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Introduction to Infant Early Childhood Mental Health and Trauma Training Program

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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Department of Counseling and Family Sciences

Introduction to Infant Early Childhood Mental Health and Trauma Training Program

by

Irene Rosaly Cortez

A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Marital and Family Therapy

June 2022

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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ABBREVIATIONS

ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
AF-CBT	Alternatives for Families-A Cognitive Behavioral Therapy
APA	America Psychological Association
ARC	Attachment, Self-Regulation, and Competence: A Comprehensive Framework
ARTIC	Attitudes Related to Trauma-Informed Care Scale
BUD	Bottom-Up Dissemination
CBT	Cognitive Behavioral Therapy
CCCT	Curriculum on Childhood Trauma
CDC	Centers of Disease Control and Prevention
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
CPP	Child Parent Psychotherapy
CPPT	Child-Centered Play Therapy
CPS	Child Protective Services
DBT	Dialectical Behavior Therapy
I-ECMH	Infant-Early Childhood Mental Health
LACDMH	Los Angeles County Department of Mental Health
NCTSN	National Child Traumatic Stress Network
ODD	Oppositional Defiant Disorder
PC-Care	Parent-Child Care

PCIT	Parent-Child Interaction Therapy
PTSD	Post Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
TF-CBT	Trauma Focused-Cognitive Behavioral Therapy
TIC	Trauma-Informed Care

ABSTRACT OF THE DOCTORAL PROJECT

Introduction to Infant-Early Childhood Mental Health and Trauma Training Program

by

Irene Rosaly Cortez

Doctor of Marital and Family Therapy,
Department of Counseling and Family Sciences
Loma Linda University, June 2022
Dr. Nichola Seaton Ribadu, Chairperson

This program aims to understand the lack of infant-early childhood trauma-informed care training for mental health clinicians. The current efforts to enhance mental health clinicians' therapeutic knowledge and awareness through the development of the CCCT with the emphasis on trauma-informed care show significance to treat infant-early childhood trauma. Due to children's susceptibility to trauma and developmental vulnerability, if trauma remains unaddressed, there are long lasting negative effects throughout their adulthood, as shown through the ACE's study. Furthermore, the program's theoretical framework encompasses Attachment Theory with the integration of the Theory of Neuroscience, Bowen family systems theory, Reflective Practice Model, and Mindfulness to develop a basic competent trauma-informed care training. The development of the Introduction to Infant-Early Childhood Mental Health and Trauma Training Program was designed for mental health clinicians to enhance their therapeutic knowledge and awareness when serving children with infant-early childhood trauma. The key interventions are *psychoeducation on infant-early childhood mental health and trauma*, *nondirective play therapy*, and *reflective practice and mindfulness*. The Introduction to Infant-Early Childhood Mental Health and Trauma Training Program occurs yearly on a quarterly basis, meaning there are different cohorts of participants,

whether they are participating in beginning of the trauma-informed care training or attending a booster. Lastly, the evaluation plan of the Introduction to Infant-Early Childhood Mental Health and Trauma Training Program measures the three dimensions of competence: trauma-informed care (TIC) knowledge, trauma awareness, and trauma beliefs among mental health therapists.

Keywords: *clinician, trauma, child-caregiver relationship/dyad, infant-early childhood trauma*

CHAPTER ONE

EXECUTIVE SUMMARY AND PROJECT PURPOSE

Executive Summary

The American Psychological Association (APA) reports that mental health clinicians have expressed interest in trauma educational opportunities (as cited in Cook et al., 2019). There has been an emphasis on understanding adult trauma with the development of trauma competencies, such as the APA Trauma Competencies and the APA PTSD Guidelines. Yet, there has been a lack of awareness on infant-early childhood trauma until the National Child Traumatic Stress Network (NCTSN) developed the *Core Curriculum on Childhood Trauma* (CCCT). Furthermore, some evidence-based practices (EBPs) are not appropriate for children under five years old despite the focus on post-traumatic stress disorder symptoms. Examining the effects of infant-early childhood trauma, researchers have also investigated adverse childhood experiences (ACE's), which greatly impact adults later in life. Children are susceptible to multiple effects from infant-early childhood trauma as the symptoms affect the children's development through adulthood. Therefore, it is important to address infant-early childhood trauma through an early intervention and prevention process to increase clinician's awareness of trauma to decrease child and family trauma symptoms.

To understand infant-early childhood trauma, mental health clinicians must understand what infant-early childhood mental health is within the mental health field. The understanding of infant-early childhood mental health includes the comprehension of mastering motor skills, language development, socioemotional development, and child-

caregiver attachment. The literature review demonstrates that children under five years old suffer from multiple traumatic effects, which can cause long-term health problems, increase involvement in the justice system, and increase usage of mental health services. The ACE's study reports the 10 prominent ACEs that cause long term health issues and affect the epigenetics of an individual (CDC, n.d.). With the development of the trauma-informed care (TIC) movement, providers have started to recognize the impact of trauma on children and families. Furthermore, there are a few specific services for families with children aged 0-5 years old such as parent education, homes visits, and parent training. On the other hand, there are a few evidence-based practices that have been evaluated to support infant-early childhood trauma. For example, nondirective play therapy is significant in improving children's capabilities in expressing and processing their traumatic experiences.

In addition, there are limited interventions to treat infant-early childhood trauma with three different types of prevention programs: primary prevention, secondary prevention, and tertiary prevention. Research has demonstrated the need for trauma trainings and the development of treatment modalities to treat infant-early childhood trauma. The treatment model Child Parent Psychotherapy (CPP) is designed to address the trauma for children under 5 years old, through enhancing mental health clinicians' clinical skills using the CPP concept of reflective practice. Furthermore, TIC has supported the improvement of trauma knowledge in mental health clinicians, but multiple barriers were identified in adequately preparing mental health clinicians to address trauma. Therefore, change needs to occur in increasing trauma trainings for mental health

clinicians; but most importantly, an infant-early childhood trauma curriculum needs to be developed to increase confidence and competence to treat children with trauma.

The Infant-Early Childhood Conceptual Framework explains the development of the curriculum as it will address important concepts for mental health clinicians to understand infant-early childhood mental health and trauma. The program's questions focus on:

How can Attachment Theory with the integration of the Theory of Neuroscience enhance trauma awareness and knowledge and Bowen family systems theory explain the absence of mental health clinicians in the infant-early childhood trauma field?

In addition,

How can reflective practice emphasize the importance of a training curriculum and mindfulness support the well-being of the mental health clinicians and those part of the infant-early childhood population?

Integrating the theories supports each theory to enhance trauma knowledge, trauma awareness, and support mental health clinicians to treat children with infant-early childhood trauma. The theoretical framework assists in providing mental health clinicians with trauma-informed information, interventions, and emotional support for mental health clinicians when treating infant-early childhood trauma.

The Introduction to Infant-Early Childhood Mental Health and Trauma Training program is composed of a four-day course training (one preliminary training day and three following training days) and two one-day booster sessions. There are three phases in the curriculum to help mental health clinicians gain knowledge and awareness about the infant-early childhood population. The key phases are *psychoeducation on infant-early childhood mental health and trauma*, *nondirective play therapy*, and *reflective*

practice and mindfulness. Mental health clinicians who are pre-licensed (students and associates) and licensed (marriage and family, social work, professional clinical counselor) mental health clinicians are the targeted population to increase knowledge and awareness of infant-early childhood mental health and trauma. The purpose of the training is to provide an overview of trauma-informed care about the infant-early childhood population.

The preliminary training day, which is optional, is a more in-depth informational, overview process of the trauma-informed care approach of the infant-early childhood population. The following three training days focus on the three phases of the curriculum, while the two one-day booster sessions occur throughout the year to review the lecture material from the four-day training. The curriculum consists of PowerPoint lectures, vignettes, video segments, role plays, and group discussions. Mental health clinicians will have access to worksheets, handouts with brief overviews of the lectures, and participate in group activities. The end goal of the program is for mental health clinicians to develop competent knowledge and awareness about infant-early childhood trauma.

The Introduction to Infant-Early Childhood Mental Health and Trauma Training Program's evaluation plan is to measure the three dimensions of competence: trauma-informed care (TIC) knowledge, trauma awareness, and trauma beliefs among mental health clinicians. The three measurements being used for the evaluation process are the Attitudes Related to Trauma-Informed Care (ARTIC), Commitment to Trauma Informed Care Survey, and the Child Trauma Clinical Beliefs. The mental health clinicians will complete the questionnaires as a pre-assessment before the four-day training, after the

two booster sessions, and at the 18-month post-training timepoint.

The next step to ensure the implementation of the trauma-informed care training is contacting the Los Angeles County Department of Mental Health (LACDMH), National Alliance on Mental Health, National Child Traumatic Stress Network (NCTSN), the Child Mind Institute, Zero to Three organization, and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) to start networking. The goal is to have a “live” training due to the “on-hands” experiential activities of the manual; yet there would be modifications necessary to adjust to the current COVID-19 pandemic. There are some anticipated challenges and limitations to the trauma-informed care training to be aware of when following through the implementation process. The Infant-Early Childhood Mental Health and Trauma Training program addresses mental health clinicians’ needs while they create hope for children and families in a healing environment.

Problem Statement

According to the American Psychological Association (APA) Practice Organization, 64% of psychologists treating trauma survivors expressed interest in educational opportunities to learn about trauma related concepts (as cited in Cook et al., 2019). This demonstrates a need for more efficient trauma-informed care training opportunities such as a curriculum, internship opportunities, and continuing education courses (Cook et al., 2019). It is unknown the reason why mental health clinicians do not routinely assess for trauma but failing to assess can lead to inappropriate treatments for patients and most trauma survivors do not disclose or recognize trauma experiences

(Cook et al., 2019). The creation of different *trauma competencies* by the APA concluded with “eight cross-cutting competencies and five broad competencies (*scientific knowledge, psychological assessment, psychological intervention, professionalism, relational and systems*)” to determine a clinician level of understanding related to trauma (as cited in Cook et al., 2004, p. 441).

In the last 15 years efforts to train mental health clinicians in trauma assessments and treatments (Cook et al., 2019) has been moving forward starting with the APA Trauma Competencies and the APA PTSD Guidelines, but only with the focus on adults. Though in 2007, the National Child Traumatic Stress Network (NCTSN) developed the *Core Curriculum on Childhood Trauma* (CCCT), to increase trauma training in graduate programs and post-graduate, along with trauma-informed care (TIC) focusing on childhood trauma (as cited in Layne et al., 2011). The trauma-informed care (TIC) movement supports mental health clinicians to recognize and respond appropriately to trauma’s impacts (NCTSN, n.d.). TIC involves the participation of programs and agencies to develop trauma awareness, knowledge, and skills (NCTSN, n.d.). Currently, the CCCT is an experiential learning tool implemented across the US in different community-based settings to increase trauma-informed care knowledge and skills (NCTSN, n.d.). The CCCT focuses on incorporating foundational knowledge about trauma-informed care through problem-based learning (PBL) groups with a trained educator to explore multiple points of view on different case studies and solutions to complex problems (NCTSN, n.d.).

Trainings in evidence-based practices (EBPs) have focused on post-traumatic stress disorder by implementing prolonged exposure and cognitive processing therapy

(Cook et al. 2009). So far, the EBP, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), has been implemented for children and adolescents (Cook et al., 2009). TF-CBT is a structured approach for children and adolescents to *verbally* share their experiences (Cook et al., 2009), which is not appropriate for children under 5 years old without fully developed verbal skills and/or verbal delays. Children under 5 years old are part of the infant-early childhood mental health (I-ECMH) population, which refers to the capacity of a child from birth to five years old to develop secure relationships with adults; experience, regulate, and express a spectrum of emotions, and explore surroundings while learning (Zero to Three, 2016).

Unfortunately, many children are susceptible to infant-early childhood trauma, which can cause long lasting negative effects on development, health, and well-being (CDC, n.d.). Furthermore, the effects of infant-early childhood trauma can be examined through adverse childhood experiences (ACE's). ACE's are traumatic events between the ages of 0-17 years old, such as experiencing violence, abuse, or neglect; witnessing home and/or community violence; and/or having a family member attempt or commit suicide (CDC, n.d.). Also, this includes situations impairing the child's sense of safety, stability, and bonding due to substance abuse, mental health illnesses, and/or unstable household (CDC, n.d.). The CDC (n.d.) states that about 61% of adults have experienced at least one type of ACE, while nearly one in six adults report experiencing four or more types of ACEs. Therefore, to reduce the negative effects of ACEs, infant-early childhood interventions can prevent harm for children and families.

The CDC (n.d.) reports how important infant-early childhood interventions are for good physical health and supporting a functional mental health environment. In addition,

the American Psychological Association (APA, n.d.) states that one in five children receive mental health services from a specialized child mental health clinician. This is an alarming statistic to understand the lack of focus on trauma training as it relates to infant-early childhood trauma.

According to the National Child Traumatic Stress Network (NCTSN, n.d.), infant-early childhood trauma reactions include experiencing symptoms interfering with the child's daily functioning, interactions, and affecting the child's developmental stage (NCTSN, n.d.). Furthermore, sensory development is impacted by infant-early childhood trauma since a child's sense of safety has been disrupted. When trauma occurs, there are biological responses impacting sensory processes and affecting how memories are stored for the child (Robinson & Brown, 2016). Traumatic responses are registered through visual, sensory, and emotional processes causing disruption not only in the child's development, but also in the child's environment (Robinson & Brown, 2016). Therefore, when children display symptoms that caregivers do not understand, they will not know how to respond accordingly (NCTSN, n.d.). Lastly, caregivers seek guidance and support and if mental health clinicians are not properly trained in infant-early childhood trauma, then risks arise.

Rationale of the Project

The current efforts to enhance mental health clinicians' therapeutic skills through the development of the CCCT with the emphasis on trauma-informed care show significance to treat infant-early childhood trauma. Therefore, the lack of trauma trainings (Kumar et al., 2019) illustrates the need for the development of an infant-early

childhood trauma curriculum for mental health clinicians. As stated above there are few evidence-based practices for infants to 5-year-old children focusing on interventions to support this population in therapy when addressing trauma. Therefore, the development of an infant-early childhood trauma-focused curriculum for mental health clinicians is necessary to gain knowledge and awareness about the infant-early childhood population.

Due to children's susceptibility to trauma and developmental vulnerability, if trauma remains unaddressed, there are long lasting negative effects throughout their adulthood, as shown through the ACE's study (CDC, n.d.). Furthermore, pertaining to understanding the development of infants and children, a trained clinician should understand the biological effects of trauma and have the capability to explain the effects to caregivers to help create appropriate responses to trauma triggers. Not only are children under 5-years-old who have experienced trauma susceptible to mental health problems, but also their functioning, interactions, and sense of safety are threatened. This creates possible issues throughout adulthood if not addressed in early intervention and prevention through mental health services. The development of an infant-early childhood trauma-focused curriculum for mental health clinicians will address the gap in the trauma field and offer effective interventions to mental health clinicians treating infants to 5-year-old children with traumatic experiences.

According to the San Francisco Child Abuse Prevention Center in collaboration with the Haas School of Business at the University of California, Berkeley an incidence of child maltreatment over the course of the victim's lifetime cost \$400,533 to the public (Loudenback, 2017). Therefore, a child who has sustained a case of child abuse or neglect collects \$11,035 in costs of utilizing services from child welfare agencies

(Loudenback, 2017). Since victims of child abuse are more likely to be involved in juvenile and adult justice system, the average cost per victim is \$7,637 in the criminal justice system (Loudenback, 2017). Consequently, child abuse has shaped the expectations of lifetime productivity for the economy with the potential loss of employment opportunities (Loudenback, 2017). Not only are these estimates conservative, but researchers say the actual number might be higher; but reports are not adequate due to child abuse cases not being sustained (Loudenback, 2017).

Therefore, to avoid child abuse Loudanback (2017) shared three preventative measures from the research: 1) “adopt a public health approach towards child abuse prevention,” 2) “provide greater access to services,” and 3) provide educational measures to increase awareness. Therefore, the development of an infant-early childhood trauma-focused curriculum supports an educational approach to increase awareness and decrease financial strain on the public.

Key Terms

Key terms will be defined related to the infant-early childhood trauma-informed care training. *Clinician* is defined as therapists, counselors, psychologists, and clinical social workers, who hold a Master’s degree and/or Doctoral degree trained to evaluate people’s mental health (NAMI, n.d.). According to the APA (n.d.), *trauma* is defined as an “emotional response to a terrible event like an accident, rape, or natural disaster. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea.” In addition, *child-caregiver relationship/dyad* is defined as “a pair of individuals in an interpersonal situation” (APA,

n.d.). According to the NCTSN (n.d.), *infant-early childhood trauma* is defined as “traumatic experiences that occur to children aged 0-6 affecting their safety or the safety of their parents/caregivers.”

CHAPTER TWO

LITERATURE REVIEW

Infant-Early Childhood Mental Health and Trauma

According to *Zero to Three*, a national organization advocating on behalf of infants, toddlers, and families, define infant-early childhood mental health as the child's ability to experience, regulate, express emotions, form secure relationships, and explore the environment safely (Zero to Three, n.d.). By understanding infant-early childhood mental health, therapists can prevent and treat mental health concerns of young children and families (Zero to Three, n.d.). Additionally, advocates of infant-early childhood mental health emphasize on the importance of prenatal and postnatal environment to promote healthy development and reduce future mental health issues (Simpson et al., 2016). The early childhood stage is crucial as the child is facing tremendous growth in all areas of development.

Infant-early childhood population is usually defined, by researchers and professionals, as birth to eight years old focusing on skill development (Tomonari, n.d.). The stages of childhood are defined according to social institutions, customs, and laws depending on society (Tomonari, n.d.). For example, in the United States age five is considered a better end point for the early childhood stage as it aligns with the start of school (Tomonari, n.d.). Therefore, for this project the population will focus on birth to five years old to align with the United States school age culture.

From birth to age three, a child typically grows fast becoming a toddler while mastering skills, such as sitting, walking, toilet training, motor development, and hand-

eye coordination to catch and throw a ball (Tomonari, n.d.). Furthermore, between three and five years old, children continue to grow rapidly and further develop fine-motor skills such as being able to control pencils, crayons, and scissors (Tomonari, n.d.). The child's gross motor skills include the ability to skip and balance on one foot, as well as furthering cognitive and language development (Tomonari, n.d.). The child's ability to use all their senses to stay attuned to their environment and how to respond to their caregivers is important to acknowledge when treating children who have experienced trauma.

Furthermore, a child's vocabulary increases between 300-1,000 words over the first three years giving them the ability to use some language to describe situations (Tomonari, n.d.). By age five, the child's vocabulary has grown to approximately 1,500 words giving the child the chance to tell stories using pictures (Tomonari, n.d.). Language allows the child to communicate with others and solve problems (Tomonari, n.d.), which becomes important when noticing that children with traumatic experiences impact their skills development.

In addition, in early childhood the socioemotional development of a child occurs around the age of one making attachment formation crucial (Tomonari, n.d.). Attachment development, or emotional attunement, serves as a model for later relationships as it shapes the child's early experiences from their caregivers (Tomonari, n.d.). During the ages three and five, socioemotional skills help form peer relationships, gender identification, and learning from right and wrong (Tomonari, n.d.). Socioemotional development increases resiliency when treating children with traumatic experiences to decrease the impact from trauma.

Mental and emotional concerns can rise when caregivers do not know how to support a child when they are in distress. Some warning signs when a child is in distress include poor sleep patterns, difficulties with feeding, restlessness, anxiety and tension, persistent or unremitting crying, failure to meet expected developmental milestones, and so on (Stygar & Zadroga, 2021). In the center of supporting infant-early childhood mental health, caregiver “attachment” relationship is important protective factor emphasizing on bonding, mental health, and emotional growth for the child (Stygar & Zadroga, 2021). Caregivers provide social and emotional environment support to regulate a child in their development (Simpson et al., 2016).

On the other hand, risk factors towards infant-early childhood mental health include caregiver’s mental illnesses, financial stress, caregiver’s history of neglect and abuse, caregiver’s alcohol or drug abuse, and so on (Stygar & Zadroga, 2021). Children are at risk of physiological disruptions such as alterations to the brain, immune system, cardiovascular system, and other biological changes (Simpson et al., 2016). Therefore, acknowledging the risk factors towards a child’s mental health, it is significant to have professionals acknowledge infant-early childhood mental health to provide adequate support.

Furthermore, to understand the importance of having an infant-early childhood trauma-informed care training curriculum, mental health clinicians must understand what infant-early childhood trauma is. There is no universal definition of trauma, but SAMHSA (2020) states that “*individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s*

functioning and mental, physical, social, emotional, or spiritual well-being.” Infant-early childhood trauma are experiences of physical abuse, sexual abuse, domestic violence, and/or events threatening their safety are traumatic experiences (NCTSN, n.d.). There are multiple traumatic stress responses such as nightmares, creation of new fears, and lack of sense of safety making children aged 0-5 years vulnerable (NCTSN, n.d.).

