

The Child and Family Traumatic Stress Intervention for Young Children: A Pilot Study

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Abstract

Background: The Child and Family Traumatic Stress Intervention (CFTSI) is a brief, evidence-based, trauma-focused treatment developed specifically for implementation with children and caregivers in the early phase of trauma response. CFTSI has demonstrated effectiveness in reducing posttraumatic stress symptoms (PTSS) and interrupting the development of posttraumatic stress disorder among trauma-exposed school-aged children and adolescents and their participating caregivers. **Objective:** This pilot study evaluated preliminary outcomes associated with CFTSI for Young Children (CFTSI-YC), a specialized treatment application tailored to meet the unique clinical and developmental needs of children aged 3 to 6.

Participants/Setting: We used de-identified clinical data from 50 racially and ethnically diverse caregiver-child dyads who completed CFTSI-YC. **Methods:** We examined whether completing CFTSI-YC was associated with statistically significant and clinically meaningful reductions in PTSS for preschoolers and participating caregivers. We also evaluated whether CFTSI-YC was associated with comparable outcomes across demographic groups and trauma types. Finally, we examined post-treatment disposition by determining whether treating clinicians referred children for additional trauma-focused treatment at the completion of CFTSI-YC. **Results:** Paired samples t-tests revealed significant reductions in child PTSS (Cohen's $d = .76, p < .001$) and caregiver PTSS (Cohen's $d = .65, p < .001$) from pre- to post-treatment. CFTSI-YC was associated with comparable symptom reduction across child gender, age, racial background, and trauma histories. At the completion of CFTSI-YC, 80% of participating children were not referred for additional trauma-focused treatment. **Conclusion:** If replicated, findings suggest that CFTSI-YC may be a promising early intervention for young children and caregivers following potentially traumatic events.

Keywords: trauma; child traumatic stress; child PTSD; trauma-focused treatment; preschoolers; early intervention

The Child and Family Traumatic Stress Intervention for Young Children: A Pilot Study

Youth are exposed to potentially traumatic experiences (PTEs) at alarming rates (Finkelhor & Turner, 2016). Common traumatic experiences for children include physical and sexual abuse, neglect, community and domestic violence, motor vehicle accidents, and natural disasters. Preschool-aged children are particularly vulnerable to certain forms of maltreatment due to their reliance on adult support with tasks of daily living, including bathing, changing, and toileting. As a result, some studies have found that preschoolers are at heightened risk for abuse and exposure to domestic violence compared to children in other age groups (Fantuzzo & Fusco, 2007; U. S. Department of Health & Human Services, 2020). Approximately 30-40% of children exposed to child sexual abuse (CSA) are preschoolers, though this age group has been relatively less well studied (Brilleslijper-Kater et al., 2004; Putnam, 2003). The National Survey of Children's Exposure to Violence found that 43.9% of children between 2 and 5 years old had been physically assaulted, 14.4% had witnessed violence, and 9.5% had experienced maltreatment (i.e., defined as physical, emotional, and/or sexual abuse or neglect) within the last year (Finkelhor et al., 2013). Similarly, substantial early exposure to PTEs was documented in a healthy birth cohort sample, with estimates suggesting that 26% of children experienced at least one PTE by 2 to 4 years of age (Briggs-Gowan et al., 2010). Globally, up to 75% of 2- to 4-year-olds experience abuse and neglect (World Health Organization, 2020). Compared to older children, younger maltreated children are at greater risk for out-of-home placements, serious injury, and death (Australian Institute of Health and Welfare, 2022; U.S. Department of Health & Human Services, 2023).

Like older children, preschoolers' responses to PTEs vary widely, but a wide range of negative outcomes can develop when symptomatic children are not identified and appropriately supported (Roberts et al., 2013; Scheeringa & Zeanah, 2008). For example, maltreatment during early childhood has been associated with a host of difficulties across multiple domains of

functioning, including poor self-regulation and behavioral difficulties (Choi & Graham-Bermann, 2018). Exposure to sexual and physical abuse has been associated with a higher prevalence of dissociative symptoms compared to non-maltreated children (Hébert et al., 2017; Macfie et al., 2001). Maltreatment history is associated with preschoolers' problematic sexual behaviors (Barton et al., 2025), and young children's exposure to CSA specifically has been linked to the development of problematic sexual behaviors over time (Tsang et al., 2023). Preschoolers exposed to CSA may also be more likely than older children to exhibit additional symptoms that can seriously disrupt their development, including regression and sleep disturbances (Hébert et al., 2017; Putnam & Trickett, 1993; Tejada & Linder, 2020).

Physiological changes and negative physical health correlates have been documented in preschoolers following PTEs, including alterations in biomarkers of stress exposure, aging, and associated behavioral problems (Ridout et al., 2019), obesity during the preschool years (Whitaker et al., 2007), markedly higher rates of motor coordination difficulties (Wade et al., 2018), and increased risk of maternal-reported child health problems (Graham-Bermann & Seng, 2005). Exposure to PTEs has also been linked to difficulties as preschoolers transition to school. For example, maltreatment allegations during early childhood were associated with teacher-rated difficulties across social, emotional, physical, cognitive, and language domains during the first year of school (Bell et al., 2018). Further, early exposure to physical abuse and neglect was associated with lower cognitive and language functioning, lower parent and teacher-ratings of prosocial behavior, worse executive functioning during preschool, and poorer academic outcomes later in elementary school compared to those without maltreatment histories (Fantuzzo et al., 2011; Fay-Stammbach & Hawes, 2019; Fay-Stammbach, 2016).

