schore (2001a), children and adults who experienced relational trauma during infancy are often faced with the struggles of mental disorder due to right brain impairment (p. 239). More recently, Teicher, Anderson, and Polcari (2012) found exposure to maltreatment and other types of stress as a child impacts hippocampal neurons leading to alterations in the brain and potential developmental delays. Additionally, there is evidence of relationships between mistreatment, bullying and accidents in early childhood and the development of delusional symptoms in later childhood (Arseneault et al., 2011). Young children who experience trauma and later use cannabis in adolescence are also at a higher risk for experiencing psychotic symptoms (Harley et al., 2010). Other studies have shown a correlation between early childhood trauma and development of schizophrenia later in life (Bendall, Jackson, Hulbert, & McGorry, 2008; Morgan & Fisher, 2007; Read, van Os, Morrison, & Ross, 2005). Changes in the brain may mediate these relationships between trauma exposure and mental health, as suggested by Schore (2001a, 2001b) and others.

Infants exposed to trauma are often inhibited by emotional and behavioral dysregulation in childhood and as an adult (Ford et al., 2013; Schore, 2001a, 2001b). Dysregulation resulting from trauma is predictive and related

to substance use and functionality (Holtmann et al., 2011). For example, findings from a study by Strine et al. (2012) suggested that early childhood trauma and substance abuse are directly correlated. Children who had experienced more than one traumatic event were found to be 1.4 times more likely to become alcohol dependent. Strine et al. (2012) noted that females who experience trauma are more likely than males to abuse or become dependent on alcohol. The relationship between trauma and alcohol use and dependence often stems from untreated psychological distress (Strine et al., 2012).

In addition, there is ample evidence that early childhood trauma impacts later physical health. Some of the most well-known data on this topic come from the adverse childhood experiences study (Edwards et al., 2005). Multiple studies have found that early childhood trauma is associated with autoimmune disorders (Dube et al., 2009), headaches (Anda, Tietjen, Schulman, Felitti, & Croft, 2010), heart disease (Dong et al., 2004), lung cancer (Brown et al., 2010) and other illnesses. In fact, these studies often have found that the more frequent the exposure to early childhood trauma, the higher the risk of poor health outcomes in adulthood (Felitti et al., 1998).

Researchers have found clear evidence that children who experience traumatic events in early childhood are impacted well beyond their youth. Mental health disorders as well as alcohol and substance abuse emerge intermittently with age. Changes in brain functioning and physical health issues are also associated with early childhood trauma.

## **Risk and Protective Factors**

Researchers have begun to explore factors that interact with trauma and the effects they may produce in young children. Environmental and demographic factors as well as parent–child relationships significantly impact outcomes for young children exposed to traumatic events (Briggs-Gowan et al., 2010). These factors may either insulate a child from adverse effects of trauma or increase the child’s risk for developing psychological distress.

Briggs-Gowan et al. (2010) found that symptoms of psychopathology and trauma were related to factors such as economic disadvantage and parent depressive and anxious symptoms. While ethnicity of the minor, parental education level and number of parents were associated with violence exposure, those factors were not associated with symptoms of mental illness. A more recent study found that young children exposed to a traumatic event along with a combination of socio-demographic factors (e.g., poverty, minority status, single parent, parental education less than high school, teenage parenting) are at greater risk for mental illness (Briggs-Gowan et al., 2011). Additionally, Crusto et al. (2010) found that high levels of parental stress are associated with adverse trauma reactions in young children. Parental dysfunction, family adversity, residential instability and problematic parenting can increase the impact of traumatic events as well (Turner et al., 2012). Young children exposed to chronic and pervasive trauma in addition to these risk factors are especially vulnerable to adverse effects (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008).

There are factors that may help protect young children from the negative impact of exposure to trauma. Turner et al. (2012) found that nurturing familial relationships can insulate children from psychological distress associated with traumatic events. Other factors such as safety and stability also might serve as protective factors. Safety implies that the child is free from harm or fear of harm, both physically and socially. Stability indicates consistency in the family environment, while nurturing suggests availability, sensitivity and warmth of caregivers or parents. Well-established, secure parent–child relationships are likely to provide protection from negative effects of trauma experienced by young children. A secure parental attachment has been shown to help children effectively regulate emotional arousal (Aspelmeier, Elliot, & Smith, 2007). Emotional regulation may

be a mechanism that protects young children from extreme trauma reactions (De Young et al., 2011). Similarly, Crusto et al. (2010) found that caregiver support and healthy family functioning reduce the risk of psychological distress in young children after a traumatic event.