Children suffering from traumatic stress became easily frightened, stunt their developmental skills growth, dysregulation of their emotions, difficulty sleeping, and so on (NCTSN, n.d.). In addition, the impact of trauma beyond childhood years are learning problems, long-term health problems, increase involvement with the child welfare and juvenile justice systems, and increase usage of mental health services (SAMHSA, 2020). Most importantly, trauma is tremendous risk factor for the development of behavioral health and substance use disorders (SAMHSA, 2020). A protective factor to infant-early childhood trauma is resiliency from a caring caregiver who can protect children from adverse experiences (NCTSN, n.d.).

Also, trauma can be associated with adverse childhood experiences (ACEs) that enhance the impact of trauma. ACEs were identified through the ACE’s study which investigated childhood abuse, childhood neglect, and household challenges in later life health and well-being (CDC, n.d.). The ACE’s study was conducted in 1995-1997 given to adults asking about their childhood experiences prior the age of 18 (CDC, n.d.). The CDC-Kaiser identified a huge impact on future violence victimization and perpetration on the adults. In addition, the ACE’s study demonstrated psychological effects and long-term health complications of recurring exposure to ACEs (CDC, n.d.). The 10 ACEs identified were physical abuse, emotional abuse, sexual abuse, physical neglect,

emotional neglect, caregiver's mental illness, domestic violence, divorce, substance abuse, and incarcerated relative (Joining Force for Children, n.d.).

Furthermore, the effects of ACEs lead to long term behavior issues, health complications and diseases, anxiety, depression, impaired learning and memory, hypervigilance, and difficulty experiencing joy (Joining Forces for Children, n.d.). ACEs produce toxic stress, which is prolonged activation of body stress response to frequent, intense situations/events (Joining Forces for Children, n.d.). The ACE study determine epigenetics are affected by ACEs as life experiences can change the structure of genes and stress can be passed from one generation to another (Joining Forces for Children, n.d.). Therefore, to prevent toxic stress a child needs a nurturing, safe and stable environment, learn how to cope, reduce ACE exposure, and build resiliency (Joining Forces for Children, n.d.).

Mental health clinicians typically should work from an early-childhood mental health framework based on awareness of early childhood experiences, which can both be negative and positive in shaping the child's development (Oser, n.d.). Mental health clinicians address the relationship with caregivers in a nurturing environment to address emotional needs (Oser, n.d.). The "attachment" relationship between the child and caregiver is the identified client to improve socio-emotional development (Simpson et al., 2016). Furthermore, other family needs are addressed to support the child-caregiver relationship and the child's development (Simpson et al., 2016). Therefore, mental health clinicians promote healthy nurturing relationships while addressing the child's socio-emotional needs for a healthy development.

Not only do mental health clinicians should acknowledge early childhood experiences and the “attachment” relationship but should comprehend birth to 5-year-old children using the *DC:0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. The development of the DC:0-5 is to provide effective early intervention by identifying and classifying disorders (Simpson et al., 2016). Lastly, the DC: 0-5 allows for mental health clinicians to assess the “attachment” relationship in their different environments (Simpson et al., 2016). These concerns will be addressed in the infant-early childhood trauma-informed care training.

Systemic Response to Infant-Early Childhood Trauma

The NCTSN (n.d.) explains how to identify and detect infant-early childhood trauma through the involvement of different systems such as the health system, Early Intervention programs, child welfare agencies, Head Start, childcare programs, and early educational systems, while connecting families to mental health services. Those working with children and families use assessments to identify potential trauma experiences. Some examples of the assessment content include trauma questions to have a better understanding of the family and the child to increase protective factors and reduce risks (NCTSN, n.d.). A clinician’s understanding of infant-early childhood trauma relies on having trauma-informed care training focusing on the specifics of traumatic experiences to help understand the context of the child’s behaviors.

Henning and Brand (2019) investigate the APA PTSD Guideline level of support for mental health clinicians working with the trauma population. The authors conclude

that there is difficulty applying guidelines to complex trauma and having untrained trauma supervisors with the appropriate knowledge and skills, which has a negative outcome (Henning & Brand, 2019). Even though the APA PTSD guideline encourages mental health clinicians to obtain additional specialized trauma trainings, barriers such as time and resources impact the mental health clinicians' ability to enhance their therapeutic skills (Cook et al., 2009). As difficulties arise to apply guidelines, the significance of trauma-informed care training rises; especially for the infant-early childhood population.

Multiple barriers were mentioned for mental health clinicians impeding them from becoming competent trauma clinicians, but there is hope for improvement. The start of incorporating trauma competencies highlights the significance of trauma effects, but the lack of focus on infant-early childhood trauma-informed care training convey a need for mental health clinicians to enhance their knowledge and awareness. Currently, the preventive measures evaluate the clinician's overall trauma competency, but the creation of an infant-early childhood trauma-informed care training curriculum will address challenges in the infant-early childhood mental health field.

Furthermore, Kumar et al. (2019) state why there is a lack of trauma training among professionals. The authors determined this lack of trauma training is detrimental to the public, since it is usually people with traumatic experiences that seek mental health services (Kumar et al., 2019). The lack of trauma training is concerning because mistakes occur, which can be avoided. Mistakes such as misattributions of trauma symptoms and the lack of mental health clinicians' preparation to experience vicarious traumatization and secondary trauma have been recognized as negatively impacting the patient and

clinician (Kumar et al., 2019). Kumar et al.'s (2019) trauma training project reveals that participants experienced an increase in trauma knowledge, an increase in confidence and comfort addressing trauma, and an increased need for more trauma training. Therefore, the lack of trauma training is recognized by mental health clinicians, and they are asking for more trauma trainings. This research demonstrates that there is only a small amount of focus on a universal trauma training for mental health clinicians so far; therefore, revealing a need for infant-early childhood trauma-informed care training.

Furthermore, Miron and Scheeringa (2019) examined mental health clinicians' interest to experience a free trauma training, while the researchers evaluated the improvement of the clinician's trauma skills. The authors' three-level training included attending a one-day training and completing consultation calls. The effort of completion for the trauma training varied by clinician: 1) Mental health clinicians only attended the one-day training, but did not complete the consultation calls, 2) mental health clinicians completed the basic training, which included the one-day training and a few consultation calls, and 3) mental health clinicians completed the advanced training, which included the free trauma training and weekly consultation calls (Miron & Scheeringa, 2019). The results reveal that 57% of patients reduced their PTSD symptoms with mental health clinicians who completed the advanced training. Also, Miron and Scheeringa (2019) identify lack of professional involvement as a huge barrier to completing a trauma training, as participants did not complete the consultation calls and did not proceed to basic or advanced training. Furthermore, Miron and Scheeringa's (2019) results explain the gap of trauma training and how it highlights the importance of having an infant-early childhood trauma-informed care training for mental health clinicians.

Cook et al. (2019) focus on the importance of basic competent trauma training for mental health clinicians. The risks associated with lack of basic competent trauma training are misdiagnoses, incorrect treatments, and an impact on the patient-clinician relationship (Cook et al., 2019). Cook et al. (2019) share additional barriers to lack of trauma training, such as insufficient funds, lack of trained supervisors, and lack of trauma-informed administrators in the trauma population. Cook et al. (2019) recognize a public health issue of not having specialized trauma trainings for mental health clinicians. Therefore, the creation of trauma-informed care (TIC) has focused on recognizing trauma symptoms and the need in clinical settings for trained mental health clinicians and supervisors (Cook et al, 2019). Additionally, graduate program practicums and internships are lacking in trauma focus and education creating barriers to appropriately treat complex trauma (as cited in Cook et al., 2011). The creation of the *Core Curriculum on Childhood Trauma* (CCCT) emphasizes childhood trauma, but more is needed to accomplish a trauma-informed care training focusing on infant-early childhood trauma.

Due to the ACE's study, the trauma-informed care (TIC) movement started for health care providers to become aware of trauma's impact on children and families (Menschner & Maul, 2016). TIC approach shifts the focus from "What's wrong with you?" to "What happened to you?" (Menschner & Maul, 2016). TIC approach informs health care providers to gather a complete history of a child's and family's life to provide effective services (Trauma-Informed Care Implementation Resource Center, n.d.). TIC allows for health care providers to realize the impact of trauma and understand paths to recovery, recognize trauma signs and symptoms, avoid re-traumatization, and integrate

knowledge about trauma into policies, procedures, and practices (Trauma-Informed Care Implementation Resource Center, n.d.).

Furthermore, the core principles of TIC include safety, trustworthiness and transparency, peer support, collaboration, empowerment, humility, and responsiveness (Trauma-Informed Care Implementation Resource Center, n.d.). Safety allows for patients and staff to feel physically and psychologically safe and decisions are transparent while maintaining trust (Trauma-Informed Care Implementation Resource Center, n.d.). Also, staff and patients collaborate in decision-making, while believing in resiliency and the ability to heal from trauma (Trauma-Informed Care Implementation Resource Center, n.d.). Lastly, biases, stereotypes, and historical trauma is recognized and addressed in a trauma-informed care manner (Trauma-Informed Care Implementation Resource Center, n.d.).

By having a TIC approach integrated in addressing infant-early childhood trauma, it allows for mental health clinicians to recognize the direct impact of trauma on the child and family. The TIC approach emphasizes and acknowledges the role trauma plays in the staff and patient's life. Therefore, the Introduction to Infant-Early Childhood Mental Health and Trauma Training program will integrate a trauma-informed care approach to support mental health clinicians' therapeutic knowledge and awareness.

On the other hand, besides the TIC approach, there are a few specific trainings addressing trauma and attachment for children aged 0-5 years old. Infant-early childhood services promote and maintain social-emotional well-being to maintain protective factors (Oser, n.d.). Services also prevent negative consequences of early experiences that might affect the socio-emotional development of a child (Oser, n.d.). In addition, interventions

are provided by trained, skilled mental health clinicians to support children and families (Oser, n.d.). Providing infant-early childhood mental health is about receiving help early once concerns arise regarding a child's development. An example of an early intervention service is *parent education* in which caregivers learn to recognize a child's cues and act (Keltly Mental Health, n.d.). Another example are *home visits* in which mental health clinicians can identify problems as soon as possible such as low income. In addition, *parent training* which is a service that helps parents learn what the child needs and increases attachment between caregiver and child (Keltly Mental Health, n.d.).

Cutuli et al. (2019) review 18 articles about the TIC movement, whether TIC strengthens therapeutic skills for mental health clinicians to provide better services and outcomes for children and families with a trauma history. The authors still report a lack of trauma training with infant-early childhood therapists impacting the clinician's ability to properly treat and support the child and family (Cutuli et al., 2019). Therefore, the TIC movement should continue to address infant-early childhood trauma-informed care training for mental health clinicians. The authors emphasize how agencies should have a commitment to the TIC movement for appropriate trauma interventions (Cutuli et al., 2019). Therefore, the goal to focus on infant-early childhood trauma should incorporate a better use of the TIC movement to develop competent clinicians.

As the TIC movement is incorporated within organizations, Kuhn et al. (2019) discuss that CPS workers from the Tennessee Department of Children's Services recognized primary and secondary effects of trauma after instilling a trauma-informed approach within the department. The CPS workers felt satisfied with the trauma-informed training and found the TIC curriculum relatable to their employee responsibilities (Kuhn

et al., 2019). In addition, the CPS workers improved in their trauma knowledge and associating behaviors with the families' traumatic experiences (Kuhn et al., 2019). Therefore, the article supports the need for a trauma-informed approach to provide better services to children and families with traumatic experiences.

Trauma-Based Modalities

Some evidence-based practices (EBPs) such as cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), trauma-focused cognitive behavioral therapy (TF-CBT), and other behavioral therapies (NAMI, n.d.) do not focus on infant-early childhood trauma. CBT treats depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorder, and other severe mental health illnesses by identifying unhelpful ways of thinking and behaviors (APA, n.d.), but there is no emphasis on trauma. On the other hand, DBT was created for individuals with borderline personality disorder, self-harming, or suicidal thoughts (Skyland Trail, 2017). TF-CBT is one intervention that includes 3-year-old children, but it is mostly tailored to older children and adolescents to treat posttraumatic stress (Good Therapy, 2018). Therefore, these evidence-based practices are not appropriate to directly treat infant-early childhood trauma.

Furthermore, most interventions for children aged 0-5 years old focus on healing and supporting the child-caregiver relationship (NCTSN, n.d.). The following interventions have been developed and evaluated to support infant-early childhood trauma: Alternatives for Families-A Cognitive Behavioral Therapy (AF-CBT), Attachment, Self-Regulation, and Competence: A Comprehensive Framework (ARC),

Child-Parent Psychotherapy (CPP), Parent-Child Care (PC-Care), and Parent-Child Interaction Therapy (PCIT) (NCTSN, n.d.). In addition, Filial Play Therapy is an intervention focusing on child-parent attachment through nondirective play (APA, n.d.).

AF-CBT is a trauma-informed, evidence-based treatment supporting child-caregiver relationships who have encountered arguments, frequent conflict, physical force/discipline, child physical abuse, or child behavior problems (NCTSN, n.d.). Some components of AF-CBT involve psychoeducation about abuse, cognitive processes on caregiver's automatic thoughts, prosocial problem-solving skills, and social skills training (NCTSN, n.d.). The intervention is designed to support a child with externalized behavior problems, poor social competence, coping skills/adjustment problems, aggressive behavior, internalized symptoms, and developmental deficits (NCTSN, n.d.).

ARC is an intervention addressing multiple and/or prolonged traumatic stress for youth and their families (NCTSN, n.d.). ARC is an attachment-based theory with early childhood development to support the child's family system (NCTSN, n.d.). Some key domains of ARC are attachment, self-regulation, competency, and trauma experience integration (NCTSN, n.d.). Furthermore, CPP is an intervention for children aged 0-5 who have experienced traumatic experiences, attachment and/or behavioral problems (NCTSN, n.d.). CPP supports and strengthens the child-caregiver relationship to enhance the child's development (NCTSN, n.d.). Some key components of CPP are focusing on safety, affect regulation, normalizing trauma related response, and construction of a trauma narrative (NCTSN, n.d.).

PC-Care is an intervention to enhance child-caregiver relationships and improve behavioral management (NCTSN, n.d.). PC-Care provides psychoeducation in the

treatment process to teach and coach caregivers the way trauma exposure affects the child's mental health cognitive-behavioral strategies to reduce trauma symptoms (NCTSN, n.d.). Some essential components are live coaching, homework to reinforce positive parenting skills, emotional regulation strategies, and behavioral management strategies (NCTSN, n.d.).

PCIT is an evidenced based treatment in which the caregiver is live coached in sessions on specific skills while interacting with the child in play (NCTSN, n.d.). PCIT treats behavioral challenges due to trauma, ADHD, and ODD while strengthening child-parent relationship, decrease in parenting stress, improve child's pro-social behaviors, and improve frustration tolerance and anger management (NCTSN, n.d.). Filial Play Therapy allows for a safe environment where the child can express themselves, try new things, develop family attachments, and develop effective social skills and bonds (APA, n.d.). Therefore, Filial Play Therapy is a preventive program to strengthen child-caregiver relationship and address problems such as depression, anxiety, attachment problems, traumatic event, relationship problems, and so on (APA, n.d.).

Nondirective play therapy is one of the components of the Introduction to Infant-Early Childhood Mental Health and Trauma Training program, so mental health clinicians need to have a better understanding of nondirective play therapy's purpose. Nondirective play therapy helps children communicate, explore repressed thoughts and emotions, and address unresolved trauma in a healthy, effective appropriate mental health treatment (Petruk, 2009). Play is considered important for a child's healthy development who have experiences traumatic stress as it helps the child communicate and process the trauma (Petruk, 2009). Play is significant as it supports the development of the brain.

When trauma occurs the hippocampus, amygdala, thalamus, and brain stem is affected; therefore, impairing the child's ability to communicate, process, and ask for help (Petruk, 2009).

Mental health clinicians create a safe environment for the child to interact with symbolic toys for the clinician to learn about the child's thoughts and emotions (Petruk, 2009). In addition, nondirective play therapy encourages creativity, facilitates expression of emotions, promotes healing from traumatic experiences, develops better social skills, introduces new way of thinking and behaving, and so on (Petruk, 2009). Play allows for children with challenging emotional and behavioral issues to nonverbally communicate their thoughts and emotions. Therefore, despite there being a few treatment modalities to address trauma and attachment in a child-caregiver relationship, there is not a specific infant-early childhood trauma-informed care training for mental health therapists to have fundamental information about and how to treat infant-early childhood mental health and trauma.

In addition, Harden et al. (2016) discuss limited interventions for within the infant-early childhood mental health field, and most interventions are not being evaluated for effectiveness. The authors discuss three different types of prevention programs: primary prevention, secondary prevention, and tertiary prevention to address child maltreatment (Harden et al., 2016). Primary prevention involves outreach programs, secondary prevention includes in-home services and reduction of child maltreatment risks, and tertiary prevention focuses on engaging high-risk families into services and most importantly, to increase trained interventionists in the infant-early childhood mental health field (Harden et al., 2016). The current data indicates that prevention and

intervention programs focusing on the parent-child relationship have been effective in the child's treatment course (Harden et al., 2016). Therefore, this reveals the need of infant-early childhood trauma-informed care training within the tertiary prevention level to reduce risks of childhood trauma and enhance infant-early childhood mental health services to the families.

Amaya-Jackson and DeRosa (2007) investigate if evidence-based practices (EBPs) are appropriate to treat child trauma. EBP's are difficult to implement, do not address complex problems, and there are expectations for major changes (Amaya-Jackson & DeRosa, 2007). The authors highlight the significance of the mental health clinicians' skills to gather and understand the child's trauma history (Amaya-Jackson & DeRosa, 2007). In addition, the authors explain how EBPs should focus on emotional and behavioral dysregulation, attachment issues, self-efficacy, self-perception, and the purpose and meaning of life instead of trying to "fit" an EBP model in a complex trauma population (Amaya-Jackson & DeRosa, 2007).

Furthermore, as infant-early childhood trauma continues to increase, there are new developments of treatment modalities to support families on a relationship-based model to strengthen the child-parent relationship (NCTSN, n.d.). One specific treatment model, Child Parent Psychotherapy (CPP), is designed for infants to 5-year-old children having post-traumatic stress disorder, mental health issues, attachment issues, and/or behavioral problems (NCTSN, n.d.). There are other EBPs generalized for trauma treatments to all ages 0-18 years old. Yet, if treatment models are not properly addressing the age and developmental stages of a child then risks of clinical mistakes increase.

Therefore, the need to focus on infant-early childhood trauma is significant to reduce risks and relieve trauma symptoms.

Moreover, David and Schiff (2018) complete a bottom-up dissemination (BUD) research on CPP addressing if the elements are applicable to learn about trauma. A BUD is a process of spreading an EBP's interventions among colleagues in a network (David & Schiff, 2018). The authors agree that the CPP concepts such as the trauma narrative, regulation techniques, psychoeducation, and the parent-dyad concept can create a better understanding of trauma in general (David & Schiff, 2018). Therefore, implementing CPP concepts into a trauma-informed care training will enhance the clinician's trauma knowledge and awareness. In addition, Noroña and Acker (2016) explore the uniqueness of CPP consultation as it relates to reflective practice. The authors explain that supervisors trained in reflective practice helped combat secondary trauma in the field (Noroña & Acker, 2016). Therefore, reflective practice is a unique component needed in a trauma training to avoid risks of clinician burnout within a complex trauma training. Reflective practice helps mental health clinicians approach mental health issues from a relational perspective, instead of finding the "identified patient" (Noroña & Acker, 2016).

Osofsky (2009) emphasizes supervisory support and reflective supervision for mental health clinicians treating the trauma population. The principles of reflective supervision involve reflection, collaboration, and regularity to support mental health clinicians hearing traumatic stories and prepare them for their own emotional reactions in treatment (Osofsky, 2009). Osofsky (2009) concludes that reflective supervision mirrors the therapeutic process occurring between the therapist and patient, so reflective supervision is a need when working with the trauma population. Moreover, Berger and

Quiros (2014) state trauma-informed supervision serves as a protective factor from vicarious trauma. A trauma-informed environment can maintain mental health clinicians in community mental health to reduce the effects of vicarious trauma (Osofsky, 2009). Mental health clinicians need to feel emotionally safe to provide effective services and practice self-reflection (Berger & Quiros, 2014).

Furthermore, Ellis et al. (2019) address supervisors' lack of knowledge within the trauma population and the inability to mentor mental health clinicians working with complex trauma. The authors state that having a supervisor knowledgeable in trauma is important to apply appropriate therapeutic strategies and strengthen the clinician's skills (Noroña & Acker, 2016). Therefore, supporting the need of infant-early childhood trauma-informed care training continues with the lack of trauma trained supervisors who can support the growth of a clinician specializing in infant-early childhood trauma.