In addition to these developmental correlates of PTE exposure during preschool, some studies have found that young children develop posttraumatic stress disorder (PTSD) at rates comparable to or exceeding those of school-aged children, adolescents, and adults, though developmentally appropriate criteria and standardized assessment approaches are required

(Dunn et al., 2017; Scheeringa et al., 2006). Early work examining preschoolers' rates of PTSD following natural disasters using developmentally grounded diagnostic criteria and standardized assessment tools found a 50% prevalence rate in a sample of young children exposed to Hurricane Katrina (Scheeringa & Zeanah, 2008). A recent meta-analysis found that approximately 26% of preschoolers who directly experienced PTEs of different types met full criteria for PTSD (Woolgar et al., 2022).

The course of PTSD in preschoolers can be chronic, even in the context of community “treatment as usual” (Scheeringa et al., 2005), highlighting the need for evidence-based, trauma-focused interventions specifically tailored for this age group. Retrospective and longitudinal studies have demonstrated robust associations between childhood PTEs and psychiatric and interpersonal difficulties in adulthood (Teicher et al., 2022). For example, CSA is associated with several mental health disorders and related challenges in adulthood, including major depression, PTSD, addiction, and eating disorders (Nemeroff, 2016; Putnam, 2003). Exposure to physical and emotional abuse during preschool is associated with subsequent victimization within intimate partner relationships during young adulthood (Gan et al., 2025). Child maltreatment in preschool and middle childhood is also associated with subsequent perpetration of intimate partner violence in adulthood (Fedina et al., 2024).

To prevent negative developmental and long-term outcomes and support resilience and recovery, there is an urgent need for specialized treatment approaches for young children exposed to PTEs, with a focus on early identification and intervention with symptomatic children and their caregivers. Such treatments have the potential to reduce children's suffering and support their return to the path of optimal development (Colizzi et al., 2020). Because social support, particularly from caregivers, is a key protective factor for youth who have experienced adversity (Gartland et al., 2019), early interventions for preschoolers following exposure to PTEs should explicitly aim to strengthen caregiver support and caregiver-child relationships.

Despite the high prevalence of trauma exposure and the significant short- and long-term consequences associated with early childhood PTEs, there remains a critical gap in the availability of brief, developmentally appropriate, evidence-based interventions that can be delivered in the immediate aftermath of trauma exposure. Several evidence-based trauma-focused treatments for young children, including Child-Parent Psychotherapy (Lieberman et al., 2015) and Trauma-Focused Cognitive Behavioral Therapy (Cohen et al., 2017; Pollio & Deblinger, 2017), have demonstrated effectiveness in reducing traumatic stress symptoms and promoting recovery. However, these interventions were not specifically developed for implementation during the acute post-trauma period. Consequently, there remains a need for brief interventions for young children that can be delivered soon after trauma exposure, reduce traumatic stress reactions, support recovery during the acute post-trauma period, and help determine whether referral for additional trauma-focused treatment is indicated at the completion of early intervention. As a result, many young children and families either receive no intervention during this critical early period or are referred to treatments that may not align optimally with the timing of their needs.

The Child and Family Traumatic Stress Intervention (CFTSI)

The Child and Family Traumatic Stress Intervention (CFTSI; Epstein et al., 2025; Marans et al., 2024) is a brief (i.e., 5-8 session), evidence-based, trauma-focused mental health treatment specifically developed for implementation during the acute phase of trauma response following a recent PTE or recent disclosure of past abuse in a forensic setting, such as a Child Advocacy Center. This brief, early treatment has demonstrated effectiveness in reducing PTSS and interrupting PTSD and related disorders among trauma-exposed school-aged children and adolescents, including those with extensive trauma histories prior to the recent event that precipitated their CFTSI referral (Hahn et al., 2016; Hahn et al., 2019; Stover et al., 2022).

CFTSI utilizes a developmentally informed, family-strengthening approach and aims to help children and caregivers find words to describe their PTSS and reduce trauma symptoms by

enhancing caregiver-child communication about the child's PTSS, increasing caregiver understanding of the child's trauma responses, and strengthening the caregiver's ability to support the child's recovery. Children and caregivers learn about trauma and common trauma reactions, participate in a structured, comprehensive assessment of their trauma symptoms, and collaborate to identify coping strategies that target the symptoms contributing to the greatest distress or impairment (e.g., behavioral activation for depressive withdrawal, guided visual imagery for intrusive thoughts and images).

Evidence from randomized controlled, effectiveness, implementation, and community-based studies has demonstrated significant reductions in children's PTSS following CFTSI (Berkowitz et al., 2011; Hahn et al., 2016; Hahn et al., 2019; Stover et al., 2022). In a randomized controlled trial (RCT), youth receiving CFTSI were 65% less likely than those in a supportive control condition to meet full criteria for PTSD 3 months after treatment, and 73% less likely to meet criteria for partial PTSD (Berkowitz et al., 2011). Significant decreases in children's PTSS from pre- to post-treatment have also been documented using chart review and open trial research paradigms (Hahn et al., 2016; Hahn et al., 2019). In addition, a recent naturalistic treatment study of CFTSI implementation in 13 community-based clinical settings across the U.S. revealed significant reductions in child-reported PTSS from pre- to post-treatment (Stover et al., 2022). Symptom reduction was not associated with child age, gender, ethnicity, race, prior trauma history, level of caregiver distress, or type of traumatic event leading to referral, indicating that CFTSI was associated with significant symptom improvement across a wide range of youth treated in real-world settings (Stover et al., 2022). CFTSI has been widely disseminated nationally and internationally in Child Advocacy Centers and community mental health agencies (Hahn et al., 2019; Marans, 2024; Stover et al., 2022).

