Commentary

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Stress Disorder in Very Young Children Recognizing Early Trauma

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Introduction

Recent editions of diagnostic manuals for mental health disorders include an increased focus on identifying posttraumatic stress disorder (PTSD) in preschool children aged 6 years or younger (e.g. the PTSD Preschool diagnosis in the Fifth edition of the Diagnostic and Statistical Manual: DSM-5 using developmentally appropriate symptom algorithms. This shift emerged following pioneering research demonstrating that traumatic stress diagnoses derived from adult-led PTSD criteria fail to identify many young children with clinical needs in contrast to a developmentally sensitive 'alternative algorithm'. Developmentally tailored PTSD diagnoses for young children (PTSD-YC) are now in widespread use, with a growing number of trials demonstrating that cognitive behavioral therapy (CBT) can efficaciously treat PTSD symptoms in this younger age range. Here, across two studies, we aimed to further advance understanding of the course and treatment options for PTSD-YC diagnosis by exploring (a) early post-trauma predictors of the course of DSM-5 PTSD-YC and specifically whether the current DSM-5 version of the acute stress disorder diagnosis may also need developmental modification, and (b) providing proof of concept in 3- to 8-year-olds for a cognitive-focused therapy for PTSD which has been shown to be effective in older children and adolescents via an early-stage randomized controlled trial.

Many young people show natural attenuation of posttraumatic stress symptoms in the months following exposure. In terms of very young children, to date, there have been a small number of longitudinal studies charting the course of PTSD symptoms and/or of the PTSD-YC diagnosis using the alternative algorithm. In addition, wait-list control arms of prior CBT studies have tracked the untreated course of PTSD symptoms in this age-group. To our knowledge, there have been no studies evaluating the early course of the DSM-5 PTSD-YC, as opposed to severity of symptoms, in very young children.

Parent-Child Relationship Support

In older youth, several predictive factors reliably distinguish children who recover from those who go on to develop PTSD. However, we know far less about predictors in very young children. The first aims of Study 1 were therefore to examine both the course of, and predictors of, DSM-5 PTSD-YC in very young children.

One such putative predictor is meeting criteria for DSM-5 acute stress disorder (ASD) within the first month post-trauma. ASD was introduced in the DSM-IV to identify in the acute stage those at higher risk of later PTSD. In 8- to 16-year-olds, the presence of ASD markedly increases the likelihood of later PTSD. However, despite the significant update to the PTSD criteria to accommodate very young children in the DSM-5 there has been no corresponding change in the ASD criteria which remain grounded in the adult literature. The further aims of Study 1 were therefore to examine the utility of the DSM-5 ASD criteria in very young children both in detecting early cases of young children in clinical need and in predicting later PTSD-YC.

One alternative to the current DSM-5 ASD criteria for very young children would be to use the current developmentally sensitive DSM-5 PTSD-YC criteria in the first month post-trauma (i.e. with the usual PTSD duration criterion removed) in the form of an 'acute DSM-5 PTSD-YC' diagnosis. In one study in children aged 2–6 years, meeting acute PTSD-YC criteria in the month post-trauma significantly predicted increased risk of later AA-PTSD-YC. Our final aim for Study 1 was therefore to examine the utility of an acute DSM-5 PTSD-YC diagnosis in identifying cases and predicting later DSM-5 PTSD-YC.

Previous research has suggested that the PTSD-YC diagnosis may be a more appropriate conceptualization of PTSD beyond the preschool range for children up to 8 years of age. For this reason, the present study also reports prevalence estimates for children both up to 6 years and up to 8 years.

Study 1 therefore addressed five questions: (1) what is the course of DSM-5 PTSD-YC symptoms in 3- to 6-year-olds (and 3- to 8-year-olds) over the first 3 months post-trauma following attendance at an Emergency Room? (2) What trauma-related and demographic factors predict later DSM-5 PTSD-YC? (3) What is the prevalence of DSM-5 ASD in young children? (4) Does the DSM-5 ASD diagnosis – designed to aid early identification of those at risk – have prognostic utility in this age-group? and (5) Is 'acute PTSD-YC' a superior alternative?

Memory and Narrative Development

As we are now able to identify young children burdened by debilitating PTSD, it is imperative that we continue to develop and expand on suitable interventions for this age-group to provide choice for therapists and families. Here, we have

provided proof-of-principle support that a trauma-based cognitive therapy (CBT-3M) can be successfully adapted for younger children (with a slightly broader range of traumas relative to Study 1) ensuring that the same intervention protocol has applicability across the young age range from 3–18 years A fully powered, definitive trial is now necessary to evaluate treatment efficacy and identify mechanisms of action, as well as extending evaluation of the intervention to more complex presentations.

The study highlighted important feasibility issues, in particular the completion of follow-up assessments, which will be important to consider when designing a later-stage trial. Specifically, a number of families who completed the intervention stage of the trial were unavailable for the post-treatment outcome assessment, in the majority of cases because the families had moved away from the area. Closer attention to making alternative arrangements for assessment in these circumstances will be required.