Theory of Change

The lack of knowledge of infant-early childhood trauma provides a dysfunctional equilibrium in the mental health field as it continues to generalize therapeutic techniques to a trauma situation that may not be appropriate. The dysfunctional equilibrium of the problem continues to reinforce a general lack of trauma-informed care training; therefore, translating to a lack of focus on infant-early childhood trauma. Furthermore, there is both support and criticism about evidence-based practices (EBPs) and whether the techniques that are tailored specifically to children with trauma are appropriate to the child's developmental age. Making changes in the mental health field one must recognize *first order change*, what continues to remain the same in the existing system (Smith, 2018).

While *second order change* transforms the existing system by making changes (Smith, 2018). To move from *first order change*, which is the continuation of the lack of infant-early childhood trauma training, the *second order change* needs to address specific infant-early childhood trauma knowledge and awareness to be applicable in various mental health situations. Recent research emphasizes how mental health clinicians do not feel confident or competent to treat individuals with trauma, which creates risks of misdiagnoses, mistreatments, and a potential impact on the client-therapist relationship (Cook et al., 2019).

As stated, *the second order change* is the infant-early childhood trauma-informed care training for mental health clinicians to gain knowledge, learn, and understand appropriate techniques for children with trauma symptoms. This is a training preparing mental health clinicians to have an understanding of appropriate therapeutic techniques when interacting with the trauma population while having a knowledgeable background in infant-early childhood mental health and trauma. The issue is how techniques are being generalized to trauma situations making the therapeutic process detrimental when treating children under 5 years old with traumatic experiences. Therefore, having knowledge of infant-early childhood mental health aspects such as brain development, developmental delays and developmental ages, attachment, and regulation are important concepts needed to understand either a child or adult's trauma mental health history. A clinician will have a better understanding of trauma by having basic knowledge of infant-early childhood mental health concepts and contributing to narrowing the gap in trauma training.

A gap in general trauma training illuminates a wider gap of infant-early childhood trauma-informed care training, therefore, presenting an issue of supervisors lacking

training in appropriate trauma care for clients and mental health clinicians. It may seem practical for supervisors only to be trained in infant-early childhood mental health and trauma concepts; but unfortunately, they are not the ones working in schools, homes, or daycares addressing a child's trauma symptoms. Though mental health clinicians will need support from a reflective supervisor to prevent secondary trauma, the infant-early childhood trauma training will help mental health clinicians feel prepared to treat the infant-early childhood trauma population (Noroña & Acker, 2016).

The significance of an infant-early childhood trauma-informed care training prepares mental health clinicians to support each other and build their therapeutic knowledge and awareness skills. For *second order change* to occur, the program developer will highlight the gravity of mental health clinicians having knowledge of infant-early childhood mental health concepts. Not only do these concepts focus on the child, but most importantly on strengthening the child-caregiver relationship (dyad). The dyad is the main source for a child's family system to obtain a functional equilibrium as a child depends on safety, love, and security from the caregiver (NCTSN, 2019). Starting with the mindset of the child-caregiver relationship system will help alleviate trauma symptoms and address the needs of the mental health clinicians who are feeling incompetent treating children under 5 years old with traumatic experiences. Overall, the trauma-informed care training is a preventative tool for future challenges of children with infant-early childhood trauma.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

Introduction to the Infant-Early Childhood Conceptual Framework

Infant-early childhood mental health and trauma is a growing phenomenon as researchers are beginning to take into consideration that this population has adverse effects from childhood trauma. Cook et al. (2019) center on the importance of mental health clinicians having basic competent trauma training. There is a gap in general trauma training, specifically there is no attention on infant-early childhood trauma-informed care training and mental health clinicians continue to lack awareness and knowledge. Also, the researchers emphasize the issues of misdiagnoses, mistreatment, and impact on the patient-clinician relationship.

So, to further explore the population of the clinical issue, Miron and Scheeringa (2019) examine the interest of mental health clinicians in receiving free trauma training to improve their trauma skills. The researchers demonstrate those mental health clinicians who received and followed through with the training had 57% of their clients reduce their PTSD symptoms. Miron and Scheeringa (2019) emphasize one huge barrier of mental health clinicians was the lack of professional involvement in completing the trauma training. This is a possible reason why there is a continuation of the gap in trauma training as well as expanding the lack of attention on infant-early childhood trauma. Even though there are multiple trauma training programs, especially evidenced-based practices (EBPs), there is still a growing concern whether these are applicable for the infant-early childhood field. Therefore, the development of the Infant-Early Childhood

Conceptual Framework provides immense support by presenting mental health clinicians with trauma-informed information, interventions, and mental health support when engaging in treatment courses for the infant-early childhood population.

Theoretical Framework Concepts

Attachment Theory

John Bowlby's Attachment Theory explains children have a biological need to attach to a constant object, usually the mother (Bitter, 2014). Attachment theory's concept of a child innately bonding to the main object, most likely the mother (Bitter, 2014) explains the importance of providing psychoeducation to mental health clinicians in the training program. The second concept of the internal working model of relationships defines the child having a sense of trustworthiness among others; that the child is valuable and lovable, as well as the child can socially interact with others (Bitter, 2014). This concept supports the relevance of having family therapy to build a secure attachment with a child who has endured trauma.

Theory of Neuroscience

Alan Schore, a neuroscientist, extends Bowlby's Attachment Theory believing a secure attachment with the mother stimulates a psychobiological response for the child (Bitter, 2014). Schore believes "that individual development arises out of the relationship between the brain, mind, and body of both the infant and caregiver held within a culture and environment that either supports, inhibits, or even threatens it" (Bitter, 2014). This

supports the main objective of the training program for mental health clinicians to understand how trauma creates an insecure attachment affecting the development of the brain, mind, and body. The Theory of neuroscience supports therapy helping with the development of the human connection (Bitter, 2014) as it pertains to children with disrupted attachments.

Bowen Family Systems Theory

Murray Bowen is one of the developers of mainstream family therapy with the premise that a family can be best understood three generations back to analyze predictable patterns in the relationships among family members across generations (Bitter, 2014). The concept of differentiation of self, “involves the psychological separation of intellectual and emotion, and independence of self from others” (Bitter, 2014). It helps explain the emotional responses of mental health clinicians who can relate due to their unresolved emotional issues in their family of origin. Furthermore, the concept of disengagement is emotional cutoff, indicating an undifferentiated self (Bitter, 2014) as mental health clinicians experience burnout and secondary trauma when treating the trauma population. Lastly, the concept of the family projection process and multigenerational transmission develops from triangulation when caregivers have poor differentiation leading to the child involved in the conflict (Bitter, 2014). As mental health clinicians learn about the multigenerational transmissions of the family, they understand how the child’s behaviors have been influenced by unresolved emotional attachments.

Reflective Model

The Schon Reflective Model by Donald Schon presents the concepts of “reflection in action” and “reflection on action” (All Answers Ltd., 2018). Schon states reflection is the capability to “think what they are doing while they are doing it” (All Answers Ltd., 2018). The concept of “reflection in action” is the act of reflection as something happens, in which the clinician acts immediately about the situation (All Answers Ltd., 2018). Schon describes “reflection in action” is the “doing” stage allowing the clinician to react and change the event as it is happening (All Answers Ltd., 2018). The “reflection in action” explains how a therapist can enhance their skills in a therapeutic session. Therefore, the concept of “reflection on action” is the act of reflecting after something has happened, in which the clinician reconsiders the situation and thinks about future changes (All Answers Ltd., 2018). Therefore, for the purpose of the training curriculum the concept of the “reflection in action” will be used to understand the concept of reflective practice.

Mindfulness

Mindfulness is defined as the ability for the human to be “fully present, aware of where we are and what we’re doing and not become overwhelmed by what’s going on around us” (Mindful Staff, 2020, para. 3). Williston et al. (2021) define mindfulness as “an openhearted, moment-to-moment, nonjudgmental awareness” (as cited in Kabat-Zinn, 2005, p. 24) with ancient roots in Buddhist tradition (as cited in Thera, 1962). There are many benefits of mindfulness practices, which include reduction of stress, enhancing performance, and gaining insight and awareness through the observation of

our own mind (Mindful Staff, 2020). Therefore, mindfulness supports the well-being of the mental health clinicians and children/families in the infant-early childhood population. Mindfulness is paying attention to the body, where we are, and what is going on to help an individual calm down (Mindful Staff, 2020). Not only does mindfulness provide a new perspective about awareness, but mindfulness is also an intervention used to treat infant-early childhood trauma.

Conceptual Lens of Theoretical Framework

The idea of a training program for mental health clinicians is to provide psychoeducation using Attachment Theory with the integration of the Theory of Neuroscience, as it will address the first two main components of the training manual. The third component of the training manual is assisted by Bowen Family Systems Theory to explain how mental health clinicians can be supported when treating infants to 5-year-old children with trauma. Therefore, the reflective model and mindfulness are used in the third component of the training manual to support mental health clinicians and the infant-early childhood population. To understand how to properly treat infants to 5-year-old children with trauma experience, the training manual will address the following: *1) What is infant and early childhood mental health and trauma?, 2) What is nondirective play therapy?, and 3) What is reflective practice?"*

Attachment Theory and Theory of Neuroscience

The first component composes psychoeducation on understanding the neuroscience of trauma, attachment, and how to properly use the *DC 0-5: Diagnostic*

Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5). Bowlby defines Attachment Theory as the belief of children needing a single constant object for care, nurturance, and responsiveness (Bitter, 2014). According to Breidenstine et al. (2011), understanding the developmental milestones of the child helps understand the attachment behaviors. Unfortunately, trauma affects attachment leading to sensitivity and trauma symptoms affecting the well-being of the child (Breidenstine et al., 2011). As mental health clinicians learn about the importance of a constant object, they will understand how trauma impairs the child's ability to attach healthily. Therefore, mental health clinicians will learn how to conceptualize using Attachment Theory, while gaining knowledge of attachment styles from the caregiver since children seek physical safety in the presence of a caregiver to grow healthily.

The concept of bonding shares the idea of setting up the children for social relationships (Bitter, 2014) and mental health clinicians will learn about the importance of attachment as it pertains to rebuilding a trustful relationship between the child and caregiver through nondirective play therapy. Besides, Breidenstine et al. (2011) summarize how parents' trauma affects the attachment with their children. They share it is the start of understanding attachment patterns between diagnosis and parents' mental health and most importantly to start the bonding process. It is important to note parental trauma influences on attachment, especially if parent trauma has been unresolved. Mental health clinicians will acquire the skills to address parental trauma through multigenerational transmissions of the family from Bowen Family Systems Theory.

As the mental health clinicians use Attachment Theory in their conceptualization process, the concept of an internal working model of relationships supports the idea of having psychoeducation on the importance of trustworthiness in a child-caregiver relationship and understand how family therapy supports the child's development when trauma has occurred (Bitter, 2014). To further expand on Attachment Theory's concept of bonding, this supports how to properly use the *DC:0-5* and support clinical knowledge and awareness when serving the infant-early childhood population. The diagnostic manual focuses therapists to view mental health issues of a child from a family system perspective instead of an individual problem (Klaehn, 2018). The *DC:0-5* promotes staying away from labeling a child as "problematic," but considering the parent-child relationship and how it affects the development and well-being of the child (Klaehn, 2018). Furthermore, Breidenstine et al. (2011) investigate attachment disorders to properly diagnose, know the complex interplay of trauma, cognitions, expectations, emotions, memories, and behaviors that can assist mental health clinicians in promoting healthier functioning in adults and their children. Attachment theory supports my training program in achieving proper diagnoses while focusing on the internal working model of relationships.

Integrating Theory of Neuroscience into Attachment Theory supports the component of psychoeducation for mental health clinicians as they learn how to address trauma effects on brain development. The Theory of Neuroscience by Schore states "that individual development arises out of the relationship between the brain, mind, and body of both the infant and caregiver held within a culture and environment that either supports, inhibits, or even threatens it" (Bitter, 2014). The statement encompasses the

idea of understanding how the relationship between a caregiver and child either supports or inhibits the development of the brain as it pertains to the attachment. Pleines (2019) uses a modified Trauma-Focused Cognitive Behavior Therapy with attachment theory principles and neuroscience psychoeducation showing support for the child in the process of therapy and the importance of the involvement of the family. As mental health therapists learn the biology of the brain and how the brain responds to trauma experiences, Attachment Theory and the Theory of Neuroscience will support the learning process and the development of the theoretical framework of the training program.

Also, as the training program focuses on providing neuroscience psychoeducation, Solomon and Heide (2005) emphasize understanding the biology of trauma to support the brain development of the child to develop a healthy attachment. The concept in Theory of Neuroscience supports therapy in helping the healing process for the family. Research articles support the Theory of Neuroscience and childhood trauma, while providing psychoeducation on the neurobiology of trauma. Since the training program's first component focuses on psychoeducation, Mahajan (2018) emphasizes acknowledging childhood trauma and how neuroscience knowledge integrated with therapy supports an effective treatment plan. Furthermore, mental health clinicians having the knowledge of the effects of trauma on the brain and using talk therapy will enhance their trauma knowledge and awareness. In addition, neurobiological resiliency protects the child's brain from regressing, so providing effective interventions related to brain development can develop supportive and responsive caregivers (Cross et al., 2017). If children have supportive caregivers, then they can experience buffers to

lower the effects of childhood trauma on the brain development. Therefore, the involvement of supportive and responsive caregivers promotes resiliency in the brain's executive function and regulation to avoid further impact on the child (Cross et al., 2017).

Furthermore, the second component of the training program pertains to nondirective play therapy as it reinforces attachment between child and caregiver. Play is the language of children in which they express their feelings, thoughts, and behaviors (Play Therapy International, 1995). Play therapy allows children to non-verbally express themselves about their traumatic experiences in order to heal (Play Therapy International, 1995). The Theory of Neuroscience supports the psychobiological connection on the secure attachment between mother and child (Bitter, 2014) that can be developed through the intervention of nondirective play therapy. Attachment Theory and Theory of Neuroscience integration support the component of nondirective play therapy in the training program by emphasizing how play supports a healthy communication of the trauma while leading to a healthy trajectory of the brain through the development of a secure relationship.

Hughes (2017) uses dyadic developmental psychotherapy to bring about positive experiences in treatment through attachment components and learning about the neurobiology of trauma. Using attachment interventions to engage caregivers in the child's trauma treatment demonstrates how attunement, attention, and engagement promote healthy play therapy (Hughes, 2017). Nondirective play therapy supports the Attachment Theory concepts of bonding innately in both children and mother and supporting the child to feel valuable and lovable by a caregiver (Bitter, 2014). Theory of

Neuroscience states “therapy helps with the development of human connection” (Bitter, 2014) accomplished through the intervention of nondirective play therapy.

Bowlby viewed attachment as critical for a stable trajectory of children. If children are left alone to cope with dysregulation without support, it creates additional trauma for the children, so nondirective play therapy is necessary (Pearlman & Courtois, 2005). The risk of developing an insecure, disorganized, and dissociated attachment style is related to severely impacting the neurophysiological development of the children, restricting of their ability to regulate (Pearlman & Courtois, 2005). If the therapist can model appropriate secure attachment to a caregiver through nondirective play therapy, then the intervention can recreate appropriate attunement and competence for the child-caregiver relationship.

Attachment theory supports a developmental perspective to explore the client’s history, current psychological and relational issues contributing to building a secure attachment (Pearlman & Courtois, 2015). In addition, attachment theory helps the clinician empathize with the child and family. Through an attachment perspective, the clinician identifies the child’s attachment needs through appropriate exploration about the past while moving forward to emotional regulation and behavioral changes (Pearlman & Courtois, 2015). The authors concluded an attachment perspective is needed to treat complex trauma to understand emotional and attachment needs, which can be addressed through nondirective play therapy.

Attachment Theory and Theory of Neuroscience interchangeably support each other to further enhance the understanding of infant-early childhood trauma. Attachment theory is based on a psychological standpoint on providing a corrective experience

between a child and caregiver to enhance functioning after a traumatic experience. The Theory of Neuroscience provides an understanding from a biological standpoint on how trauma affects the developing brain of a child. Both theories provide effective knowledge and awareness about the effects of trauma on children and most importantly emphasize the importance of mental health clinicians to understand these theories and how the theories support the interventions of the training program to enhance trauma knowledge and awareness.

Bowen Family Systems Theory

On the other hand, Bowen Family Systems Theory supports the intervention of reflective practice in the training manual for mental health clinicians to support caregivers as well as feel supported when treating infants to 5-year-old children with trauma. Reflective practice is when caregivers can understand the meaning of a child's behaviors while promoting attunement and repair of the child-parent relationship (Ferreira et al., 2017). The concept of family projection process and multigenerational transmission will help mental health clinicians understand addressing how infant-early childhood trauma occurs especially with caregivers' unresolved emotional attachments and how that influences the children's behaviors.

Through reflective practice mental health clinicians will learn how to address multigenerational trauma and help caregivers build a secure attachment with their children. Figley and Figley (2009) address the limitations of current evidence-based practices not promoting a systemic approach, ignoring family involvement in treatment. According to Figley and Figley (2009), to treat trauma systemically treatment starts with

the family by addressing the primary and secondary traumatic reactions. To have a better grasp of trauma within the family unit it is important to address the family culture, family of origin, personality, relational, emotional, and systemic influences on the impact of trauma (Figley & Figley, 2009). Therefore, working from a systemic framework the mental health clinician should take the time to gather each family member's perceptions about the traumatic event to understand the amount of impact on the family's life and address the needs of the family to deal with the traumatic event.

By addressing the trauma through a systemic approach, the child will receive support in the treatment course. The authors concluded that working with the family is an important intervention to address the impact of trauma to help alleviate symptoms by having the support from the family in the healing process (Figley & Figley, 2009). Therefore, the Introduction to Infant-Early Childhood Mental Health and Trauma Training program's systemic approach will utilize the concept of the family projection process and multigenerational transmission to develop a family healing theory to support the whole family in the process of healing.

Furthermore, reflective practice is acquired with experience and knowledge, but reflective practice demonstrates the importance of how it prevents mental health clinicians from secondary trauma and burnout if they have someone to consult about their trauma cases (Norona & Acker, 2016). The concept of emotional cutoff/disengagement explains how mental health clinicians suffer from burnout when treating the trauma population. Therefore, having the intervention of reflective practice will support mental health clinicians to take interest in treating the infant-early childhood trauma population and lessen their burnout and secondary trauma.

In addition, Bowen Family Systems Theory views child abuse as “insufficient emotional separation” from family members as they are not able to emotionally reactive (MacKay, 2012, p.236). Therefore, having reflective practice supports the mental health clinician to understand the effects of trauma on the family unit. Bowen Family Systems Theory helps mental health clinicians understand how an individual’s functioning plays a role in the act of violence (MacKay, 2012). Therefore, reflective practice will support the therapeutic process. Bowen Family Systems Theory supports the clinician to respond accordingly to the client’s needs by guiding parents to reduce anxious responses from a child.

Bowen Family Systems Theory’s concept of differentiation of self is related to vicarious traumatization, secondary stress, and burnout due to working with the trauma population (MacKay, 2017). MacKay (2017) emphasizes increasing protective factors of mental health clinicians to reduce emotional reactivity when working with families with traumatic experiences. Through the usage of reflective practice by mental health clinicians treating infants to 5-year-old children, the concept of differentiation of self builds resiliency, self-efficacy, and autonomy to improve mental health clinician’s efforts in the training program. The goal of reflective practice is for mental health clinicians to feel supported by other peers in the training program, whom they will eventually consult throughout the course of the program to enhance their knowledge and awareness, while increasing mental health clinicians in this population.

Through a systemic approach the clinician focuses on treating the family to support the functioning of the family as a whole. Through the family healing process, the family as a unit helps with regulation within the relationship context to address the

impact of trauma (Papero, 2017). When addressing infant-early childhood trauma the focus is on healing the family and making changes to support the process of the trauma work. Lastly, by addressing the family as a unit the clinician is addressing chronic anxiety and chronic stress, while creating stability in the family system (Papero, 2017).

Reflective Model and Mindfulness

Bowen Family Systems Theory does a substantial effort to support the intervention of reflective practice in the training program. To reiterate the concept of “reflection in action,” the therapist will utilize the concept to enhance their reflective practice knowledge in the therapy session to address traumatic symptoms. The reflective model fosters the ability to reflect during and after each therapeutic session with a client/client’s family to support the treatment process. The therapist learns to process reflection in the moment of the therapeutic process to address current issues and make changes.

Furthermore, Attachment Theory provides a lens to view the reflective process to gain understanding and empathy within the therapist-client relationship (Foley et al., 2009). When discussing Attachment Theory in social work practice, the Attachment Theory first helps understand how the social worker responds to the client in distress (Foley et al., 2009). Second, Attachment theory explains the impact of the response and if there is a need of a reflective process for exploring possible solutions (Foley et al., 2009). Third, Attachment theory explores the social worker’s capability to follow through with the social work plan and if the client can receive help (Foley et al., 2009). Foley et al. (2019) state that Attachment Theory is useful to guide the reflection process in

situations where relationships are under stressful or overwhelming experiences.