Participation in CFTSI is also associated with significant decreases in PTSS for participating caregivers of school-aged children and adolescents (Hahn et al., 2019). This finding is important because caregiver functioning is a key predictor of children's PTSS

following PTEs (Morris et al., 2012). Given their developmental status, caregiver well-being may be especially influential for preschoolers' recovery from PTEs. For example, following CSA, associations between caregiver symptoms and preschoolers' emotion regulation difficulties have been documented (Langevin et al., 2016).

To our knowledge, CFTSI is currently the only brief, evidence-based, trauma-focused treatment for children exposed to PTEs that is specifically designed to be implemented in the acute phase (i.e., shortly after exposure to a PTE or after the formal disclosure of abuse). However, CFTSI has only been studied in children 7 years and older. Recent work has highlighted the need for the development and evaluation of treatments designed to meet the unique needs of young children exposed to PTEs, with adaptations that reflect their developmental status (e.g., cognitive, linguistic, and self-regulation skills), the specific ways that trauma reactions manifest in young children, and their normative reliance on caregivers to meet their daily instrumental and emotional needs (Moner et al., 2024).

Adapting CFTSI to meet the needs of young, traumatized children

The CFTSI Treatment Application for Young Children (CFTSI-YC) is a 6- to 8-session, early, trauma-focused treatment model adapted to meet the specific developmental and clinical needs of young, traumatized children aged 3 to 6 and their primary caregivers during the acute phase of trauma response. CFTSI-YC integrates principles of child development and young children's trauma responses to inform assessment and treatment approaches that will be most effective for supporting preschoolers following exposure to PTEs. This treatment application capitalizes on the central role of caregivers during early childhood. For example, given preschoolers' still-burgeoning cognitive, linguistic, and self-regulatory capacities, CFTSI-YC relies more heavily on caregiver participation to help identify, articulate, and manage young children's trauma-related symptoms. Caregivers receive specialized information (i.e., psychoeducation) about how trauma reactions commonly present in preschoolers. With this knowledge as a foundation, caregivers engage in a structured assessment of preschoolers' PTSS

using standardized clinical instruments that capture the unique ways that traumatic stress often manifests during this developmental period.

A developmentally grounded, comprehensive approach to screening and assessment is necessary for clinicians working with young children to understand the full range of trauma-related symptoms and functional impairments following PTEs and select appropriate symptom targets for clinical intervention (Scheeringa, 2019). For example, traumatized children commonly demonstrate behavioral challenges that are readily identifiable by their caregivers. However, it is important to assess the full range of PTSS a child may experience, including internalizing symptoms that may be less immediately apparent. In addition, although individuals of all ages may exhibit intrusion symptoms following exposure to PTEs, preschoolers may be more likely to demonstrate this traumatic stress reaction by reenacting their traumatic experiences through play. Further, regression to functioning that is more characteristic of earlier phases of development (e.g., bedwetting, thumb-sucking, using baby talk) is another common way that preschoolers manifest PTSS. CFTSI-YC incorporates this developmental knowledge and utilizes assessment measures tailored to preschool children's developmental characteristics and common trauma presentations.

Targeted psychoeducation and assessment approaches designed for preschoolers allow CFTSI-YC clinicians to partner with caregivers to identify the child's most impairing trauma-related symptoms. Once symptoms are identified, specific coping strategies and behavioral interventions tailored for preschoolers are introduced, with the caregiver taking the lead in supporting implementation outside of sessions. This approach supports both the child's recovery and the caregiver's capacity to promote healing. As in CFTSI for older children, participating caregivers are also supported to identify and address their own PTSS early in the treatment, which provides relief and may enhance their ability to implement recommended strategies to support their child effectively. Although this work builds on decades of clinical experience working with young children exposed to trauma, CFTSI-YC has not yet been formally

evaluated. Accordingly, adapting and evaluating CFTSI for young children represents a critical next step in extending early, brief trauma-focused intervention to a developmentally vulnerable population with substantial unmet need.

The Present Study

Given the need for developmentally appropriate, early, trauma-focused interventions for young children, and in the absence of prior empirical evaluation of CFTSI-YC, the present study evaluated preliminary outcomes associated with CFTSI-YC in reducing preschoolers' and participating caregivers' PTSS. We also evaluated whether CFTSI-YC was associated with comparable outcomes for children with different demographic backgrounds and types of traumatic experiences. Finally, given the brief nature of the intervention, we examined post-treatment disposition by determining whether the treating clinician referred the child for additional trauma-focused treatment at the completion of CFTSI-YC.

We hypothesized that children and participating caregivers who completed CFTSI-YC would experience statistically and clinically significant reductions in overall PTSS from pre-treatment to post-treatment. We also hypothesized that significant reductions would be observed across the four key PTSD symptom clusters: intrusion, trauma avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. Consistent with prior studies of CFTSI with older children, we hypothesized that there would be no significant differences in symptom reduction based on child age, gender, race, prior trauma history, or type of traumatic event leading to referral. Finally, also consistent with findings from CFTSI for older children, we predicted that fewer than 25% of children who completed CFTSI-YC would be referred by the treating clinician for additional trauma-focused treatment at the completion of CFTSI-YC.

Method

Procedure

As part of CFTSI-YC implementation, clinicians collected and submitted demographic and clinical outcome data using a centralized CFTSI data system hosted on REDCap (Research Electronic Data Capture). De-identified data from 50 caregiver-child dyads who completed CFTSI-YC were included in this open trial. Caregivers provided information about child and family demographics (e.g., child race and ethnicity, maternal education), as well as characteristics of the referral incident (e.g., trauma type, type of exposure the child experienced, and relationship of alleged perpetrator to the child). This study was conducted with an IRB-approved exemption for secondary use of de-identified clinical data. Clinical trial number: not applicable.