## Treatment

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.

Incorporating existing coping strategies can serve to minimize family stress and foster rapport with the child. Providing information about community support groups or other mental health agencies and resources also can help support and encourage the family. Informing parents and caregivers about symptoms common to young children exposed to traumatic events can foster awareness and allow for adequate support during the treatment process. Counselors can help the family establish or reestablish routines that begin to restore stability for the child, minimizing the adverse effects of the trauma (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008; Clay, 2010).

There are several evidence-based methods available to counselors treating trauma symptoms in young children. Evidence-based approaches are rooted in theory, evaluated for scientific rigor and tend to yield positive results (National Registry of Evidence-Based Programs and Practices, 2012). Trauma-focused cognitive behavioral therapy (TF-CBT) is a popular evidence-based treatment used with children aged 3–18. Based on cognitive behavioral therapy, humanism and family systems theory, TF-CBT includes many therapeutic elements for children and caretakers (Child Welfare Information Gateway, 2012). This form of therapy helps children develop different perceptions and a more adaptive understanding of the traumatic event (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008). Caretakers learn parenting and communication skills as they play active roles throughout the TF-CBT process. Multiple studies demonstrate the effectiveness of TF-CBT in reducing symptoms of trauma in early childhood (see Cohen & Mannarino, 1996, 1997; Deblinger, Stauffer, & Steer, 2001).

While TF-CBT is an established treatment for children and adolescents, there are evidence-based treatments developed specifically for treating trauma in children between birth and 6 years of age. Child–parent psychotherapy (CPP), one of the most widely used interventions for young children, was created to address exposure to domestic violence, although it can treat a variety of traumatic experiences (Lieberman & Van Horn, 2008). In this form of dyadic therapy, the child and the caregiver reestablish safety and security in the parent–child relationship (Lieberman & Van Horn, 2008). CPP is one of the few early childhood treatments validated for use with ethnic minorities (Lieberman & Van Horn, 2008). The primary goal of CPP is to equip parents to meet the psychological needs of their child and maintain a secure relationship after treatment has ended.

Attachment and biobehavioral catch-up (ABC) is another treatment option that is designed primarily for use with young children who have experienced neglect (Dozier, 2003). This approach was developed specifically for low-income families and later adapted for use with foster families. ABC is based on the neurobiology of stress and attachment theory. The goal of ABC is to foster the development of the child's optimal regulatory strategies by equipping parents with tools for effective response (Dozier, 2003; Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008).

Counselors also can utilize parent–child interaction therapy (PCIT) when working with traumatized youth. PCIT is a structured technique for children ages 2–8 years in which the counselor teaches the parent or caregiver how to interact with the child and set effective limits (Chaffin et al., 2004). In this form of therapy, the counselor often assumes the role of coach, instructing the client on specific skills. Counselors frequently use PCIT when working with children abused by a caregiver. PCIT has been implemented successfully with various populations including Hispanic and Latino clients (Chaffin et al., 2004). The focus of PCIT is on improving the quality of the parent–child relationship as well as child behavior management (Chaffin et al., 2004; McCabe, Yeh, Garland, Lau, & Chavez, 2005).

The treatment interventions previously mentioned are geared toward very young children, all incorporating play as a treatment modality. Since young children do not have extensive vocabularies, they often communicate information about themselves, their trauma and relationships with their caregivers through play (Landreth, 2012). Play therapy intervention research using samples with children between birth and 5 years of age is scant; however, several case studies indicate that play therapy is effective with trauma in early childhood. For example Dugan, Snow, and Crowe (2010) utilized play with a 4 year old exhibiting PTSD symptomology after experiencing Hurricane Katrina in 2005. Anderson and Gedo (2013) provided a case study in which play was used to treat a 3 year old with aggressive behaviors who was separated from his primary caregiver. There also are intervention examples of using play therapy with young children exposed to domestic violence (Frick-Helms, 1997; Kot, Landreth, & Giordano, 1998).

Finally, there are emerging approaches specifically for treating young children exposed to trauma. Tortora (2010) developed Ways of Seeing, a program combining movement and dance therapy with Laban movement analysis to create a sense of regulation and homeostasis for the child exposed to a traumatic event. The Ways of Seeing program does not yet have empirical evidence of its effectiveness. However, it is rooted in attachment theory, multisensory processing, play and sensorimotor psychotherapy. Counselors can use this program to determine how a parent and child experience each other, implement creative interventions for healthy bonding, and renew a sense of efficacy for the parent and child. While much more research is needed, this program appears to be a promising approach to treating trauma in early childhood (see <http://www.suzitortora.org/waysofseeing.html>).