Furthermore, Attachment theory suggests when a social worker takes on a helper role that the social worker is potentially capable to engage in reflection impacting their “sensitive responding” to the client. Therefore, reflective practice is significant throughout the creation of the training curriculum.

On the other hand, when treating children and families with trauma, it is crucial to be in the present and attuned during nondirective play therapy. Not only do mindfulness-based interventions support the enhancement of trauma knowledge, but the interventions are useful to address a mental health clinician’s burnout and secondary trauma. In mindfulness there are five core psychological processes: “1) observation of personal experiences in the present moment, b) describing and labeling those experiences, c) responding to those experiences nonreactivity, d) nonjudgmental acceptance of the present-moment experiences, and e) acting with awareness within the present moment” (Williston et al., 2021, para. 3). These five core psychological processes assist in understanding the importance of reflective practice during nondirective play therapy and to avoid burnout. Mental health clinicians’ ability to be mindful about trauma effects on attachment, relationship building, and brain development allows them to understand the infant-early childhood population.

Furthermore, mindfulness-based interventions have restored the functionality of the brain networks of individuals experiencing PTSD and other psychopathology (Williston et al., 2021). Since a child’s brain is impacted by trauma, the practice of mindfulness supports the importance of regulation in moments of distress. Mindfulness-based interventions regulate signals that are hyper aroused through relaxation instead of

stress reactivity (Williston et al., 2021). Therefore, mindfulness allows for mental health clinicians and families to understand the biological effects of trauma on a child's development.

In addition, mindfulness allows for “compassionate awareness and acceptance” of uncomfortable and comfortable experiences (Williston et al., 2021). Mindfulness-based interventions allow for individuals to observe rather than push away the thoughts and feelings occurring in the moment (Williston et al., 2021). Also, mindfulness-based interventions provide the opportunity for “mindful distraction” to help shift one's attention away from a trauma-related response (Williston et al., 2021). Not only does mindfulness provide an alternative intervention to treating trauma symptoms, but it also allows for emotional regulation during an uncomfortable experience. Therefore, mindfulness-based interventions foster effective treatment comprehension regarding the infant-early childhood population.

Furthermore, a current strategy to enhance self-regulation is mindfulness-based practices in early childhood education (Razza et al., 2020). Razza et al. (2020) conducted a pilot study for preschoolers to infuse yoga into their daily physical school activities while assessing the needs of the teachers. The children were taught some mindfulness interventions, while the teachers received two trauma-informed workshops to increase their knowledge of trauma-informed care. The staff received an experiential, mindfulness-based stress reduction workshop introducing teachers to mindfulness techniques that they could use for self-care and well-being (Razza et al., 2020). In addition, the staff learned about trauma effects and tools to help cope with trauma symptoms. Furthermore, the staff shared the workshops were relevant and wanted future

opportunities. Also, the children experienced an increase of attention and growth in socio-emotional and behavioral skills, while the program was accepted to reduce stress and improve well-being.

Not only were there positive results of incorporating mindfulness-based interventions at the early childhood level, but also the staff appreciated learning mindfulness techniques for self-care and how to address trauma symptoms (Razza et al., 2020). Therefore, incorporating mindfulness into the Introduction to Infant-Early Childhood Mental Health and Trauma Training Curriculum allows for the child, child's family, and mental health clinicians to understand the effectiveness of reflective practice throughout the treatment process.

Implications of Theories

The research question explored for the creation of the Infant-Early Childhood Conceptual Framework of my dissertation project is the following “How can Attachment Theory with the integration of Theory of Neuroscience enhance trauma knowledge and awareness and Bowen Family Systems Theory explain the absence of mental health clinicians in the infant and early childhood trauma field?” In addition, “How can reflective practice emphasize the importance of a training curriculum and mindfulness support the well-being of the mental health clinicians and those part of the infant-early childhood population?”

It is important to note that the theories support each other, as there is an integration of a systemic approach to enhance trauma knowledge, trauma awareness, and support mental health clinicians in the infant and early childhood trauma field.

Attachment Theory integrating Theory of Neuroscience and Bowen Family Systems theory explain the importance of having trauma training in infant-early childhood field. The concepts support the learning process of mental health clinicians to incorporate knowledgeable facts from psychoeducation on attachment, neuroscience, understanding how nondirective play therapy supports the development of attachment and a healthy brain, and how reflective practice avoids secondary trauma for mental health clinicians.

Furthermore, Reflective Model and Mindfulness emphasizes the significance of the curriculum as mental health clinicians learn and teach mindfulness and reflective practice. The integration of Reflective Model and Mindfulness support the concepts of psychoeducation on the effects of trauma, nondirective play therapy and reflective practice for the development of the training curriculum. Mindfulness provides bodily awareness about trauma effects, but also helps the mental health clinician focus on “sensitive responding” to the child/child’s family. Therefore, Reflective Model and Mindfulness will enhance the mental health clinician’s skills to appropriately address infant-early childhood trauma.

The theories emphasize the importance of understanding family involvement, the biological aspects of trauma, and instinctual attunement for proper treatments in supporting the reduction of misdiagnoses and misattributions given to the infant and early childhood population. Not only do all five theories support the Infant-Early Childhood Conceptual Framework of the program, but the conceptual framework provides immense support by presenting mental health clinicians trauma-informed information, interventions, and mental health support to mental health clinicians when engaging with the infant-early childhood population. The Infant-Early Childhood Conceptual

Framework of the program is new, but it will provide a foundation for future trauma-informed care training programs to take into consideration the importance of using the theoretical concepts for the development of a program supporting mental health clinicians.

CHAPTER FOUR

METHODOLOGY

Introduction to Infant-Early Childhood Mental Health and Trauma

Carter et al. (2004) and Egger and Angold (2006) argue that the mental health field is behind on infant-early childhood mental health for the following reasons: 1) resistance to acknowledging infant-early childhood mental health, 2) stigma with diagnosing young children, 3) difficulties with diagnosing young children, 4) not appropriately understanding developmental aspects of children, and 5) limitation of assessment measures (as cited in Young et al., 2011).

The Introduction to Infant-Early Childhood Mental Health and Trauma Training program is an introductory curriculum for mental health clinicians to obtain an overview of trauma-informed care about the infant-early childhood population. As an overview training program, it does not provide sufficient training to practice, but it encapsulates the importance of having a foundational knowledge and awareness of infant-early childhood trauma. The course training has one preliminary training day (optional), three following training days with two one-day booster review sessions throughout the year. Day 1 (preliminary training day) of the course training is from 8:00am- 5:30pm, Day 2 (experiential training day) is from 8:00am- 5:30pm, Day 3 (experiential training day) is from 8:00am- 5:00pm, and Day 4 (experiential training day) is from 8:00am- 4:30pm. In addition, booster session #1 is from 8:00am- 5:00pm and booster session #2 is from 8:00am- 5:30pm.

The key interventions for the Introduction to Infant-Early Childhood Mental Health and Trauma Training program are for mental health clinicians who provide or plan to serve children under the age of 5 years old. The curriculum is designed to effectively educate mental health clinicians about infant-early childhood mental health and trauma. There are three phases of the program with critical information about infant-early childhood mental health to strengthen mental health clinicians' clinical knowledge and awareness when working with children who are impacted by trauma. Therefore, the key interventions are *psychoeducation on infant-early childhood mental health and trauma*, *nondirective play therapy*, and *reflective practice and mindfulness*.

The preliminary training day, which is optional, is a more in-depth informational, overview process of the trauma-informed care approach of the infant-early childhood population. Numerous topics will be addressed in-depth during the preliminary training day to mental health clinicians who have limited knowledge and awareness of infant-early childhood mental health and trauma. The following topics create the preliminary day- Introduction to Infant-Early Childhood Mental Health, Neuroscience of Trauma, Child-Caregiver Relationship, Introduction to DC 0-5, Introduction to Reflective Practice, Introduction to Play Therapy, and Introduction to Self-Care for Clinicians and Parents.

Furthermore, there are no experiential activities and one discussion group section during the preliminary training day, so PowerPoint lectures will be filled with research information, case examples, and videos to enhance clinical knowledge and awareness. The lecture sessions range from 1 hour to 1.5 hours to increase the educational aspect of the training program.

The first phase of the curriculum involves the *psychoeducation on infant-early childhood mental health and trauma* which addresses an overview of infant-early childhood mental health, the neuroscience of trauma, child-caregiver attachment, and properly using the *DC: 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC: 0-5)*. Mental health clinicians will learn how trauma affects the developing brain, the importance of an “attachment” relationship between the caregiver and child, and lastly how to properly diagnosis children under 5 years old to recognize effective treatment courses.

The second phase of the curriculum involves learning and understanding the importance of *nondirective play therapy* in therapy. The mental health clinicians will learn nondirective play therapy concepts from the treatment modality Child-Centered Play Therapy to address social, emotional, behavioral, and relational disorders (CEBC, 2006). Furthermore, mental health clinicians will have the opportunity to understand nondirective play therapy techniques through role plays.

The third phase of the curriculum involves *reflective practice and mindfulness*, which mental health clinicians will gain awareness, competency, and knowledge to identify trauma symptoms. Reflective practice allows for mental health clinicians to focus on the child-parent relationship to understand the child’s behaviors and thoughts. Therefore, towards the end of the program, mental health clinicians are expected to have a basic understanding of infant-early childhood mental health and trauma, nondirective play therapy, and reflective practice to increase support to children and the children’s families.

Description of the Treatment Population

The infant-early childhood population is also part of the treatment as mental health clinicians will be providing effective services to this population. The infant-early childhood population is usually considered from birth to eight years old focusing on skill development (Tomonari, n.d.). There are three different stages of and they are defined according to social institutions, customs, and laws depending in the society (Tomonari, n.d.). There are different characteristics children display as they develop and grow. From birth to age three, a child typically grows fast becoming a toddler while mastering skills, such as sitting, walking, toilet training, motor development, and hand-eye coordination to catch and throw a ball (Tomonari, n.d.). Also, the child's gross motor skills include the ability to skip and balance on one foot, as well as furthering the cognitive and language development (Tomonari, n.d.).

Furthermore, the child's ability to use all their senses to stay attune to their environment and how to respond to their caregivers is important to acknowledge when treating children who have experienced trauma. Language allows for the child to communicate with others and problem solve (Tomonari, n.d.), which becomes important when noticing that children with traumatic experiences impact their skills development. In addition, in early childhood the socioemotional development of a child occurs around the age of one making attachment formation crucial (Tomonari, n.d.).

Infant-early childhood trauma are experiences of physical abuse, sexual abuse, domestic violence, and/or events threatening their safety are traumatic experiences (NCTSN, n.d.). Trauma can be associated with adverse childhood experiences (ACEs) that enhance the impact of trauma. ACEs were identified as childhood abuse, childhood

neglect, and household challenges in later life health and well-being (CDC, n.d.). The 10 ACEs identified were physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, caregiver's mental illness, domestic violence, divorce, substance abuse, and incarcerated relative (Joining Force for Children, n.d.). Therefore, ACEs produce toxic stress, which prolongs body stress response to frequent, intense situations/events (Joining Forces for Children, n.d.).

Yet, the Introduction to Infant-Early Childhood Mental Health and Trauma Training Curriculum was created for mental health clinicians to learn about infant-early childhood mental health concepts and enhance their therapeutic knowledge and awareness. Infant-early childhood mental health is about children under 5 years old who have developed the resiliency to “experience, regulate, and express emotions” in a safe environment while building a secure relationship with a primary caregiver (MI-AIMH, n.d.). Young children's mental health is crucial during this time as their brain and social emotional development grows under the care of a secure and nurturing caregiver relationship. When trauma occurs, it affects the overall development of children and disrupts child-caregiver relationship. Therefore, mental health clinicians treating children under 5 years old should be using a different therapeutic approach due to the child's cognitive development, since many are pre-verbal, to address disruptions in their development and relationship with their caregiver.

The population this program addresses is pre-licensed (students and associates) and licensed (marriage and family therapist, social worker, professional clinical counselor) mental health clinicians. Mental health clinicians help people have a better understanding of themselves and provide coping skills to handle distressing experiences

(NAMI, n.d.). Mental health clinicians are known as therapists, counselors, psychologists, and clinical social workers, who hold a Master's degree and/or Doctoral degree and are trained to evaluate people's mental health. Pre-licensed (students and associates) and licensed mental health clinicians work in the following settings: hospitals, psychiatric facilities, and outpatient facilities such as community mental health agencies, schools, and private practices (NAMI, n.d.). Many clinicians are trained in a variety of evidenced based practices (EBPs) focusing on trauma such as cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), trauma-focused cognitive behavior therapy (TF-CBT), child-parent psychotherapy (CPP), and other behavioral therapies (NAMI, n.d.).

Overall, the EBPs address mental health issues with many different models of interventions and strategies, but some do not focus on infant-early childhood trauma. Therefore, my program design addresses the lack of focus on infant-early childhood trauma among mental health clinicians who are not knowledgeable in infant-early childhood mental health concepts, techniques, and diagnoses. In addition, mental health clinicians lack the expertise to effectively children under 5 years old.

Inclusion and Exclusion Criteria

The Introduction to Infant-Early Childhood Mental Health and Trauma Training curriculum was created for mental health clinicians who are seeking to expand their infant-early childhood mental health knowledge to appropriately treat children who have experienced trauma. As stated above, the participants are either pre-licensed (students and associates) or licensed mental health clinicians to receive the training in infant-early

childhood trauma. The training program is not appropriate for other professionals such as teachers, nurses, doctors, lawyers, and so forth due to this training addressing clinical issues pertaining to mental health professionals. The training program is designed to address the following issues in the mental health field: 1) lack of trauma training for mental health clinicians, 2) lack of focus on infant-early childhood trauma, 3) lack of knowledge on infant-early childhood mental health concepts, and 4) lack of evidence-based practices focusing on children under 5 years old.

Program Overview

The Introduction to Infant-Early Childhood Mental Health and Trauma Training program has one preliminary training day (optional), three following training days with two one-day booster review sessions throughout the year. Day 1 (preliminary training day) of the course training is from 8:00am- 5:30pm, Day 2 (experiential training day) is from 8:00am- 5:30pm, Day 3 (experiential training day) is from 8:00am- 5:00pm, and Day 4 (experiential training day) is from 8:00am- 4:30pm. In addition, booster session #1 is from 8:00am- 5:00pm and booster session #2 is from 8:00am- 5:30pm.

During the preliminary training day, which is optional, it is a more in-depth informational, overview process of the trauma-informed care approach of the infant-early childhood population. The following days of the training focuses on the different phases of the training program. There are two booster sessions throughout the year occurring every 4 months to review training information, have role play sessions among colleagues, and display video case examples referring to the four-day course training.

The booster sessions support mental health clinicians to further ask questions on each phase and, most importantly, understand infant-early childhood techniques. The booster sessions are reviewing infant-early childhood mental health concepts and techniques. Therefore, the four-day training has three main components: 1) *What is infant and early childhood mental health and trauma?*, 2) *What is nondirective play therapy?*, and 3) *What is reflective practice and mindfulness?*

Preliminary Training Day

The preliminary training day consists of comprehending an in-depth educational information session about infant-early childhood mental health and trauma, nondirective therapy, reflective practice and self-care for clinicians and parents. There will be PowerPoint lectures, video segments, research articles, case examples, and resource handouts to increase clinical awareness and knowledge. In addition, the instructors have access to case examples, books, websites, and video links to help create PowerPoint lectures to help discuss the topics in the training course.

In the Introduction to Infant-Early Mental Health encompasses in-depth information about infant-early childhood mental health, ACE's Study, the TIC movement, and developmental milestones. The Neuroscience of Trauma includes in-depth information about the changes of the brain and how the ACEs related to the body stress response due to complex trauma. Furthermore, the Child-Caregiver Relationship involves understanding how important the child-caregiver relationship is for developmental purposes. In addition, this section involves discussion the influence of parental history that impacts the child-caregiver relationship.

In addition, the Introduction to DC 0-5 encompasses in-depth information about the DC 0-5 diagnostic manual, how to use the DC 0-5 diagnostic manual, history of the manual, changes done to the manual in 2022, and reviewing the diagnoses. Also, the Introduction to Reflective Practice connects the importance of parents understanding their children's symptoms and behaviors, while mental health clinicians learn about the execution of reflective practice. The Introduction to Play Therapy discusses about the history of play therapy, shares some play therapy strategies, and child-directed play suggestions. Lastly, the Introduction to Self-Care for Clinicians and Parents involved self-care activities and strategies as well as the importance of self-care to avoid burnout.

Psychoeducation on Infant and Early Childhood Mental Health

The first phase of the curriculum is the *psychoeducation on infant-early childhood mental health and trauma*, which includes understanding the an overview of infant-early childhood mental health, neuroscience of trauma, the ACEs study and TIC movement, developmental milestones, child-caregiver attachment styles, understanding parental trauma, and properly using the *DC:0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)* to understand infant-early childhood diagnoses.

The first learning objective of the phase is providing an overview of infant-early childhood mental health. By providing an overview of infant-early childhood mental health, the objective will emphasize the importance of promoting a healthy environment in a family's home to build healthy attachments (Simpson et al., 2016). Infant-early childhood mental health will be defined to provide sufficient support and understanding

to mental health clinicians. The mental health clinicians will gather foundational knowledge and awareness about infant-early childhood mental health as they start their comprehension of the infant-early childhood population's needs in therapy.

The second learning objective of phase one addresses how trauma affects brain development, so mental health clinicians learn the biology of the brain and how the brain responds to traumatic experiences. Therefore, mental health clinicians will understand how trauma affects the body and, most importantly, the brain. Brain studies show how trauma affects the structure of the brain impacting memory, learning, ability to regulate, social skills, and moral development (Solomon & Heide, 2005). Therefore, traumatic experiences affect the brain's capacity to process information and this training will make the difficulty for a child to participate in therapy understandable for the mental health clinician. If clinicians understand how the brain is impacted, then they will emphasize on the child-caregiver relationship to acknowledge improvement in treatment. Mental health clinicians will participate in an activity of viewing videos on the impact of trauma on the brain followed by a discussion among their colleagues. Therefore, mental health clinicians will learn the neuroscience of trauma and understand how that affects the attachment style of the caregiver and child.

The third objective of phase one addresses the ACEs Study and TIC movement. During this section mental health clinicians will learn about the ACEs Study and the importance of understanding what adverse childhood experiences are as well as learning the short-term/long-term effects of multiple ACEs in an individual's life. In addition, mental health clinicians will gain awareness of the TIC movement and how it influences the infant-early childhood mental health field. The TIC movement allows for an

understanding of the impact of trauma on the family and how the mental health clinician can address trauma in a trauma-informed care manner (Trauma-Informed Care Implementation Resource Center, n.d.). Lastly, mental health clinicians will be engaging in an activity of completing the ACE's study questionnaire on their own followed by a discussion among their colleagues.

The fourth objective of phase one addresses developmental milestones of a child. An understanding of a child's developmental milestones supports the growth and development of a clinician's therapeutic knowledge and awareness to understand how trauma impacts a child's life. A child typically meets different developmental milestones throughout their first five years. The main categories of a child's developmental milestones are movement/physical, cognitive, social/emotional and language/communication skills (CDC, n.d.). The CDC (n.d.) highly recommends monitoring a child's development to understand the impact of trauma and possible developmental delays. Mental health clinicians will have a better understanding of how to approach a child in therapy by learning about a child's developmental trajectory.

The fifth objective of phase one addresses child-caregiver attachment styles, the foundation to understanding the relationship between the child and caregiver, enhancing well-being, and supporting appropriate development of the child (Breidenstine et al., 2011). To understand the attachment style of a relationship, mental health clinicians learn about attachment behaviors that help children seek physical safety from their caregiver. There are four types of attachment styles: *secure*, *avoidant*, *resistant/dependent*, and *disorganized*, which help mental health clinicians understand how a child's mental health can either be supported or unsupported by the caregiver, impacting the progression in

treatment (Breidenstine et al., 2011). Mental health clinicians will watch a video of infant-early childhood trauma and the Strange Situation to understand the different attachment styles. Furthermore, mental health clinicians learn about the importance of attachment as it pertains to rebuilding a trustful relationship between the child and caregiver through nondirective play therapy. Nondirective play therapy is addressed in the second component of the infant-early childhood trauma-informed care training.

The sixth objective of phase one addresses how to perceive parental trauma. Breidenstine et al. (2011) emphasize how to properly assess caregivers' trauma, which affects how they respond to the children's attachment style. Therefore, the mental health clinicians' awareness of any possible caregivers' trauma helps to properly support the child-caregiver relationship. Breidenstine et al. (2011) reports that having attachment knowledge supports mental health clinicians to promote healthier functioning in the caregivers and children. Understanding the attachment style of the caregiver and child enhances clinicians' skills to comprehend appropriate treatment to children under 5 years old. Mental health clinicians will engage in a group activity addressing child-caregiver attachment style, role playing how to ask a parent about their trauma through a parental trauma questionnaire followed by reflective questions.