Measures

Child Posttraumatic Stress Symptoms

Caregivers provided information about children's PTSS before treatment began and at the completion of CFTSI-YC using a standardized, validated instrument designed to assess PTSS in preschoolers (Child and Adolescent Trauma Screen-Caregiver; CATS-C) (Sachser et al., 2017). In the context of CFTSI-YC, the CATS-C was administered as a semi-structured clinical interview assessing the frequency of 16 common trauma symptoms in young children, with items rated on a 4-point Likert scale from 0 (*Never*) to 3 (*Almost Always*). Five additional items assessed functional impairment across key domains of functioning in children's daily life in a yes/no format. A total symptom score was derived by summing the scores for items 1 to 16, with a range of possible scores from 0 to 48. A clinical cutoff score of ≥ 16 is recommended for preschoolers. To determine whether CFTSI-YC was associated with symptom reduction across the four key PTSD symptom clusters (intrusion, trauma avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity), subscores were created by summing items 1 to 5 (intrusion), 6 to 7 (trauma avoidance), 8 to 11 (negative alterations in cognitions and mood), and 12 to 16 (alterations in arousal and reactivity).

Children were considered to meet full DSM-5 criteria for PTSD at the post-treatment assessment if caregivers reported one intrusion symptom at a frequency ≥ 2 (i.e., “half the time”) (criterion B), one symptom of trauma avoidance at a frequency ≥ 2 or one symptom of negative alterations in cognitions and mood at a frequency ≥ 2 (criterion C), two symptoms of alterations in arousal and reactivity at a frequency ≥ 2 (criterion D), as well as functional impairment rated as present (i.e., “yes”) for any of the five domains assessed (Criterion F). An international validation study demonstrated good reliability and validity of the CATS, which is widely used across the United States and in other countries (Sachser et al., 2017).

Caregiver Posttraumatic Stress Symptoms

The PTSD Checklist-Civilian version (PCL-C) is a commonly used, validated measure of adult PTSS (Weathers et al., 1993). This measure contains 17 symptom questions which were administered in a semi-structured interview format by CFTSI-YC clinicians. Caregivers rated how much they had been bothered by these 17 symptoms since the referral incident on a 5-point Likert scale (1 = *Not at all*; 5 = *Extremely*). A total symptom score was generated by summing all items. The PCL-C displays good convergent validity with self-report measures and diagnostic interviews assessing PTSD in adults (Wilkins et al., 2011).

During the course of this study, CFTSI-YC providers began using the PCL-5, which assesses 20 DSM-5 symptoms of PTSD in adults (Weathers et al., 2013). As with the original PCL, items were rated on a 5-point Likert scale (0 = *Not at all*; 4 = *Extremely*). A total symptom score (range = 0 - 80) was obtained by summing the 20 symptom items. A clinical cutoff score ≥ 31 has been proposed as indicative of probable PTSD diagnosis using this measure. Caregivers provided information about their own PTSS using the PCL-C or PCL-5 during CFTSI-YC Session 1 and at the completion of CFTSI-YC.

To facilitate direct comparison between the PCL-C and PCL-5 total scores, we used a “crosswalk” developed and validated by Moshier and colleagues using equipercentile equating

with loglinear smoothing (Moshier et al., 2019). This approach creates standardized comparisons across both versions of the PCL and ensures consistency with prior research.

Child and Caregiver Trauma History

Children's history of exposure to PTEs was assessed using the 23-item Child Trauma History Questionnaire (CTHQ). The original version of the CTHQ was developed for the original CFTSI randomized trial and adapted with permission for use as part of ongoing CFTSI treatment (Berkowitz & Stover, 2005; Epstein & Hahn, 2013). The CTHQ is administered via clinical interview with caregivers during CFTSI-YC Session 2. The CTHQ assesses child exposure to a wide range of PTE types, including physical abuse, sexual abuse, neglect, community violence, domestic violence, medical trauma, and natural disasters. A total score was calculated to reflect the number of trauma types experienced during the child's lifetime according to their caregiver, with a possible range of 0 to 23.

Caregivers' history of exposure to PTEs was assessed using the 23-item Adult Trauma History Questionnaire (ATHQ), which was administered via clinical interview with caregivers during CFTSI-YC Session 1. Like the CTHQ, the ATHQ assesses adult exposure to a wide range of PTE types. A total score was calculated to reflect the number of trauma types experienced in the adult's lifetime according to the caregiver, with a possible range of 0 to 23. The ATHQ was adapted from the CTHQ and used with permission as part of ongoing CFTSI implementation.

Post-treatment Disposition

Post-treatment disposition was operationalized as whether the treating clinician referred the child for additional trauma-focused treatment at the completion of CFTSI-YC. Treating clinicians documented this information on a standardized closing survey completed following the final CFTSI-YC session.

Results

Sample

Study participants included 50 caregiver-child dyads who completed CFTSI-YC after the child's recent (i.e., within the last 3 months) PTE or recent disclosure of past physical or sexual abuse in the context of a formal forensic interview at a Child Advocacy Center. Families were eligible for inclusion if the child was between 3 and 6 years old, the caregiver reported at least one child PTSS on the pre-CFTSI-YC CATS-C, and there was a caregiver available to participate in CFTSI-YC who did not intentionally harm the child. Children who were actively psychotic or who had severe developmental or intellectual disabilities were excluded because CFTSI-YC requires sufficient cognitive and linguistic capacity to understand and respond to the clinician verbally and participate in coping strategies introduced.