Another emerging treatment, known as Honoring Children, Mending the Circle (HC-MC), is based on TF-CBT. The HC-MC approach was developed to address the spiritual needs of young Native American and Alaska Native children exposed to trauma. This method emphasizes preestablished relationships, wellness and healing during the treatment process. Spirituality is a critical component of healing and is integrated throughout the HC-MC approach. The goal of HC-MC is to help the traumatized child attain and reestablish balance (BigFoot & Schmidt, 2007, 2010). Additional research is needed on the efficacy of the HC-MC approach in working with Native American and Alaska Native youth.

A third emerging treatment, Trauma Assessment Pathway, is an assessment-based treatment that focuses on providing triage to young children exposed to traumatic events (Conradi, Kletzka, & Oliver, 2010). In this approach, the counselor uses assessment domains to determine the focus of treatment, provides triage to identify an appropriate pathway for intervention and establishes referrals to community resources if needed (Chadwick Center for Children and Families, 2009). The trauma assessment pathway method, which includes the trauma wheel, is a versatile mode of treatment available for the child and family. However, in many instances counselors may determine that an evidence-based practice, such as CPP, is the most appropriate mode of treatment (see Chadwick Center for Children and Families, 2009).

Each method of treatment offers specific strategies for working with traumatized young children and their families. However, findings from most studies investigating the effectiveness of these treatments are inconclusive (Forman-Hoffman et al., 2013). The strength of evidence for these and many other interventions are relatively low while the magnitudes of treatment effects are small (see Fraser et al., 2013). Common to the treatment models presented is the emphasis on system support, the importance of relationships in the recovery process and developmentally appropriate intervention modalities. These factors likely will serve as integral components of future methods focused on the treatment of traumatized young children.

## **Discussion and Implications**

Young children are at high risk for exposure to traumatic events and are particularly vulnerable for several reasons. They are dependent upon caregivers and lack adequate coping skills. Children also experience rapid development and growth, leaving them particularly impressionable when faced with a traumatic event. Young children benefit from preventive psychoeducation aimed at teaching parents and caregivers about child development and parenting skills (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Valentino, Comas, Nuttall, & Thomas, 2013). Counselors who work with this population endeavor to increase protective factors and decrease risk factors while exploring preventive methods, which may reduce young children's exposure to traumatic events. Similarly, legislators can influence public policy related to enhancing childhood mental health. For example, legislation can address prevention and offer incentives to parents participating in psychoeducation focused on enhancing protective factors and reducing childhood trauma exposure.

In recent years research has emerged that provides an understanding of how trauma impacts young children. Researchers and clinicians know that infants, toddlers and preschoolers have the capacity to perceive trauma and are capable of experiencing psychopathology following a traumatic event. Although these children can experience mental illnesses often associated with older children, adolescents and adults, the symptomology can manifest in various ways. Additionally, professional counselors working with children in a variety of settings should consider the residual impact 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. For example, the trauma-sensitive schools initiative provides school counselors with a framework for fostering schoolwide awareness and creating a safe and supportive environment (Cole et al., 2013). School counselors can easily embed these types of preventive measures as part of a comprehensive school counseling program. These efforts will presumably result in increases in student success, wellness and awareness, three outcomes that will benefit all children exposed to traumatic events.

While great strides have been taken recently in understanding and treating early childhood trauma, there are clear gaps in the dissemination of information to counselors. Professional counselors should receive training in specifically designed interventions and attempt to raise public awareness of early childhood trauma in hopes that young children will receive necessary treatment. The findings of this literature review suggest that various methods of treatment might effectively reduce symptoms experienced by traumatized children. Parent-child relationships and other environmental factors also can have significant influence on children's reaction to trauma.



A major purpose of this article is to educate counselors about the impact of trauma in early childhood and advocate for appropriate assessment and treatment of these traumatic exposures. While not all counselors choose to work with this vulnerable population, they often work with clients who have extended families with young children. Counselors who work with adult clients can provide psychoeducation about this important issue and initiate referrals to counselors trained to work with early childhood trauma. There is a body of information about trauma in early childhood available for further review. Sources include the National Child Traumatic Stress Network ([nctsn.org](http://nctsn.org)), the California Evidence-Based Clearinghouse for Child Welfare ([cebc4cw.org](http://cebc4cw.org)), and the Association for Child and Adolescent Counseling ([acachild.com](http://acachild.com)). Counselors interested in learning more about this issue can review these online resources.

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