The seventh objective of phase one is learning about infant-early childhood diagnoses by using the *DC: 0-5* diagnostic manual. Klaehn (2018) reviews whether the *DC:0-5* diagnostic manual provides correct representation of the mental health needs of children under 5 years old. Klaehn (2018) was satisfied with the renewal of the *DC:0-5* diagnostic manual proclaiming a "giant step forward for the field of infant and toddler mental health" (p. 491). The Zero to Five organization revised the previous diagnostic

manual to include infants to five-year-old children, Attention Deficit Hyperactivity Disorder, and Autism Spectrum Disorder. The *DC:0-5* diagnostic manual focuses on diagnosing children based on the dyadic relationship between the child and caregiver. Therefore, having knowledge of the *DC:0-5* diagnostic manual provides an additional therapeutic lens to properly understand the needs of the child-caregiver relationship. Lastly, instructors will teach mental health clinicians how to use the Crosswalk from DC 0-5 to the DSM-5 and ICD-10. Mental health clinicians will practice how to use the Crosswalk to understand the common diagnoses referred to in the DSM-5.

Zeanah and Lieberman (2016) share how important the *DC:0-5* diagnostic manual is as it considers the parent-child relationship and relationship disturbances affecting the development and well-being of the child. According to their results, if mental health clinicians have knowledge of the *DC:0-5* diagnostic manual, they can identify if the caregiver knows how to be emotionally consistent, if the caregiver values the child as unique, and if the caregiver has the capacity to provide empathic care to the child (Zeanah & Lieberman, 2016). Therefore, mental health clinicians will engage in two activities learning how to use the *DC: 0-5* diagnostic manual. Mental health clinicians will have two vignettes to help understand the diagnosing process of children for treatments and role play using a child developmental milestone assessment followed by reflective questions.

Nondirective Play Therapy

The second phase and first objective of the curriculum is understanding *nondirective play therapy*, which allows for self-expression in a positive way to regulate

emotions, stimulate creative thinking, and encourage exploration (Association for Play Therapy, 1982). Nondirective play therapy is appropriate for children who are unable to express themselves verbally about their traumatic experiences. According to Play Therapy International (1995), play therapy provides a safe environment for children to heal. To use nondirective play therapy with infants to 3-year-old children, mental health clinicians will learn to use the *reflective practice* technique. Along with *reflective practice*, mental health clinicians will comprehend developmental milestone techniques through engagement such as singing, talking, touching, attunement; tummy time, exploration time, communication, development of feelings vocabulary, and social skills (Zero to Three, 2019). Furthermore, *reflective practice* is addressed in the third component of the training program.

Therefore, mental health clinicians will learn about the eight principles of Child-Centered Play Therapy (CCPT), known as nondirective play therapy, to utilize with children 3 years old to 5 years old. The play treatment model addresses social, emotional, behavioral, and relational disorders (CEBC, 2006). CCPT provides a safe environment to experience empathy and understanding from mental health clinicians and caregivers towards the children's traumatic experiences. Children can reach the healing process and create meaningful changes in their lives through nondirective play therapy (CEBC, 2006). Mental health clinicians will learn to use CCPT concepts in a family therapy model to enhance and repair the child-parent relationship. Therefore, mental health clinicians will gain knowledge and awareness of nondirective play therapy applicable to infant-early childhood mental health.

During the second phase, the instructors demonstrate appropriate nondirective play therapy skills when serving the infant-early childhood population. The instructors will demonstrate non-directive play therapy techniques for 15 minutes. Furthermore, mental health clinicians will participate in play for one hour to build up their comfortability with play, followed by a group conversation about the importance of play. A second objective of phase two is learning about what appropriate play therapy toys are needed when working with children. According to the University of North Texas (n.d.), appropriate play therapy toys allow for creative expression, assist with limit setting, gain a child's interest and engagement, and develop other important aspects for an organized and therapeutic space. In addition, some recommended toys are the following: baby dolls, paints, books, blocks, Play Doh, diverse family sets, and much more (University of North Texas, n.d.).

A third objective of phase two is about nondirective play therapy techniques. Ahuja and Saha (2016) share about non-directive play based on Carl Roger's client centered approach to encourage children to express their needs and heal from the trauma. The researchers emphasize the effects of non-directive play as it helps children with externalizing and internalizing behaviors, self-esteem, self-concept, anxiety, and depression (Ahuja & Saha, 2016). Most importantly, they emphasize how play demonstrates growth of a healthy relationship between the child and caregiver.

Furthermore, a fourth objective of phase two is understanding what a child learns through their participation in nondirective play therapy. Wilson and Ray (2018) investigate Child-Centered Play Therapy (CCPT) in relation to decreasing aggression, increasing empathy, and improving self-regulation in elementary children. This form of

nondirective play therapy allows the children to feel safe and express the root cause of their aggression. Mental health clinicians demonstrated empathic understanding, while children improved on their regulation and enhanced their empathy skills. In addition, Landreth et al. (2009) state that children learn to accept and respect themselves, learn to be creative in problem solving, and many other aspects of Child-Centered Play Therapy. As children experience trauma, most of their symptoms reflect some form of aggression since their brains have been overstimulated, therefore nondirective play therapy allows children a healthy outlet of expression.

In addition, a fifth objective of phase two is demonstrating play techniques to parents in the play therapy session. According to Stygar and Zadroga (2021), parents should have the capacity to emotionally regulate themselves to understand their children's emotions. As parents learn to understand their own emotional state and develop empathy for their children's feelings (Stygar & Zadroga, 2021), it will strengthen the child-caregiver relationship during play therapy. The techniques for the parents support the concept of reflective process when the parents are acknowledging a child's traumatic experiences. Therefore, instructors will demonstrate nondirective play therapy for 15 minutes, followed by mental health clinicians engaging in a one hour experiential activity to practice nondirective play therapy. There are two vignettes for mental health clinicians to engage in nondirective play therapy role plays followed by reflective questions.

The sixth objective is introducing socio-emotional techniques for infants to three-year-old children. According to the Zero to Three organization (n.d.), some socio-emotional techniques are music, loving touches, puppets, and other strategies to help

build a child's socio-emotional development. Since children within the infant to toddler stage cannot form full sentences, they cannot share their socio-emotional needs with caregivers. Instructors will demonstrate how to use socio-emotional techniques for 15 minutes and then mental health clinicians will engage in a one-hour experiential activity. There are two vignettes for mental health clinicians to use socio-emotional techniques in roles plays followed by reflective questions.

Furthermore, Mountain (2016) discusses spiritual development and play therapy to help the children heal. The researcher reports that play therapy is non-judgmental and supports the child's inner spirit. He focuses on the idea of "play" being the language of the child to enhance communication and empathy while building trust and confidence (Mountain, 2016). For the clinician to support the child through nondirective play therapy, the clinician learns to "track" the child's behavior while reflecting verbally to express the child's feelings. Mountain (2016) emphasizes how play therapy helps with attachment to link "spirit to spirit," caregiver and child, to help the child regulate and promote healthy brain development. Overall, nondirective play therapy supports the child-caregiver relationship in the healing process. Mental health clinicians will acquire nondirective play therapy knowledge to support and enhance the effectiveness of the healing process when providing services to children under the age of 5 years old.

Reflective Practice and Mindfulness

The third phase of the curriculum is *reflective practice* and *mindfulness*. The first objective is understanding reflective practice. Mental health clinicians will learn to provide competent knowledge and awareness to caregivers in understanding the effects of

trauma on children. Ferreira et al. (2017) define reflective practice as a therapeutic skill a clinician uses to observe the family's interaction to promote attunement of the parent to the child's emotions. Reflective practice allows mental health clinicians to explore with caregivers "what happened" to the child instead of "what is wrong" with the child, who has experienced trauma. Cooper and Wiechowski (2017) research the value of reflective practice among mental health clinicians and the results shows mental health clinicians find reflective practice valuable. The metal health clinicians value how reflective practice focuses on the relationship between the therapist and child/caregiver enhancing competent skills to understand the meaning of the child's behaviors and how it relates to the child's trauma and attachment style.

The evidenced-based practice, Child Parent Psychotherapy (CPP), is a treatment model focusing on infant-early childhood trauma that uses reflective practice/consultation. Even though reflective practice is acquired with experience and knowledge, reflective practice often prevents mental health clinicians from secondary trauma and burnout if they have someone to consult with about their trauma cases (Norona & Acker, 2016). Therefore, the instructors will demonstrate how to use reflective practice. Mental health clinicians will engage in a one-hour experiential activity to practice nondirective play and reflective practice followed by reflective questions.

To discuss *mindfulness* in the curriculum, mental health clinicians should understand the difference between secondary traumatic stress and burnout. Therefore, the second objective is discussing secondary traumatic stress and burnout experienced by mental health clinicians. According to the NCTSN (n.d.), professionals working with traumatized children are at high risk of developing secondary traumatic stress. Some

signs of burnout are headaches, loss of motivation, isolation, procrastination, and a sense of failure (Smith et al., 2020). Therefore, mental health clinicians will be encouraged to identify and discuss the signs of burnout and secondary traumatic stress to gain awareness.

The third objective is self-care for mental health clinicians to help them take care of their minds, bodies, and souls while working with children with infant-early childhood trauma. During the mindfulness part of the training mental health clinicians will incorporate the aspect of mindfulness into their self-care routine to avoid burnout and secondary traumatic stress. Also, mental health clinicians will participate in self-care activities to promote healthy coping to manage burnout and secondary traumatic stress. Recommending self-care to mental health clinicians during the training emphasizes the importance of a clinician's mental health as they interact with the infant-early childhood population when engaging in trauma cases.

Furthermore, *mindfulness* is the fourth objective discussing how mindfulness-based interventions help regulate trauma symptoms instead of having a reactive response. The concept of mindfulness allows for mental health clinicians to regulate their responses to hearing a child's trauma. In addition, there are multiple mindfulness-based interventions to use to stabilize the family and the child such as guided imagery, meditation, and body scan (Lyness, 2017). Using mindfulness-based interventions with a child and their family allows for the family to healthily process the trauma, while nurturing a supportive attachment. Instructors will demonstrate mindfulness in therapy for five minutes and discuss the benefits of mindfulness. Lastly, mental health clinicians will engage in a one-hour experiential activity to practice mindfulness-based

interventions in a therapeutic session. Mental health clinicians will have two vignettes for the experiential activity and then answer some reflective questions.

At the end of the four-day training mental health clinicians will have knowledge and awareness about infant-early childhood mental health and trauma, DC 0-5 diagnoses, and insight about this population. Therefore, the three key interventions, *psychoeducation on infant-early childhood mental health and trauma*, *nondirective play therapy*, and *reflective practice and mindfulness*, enhance the therapeutic knowledge and awareness of mental health clinicians serving the infant-early childhood population. After the four-day training mental health clinicians will be expected to have a competent trauma-informed understanding of infant-early childhood mental health such as the neuroscience of trauma and attachment to address trauma symptoms at a systemic level instead of at an individual level.

Furthermore, reflective practice provides the opportunity for the mental health clinician to explore and reflect on the effects of trauma in the family system and help caregivers ask the question “How can I support my child?” instead of “How can you (clinician) fix my child?” Mindfulness addresses therapeutic interventions for children with trauma, while helping mental health clinicians become mindful about self-care, burnout, and secondary traumatic stress.

Moreover, nondirective play therapy helps mental health clinicians facilitate the healing process by providing an empathic understanding and a safe environment for children to share their trauma with the mental health clinician and caregiver. Nondirective play therapy allows mental health clinicians to narrate the child’s story and behaviors, while incorporating the caregiver to be the agent of change and promote a

healthy child-caregiver relationship. Hence, the key interventions are preventive measures to challenge future mental health issues for children with infant-early childhood trauma and helping families understand their children.

Worksheets and Booster Sessions

In addition, the curriculum includes “notes” sections for mental health clinicians to write additional notes from the PowerPoint lectures. Worksheets have been included to support the growth and development of mental health clinicians in the infant-early childhood mental health field. Mental health clinicians will receive worksheets and handouts pertaining to the neuroscience of trauma, the adverse childhood experience (ACE) questionnaire, a list of developmental milestones assessments, an overview of the different attachment styles, a list of parental trauma questionnaires, a list of infant-early childhood trauma assessments, and a list of additional play therapy treatment models.

Booster sessions are designed to review important lecture material from the four-day training course. There will be PowerPoints and experiential activities to strengthen mental health clinicians’ clinical knowledge and awareness. The booster sessions will help mental health clinicians feel competent to treat the infant-early childhood population. Since there is a need of trauma-informed care trainings and limited evidence-based practices focusing on infant-early childhood trauma, the booster sessions focus on reviewing lecture material and providing opportunities for experiential activities. In addition, vignettes have been provided to support the mental health clinicians’ growth during the booster sessions. To conclude the Introduction to Infant-Early Childhood Mental Health and Trauma Training program will provide adequate support and guidance

for mental health clinicians to increase the focus in infant-early childhood trauma-informed care training among mental health clinicians and educate them on infant-early childhood diagnoses and concepts to be utilized effectively when working with the child trauma population.

Logic Model

The Logic Model demonstrates the goal to develop competent mental health clinicians in the field of infant-early childhood mental health. The trauma curriculum focuses on developing therapeutic knowledge and awareness applicable to children with trauma while avoiding misdiagnoses and ineffective treatments. The development of competent skills to serve the infant-early childhood population encourages clinician's confidence and enhances their knowledge. The overall goal is to prevent aversive effects of trauma at an early age instead of waiting to address the trauma when the child is older.

Problem	Contributing Factors	Inputs	Program Activities	Process Outcomes	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
Increase the focus in infant-early childhood trauma training among mental health clinicians and educate them on infant-early childhood diagnoses and concepts to be utilized effectively when serving the childhood trauma population	1.lack of trauma training for mental health clinicians 2.lack of focus on the field of infant-early childhood mental health 3. lack of knowledge in infant-early childhood mental health concepts 4. lack of EBPs focused on children under the age of 5 years old	1. Grants 2. Training for mental health clinicians 3. Birth to Five organization 4.NCTSN 5. Knowledge based 6. Expertise 7. Materials 8.Office space 9.Equipment	1. provide an educational training to mental health clinicians about infant-early childhood concepts and diagnoses 2. provide infant-early childhood knowledge and awareness to mental health clinicians for a therapeutic setting	1. 80% of participants will feel confident with infant-early childhood concepts within a year 2. 80% of participants will feel confident to serve the infant-early childhood population and use their knowledge and awareness of infant-early childhood trauma	1.increase clinician's knowledge in infant-early childhood trauma 2. provide additional therapeutic knowledge and awareness for effective treatments with the infant-early childhood population 3. increase recognition on the differences between trauma symptoms vs. no trauma	1. increase clinician's ability to appropriate identify and respond to infant-early childhood trauma 2. increase clinician's ability to recognize appropriate techniques for the infant-early childhood population symptoms 3. learn appropriate infant-early childhood diagnoses	1. increase clinician's confidence and competence in the field of infant-early childhood mental health 2. decrease effects of trauma in children at an early intervention level 3. decrease misdiagnoses and incorrect treatments for the infant-early childhood population

Figure 1. Program Logic Model Diagram.

Program Implementation

The Introduction to Infant-Early Childhood Mental Health Trauma Training Program occurs yearly on a quarterly basis meaning there are different cohorts of participants, whether they are participating in beginning of the trauma-informed care training or attending a booster. It is the goal to have cohorts of mixed students, associates, and licensed therapists to increase cohesion and experience. Mental health clinicians who have the desire to increase their knowledge and awareness within the field of infant-early childhood mental health and trauma will be invited through the partnerships with the Zero to Three organization, the National Child Traumatic Stress Network, and the

Commission on Accreditation for Marriage and Family Therapy Education. The networking process is significant to promote the trauma-informed training.

The calculated expenses for the Introduction to Infant-Early Childhood Mental Health Trauma Training curriculum includes the following: 1) paying experts in CCPT and CPP, 2) training materials such as videos, handouts, surveys, 3) travel time, and 4) training setting. The impact of a trauma-informed care training helps prevent future risks and effects for children who have been exposed to infant-early childhood trauma. The trauma-informed care training is funded through partnerships with the three organizations mentioned above. The timeline of implementing the infant-early childhood mental health trauma-informed care training will take a year to recruit experts who share the same vision and have time to teach other mental health clinicians. Grants will help obtain funding and outreach services in the community and professional organizations will recruit mental health clinicians for the trauma-informed care training. In addition, the program developer will advocate by writing articles for peer-reviewed journals to emphasize on infant and early childhood trauma prevention and intervention.

Process Outcomes

The *process outcomes* of the Introduction to Infant-Early Childhood Mental Health and Trauma Training are the following: 1) 80% of participants will feel confident with infant-early childhood mental health concepts within a year of beginning the four-day training, and 2) 80% of participants will feel confident to serve the infant-early childhood population and use their knowledge and awareness of infant-early childhood trauma within a year of beginning the four-day training. Before the training program

begins, mental health clinicians will be given surveys to gather information about their prior experience in infant-early childhood mental health and then there will be post surveys after the booster trainings. The post surveys will analyze if there was an increase in the clinician's knowledge in infant-early childhood trauma, if they learned to effectively use nondirective play therapy concepts, and if they are able to recognize the difference between trauma symptoms and those symptoms not associated with trauma. Lastly, at least 80% of the original participants will utilize the booster trainings to further evaluate their confidence in using the learned knowledge and awareness while demonstrating competence in the infant-early childhood population.

Outcome Objectives

The surveys will be sent pre-training to determine a baseline to compare pre and post test scores. Shortly after phase two booster training, the clinician will 1) increase their knowledge in infant-early childhood trauma, 2) provide additional therapeutic knowledge and awareness for effective treatments within the infant-early childhood population, and 3) increase recognition on the differences between trauma symptoms versus no trauma symptoms.

Since boosters occur every four months for a year, the *intermediate outcomes* are 1) an increase in clinician's ability to appropriately identify and respond to infant-early childhood trauma, 2) recognize appropriate techniques for the infant-early childhood symptoms, and 3) learn appropriate infant-early childhood diagnoses. After phase three booster training, mental health clinicians will complete a survey to measure their

confidence in identifying infant-early childhood diagnoses, awareness and knowledge about the infant-early childhood population.

A 6-month post-follow up from phase three booster training, mental health clinicians will receive surveys to measure *long term outcomes* such as 1) increase mental health clinician's confidence and competence in the field of infant-early childhood mental health, 2) decrease effects of trauma in children at an early intervention level, and 4) decrease misdiagnoses and incorrect treatments for the infant-early childhood population. At this point mental health clinicians should have the appropriate knowledge and awareness to effectively serve to the infant-early childhood trauma population and, most importantly, avoid misdiagnoses and ineffective treatments to reduce trauma effects.

Evaluation Plan

The evaluation plan of the Introduction to Infant-Early Childhood Mental Health and Trauma Training program measures the three dimensions of competence: trauma-informed care (TIC) knowledge, trauma awareness, and trauma beliefs among mental health clinicians. Therefore, three measurements are ideal to gather data to measure the effectiveness of the Introduction to Infant-Early Childhood Mental Health and Trauma Training program. All three measurements have been used in similar populations measuring educators, community providers, and mental health clinicians' attitudes towards trauma-informed care. The Attitudes Related to Trauma-Informed Care (ARTIC) Scale was used with educators to measure attitudinal improvements pre-and-post training (Baker et al., 2016). In addition, Commitment to Trauma Informed Care Survey was used among community workers (i.e., mental health clinicians, directors, managers, and

supervisors) to predict commitment to trauma-informed care (Sundborg, 2019). Lastly, the Child Trauma Clinical Beliefs Scale was used with mental health clinicians to measure their beliefs about how therapy should be conducted (Allen et al., 2014).

A measurement tool is the Attitudes Related to Trauma-Informed Care (ARTIC) Scale measuring the reflection and synthesis of the current knowledge related to TIC and assessing provider's attitudes related to TIC (Baker et al., 2016). Baker et al.'s (2016) measurement, the Attitudes Related to Trauma-Informed Care (ARTIC) Scale has three different versions, a 45-item scale, 35-item scale, and a 10-item scale. ARTIC measures the readiness for TIC implementation in organizations and schools to establish whether staff need additional training and supervision (Baker et al., 2016). The survey will address trauma awareness among mental health clinicians and support the gap of the need for trauma-informed care training in the infant-early childhood mental health field.