Participating children were 52% female and 48% male. Children ranged from 3 to 6 years old ($M = 4.68$, $SD = 1.08$). Many children (i.e., 54%) were identified as Hispanic. In terms of racial background, 60% of children were identified as White, 22% multiracial or another racial identity, and 18% as Black. Slightly more than half of children (i.e., 52%) lived with both parents or had parents with shared custody, whereas 30% lived with a single parent. Six percent were in the custody of the child welfare system and lived with a foster parent and the remaining children had another custody arrangement. Fourteen percent of children had been removed from their primary caregiver at some point during childhood. Eight percent of participating families reported being involved in the military, including active duty, national guard, reserves, and/or veteran families. Most participating caregivers were birth mothers (84%), 6% were birth fathers, and the remainder were other important adults in the child's life (e.g., grandmother, kinship or non-kinship foster mother). Maternal education levels varied widely (Table 1).

In terms of the recent event prompting referral for CFTSI-YC, the most frequent trauma type was sexual abuse (46%). Other PTEs included exposure to domestic violence (20%), unintentional injuries (14%), traumatic grief (8%), community violence (6%), physical abuse (2%), and other traumatic events (4%). Most children were directly victimized (66%), with an additional 4% characterized by their caregivers as both victims and witnesses of the referral

incident. Thirty-eight percent of alleged perpetrators of the recent traumatic events were in a caregiving role with the child, and 30% lived in the home with the child at the time of the event. Participating caregivers reported that 36% of alleged perpetrators of the recent traumatic experience were birth fathers, 10% were siblings, 6% were the caregivers' partner, 4% were cousins, 2% were birth mothers, and 2% were grandparents.

Participating children and caregivers had experienced multiple PTEs, in addition to the event that precipitated the CFTSI-YC referral. Caregivers reported that child participants had experienced approximately 6 trauma types in their lifetimes ($M = 5.59$, $SD = 3.45$). For the subset of caregivers with available data ($N = 24$), caregivers reported experiencing approximately 9 trauma types in their lifetimes ($M = 9.08$, $SD = 3.41$). Additional information about participant demographics and index events is provided in Tables 1 and 2.

Child Posttraumatic Stress Symptom Reduction following CFTSI-YC

Average pre-treatment and post-treatment child and caregiver PTSS are presented in Table 3. At screening, 38% of children had caregiver-reported PTSS in the clinically significant range (i.e., CATS-C total score ≥ 16). Paired samples t-tests were used to examine changes in children's overall PTSS from pre-treatment to post-treatment. Caregiver-reported CATS-C scores decreased significantly from pre-treatment to post-treatment ($t = 5.37$, $p < .001$) (see Figure 1). The mean decrease was 7.24 points, and the effect size was considered medium to large (Cohen's $d = .76$). When considering only children who began with clinical levels of PTSS (i.e., CATS-C scores ≥ 16), the pattern of findings was similar, including statistically significant decreases in symptoms ($t = 8.58$, $p < .001$) and a large effect size (Cohen's $d = 1.97$). At the completion of CFTSI-YC, only 8% of children were experiencing PTSS in the clinical range (compared to 38% at screening).

Secondary analyses indicated that completing CFTSI-YC was associated with statistically significant reductions in each of the four key PTSD symptom clusters, with effect sizes ranging from medium to large. Specifically, paired samples t-tests indicated significant decreases in

intrusion symptoms ($t = 4.81, p < .001$; Cohen's $d = .68$), trauma avoidance ($t = 3.35, p < .01$; Cohen's $d = .48$), negative alterations in cognitions and mood ($t = 4.78, p < .001$; Cohen's $d = .68$), and alterations in arousal and reactivity ($t = 3.44, p < .01$; Cohen's $d = .49$). Four children (8%) met full criteria for PTSD at the post-treatment assessment.

Caregiver Posttraumatic Stress Symptom Reduction following CFTSI-YC

Mean Session 1 and post-treatment PCL scores are presented in Table 3. Paired samples t-tests were used to examine changes in caregiver PTSS associated with participation in CFTSI-YC. Caregiver PCL scores decreased significantly from Session 1 to the assessment conducted at the completion of CFTSI-YC ($t = 4.43, p < .001$). The mean decrease was 9.56 points, and the effect size was considered medium to large (Cohen's $d = .65$) (See Figure 2).

Background Characteristics and Child Symptom Reduction with CFTSI-YC

A repeated measures ANCOVA was used to determine whether changes in PTSS from pre- to post-treatment differed significantly by child age, gender, race, prior trauma history, or referral trauma. Child gender, race, and type of traumatic event leading to referral were entered as between-subject factors. Child age and prior trauma history were entered as covariates. To increase statistical power and avoid categories containing only 1 or 2 children, we created a variable characterizing the type of traumatic event leading to referral as either child sexual abuse ($N = 23$), other interpersonal trauma ($N = 16$), or non-interpersonal trauma ($N = 11$).

ANCOVA findings indicated a significant main effect $F(1, 36) = 15.42, p < .001$, reflecting the statistically significant reduction in PTSS from pre- to post-treatment, even controlling for these other variables. The estimated marginal mean (SD) in CATS-C scores was 15.70(1.84) at pre-treatment and 8.27(1.12) at post-treatment, representing a 7.40 point decrease in PTSS symptoms. None of the other variables were significant, indicating that symptom change did not differ based on child gender $F(1, 36) = 1.07, p = .31$, race $F(2, 36) = 1.73, p = .19$, type of traumatic event leading to referral $F(2, 36) = 2.12, p = .14$, age $F(1, 36) = .08, p = .79$, or prior trauma history $F(1, 36) = .18, p = .68$.

Post-treatment Disposition Outcomes following CFTSI-YC

We examined post-treatment disposition by determining the percentage of children referred by the treating clinician for additional trauma-focused treatment at the completion of CFTSI-YC. Twenty percent of children were referred for additional trauma-focused treatment. Accordingly, 80% of children were not referred for additional trauma-focused treatment at the completion of CFTSI-YC.

Discussion

This study provides initial evidence that children who complete CFTSI-YC experience significant improvements in PTSS in a poly-traumatized, ethnically and racially diverse sample of young children. Reductions in overall PTSS, as well as core PTSD symptom clusters, were demonstrated. At the completion of CFTSI-YC, 92% of children did not meet full criteria for PTSD. In addition, consistent with prior studies of CFTSI with older children (Goslin & Epstein, 2024), 80% of children who completed CFTSI-YC were not referred by the treating clinician for additional trauma-focused treatment. These findings are especially notable given the brevity of CFTSI-YC (i.e., 6-8 sessions) and the multiple trauma experiences children had experienced in their lifetimes (i.e., an average of approximately six different trauma types). Repeated trauma exposure has been demonstrated to be associated with a higher risk for PTSD and related problems compared to single-incident exposures (Woolgar et al., 2022). Current findings build on prior work demonstrating the effectiveness of CFTSI for school-aged children and adolescents, including those with histories of multiple prior trauma types. Rates of probable PTSD following CFTSI-YC (i.e., 8%) were substantially lower than the 26% prevalence estimates reported in a recent meta-analytic review of preschoolers exposed to PTEs (Woolgar et al., 2022). In addition, it was important to demonstrate that symptom reduction did not differ for children of different genders, races, ages, or recent and historic trauma history, suggesting that this intervention may have broad applicability across diverse groups of young children. If replicated, current pilot findings suggest that the brevity and effectiveness of CFTSI-YC may

increase early identification and intervention for trauma-exposed preschoolers, returning children to the path of optimal development, supporting recovery, and potentially reducing referrals for additional trauma-focused treatment for many children. These findings are particularly relevant in the context of lengthy waitlists that are common in community mental health clinics. As with CFTSI for older children, CFTSI-YC has the potential to simultaneously reduce children's distress and expand access to care for children and families seeking behavioral health services.

Current findings are also consistent with prior research with older children documenting that CFTSI participation is associated with PTSS reduction for caregivers. Studies have consistently demonstrated a strong correlation between children's PTSS and caregivers' PTSS (Allbaugh et al., 2024; Morris et al., 2012; Scheeringa & Zeanah, 2001). Indeed, parental symptoms in the early period after PTEs have been shown to be one of the strongest long-term predictors of children's subsequent PTSD diagnosis (Yule et al., 2019). Because caregiver support is essential to children's recovery following PTE exposure, current caregiver findings are important because they demonstrate that CFTSI-YC can address the needs of both young children and their participating caregivers. It is possible that caregivers learn coping and self-regulation skills (e.g., focused breathing, guided visual imagery) through their participation in CFTSI-YC sessions. Their enhanced self-regulation may subsequently facilitate their increased ability to recognize and attend to their young children's needs and provide effective parenting and behavioral interventions. It is also possible that, as children's PTSS improve, caregivers experience reduced stress and trauma-related symptoms. A bidirectional relationship between children and caregivers' recovery in the context of CFTSI-YC seems most plausible and should be examined in future studies.

Current findings also contribute to the growing body of literature on trauma-focused interventions for young children. It is important to acknowledge the substantial prior work devoted to developing and evaluating evidence-based interventions that address the needs of

young, traumatized children. For example, Child-Parent Psychotherapy (CPP) is a trauma-informed treatment for young children impacted by trauma that focuses on the child's relationship with their caregivers and seeks to help children regain trust in their caregiver's ability to protect them from danger, which may be disrupted in the context of PTEs (Lieberman, 2004; Lieberman et al., 2015; Lieberman & Van Horn, 2009). CPP has been demonstrated to reduce PTSS in preschoolers exposed to domestic violence and other upsetting events and is considered a "possibly efficacious" treatment for children's PTSS, based on a review of available intervention studies (Lieberman et al., 2005; Moner et al., 2024). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is another widely disseminated and well-studied trauma-focused treatment that has been adapted for preschoolers (Cohen et al., 2017; Pollio & Deblinger, 2017). There is more limited evidence regarding TF-CBT's effectiveness in preschool-aged children, and meta-analytic studies have reported larger treatment effects in studies of older youth (Lenz & Hollenbaugh, 2015; McGuire et al., 2021; Miller-Graff & Campion, 2016). Nonetheless, based on a review of available intervention studies in preschoolers exposed to PTEs, TF-CBT was considered "probably efficacious" for this age group, although more research is needed (Moner et al., 2024). Despite their important role as trauma-focused interventions for young children, neither CPP nor TF-CBT were designed specifically to be implemented in the early aftermath of PTEs. Like these interventions, CFTSI-YC aims to reduce PTSS in young children. However, unlike CPP and TF-CBT, CFTSI-YC was specifically developed for implementation during the acute post-trauma period as a brief, early intervention designed to reduce PTSS soon after trauma exposure and help determine whether referral for additional trauma-focused treatment is indicated at the completion of treatment. Finally, a recent systematic review identified no rigorous studies examining play therapy for preschoolers following PTEs (Moner et al., 2024). This paucity of empirical data is notable given the widespread use of unstructured play therapy and related approaches in community settings.

If current findings are replicated in future research trials, CFTSI-YC may address a gap in available services for young children and their caregivers experiencing PTSS in the period immediately following PTEs or the formal disclosure of past abuse. The brevity of CFTSI-YC may be particularly useful for families who are unable or reluctant to engage in longer-term treatment or who face barriers to sustained outpatient care (e.g., multiple case management demands, transportation issues). For the subset of preschoolers who are referred for additional trauma-focused treatment following completion of CFTSI-YC, evidence-based interventions such as TF-CBT or CPP may be appropriate next steps in treatment. In this way, CFTSI-YC may function as a complementary treatment within a broader continuum of care.