Another measurement tool to evaluate the curriculum is the Commitment to Trauma Informed Care Survey (Sundborg, 2019), which addresses the clinician's beliefs about trauma. The Commitment to Trauma Informed Care Survey is measuring a clinician's knowledge about trauma informed care in an organization (Sundborg, 2019). Sundborg's (2019) measurement, the Commitment to Trauma Informed Care Survey, is a seven-point Likert survey with 59 questions. The Commitment to Trauma Informed Care Survey explores mental health clinician's knowledge and commitment to trauma informed care (TIC) measured through support, self-efficacy, and beliefs about trauma. The survey will address if there is a lack of trauma-informed care training in hopes to close a gap of the trauma-informed care training in the infant-early childhood mental health field. Furthermore, this survey supports the reflection process of other important

questions such as the ACEs study and if mental health clinicians feel supported by their supervisors who may or may not have trauma informed care knowledge.

Lastly, the Child Trauma Clinical Beliefs Scale is an additional survey asking mental health clinicians about their beliefs on unstructured or structured treatment for children with traumatic experiences (Allen et al., 2014). Allen et al.'s (2014) measurement tool, the Child Trauma Clinical Beliefs Scale is an additional 8 question survey asking mental health clinicians about their beliefs on unstructured or structured treatment for children. The questions posed by the survey asks the mental health clinician if intensive training, experience, and ongoing support for structure/directive intervention is needed to have a verbal discussion of trauma with children.

Evaluation Methodology

A quantitative method will be used to collect the data about clinician's knowledge, awareness, and competency in infant-early childhood mental health and trauma. A *quantitative method* is known as hard data, objective, and measurable (McGoldrick & Tobey, 2016). The three assessments will identify if there is a lack of trauma awareness, trauma-informed care training, and knowledge in infant-early childhood mental health and trauma.

Mental health clinicians will be invited through the partnerships with the Los Angeles County Department of Mental Health (LACDMH), National Alliance on Mental Health, the Child Mind Institute, the Zero to Three organization, the National Child Traumatic Stress Network, and the Commission on Accreditation for Marriage and Family Therapy Education about the opportunity to participate in the training program.

Once the participants sign up for the training program, they will be emailed the three assessments two weeks before the training program. The participants will complete the three assessments, Attitudes to Trauma-Informed Care (ARTIC) Scale, Commitment to Trauma Informed Care Survey, and the Child Trauma Clinical Beliefs Scale to collect the pre-scores before their participation in the training program. The participants will be sent two reminders throughout the two weeks (day 7 and day 2 before the training) to complete the assessments to ensure at least 95% participation.

Furthermore, the same email procedure will be used for the following two booster training sessions and the 18 months post-participation in the training program. Since the booster training sessions are 4 months apart, the assessments will be sent out after participating in the training sessions. The participants will receive two reminder emails to complete the assessments 7 days and then 14 days after the training booster sessions. Finally, the participants will receive one final email at the 18-month post-training time point with two reminders (at the 7-day and 14-day mark) to complete the assessments.

The decision on the assessments is to address if mental health clinicians are properly diagnosing infants to 5-year-old children, gaining knowledge and awareness on the trauma effects after participating in the training program. By having the Attitudes Related to Trauma-Informed Care (ARTIC) Scale, Commitment to Trauma Informed Care Survey, and the Child Trauma Clinical Beliefs Scale as part of the evaluation process, it will improve the training manual and address the needs of mental health clinicians. It will be important to evaluate if all the needs of the mental health clinicians have been addressed from the four-day training program and the following booster sessions.

The Attitudes Related to Trauma-Informed Care (ARTIC) Scale is the first psychometrically reliable and valid measurement tool to evaluate TIC and the outcomes (Baker et al., 2016). The survey was developed to close gaps in TIC research and practice and evaluate TIC-relevant attitudes from staff working in schools, human service systems, and others serving individuals with trauma (Baker et al., 2016). Some examples of the survey questions are the following:

___ *ask [participants] about their trauma histories?*

___ *feel rewarded at work for using TIC?*

Furthermore, the Commitment to Trauma Informed Care Survey explores mental health clinician's knowledge and commitment to trauma informed care (TIC) measured through support, self-efficacy, and beliefs about trauma (Sundborg, 2019). The survey will address if there is a lack of trauma training in hopes to close a gap of the trauma-informed care training in the infant-early childhood mental health field. Some examples of the survey questions are the following:

___ *Trauma Informed Care is not necessary.*

___ *When we implement Trauma Informed Care, I feel I can handle it with ease.*

Also, the Child Trauma Clinical Beliefs Scale gathers data on the beliefs from mental health clinicians. The questions posed by the survey asks the mental health clinician if intensive training, experience, and ongoing support for structure/directive intervention is needed to have a verbal discussion of trauma with children (Allen et al., 2014). The mental health clinicians had a significant change towards being more accepting of a more structured/directive approach to treatment and greater belief that children can verbally describe their trauma (Allen et al., 2014). The mental health

clinicians who answered the survey had received a 12-month TF-CBT training and had a change in their beliefs (Allen et al., 2014). Some examples of the survey questions are the following:

___ *Children are generally capable of discussing their trauma when directed by a clinician.*

___ *The direction of treatment should be dictated by the clinician.*

Therefore, the measurements will be inputted into the Qualtrics database to make them accessible to the participants through a link that will be attached to the email. There is the hope that the program evaluator has an easier time collecting the data from the online surveys to establish if the training program was effective. Additionally, an informed consent form will be given through email by the program evaluator to the participants to inform them on the purpose of the research study. In the informed consent form, there will be an explanation on the purpose of the research study and how it is voluntary to participate. The informed consent form will provide an explanation of breach of confidentiality and the benefits of participating in the survey. In addition, contact information will be on the consent informed form for the participants to reach out if they have questions about the informed consent or the research study. There are minimal risks in completing the surveys and obtaining signatures. Therefore, a signed informed consent form will be gathered through the Qualtrics database once IRB has approved voluntary signatures to be part of the research study.

Furthermore, the data will be input into SPSS for organization, accessibility, and feasibility from the Qualtrics database. To track the number of participants, the program evaluator will data track the signed informed consent forms. Since data is being collected

at four different times from different DMH-contracted agencies, it is best to have a dedicated row for each new participant. A “Key” will be created to assign a random number to each participant and to be linked to the participants’ real name and emails. The IRB will need to approve of the “Key” and the program evaluator will password protect the “Key.” Each participant will be given a numerical ID to protect their identification and information. In addition, location will be abbreviated to keep track from which DMH-contracted agencies are participating in the training program. Furthermore, the dataset will be set up for participants to have unique IDs (001, 002, 003, etc.) associated with the different time points (T1, T2, T3, and T4) to manage the data. Also, it would be important to consider the missing data if participants do not complete the assessments throughout the four different time points.

Lastly, the research study’s data analysis will be a level of comparison as the program evaluator is finding the mean differences of the mental health therapists’ responses to the questionnaires at the different four timepoints. A repeated measures ANOVA analysis will be conducted to find out if attending the Introduction to Infant-Early Childhood Mental Health and Trauma Training program improved scores from pre-test (four-day training), mid-test (booster session 1), mid-test (booster session 2), to post-test (6 months after booster session 2) on the same group of mental health therapists for each questionnaire. Therefore, multiple repeated measures ANOVAs will be conducted for this research study presented in histograms. By conducting multiple repeated measures ANOVAs, the program evaluator will determine the effectiveness of the Introduction to Infant-Early Childhood Mental Health and Trauma Training program on improving the three dimensions of competence of the mental health therapist’s post-

participation. The pre-posttest design helps the program evaluator identify an increase in the mental health clinician's trauma-informed care (TIC) knowledge, trauma awareness, and trauma beliefs within the infant-early childhood field.

CHAPTER FIVE:
PROJECT OUTCOME

Introduction to Infant-Early Childhood Mental Health and Trauma Training Curriculum

By
Irene Rosaly Cortez, DMFT, LMFT

IMPORTANT NOTE FOR INSTRUCTOR(S)

*****page should not be included among the participants' handouts*****

PowerPoints are developed based on the following topics of the curriculum. PowerPoints are to be used during the training days. Handouts include summaries of each topic and group activities, while “notes” pages are for participants to write down notes from the PowerPoint presentations.

PowerPoint Topics

- a. *Preliminary Training Day*
 - i. *Introduction to Infant-Early Childhood Mental Health*
 - 1. *ACEs' Study and TIC Movement*
 - 2. *Developmental Milestones*
 - ii. *Neuroscience of Trauma*
 - iii. *Child-Caregiver Relationship*
 - 1. *Parental History*
 - iv. *Introduction to DC 0-5*
 - v. *Introduction to Reflective Practice*
 - vi. *Introduction to Play Therapy*
 - vii. *Introduction to Self-Care for Clinicians and Parents*
 - 1. *Self-Care*
- b. *Phase One: Psychoeducation on Infant-Early Childhood Mental Health and Trauma*
 - i. *Course Introduction and Training Objectives*
 - ii. *Infant-Early Childhood Mental Health*
 - iii. *Neuroscience of Trauma*
 - iv. *ACEs Study and TIC Movement*
 - v. *Developmental Milestones*
 - vi. *Child-Caregiver Attachment Styles*
 - vii. *Parental Trauma*
 - viii. *DC 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)*
- c. *Phase Two: Nondirective Play Therapy*
 - i. *Child-Centered Play Therapy*
 - ii. *Appropriate Toys*
 - iii. *Child-Centered Play Therapy Techniques*
 - iv. *What Children Learn in Child-Centered Play Therapy*
 - v. *Techniques for Parents*
 - vi. *Socio-Emotional Techniques for Infants to Three-Year-Old Children*
- d. *Phase Three: Reflective Practice and Mindfulness*

- i. *Reflective Practice*
- ii. *Secondary Traumatic Stress and Burnout*
- iii. *Self-Care*
- iv. *Mindfulness*

*****IMPORTANT NOTE FOR INSTRUCTOR(S)*****
*****page should not be included among the participants' handouts*****

The following are case examples, books, web sites, and video links to be used when creating PowerPoints and discussing the topics in the training course. You are also encouraged to use your own case examples to share with the participants. If there is an asterisk next to a topic, it should not be displayed in the PowerPoint to participants.*

Books

- Helping Abused and Traumatized Children: Integrating Directive and Nondirective Approaches by Eliana Gil
- The Whole Brain Child by Daniel J. Siegel, M.D. & Tina Payne Bryson, PH.D.
- Psychotherapy with Infants and Young Children by Alicia Lieberman & Patricia Van Horn

Video Links

Introduction to Infant-Early Childhood Mental Health

- *InBrief: Early Childhood Mental Health*
 - <https://www.youtube.com/watch?v=L41k2p-YRCs>
- *Infant Mental Health*
 - <https://www.youtube.com/watch?v=nwrFKS6D830>

ACEs' Study and TIC Movement

- *Experiences Build Brain Architecture*
 - <https://www.youtube.com/watch?v=VNNsN9IJkws>
- *Adverse Childhood Experiences- NHS Health Scotland*
 - <https://www.youtube.com/watch?v=VMpli-4CZK0>
- *What is Trauma-Informed Care?*
 - <https://www.youtube.com/watch?v=fWken5DsJcw>
- *TAP IN: What is a Trauma Informed Care (TIC) Approach?*
 - <https://www.youtube.com/watch?v=8ZTZrJzbLbw>
- *TREES An Introduction to Trauma Informed Care *for instructor only**
 - <https://www.youtube.com/watch?v=k4vEbuKL9I0>

Developmental Milestones

- *Your Child's Social and Emotional Development Birth to Age 6 *for instructor to use in PowerPoints and can purchase to give to participants**
 - <https://www.channingbete.com/health-care/maternal-and-child-health/child-development-ages-1-12/your-childs-social-and-emotional-development-birth-6-yrs/p-CBC0189>
- *"Developmental Milestones" by Dr. Holly Hodges and Dr. Bianca Shagrin*
 - <https://www.youtube.com/watch?v=g4HdXxz25pw>

Neuroscience of Trauma

- *Impact of Early Trauma on the Developing Brain*
 - <https://www.youtube.com/watch?v=mN14YDIx3fE>
- *Childhood Trauma and the Brain*
 - <https://www.youtube.com/watch?v=xYBUY1kZpf8>
- *Trauma and the Brain*

- <https://www.youtube.com/watch?v=4-tcKYx24aA&t=2s>
- *The Limbic Brain and It's Role in Trauma*
 - <https://www.youtube.com/watch?v=a-ddSEHRWVg&t=101s>

Child-Caregiver Relationship

- *Dr. Allan Schore on attachment trauma and the effects of neglect and abuse on the brain*
 - <https://www.youtube.com/watch?v=AB51V3fAAvs>
- *The Attachment Theory: How Childhood Affects Life*
 - <https://www.youtube.com/watch?v=WjOowWxOXCg&t=2s>
- *Secure, Insecure, Avoidant Ambivalent Attachment in Mother Babies*
 - <https://www.youtube.com/watch?v=DRejV6f-Y3c>

Parental History

- *What is Generational Trauma?*
 - <https://www.youtube.com/watch?v=sxiT7Ddd2Ts>
- *Can Trauma be Inherited?*
 - <https://www.youtube.com/watch?v=NuIM39dcUs4>
- *Breaking the Silence about Childhood Trauma*
 - https://www.youtube.com/watch?v=8NkZO3_h7vI&t=1s
- *The Strange Situation- Mary Ainsworth*
 - <https://www.youtube.com/watch?v=QTsewNrHUUH>

Introduction to DC 0-5

- *Making Appropriate Diagnoses and Establishing Eligibility *for instructor only**
 - https://www.youtube.com/watch?v=bL73ejNiG_M

Introduction to Reflective Practice

- *Introduction to Reflective Practice*
 - <https://www.youtube.com/watch?v=M9hyWVEG2x0>
- *Schon's Reflective Practice *for instructor only**
 - <https://www.youtube.com/watch?v=Tzjz-18L1lc>
- *Understanding Reflective Practice*
 - <https://www.youtube.com/watch?v=iBmtH0Qx0YU>

Introduction to Play Therapy

- *Play is a Child's Language: Play Therapy*
 - <https://www.youtube.com/watch?v=0sYif0gsFgQ>
- *Child Centered Play Therapy (Dr. Dee Ray)*
 - <https://www.youtube.com/watch?v=lmPI69VtueA>
- *Child-Centered Play Therapy*
 - https://www.youtube.com/watch?v=1_p6UbJXvLE

Introduction to Self-Care for Clinicians and Parents

- *A Self-Care Action Plan*
 - <https://www.youtube.com/watch?v=w0iVTQS8ftg>
- *What is Self-Care?*
 - https://www.youtube.com/watch?v=EguDLVf5x_U
- *Self-Care and Managing Expectations for Parents and Caregivers*
 - https://www.youtube.com/watch?v=At_rWy10T9w
- *Self Care Strategies and Trauma Work*

- https://www.youtube.com/watch?v=akz_0MWLxyw

Websites

Infant-Early Childhood Mental Health

- TIC- <https://traumainformedoregon.org/wp-content/uploads/2016/01/What-is-Trauma-Informed-Care.pdf>
- Abuse of Children Wheel- <https://www.theduluthmodel.org/product/abuse-children-wheel-poster/>
- Your Child's Early Development is a Journey- https://louisville.edu/education/kyautismtraining/files/CDC_LTSAE_Gen_Broch3_Type.pdf
- Twelve Principles of Early Child Development- Lieberman, A.F. & Van Horn, P. (2008). Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment. New York.
- Your Child's Social and Emotional Development Birth to Age 6- <https://www.channingbete.com/health-care/maternal-and-child-health/child-development-ages-1-12/your-childs-social-and-emotional-development-birth-6-yrs/p-CBC0189>

DC: 0-5 Diagnostic Manual

- <https://www.mohavecourts.com/CourtAdmin/Infantandtoddler/Symposium%202017%20handouts/DC0-5%20Overview%20Presentation%20-%20handouts.pdf> *
 - Great resource to guide instructors create the DC:0-5 training portion of the training course
- <https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training>

Reflective Practice

- <https://pacja.org.au/2020/08/reflective-practice-in-the-art-and-science-of-counselling-a-scoping-review/> *

Play Therapy

- <https://fpg.unc.edu/sites/fpg.unc.edu/files/resources/reports-and-policy-briefs/PromotingSelf-RegulationIntheFirstFiveYears.pdf> *

Self-Care

- <https://societyforpsychotherapy.org/distress-therapist-burnout-self-care-promotion-wellness-psychotherapists-trainees-issues-implications-recommendations/> *
- <https://www.samhsa.gov/dtac/ccp-toolkit/self-care-for-crisis-counselors> *
- <https://www.peps.org/ParentResources/by-topic/self-care/self-care-for-parents> *
- <https://tryingtogether.org/dap/parent-self-care/> *
- <https://www.healthychildren.org/English/family-life/family-dynamics/Pages/Importance-of-Self-Care.aspx> *

for instructor use only

Research Articles

Trauma and Brain

- Oral, R., Ramirez, M., Coohy, C., Nakada, S., Walz, A., Kuntz, A., Benoit, J., & Peek-Asa, C. (2016). Adverse childhood experiences and trauma informed care: The future of health care. *Pediatric Research* 79, 227–233. Doi:10.1038/pr.2015.197 *
- Bremner, J.D. (2002). Neuroimaging of childhood trauma. *Seminars in Clinical Neuropsychiatry*, 7(2):104-112. DOI: 10.1053/scnp.2002.31787.
- Dye, H. (2018). The impact and long-term effects of childhood trauma. *Journal of Human Behavior in the Social Environment*, 28(3), 381-392. DOI: [10.1080/10911359.2018.1435328](https://doi.org/10.1080/10911359.2018.1435328)
- De Bellis, M. D., Hooper, S. R., & Sapia, J. L. (2005). Early Trauma Exposure and the Brain. In J. J. Vasterling & C. R. Brewin (Eds.), *Neuropsychology of PTSD: Biological, cognitive, and clinical perspectives*, 153–177. The Guilford Press.

Reflective Practice

- Sarah Ross Bussey. (2020). Imperialism through virtuous helping: Baldwin’s innocence and implications for clinical social work practice. *Journal of Progressive Human Services* 31:3, pages 192-209.
- Seymour, J. W., & Crenshaw, D. A. (2015). Reflective practice in play therapy and supervision. In D. A. Crenshaw & A. L. Stewart (Eds.), *Play therapy: A comprehensive guide to theory and practice* (pp. 483–495). The Guilford Press
- Sibson, L. (2014). An introduction to reflective practice. *Journal of Paramedic Practice*, 1(3). Doi:10.12968/jpar.2008.1.3.42057

Play Therapy

- Ryan, V., & Edge, A. (2012). The role of play themes in non-directive play therapy. *Clinical Child Psychology and Psychiatry*, 17(3), 354–369. doi:10.1177/1359104511414265 *
- Ryan, V. (2004). Adapting non-directive play therapy for children with attachment disorders. *Clinical Child Psychology and Psychiatry*, 9(1), 75–87. doi:10.1177/1359104504039174 *
- Yumiko, O. (2004). Childhood trauma and play therapy intervention for traumatized children, *Journal of Professional Counseling: Practice, Theory & Research*, 32:1, 19-29, doi: [10.1080/15566382.2004.12033798](https://doi.org/10.1080/15566382.2004.12033798) *
- Hateli, B. (2021). The effect of non-directive play therapy on reduction of anxiety disorders in young children. *Counseling & Psychotherapy Research*. 22(1), 140-146. Doi:10.1002/capr.12420 *

Self-Care

- Shannon, P.J, Simmelink-McCleary, J., Hyojin Im, Becher,E. & Crook-Lyon, R.E. (2014) Developing self-care practices in a trauma treatment course. *Journal of Social Work Education*, 50(3), 440-453. DOI: [10.1080/10437797.2014.917932](https://doi.org/10.1080/10437797.2014.917932)
- Glennon, A., Doyle K. Rouland, P., & Rouland, R.S>. (2019). Integrating self-care into clinical practice with trauma clients, *Journal of Human Behavior in the Social Environment*, 29(1), 48-56, DOI: [10.1080/10911359.2018.1473189](https://doi.org/10.1080/10911359.2018.1473189)
- Lewis, M.L & King, D.M. (2019). Teaching self-care: The utilization of self-care in social work practicum to prevent compassion fatigue, burnout, and vicarious trauma. *Journal of Human Behavior in the Social Environment*, 29(1), 96-106. DOI: [10.1080/10911359.2018.1482482](https://doi.org/10.1080/10911359.2018.1482482)

In addition, the references section of the manual is filled with additional articles and websites to help build the PowerPoints for the training course. You are welcome and encouraged to use those resources.

Case Examples

Case #1

Child is a 4-year-old, Latina female who was living with her two foster parents (uncles) due to experiencing child neglect by her mother and mother's boyfriend. Child was having a difficult time with visiting her mother during visitations and would be highly dysregulated with her foster parents. Foster parents were having a difficult time soothing her because she would hit and kick. Child and foster parents started participating in a trauma-informed therapy to help build their relationship with her and provide her a safe place to discuss her trauma. Child started sharing her trauma through the toys she chose (male doll and female doll along with a car) to share how she had been left on the street with her mother and sister when other's boyfriend kicked them out of the car. Child started to voice her feelings about not feeling comfortable visiting her mother and mother's boyfriend during visitations. Foster parents were able to advocate on the child's behalf.