Strengths and Limitations

Strengths of the current study include the racial and ethnic diversity of the sample. Further, study participants, including both children and caregivers, had experienced chronic trauma exposure, in addition to the index event prompting CFTSI-YC referral. These characteristics suggest that CFTSI-YC may have applicability for both single-incident PTEs and PTEs occurring in the context of chronic trauma exposure. The use of developmentally appropriate diagnostic criteria and standardized assessment tools to examine PTSS and PTSD in preschoolers is consistent with best practices in this area (Woolgar et al., 2022). Finally, study findings reflect real-world clinical data collected during routine clinical care, increasing the likelihood that findings may generalize to broader clinical populations of families who could ultimately be served by CFTSI-YC.

While promising, this study has limitations that should be acknowledged. First, this pilot study used a small sample of participants in an open trial format. The smaller sample did not allow comparing outcomes based on caregiver gender or relationship to the child. Second, because there was no comparison condition, this study does not provide evidence of the efficacy or effectiveness of CFTSI-YC relative to no treatment or another treatment. Rather, findings indicate that young children and caregivers who completed CFTSI-YC experienced significant

reductions in PTSS. Future studies of CFTSI-YC should build on current pilot findings and incorporate comparison condition(s).

Third, given their young age, children in this study were not asked to provide data regarding their own PTSS. Consistent with other research examining PTSS in this age range, we relied on caregivers' ratings of their children's PTSS. However, caregivers may not be aware of the full extent of children's trauma reactions, particularly for internalized symptoms. Challenges of assessing PTSS in preschoolers have been extensively described elsewhere (Scheeringa, 2011). For example, it is often easier for adults to identify behavioral reactions compared to internalized reactions such as intrusive thoughts or images of an upsetting experience. Prior studies with older children have demonstrated that utilizing self-reported PTSD assessment approaches may lead to higher prevalence estimates (Meiser-Stedman et al., 2008; Scheeringa et al., 2006). In the current study, it is possible that caregivers underestimated their children's PTSS. However, given that CFTSI-YC aims to increase caregivers' understanding of trauma and common trauma reactions in young children, enhance caregivers' observational skills to identify children's trauma symptoms as they occur, and strengthen communication between children and caregivers about children's trauma reactions, it is possible that caregivers were more accurate reporters of their children's PTSS and less likely to underreport PTSS following participation in CFTSI-YC. If so, the effect size for children's symptom improvement associated with CFTSI-YC may be underestimated in the current study. Future work should incorporate multi-informant approaches to increase the accuracy of assessment of young children's PTSS.

Fourth, comorbid conditions other than PTSS and PTSD were not assessed. As summarized above, prior research has documented that preschoolers' exposure to a range of upsetting events is associated with a host of negative developmental and psychiatric conditions, both cross-sectionally and longitudinally. Certainly, PTSS are an important target for intervention due to the suffering they cause. In addition, untreated PTSS may contribute to other difficulties over time. For example, PTSS have been shown to mediate the relation

between children's exposure to maltreatment and behavioral problems, depressive symptoms, and anxiety (Milot et al., 2010). Longitudinal designs have documented similar mediational paths in the relation between young children's exposure to violence, their PTSS in preschool, and subsequent internalizing, externalizing, and social competence difficulties later in childhood, further highlighting the salience of PTSS as an important target for intervention with the potential for far-reaching developmental and psychiatric impact (Briggs-Gowan et al., 2012). Finally, the severity of preschoolers' PTSS has been shown to be associated with functional impairment in social functioning and relationships over time (Scheeringa et al., 2005). Given the central role of PTSS in subsequent development, CFTSI-YC has the potential to serve as a strong early intervention and facilitate PTSS reduction shortly after preschoolers' exposure to PTEs. Nonetheless, future studies of CFTSI-YC should examine whether this treatment is helpful for addressing a broader range of potential developmental and clinical outcomes.

Finally, this study examined changes in PTSS from pre-treatment to post-treatment without longitudinal follow-up. Therefore, data only indicate whether the treatment impacts symptoms immediately post-treatment and not whether symptom reductions are maintained over the weeks or months following treatment completion. Future randomized trials with longitudinal follow-up are needed to understand the full impact of CFTSI-YC.

Conclusion

This study provides initial evidence that completing CFTSI-YC was associated with significant improvements in child and caregiver PTSS in a diverse, poly-traumatized sample, addressing an important gap in our understanding of early, brief, trauma-focused interventions for preschoolers. If replicated, these results may inform clinical practice and future research on brief, early interventions for young children and families impacted by trauma and guide future research and dissemination efforts of CFTSI-YC. As a brief, early intervention implemented in the acute post-trauma period, CFTSI-YC has the potential to reduce suffering and support recovery for young children and their participating caregivers. If replicated, these findings may

contribute to efforts to prevent negative developmental and psychiatric outcomes and improve access to trauma-focused treatment. In addition, the brevity of CFTSI-YC may increase the capacity of behavioral health programs to serve trauma-exposed children and families, with the potential to alleviate lengthy waitlists and improve access to early trauma-focused treatment.

Declarations

Competing Interests: The authors have no competing interests to disclose.

Author Contributions: All authors made substantial contributions to the conception and design of this work. Author 1 drafted the manuscript and Authors 2 and 3 critically revised it. Author 1 completed data analysis with support from Author 2. All authors interpreted findings. Authors 3 and 1 acquired funding to support this research. Authors 2 and 3 oversaw data collection and data management. All authors reviewed and approved the manuscript.

Consent to Participate & Consent to Publish: This study was conducted with an IRB-approved exemption for secondary use of de-identified clinical data.

Availability of Data and Materials: Due to the pilot nature of this work using de-identified clinical data, data are not available in a repository. Researchers wishing to access the data may contact Author 3.