Case #2

Child is a 4-year-old, Black female who was living with her foster parents after her mother left her at foster care. Client's mother was a teen mother, who was also part of the foster family. Child was having a hard time separating from foster mother and would cry every time foster mother left her side. Foster mother engaged in play therapy to validated and reassure the child's feelings and that she would keep her safe. Child would mention her mother stating that she "missed" her. Foster mother practiced reflection about her own feelings about the child's situation to ensure she could provide appropriate love to the child. Foster mother engaged in child-directed play by allow the child to take the lead of the play as the child would share her fears about separating from foster mother. Client was able to reduce her anxiety when she would leave her foster mother to visit family members.

Case #3

Child is a 2-year-old, Hispanic male who was living with his foster parents (aunt and uncle) due to child neglect from witnessing domestic violence. Client displayed anxiety separating from foster mother and would not like to spend time with his mother. Family reunification plans were in motion and mother was concerned that client did not love her anymore. Mother, foster mother, and child engaged in play therapy to help build a healthy relationship between mother and child. Mother followed child's lead in therapy, which helped child trust mother. Child started to seek mother to play with her during visitations.

Case #4

Children are a 3-year-old, Hispanic male and 5-year-old, Hispanic female who had been reunited with their mother after being in foster care for three months due to child neglect from witnessing domestic violence. Children displayed fearing the dark, seeing monsters in the windows, and not wanting to sleep alone in their beds. The family engaged in family therapy to discuss the trauma through play. The children used a home, dolls, and furniture to share their trauma. Children shared about the domestic violence they witnessed and soon started to sleep in their own beds. Children would be dysregulated in therapy, but through play therapy they felt safe to share their trauma. Children shared the monsters in the windows started to leave once they felt safe in the home. They trusted mother to keep them safe in the home and were not having any behavioral issues at school.

Case #5

Child is a 1-year-old, White male who was physically abused by mother. Child was in foster care with his grandparents. Client was displaying anxiety, engaging in screams, and tantrums. Grandparents were having a difficult time soothing the child throughout the tantrums. They engaged in play therapy to learn appropriate soothing techniques to support the child. They engaged in play therapy to build their relationship to provide safety and love to the child. The child started to seek his grandparents for soothing and felt safe during play therapy as he no longer engaged in screaming matches with his grandparents. The grandparents felt that they could meet his needs without feeling overwhelmed.

Welcome to the “Introduction to Infant-Early Childhood Mental Health and Trauma Training” course. This training program is an overview of trauma-informed care about the infant-early childhood population. As an overview training program, it does not provide sufficient training to practice, but it encapsulates the importance of having a foundational knowledge and awareness of infant-early childhood trauma. Thank you for participating in this course to learn important clinical knowledge and awareness when serving children with trauma. Below you will find a table of contents to guide you through the curriculum:

Table of Contents

1. About This Course

- a. Introduction
- b. Course Timetable

2. Preliminary Training Day (Optional)

- a. Introduction to Infant-Early Childhood Mental Health
 - i. ACEs’ Study and TIC Movement
 - ii. Developmental Milestones
- b. Neuroscience of Trauma
- c. Child-Caregiver Relationship
 - i. Parental History
- d. Introduction to DC 0-5
- e. Introduction to Reflective Practice
- f. Introduction to Play Therapy
- g. Introduction to Self-Care for Clinicians and Parents
 - i. Self-Care

3. Course Phases

- a. Phase One: Psychoeducation on Infant-Early Childhood Mental Health and Trauma
 - i. Course Introduction and Training Objectives
 - ii. Infant-Early Childhood Mental Health
 - iii. Neuroscience of Trauma
 - iv. ACEs Study and TIC Movement
 - v. Developmental Milestones
 - vi. Child-Caregiver Attachment Styles
 - vii. Parental Trauma
 - viii. DC 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)
- b. Phase Two: Nondirective Play Therapy
 - i. Child-Centered Play Therapy
 - ii. Appropriate Toys
 - iii. Child-Centered Play Therapy Techniques
 - iv. What Children Learn in Child-Centered Play Therapy
 - v. Techniques for Parents

- vi. Socio-Emotional Techniques for Infants to Three-Year-Old Children
 - c. Phase Three: Reflective Practice and Mindfulness
 - i. Reflective Practice
 - ii. Secondary Traumatic Stress and Burnout
 - iii. Self-Care
 - iv. Mindfulness
- 4. Booster Sessions**
 - a. Phase Four: Booster Session #1
 - i. Review Lectures
 - ii. Vignettes for role plays
 - b. Phase Five: Booster Session #2
 - i. Review Lectures
 - ii. Vignettes for role plays
- 5. Appendices**
 - a. Appendix A: Certificate of Completion
 - b. Appendix B: Resource List
- 6. References**

Part 1: About This Course

What you will learn

This training course provides information on infant-early childhood mental health and trauma, infant-early childhood interventions, how to use play therapy to address trauma, learn about reflective practice and the importance of mindfulness.

Why this training course is important

This training course will help you feel competent to treat the infant-early childhood population. Since there is a need for trauma-informed care trainings and limited evidence-based practices focusing on infant-early childhood trauma, this curriculum focuses on providing competent trauma-informed care training. The infant-early childhood trauma-focused curriculum supports an educational approach to increased awareness and decrease financial strain on the public.

Who is this training course designed for

The training course is designed for pre-licensed (students and associates) and licensed mental health clinicians. Mental health clinicians are known as therapists, counselors, psychologists, and clinical social workers, who hold a Master degree and/or Doctoral degree and are trained to evaluate people's mental health. Pre-licensed (students and associates) and licensed mental health clinicians work in the following settings: hospitals, psychiatric facilities, and outpatient facilities such as community mental health agencies, schools, and private practices.

How this training course is organized

This is a four-day training course consisting of one informational day about infant-early childhood mental health and trauma and two days of experiential training. The informational training day consists of knowledge and awareness about the infant-early childhood field. During the experiential training, the participants will have the opportunity to apply what is being learned. There are two one-day booster sessions to review necessary lecture material and for the opportunity of additional experiential training.

Training Course ground rules

Some basic ground rules to follow:

1. Show respect towards others in the group
2. Actively participate
3. Ask encouraging questions for development
4. Personal disclosures should remain confidential and not be shared outside of the group

Training course evaluation and learning assessment

At the beginning of the training course, you would have taken pre-assessments to assess your level of knowledge about infant-early childhood mental health and trauma. At each booster session, the participants will complete the assessments to

measure the knowledge the participants have gained during the course. In addition, post 6 months of booster session two, participants will complete assessments for a final evaluation of the training course.

How to learn most effectively during this training course

This is an interactive training course, and every participant is encouraged to actively participate in the learning process. Participants are encouraged to ask questions throughout the course to gain understanding.

Sample Training Course Schedule

This schedule is intended as a guide only. The actual order of events may differ.

Day 1: (Optional)- In Depth Informational Session

Time	Topics Covered	Topics Covered
8:00 am- 8:15 am	Check-in	
8:15 am- 9:45 am		Introduction Infant-Early Childhood Mental Health
9:45 am-10:45 am	Neuroscience of Trauma	
10:45 am- 12:00 pm		Child-Caregiver Relationship
12:00 pm- 1:00 pm	Lunch	
1:00 pm- 2:30 pm		Introduction to DC 0-5
2:30 pm- 3:30 pm	Introduction to Reflective Practice	
3:30 pm-4:30 pm		Introduction to Play Therapy
4:30 pm- 5:30 pm	Introduction to Self-Care for Clinicians and Parents	

Day 2: Experiential Session

Time	Topics Covered	Topics Covered
8:00 am- 8:15 am	Check-in	
8:15 am- 8:45 am		Infant-Early Childhood Mental Health
8:45 am- 9:45 am	Neuroscience of Trauma/ Group Activity #1 & #2	
9:45 am- 10:15 am		ACEs study and TIC Movement
10:15 am-10:30 am	Break	
10:30 am- 11:00 am		Developmental Milestones
11:00 am- 11:45 am	Group Activity #3 & #4	
11:45 am- 12:15 am		Child-Caregiver Attachment Styles
12:15 am- 1:15 pm	Lunch	
1:15 pm – 2:00 pm		Group Activity #5
2:00 pm- 2:30 pm	Parental Trauma	
2:30 pm- 2:45 pm		Break
2:45 pm- 3:30 pm	Group Activity #6	
3:30 pm- 4:00 pm		DC 0-5
4:00 pm- 4:45 pm	Group Activity #7 & #8	
4:45 pm- 5:30 pm		Group Activity #9 & #10

Day 3: Experiential Session

Time	Topics Covered	Topics Covered
8 00 am- 8:15 am	Check-in	
8:15 am- 9:00 am		Q&A on Day 2
9:00 am- 9:30 am	Nondirective Play Therapy	
9:30 am- 10:00 am		Appropriate Play Therapy Toys
10:00 am- 11:00 am	Group Activity #1 & #2	
11:00 am-11:15 am		Break
11:15 am- 11:45 am	Client-Centered Play Therapy Techniques	
11:45 am- 12:15 pm		What Children Learn in Child-Centered Play Therapy
12:15 pm- 1:15 pm	Lunch	
1:15 pm- 1:45 pm		Techniques for Parents
1:45 pm- 2:45 pm	Group Activity #3 & #4	
2:45 pm- 3:15 pm		Socio-Emotional Techniques for Infants to Three-Year-Old Children
3:15 pm- 4:15 pm	Group Activity #5 & #6	
4:15 pm- 5:00 pm		Q&A

Day 4: Experiential Session

Time	Topics Covered	Topics Covered
8:00 am- 8:15 am	Check-in	
8:15 am- 9:00 am		Q&A on Day 3
9:00 am- 9:30 am	Reflective Practice	
9:30 am- 10:30 am		Group Activity #1 & #2
10:30- 10:45 am	Break	
10:45 am- 11:15 am		Secondary Traumatic Stress and Burnout
11:15 am- 12:00 pm	Group Activity #3 & #4	
12:00 pm- 1:00 pm		Lunch
1:00 pm- 1:30 pm	Mindfulness	
1:30 pm- 2:15 pm		Group Activity #5
2:15 pm- 2:30 pm	Break	
2:30pm -3:30 pm		Group Activity #6
3:30 pm- 4:30 pm	Q & A	

Sample Booster Session Course Schedule

This schedule is intended as a guide only. The actual order of events may differ.

Booster Session #1

Time	Topics Covered	Topics Covered
8:00 am- 8:15 am	Check-in	
8:15 am- 8:45 am		Infant-Early Childhood Mental Health/Neuroscience of Trauma
8:45 am- 9:15 am	Developmental Milestones	
9:15 am- 9:45 am		DC 0-5
9:45 am- 10:00 am	Break	
10:00 am- 10:30 am		Child-Centered Play Therapy
10:30 am- 11:00 am	Child-Centered Play Therapy Techniques	
11:00 am- 12:00 pm		Lunch
12:00 pm- 12:30 pm	Socio-emotional Techniques for Three-Year-Old Children	
12:30 pm- 1:00 pm		Reflective Practice
1:00 pm- 1:30 pm	Mindfulness	
1:30 pm- 2:15 pm		Role Play Vignette #1
2:15 pm- 3:00 pm	Role Play Vignette #2	
3:00 pm- 3:15 pm		Break
3:15 pm- 3:45 pm	Role Play Vignette #3	
3:45 pm- 4:30 pm		Role Play Vignette #4
4:30 pm- 5:00 pm	Q & A	

Booster Session #2

Time	Topics Covered	Topics Covered
8:00 am- 8:15 am	Check-in	
8:15 am- 8:45 am		Developmental Milestones
8:45 am- 9:15 am	Child-Caregiver Attachment Styles	
9:15 am- 9:45 am		Parental Trauma
9:45 am- 10:00 am	Break	
10:00 am- 10:30 am		Appropriate Toys
10:30 am- 11:00 am	What Children Learn in Child-Centered Play Therapy	
11:00 am- 12:00 pm		Lunch
12:00 pm- 12:30 pm	Techniques for Parents	
12:30 pm- 1:00 pm		Reflective Practice
1:00 pm- 1:30 pm	Secondary Traumatic Stress and Burnout	
1:30 pm- 2:15 pm		Self-Care
2:15 pm- 3:00 pm	Role Play Vignette #1	
3:00 pm- 3:15 pm		Break
3:15 pm- 3:45 pm	Role Play Vignette #2	
3:45 pm- 4:30 pm		Role Play Vignette #3
4:30 pm- 5:00 pm	Role Play Vignette #4	
5:00 pm- 5:30 pm		Q & A

Part II: Preliminary Training Day (Optional)

- A. Phase One: Psychoeducation on Infant-Early Childhood Mental Health and Trauma
- B. Phase Two: Nondirective Play Therapy
- C. Phase Three: Reflective Practice and Mindfulness

Aim of the Preliminary Training Day

Have an in-depth didactic training day for mental health clinicians who have limited knowledge of infant-early childhood mental health and trauma

Learning Objectives

- Comprehend in-depth educational information about infant-early childhood mental health and trauma
- Comprehend in-depth educational information about nondirective play
- Comprehend in-depth educational information about reflective practice and self-care

Session Activities

- Instructor Remarks
- Lecture

Preliminary Training Day Goals

- Provide participants with knowledge and tools to enhance their ability to comprehend effective care to the infant-early childhood population
- Answer questions participants have about the curriculum and related issues
- Emphasize the importance of infant-early childhood mental health, neuroscience of trauma, child-caregiver relationship, introduction to DC 0-5, introduction to play therapy, introduction to reflective practice, and introduction to self-care for clinicians and parents in-depth

Types of activities participant will engage in during this course:

- Lecture
- View video segments

Materials for participants:

- Resource Handouts
- Handouts of lectures
- “Notes” section

Topic 1:

Introduction to Infant-Early Childhood Mental Health

P1.1 Session Overview

Aim

The aim is to introduce infant-early childhood mental health, while discussing the ACEs' study, TIC movement, and developmental milestones

Learning Objectives

- Learn about infant-early childhood mental health
- Understand the ACEs Study
- Learn about the TIC movement
- Learn about developmental milestones

Session Activities

- Viewing video segments about the impact of trauma
- Handouts to enhance clinical knowledge and awareness

The following pages include handouts for your clinical development. Your instructor will guide you in the proper use of the handouts.

P1.1.1 Infant-Early Childhood Mental Health

- Children lives are complex built on emotional relationships usually with their primary caregivers (Lieberman & Van Horn, 2008)
- Children experiences are shaped by their sense of self, trust in others, and their curiosity as they learn about the world (Lieberman & Van Horn, 2008)
- A healthy development occurs when the children feel protected by caregivers to provide internal and external security (Lieberman & Van Horn, 2008)
- According to Lieberman and Van Horn (2008), infant-early childhood mental health is—the child's capacity to 1) experience, tolerate, and express a range of emotions without lasting emotional collapse, 2) form and maintain trusting intimate relationships, and 3) learn culturally appropriate strategies for the child's age

P1.1.2 ACEs' Study

- CDC-Kaiser study to investigate childhood abuse and neglect and household challenges in later life health and well-being (CDC, n.d.)
- Huge impact on future violence victimization and perpetration (CDC, n.d.)
- Study demonstrated psychological effects and long-term health complications of recurring exposure to ACEs (CDC, n.d.)
- ACE score of 4 or more are greater risk for many issues later in life (CDC, n.d.)

P1.1.3 TIC Movement (Video: TREES An Introduction to Trauma Informed Care)

- The movement influence members from the social services to learn, explore, and acknowledge trauma and encourage those who have experienced trauma to discuss it

- Learning to assess traumatic experiences from children to help them build healthy resiliency skills
 - TREES→ **T**rauma Identification, **R**ecognize, **E**mpower, **E**mpathize, **S**upport
- Learning how to identify common signs of trauma (Oregon Health Authority, n.d.)
- Understanding the principles of trauma informed care
 - Trauma Awareness
 - Safety
 - Choice & Empowerment
 - Strengths Based

P.1.1.4 Developmental Milestones

- Learning how a child develops in their first five years
 - Communicate needs and feelings, trust others, feel safe in the world, solve problems, and develop a sense of self
- Understanding parents need guidance to help the child develop emotionally and socially
- Understand how trauma influences a child’s development and regresses their growth
- Learning about the 12 principles of early child development and how it influences their ability to self-regulate, feel safe, and trust their caregivers

Notes

P1.1 Handout

Infant-Early Childhood Mental Health Vocabulary

This is a short list of important vocabulary words to understand the training course.

1. ACE's: adverse childhood experiences- are childhood experiences that have a huge impact on a child's life throughout adulthood.
2. Attachment theory: establishes the significant of the 1st year of a child's life shapes the cognitive and socio-emotional development
3. Child-caregiver relationship/dyad - a pair of individuals in an interpersonal situation
4. Co-regulation- the process of calming down for a child with the support of the caregiver's relationship (Clark, Gehl, Heffron, Kerr, Soliman, Shahmoon-Shanok, & Thomas, 2019)
5. *DC 0-5*: diagnostic manual used to define infant-early childhood diagnoses
6. Infant-early childhood mental health (I-ECMH): core needs of a child is parental love, protection, and socialization
7. {Infant}-early childhood trauma- traumatic experiences that occur to children aged 0-6 affecting their safety or the safety of their parents/caregivers
8. Reflective practice- having the self-awareness during intervention services, while appreciating the perspective of others (Clark, Gehl, Heffron, Kerr, Soliman, Shahmoon-Shanok, & Thomas, 2019)
9. Self-regulation- the ability to be self-aware of and manage emotions while maintaining calmness (Clark, Gehl, Heffron, Kerr, Soliman, Shahmoon-Shanok, & Thomas, 2019)
10. TIC: trauma-informed care- recognizing traumatic experiences and allowing a safe space to discuss it

P1.1 Resource Handout

Infant-Early Childhood Mental Health Resources

This is a short list of websites for different type of resources to help your clinical development as you gain knowledge and awareness about infant-early childhood mental health.