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Table 1
Participant Characteristics (N = 50)

Variable	Frequency (Percent) ^a
Participating Caregiver	
Birth mother	42 (84%)
Foster mother/grandmother	4 (8%)
Birth father	3 (6%)
Out of home placement	
No	39 (78.0%)
Yes	7 (14%)
Custody Arrangement	
Both parents/shared custody	26 (52%)
Single parent	15 (30%)
Other/Unknown	6 (12%)
Child welfare agency	3 (6%)
Birth mother education level	
Unknown/Missing	15 (30%)
High school diploma (or equivalent)	10 (20%)
Associate's or Bachelor's degree	9 (18%)
Some college (no degree)	8 (16%)
Master's or Doctoral degree	6 (12%)
Less than high school	2 (4%)

^aPercentages may not total 100 due to missing data collected in the context of routine clinical care.

Table 2*Characteristics of the Referral Incident (N = 50)*

Variable	Frequency (Percent)
Referral incident trauma type	
Sexual abuse	23 (46%)
Domestic violence	10 (20%)
Unintentional injury	7 (14%)
Traumatic grief	4 (8%)
Community Violence	3 (6%)
Other	2 (4%)
Physical abuse	1 (2%)
Identity of alleged perpetrator	
Birth Father	18 (36%)
Not applicable (no perpetrator)	11 (22%)
Other	9 (18%)
Sibling	5 (10%)
Caregiver's partner	3 (6%)
Cousin	2 (4%)
Grandfather	1 (2%)
Birth mother	1 (2%)
Child type of exposure to index trauma	
Victim	33 (66%)
Witness	15 (30%)
Both	2 (4%)
Alleged perpetrator in caregiving role?	
Yes	19 (38%)
No	17 (34%)
Unknown/not applicable	14 (28%)
Alleged perpetrator living in the home?	
Yes	15 (30%)
No	21 (42%)
Unknown/not applicable	14 (28%)

Table 3

Means and Standard Deviations for Child (N = 50) and Caregiver (N = 46) Posttraumatic Stress Symptoms before and after CFTSI-YC

Variable	Screening/Session 1 Mean (SD)	Post-CFTSI-YC Mean (SD)
Child Overall PTSS (CATS-C) ¹	14.04 (9.75)	6.80 (6.44)
Child Intrusion Symptoms ²	4.82 (3.76)	2.14 (2.45)
Child Trauma Avoidance ³	1.86 (1.91)	.86 (1.41)
Child Negative Alterations in Cognitions and Mood ⁴	2.49 (2.74)	.78 (1.09)
Child Alterations in Arousal and Reactivity ⁵	4.90 (3.58)	3.12 (2.87)
Caregiver Overall PTSS (PCL) ⁶	27.36 (18.47)	17.70 (15.33)

¹ $t = 5.37, p < .001$

² $t = 4.81, p < .001$

³ $t = 3.35, p < .01$

⁴ $t = 4.78, p < .001$

⁵ $t = 3.44, p < .01$

⁶ $t = 4.43, p < .001$

Figure 1

Child Posttraumatic Stress Symptoms Decrease following CFTSI-YC (N = 50)

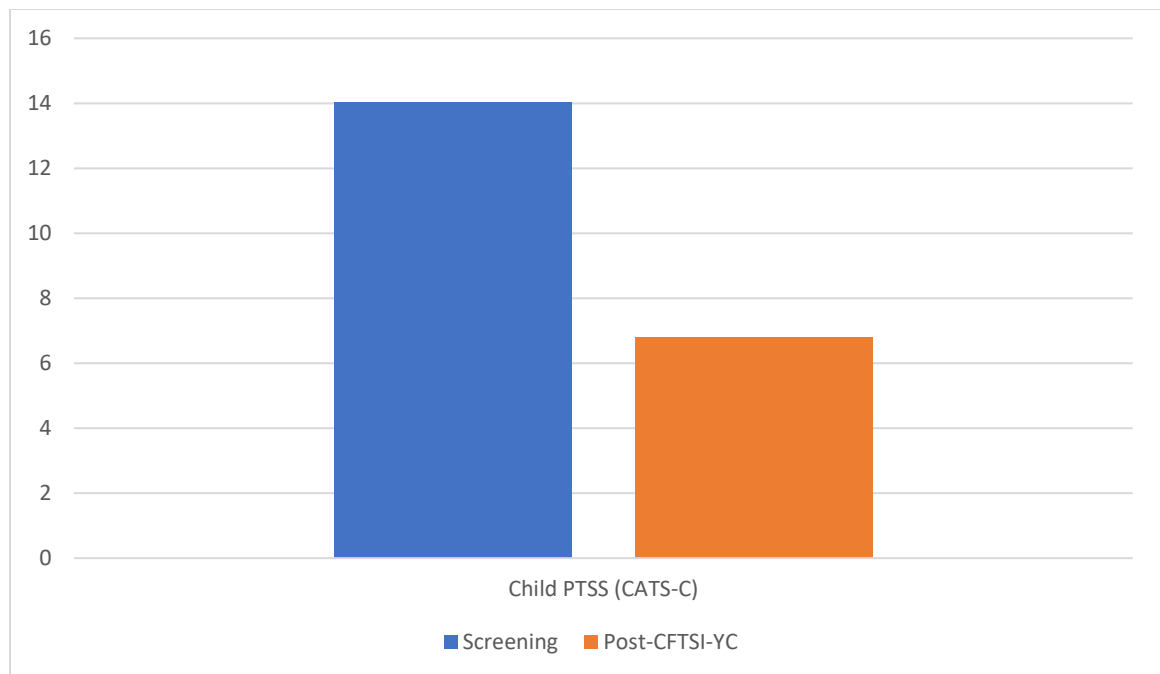


Figure 2

Caregiver Posttraumatic Stress Symptoms Decrease following CFTSI-YC (N = 46)