1. TIC
 - a. <https://traumainformedoregon.org/wp-content/uploads/2016/01/What-is-Trauma-Informed-Care.pdf>
2. Abuse of Children Wheel
 - a. <https://www.theduluthmodel.org/product/abuse-children-wheel-poster/>
3. Your Child's Early Development is a Journey
 - a. https://louisville.edu/education/kyautismtraining/files/CDC_LTSAE_Gen_Broch3_Type.pdf
4. Twelve Principles of Early Child Development
 - a. Lieberman, A.F. & Van Horn, P. (2008). Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment. New York.
5. Your Child's Social and Emotional Development Birth to Age
 - a. <https://www.channingbete.com/health-care/maternal-and-child-health/child-development-ages-1-12/your-childs-social-and-emotional-development-birth-6-yrs/p-CBC0189>
6. ACEs Study
 - a. https://static1.squarespace.com/static/5cd20b5e94d71a0baf3fe293/t/6043d7a1098f140fbbd53f2e/1615058850330/ACEs_Study_030621.pdf

Topic 2:

Neuroscience of Trauma

P2.1 Session Overview

Aim

The aim is to provide an overview of neuroscience of trauma and how it influences relationships

Learning Objectives

- Learn about the neuroscience of trauma

Session Activities

- Viewing video segments about the brain and trauma
- Handouts to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

P2.1.1 Neuroscience of Trauma

- Child respond to stress differently occurring to their attachment style (Lieberman & Van Horn, 2008)
 - Anxiously attached children have higher heart rates and higher cortisol levels responses to threatening situations
 - Secured attached children show no increase in cortisol levels to stressful situations
- Corrective experiences of safety and predictability teach children to cope with stress and trauma (Lieberman & Van Horn, 2008)
- In relation to the ACEs, the effects on the brain indicate the following toxic stress- prolong activation of our body stress response to frequent, intense situations/events (Joining Forces for Children, n.d.)
 - Leads to long term behavior issues, health complications, and diseases
 - Leads to anxiety, depression, impaired learning and memory
 - Leads to hypervigilance, difficult experiencing joy
- Childhood trauma disrupt, change, and stall the development of a healthy brain (Gil, 2006)
- Children demonstrate a higher level of cortisol after traumatic experience (Lieberman & Van Horn, 2008)
- Children have behavioral changes when responding to trauma (Lieberman & Van Horn, 2008)

Notes

P2.1 Handout

Important Key Points to Remember

- I. Stress becomes trauma when the scary events have become unmanageable for the child to handle
- II. Child's biological makeup changes with the constant threat of stress creating chronic trauma
- III. Prevention to toxic stress (Joining Forces for Children, n.d.)
 - a. Provide a nurturing, safe and stable environment
 - b. Help children learn to cope
 - c. Reduce child's ACE exposure
 - d. Build the child's resiliency to protect them from ACEs
- IV. Resiliency Tips
 - a. Acknowledge the child's experience with ACE
 - b. Ask "what happened to you?" instead of "what's wrong with you?"
 - c. Build your understanding and empathy
 - d. Visit website for more resiliency tips
 - i. <https://www.joiningforcesforchildren.org/what-are-aces/>
- V. Learning about the functions of the left brain and right brain pertaining to a child's development
- VI. "Neurons that fire together wire together"- (Siegal & Bryson, 2011)

Resources

- I. Helping Abused and Traumatized Children: Integrating Directive and Nondirective Approaches by Eliana Gil
- II. The Whole Brain Child by Daniel J. Siegel, M.D. & Tina Payne Bryson, PH.D.
- III. Psychotherapy with Infants and Young Children by Alicia Lieberman & Patricia Van Horn

Topic 3:
Child-Caregiver Relationship

P3.1 Session Overview

Aim

The aim is to understand child-caregiver-child relationships and the impact of parental trauma

Learning Objectives

- Learn about child-caregiver relationships
- Understand the impact of parental trauma on relationship

Session Activities

- Viewing video segments about child-caregiver relationship
- Handouts to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

P3.1.1 Child-Caregiver Relationship (Lieberman & Van Horn, 2008)

- Biologically innate to seek human connection, which infants have the capacity to respond or discriminate to different stimuli
- Children have the capability to imitate facial expressions and synchronize gestures, expressions, and vocalize performed from others
- Emotional connection occurs through emotional experiences which guide interpersonal relationships and explore their surrounding environments
- Healthy attachment creates “protection,” “safety,” and “security”
- Parental attunement is important to create a sense of safety for the child when danger is being perceived

P3.1.2 Parental History (Lieberman & Van Horn, 2008)

- Understanding the caregiver’s ability to provide protection when a child’s mental health is in distress
- Environmental stress: poverty- lack of access to resources, inadequate housing, increase of victimization and community violence, etc.
- Parental mental health: the caregiver’s psychological functioning compromising the caregiver’s abilities to protect the child
- Interpersonal trauma: caregiver’s can be the causers of trauma and children can be trauma triggers to the caregivers

Notes

P3.1 Handout

Key Points to Remember Handout (Lieberman & Van Horn, 2008)

- I. Developmentally appropriate parental responses needed to provide the child with protection and internal relief
- II. According to Freud, children have five anxieties:
 - a. Being abandoned
 - b. Losing the parent's love
 - c. Body damage
 - d. Doing wrong
- III. Attachment Styles
 - a. Secured attachment
 - i. Trust their caregiver for protection and comfort
 - ii. Seek caregiver in distress and calm down in union
 - b. Anxious attachment
 - i. Learn children are not reliable for help and depend on their own
 1. Engage in avoidant, resistant, or disorganized behaviors
 - a. Child feels unsupported and do not turn to parents for comfort
- IV. Parental Role
 - a. Protective behaviors
 - i. Provide children with nurturance and safety
 - b. Letting go behaviors
 - i. Encourage child to explore without fear
- V. Barriers to Parent's Ability to Protect
 - a. Environmental stressors and traumatic events compromise parental; competence
 - b. Unable to recognize unpredictable responses when child has been traumatized
 - c. Parental mental health: substance abuse, maternal depression, genetic disposition
 - d. Interpersonal trauma: parents become the agent of trauma for the children; therefore, children do not know if to approach or avoid the caregiver

P3.1 Resource Handout

Parental Resources

This is a short list of websites for different types of resources to help your clinical development as you gain knowledge and awareness about parenting.

- I. Parenting Style Questionnaire
 - a. https://www3.cde.ca.gov/pem/module2/story_content/external_files/ParentingStyleQuestionnairev8.pdf
- II. Assessing Parent Strengths and Family Connections
 - a. <https://www.childwelfare.gov/topics/systemwide/assessment/family-assess/parentalneeds/strengthsandconnections/>
- III. Living out the Five Love Languages at Home
 - a. <https://livinghopechurch.net/handouts-pdf/love-languages.pdf>
- IV. The Parental Reflective Functioning Questionnaire (PRFQ)
 - a. <https://www.ucl.ac.uk/psychoanalysis/research/parental-reflective-functioning-questionnaire-prfq>

Topic 4:

Introduction to DC 0-5

P4.1 Session Overview

Aim

The aim is to introduce the DC 0-5 diagnostic manual

Learning Objectives

- Learn about the importance of the DC 0-5 diagnostic manual
- Learn the different diagnoses to help understand infant-early childhood mental health

Session Activities

- Handouts to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

P4.1.1 DC 0-5 diagnostic manual (Zero to Three, n.d.)

- Using the DC 0-5 requires assessment, diagnosis, and formulation
 - Assessment: gathering information based on history from the caregivers, observation, and conducting interviews
 - Diagnosis: identifying specific infant-early childhood diagnoses
 - Formulation: understanding the child within the different contexts of relationships, biology, social network, and development status
- Assessing is a continuous practice to collect information about the child and family in different contexts
- Treatment plans are created based on understanding the child and the child's relationship
- A comprehensive evaluation usually requires 3-4 sessions about 45 minutes long to have comprehensive treatment
- Important to consider cultural factors when diagnosing
- Learning how to identify “red flags” of patterns
- Why do we diagnosis in infant-early childhood?
- *****NEW 2021 CHANGES***** (Zero to Three, n.d.)
 - DC 0-5 version 2.0 has clarified some language and numerical codes for inclusivity
 - Adding clarifying words, sentences, and phrases
 - Corrections of typos, revisions of sentences, and page number updates
 - Criteria extended to younger ages if appropriate
 - New disorders

- Relationship-Specific Disorder of Early Childhood, Dysregulated Anger and Agrees Disorder of Early Childhood, Atypical Social-Communication Emergent Neurodevelopmental Disorder
 - Maintains the multi-axis system, which considers context in assessment and diagnosis
- History of the Diagnostic Classification Manual
 - A task force created by the ZERO TO THREE organization in 1987 and in 1994 the DC:0-3 was published
 - In 2003, the DC:0-3R was released after revisions
 - In 2016, the DC:0-5 was released → 2022 new revisions to the DC:0-5 were release
 - Revisions are done due to new empirical data and studies
- DC:0-5 is different from the DSM-5
 - DC: 0-5 is comprehensive and includes an impairment criterion for every disorder
 - Identifying impairments pertains to how the caregiver responses to the symptoms, which impacts the child, family, and child-caregiver's relationship
 - Disorders range for the ages of birth to five years old
 - Includes a multiaxial classification system
 - Axis I: Disorders
 - Axis II: Relational Context
 - Axis III: Physical Health Conditions and Considerations
 - Axis IV: Psychosocial Stressors
 - Axis V: Developmental Competence
- Reviewing every section in the DC: 0-5 diagnostic manual

Resource

DC: 0-5 diagnostic manual

- <https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training>
- <https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10>

Notes

Topic 5:
Introduction to Reflective Practice

P5.1 Session Overview

Aim

The aim is to introduce the concept of reflective practice

Learning Objectives

- Learn about reflective practice
- Process the information of reflective practice

Session Activities

- Viewing video segments about reflective practice
- Handouts to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

P5.1.1 Introduction to Reflective Practice

- Help parents understand dysregulated behaviors are emotional reactions to unmanageable emotions to the five anxieties (Lieberman & Van Horn, 2008)
- Reflective practice is a process used to critically think when there are no clear solutions (Taylor, n.d.)
- Reflective practice is the practice of observation and analytical thinking of one's own thinking and behaviors (Taylor, n.d.)
- Reflective practice involves reflecting on thoughts, feelings, attitudes, therapeutic experiences, life history, beliefs, values, bias, and others (Taylor, n.d.)
- Asking reflective questions that promote reflection and encouragement (Zero to Three, n.d.)

Group Discussion: Process the meaning of reflective practice as a therapist and how it would improve your clinical skills? Process how you think reflective practice might look like in your clinical practice?

Notes

Topic 6:
Introduction to Play Therapy

P6.1 Session Overview

Aim

The aim is to introduce the concept of play therapy through research and videos

Learning Objectives

- Learn about the effectiveness of play therapy with trauma
- Understand play therapy techniques

Session Activities

- Viewing video segments about play therapy and client-centered play therapy
- Handouts to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

P6.1.1 Introduction to Play Therapy

- Anna Fred (1965) viewed play therapy as a process to include children into therapy while building rapport with the clinician. The goal was to have transference responses in the child (Gil, 2006)
- Play is a child's way to communicate, express, and self-soothe (Gil, 2006)
- Psychoanalytical play was the first model to help promote a child's insight and behavioral change (Gil, 2006)
- Play therapy allows children to share invisible concerns in a safe manner (Gill, 2006)
- Play therapy does not confine a child and they have the freedom to self-express, create stories, undo the stories, transform stories, keep bringing up the stories, and change the meaning of the toys (Gil, 2006)
- Some play therapy strategies (Gil, 2006)
 - Play genograms
 - Following the child's lead
 - Color your feelings technique
 - Puppets Play
 - Storytelling in play therapy
 - Including family in the play therapy

Notes

P6.1 Resource Handout

Child-Directed Play (Webster-Stratton, 2006)

- Follow the child's lead and interest
- Do not compete with the child
- Have realistic play expectations-give the child time
- Encourage and praise the child's creativity
- Do not judge or criticize the child's play
- Describe the child's play instead of asking questions
- Encourage the child's problem-solving skills

Websites

<https://www.therapistaid.com>

- Excellent website with worksheets, interactive sessions, guides, videos and articles for therapeutic strategies

Strategies for Teaching Kids Self-Regulation

- <https://www.pbs.org/parents/thrive/strategies-for-teaching-kids-self-regulation>

Worksheets to recognize stress in infants

Awake States with Stress Responses

- <https://www.erikson.edu/wp-content/uploads/Awake-States-with-Stress-Responses-4-16-14.pdf>

Possible Regulation and Stress Response Correlates of Interpersonal Modes Across Life Cycles

- <https://uwm.edu/mcwp/wp-content/uploads/sites/337/2016/01/Awake-States-w-Stress-Responses.pdf>

Topic 7:

Introduction to Self-Care for Clinicians and Parents

P7.1 Session Overview

Aim

The aim is to introduce the concept of self-care for clinicians and parents

Learning Objectives

- Learn about the importance of self-care for clinicians and parents
- Learn how to engage in self-care

Session Activities

- Viewing video segments about self-care
- Handouts to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

P7.1.1 Self-Care

- Self-care is crucial when dealing with secondary trauma stress, stress and burnout when working with an overwhelming number of trauma cases
- The ability to engage in self-care comes from the capability to have self-awareness and self-understanding (Taylor, n.d.)
- Burnout contributes to the inability of the therapist to fully engage in therapy
- Reflective practice helps therapists prevent excessive emotional strain (Taylor, n.d.)
- Self-care activities and strategies (Barnett, 2014)
 - Sleep each night
 - Maintain a healthy diet
 - Yoga or meditation
 - Pleasurable reading
 - Building resiliency skills
- Encourage parents to engage in self-care activities to help with self-regulation
- Parents also experience burnout making it difficult to meet the needs and demands of their children (Bedortha, Davis, Swartz, & Thompson, n.d.)

Notes

P7.1 Resource Handout

Self-Care Resources

- I. Compassion Fatigue and Self-Care for Crisis Counselors
 - a. <https://www.samhsa.gov/dtac/ccp-toolkit/self-care-for-crisis-counselors>
- II. Self-Care Resources for Therapists
 - a. <http://www.camft.org/self-care>
- III. Self-Care Resources for Psychologists
 - a. <https://www.apa.org/monitor/2014/04/self-care>
- IV. Self-Care Resources
 - a. <https://www.apaservices.org/practice/ce/self-care>
- V. A Guide to Self-Care for Parents: Why Making time for Yourself Matters
 - a. <https://www.waterford.org/education/self-care-for-parents/>
- VI. Self-Care for Parents
 - a. <https://www.pbs.org/parents/thrive/self-care-for-parents>
- VII. Self-Care Wheel
 - a. <https://olgaphoenix.com/self-care-wheel/>
- VIII. Resilience Wheel
 - a. <https://olgaphoenix.com/resilience-wheel/>

Part III: Course Phases

Phase 1:

Psychoeducation on Infant-Early Childhood Mental Health and Trauma Overview

1.1 Course Introduction

Aim

The aim is to understand the training objectives and goals of the course.

Learning Objectives

- Understand the rationale and goals of the course
- Understand how the course supports the participant to provide better client care
- Understand the learning objectives for the course
- Understand the reasons for an infant-early childhood trauma-informed care training

Session Activities

- Instructor Remarks
- Icebreaker activity
- Lecture
- Group Discussion
 - Course expectations
 - Setting ground rules
 - Q&A

Training Course Goals

- Provide participants with knowledge and tools to enhance their ability to comprehend effective care to the infant-early childhood population
- Answer questions participants have about the curriculum and related issues
- Emphasize the importance of psychoeducation on infant-early childhood mental health and trauma, nondirective play therapy, reflective practice, and mindfulness

Purposes of Pre- and Post-Tests

- Assess pre-existing knowledge in the topic areas covered by the course
- Provides the instructor with information about participant's knowledge before and after the course
- Improve the effectiveness of the course for future participants

Training Course Objectives

- Support mental health clinicians understand the infant-early childhood population
- Provide critical information about infant-early childhood mental health to facilitate the healing process to children who are impacted by trauma
- Provide a systemic approach to treating the infant-early childhood population as a family unit

Types of activities participant will engage in during this course:

- Lecture
- View video segments
- Role Play
- Group Discussion

Materials for participants:

- Worksheets
- Group Activities
- Handouts of lectures

Phase 1:

Psychoeducation on Infant-Early Childhood Mental Health and Trauma

1.2 Session Overview

Aim

The aim of this session is to increase the clinician's awareness and knowledge about the neuroscience of trauma.

Learning Objectives

- Understand infant-early childhood mental health
- Understand the neurobiology of trauma
- Understand the ACE's study and TIC movement
- Learn about the developmental milestones
- Understand the different attachment styles
- Comprehend potential trauma within the family unit
- Learn how to use the DC:0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)

Session Activities

- Viewing videos on trauma effects on brain development
- Assessments to learn about caregiver trauma
- Worksheets and vignettes to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

1.2.1 Infant-Early Childhood Mental Health

What is infant-early childhood mental health?

- Infant-early childhood mental health as the child's ability to experience, regulate, express emotions, form secure relationships, and explore the environment safely (Zero to Three, n.d.)
- Advocates of infant-early childhood mental health emphasize on the importance of prenatal and postnatal environment to promote healthy development and reduce future mental health issues (Simpson et al., 2016)
- In the center of supporting infant-early childhood mental health, caregiver "attachment" relationship is important protective factor emphasizing on bonding, mental health, and emotional growth for the child (Stygar & Zadroga, 2021)

1.2.2 Neuroscience of Trauma

What is neuroscience of trauma?

- Traumatic experiences disrupt the homeostasis of the child's biological system (Solomon & Heide, 2005)
- Brain studies show how trauma affects the structure of the brain impacting memory, learning, ability to regulate, social skills, and moral development (Solomon & Heide, 2005).
- Neurobiological resiliency protects the child's brain from regressing, so providing effective interventions related to brain development can develop supportive and responsive caregivers (Cross et al., 2017)

What is the Theory of Neuroscience?

- Alan Schore believed a secure attachment with the mother stimulates a psychobiological response for the child (Bitter, 2014)
- Schore states "that individual development arises out of the relationship between the brain, mind, and body of both the infant and caregiver held within a culture and environment that either supports, inhibits, or even threatens it" (Bitter, 2014)

Group Activity #1: Watch Video on Trauma and the Brain (9 min), The Limbic Brain and It's Role in Trauma (5 mins)

Group Activity #2: Discuss Neuroscience of Trauma

- What are some brain responses that children can have to trauma?
- What are some techniques that can be possibly useful to lower brain responses to trauma?
- How would explain neuroscience of trauma to a co-worker who does not have any knowledge about infant-early childhood trauma?

Notes

Worksheet 1.2

Definition of Trauma

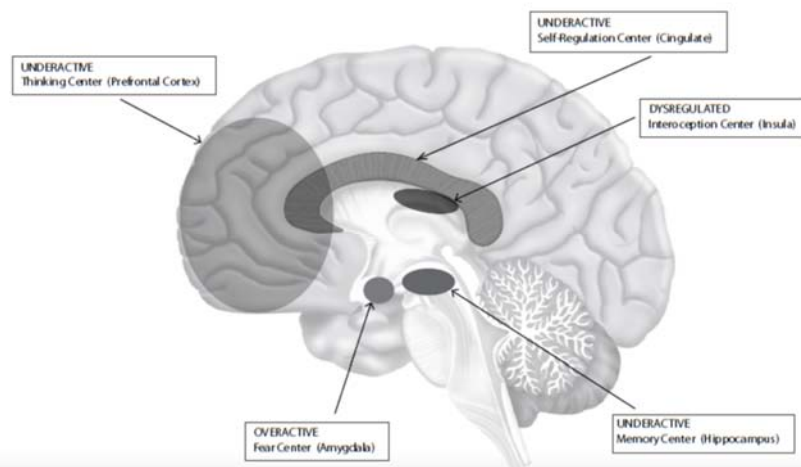
- SAMHSA (2020) states that “*individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*”

How would you explain the neuroscience of trauma to a family?



As a clinician, it's important to understand the latest developments in brain science because it explains why traumatized individuals experience such strong and distressing symptoms. This understanding can help therapists choose techniques that change the brain in ways that reduce these symptoms.

The Brain On Trauma



1.2.3 ACEs study and TIC Movement

What are ACEs?

- Trauma can be associated with adverse childhood experiences (ACEs) that enhance the impact of trauma
- ACEs were identified through the ACE's study which investigated childhood abuse, childhood neglect, and household challenges in later life health and well-being (CDC, n.d.)
- The 10 ACEs identified were physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, caregiver's mental illness, domestic violence, divorce, substance abuse, and incarcerated relative (Joining Force for Children, n.d.)

What is the TIC movement?

- TIC approach shifts the focus from "What's wrong with you?" to "What happened to you?" (Menschner & Maul, 2016)
- TIC allows for health care providers to realize the impact of trauma and understand paths to recovery, recognize trauma signs and symptoms, avoid re-traumatization, and integrate knowledge about trauma into policies, procedures, and practices (Trauma-Informed Care Implementation Resource Center, n.d.)
- TIC allows for mental health clinicians to recognize the direct impact of trauma the child and family

1.2.4 Developmental Milestones

What are a child's developmental milestones?

- From birth to age three, a child typically grows fast becoming a toddler while mastering skills
- Language allows the child to communicate with others and solve problems (Tomonari, n.d.), which becomes important when noticing that children with traumatic experiences impact their skills development
- During the ages three and five, socioemotional skills help form peer relationships, gender identification, and learning from right and wrong (Tomonari, n.d.)

Group Activity #3: Complete the ACEs study questionnaire on your own.

Group Activity #4: Discussion on ACEs Study

- What are your initial reactions to your ACE score?
- How can you use the ACEs questionnaire to understand a child and their family?
- How do you or your agency use TIC in their clients? Do you find TIC useful? Yes, or no?

Notes

1.2.3 Worksheet

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically, the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often:

Swear at you, insult you, put you down, or humiliate you?

Or

Act in a way that made you afraid that you might be physically hurt?

Yes/No

2. Did a parent or other adult in the household often:

Push, grab, slap, or throw something at you?

Or

Ever hit you so hard that you had marks or were injured?

Yes/No

3. Did an adult or person at least 5 years older than you ever:

Touch or fondle you or have you touch their body in a sexual way?

Or

Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes/No

4. Did you often feel that:

No one in your family loved you or thought you were important or special?

Or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes/No

5. Did you often feel that:

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

Or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes/No

6. Were your parents ever separated or divorced?

Yes/No

7. Were any of your parents or other adult caregivers:

Often pushed, grabbed, slapped, or had something thrown at them?

Or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

Or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes/No

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

Yes /No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes/No

10. Did a household member go to prison?

Yes/No

ACE SCORE (Total "Yes" Answers): _____

Adverse Childhood Experience (ACE) Questionnaire

PROVIDER INSTRUCTIONS (Revised April 11, 2019)

Beginning June 1, 2019, the ACE Questionnaire shall be given to all adults ages 18 and older* who are seeking behavioral health services from the ODMHSAS and the OHCA (SoonerCare/Medicaid); with minimal exception**. The ACE score shall be reported on all CDC/PA 23 (admissions) and CDC/PA 42 (6-month updates/extensions). The questionnaire only has to be given once per person, per provider- but the score must be reported/carried forward on all subsequent CDCs like some of the other CDC responses (ex: gender and race are typically reported/carried forward on each CDC and rarely change). Valid ACE Scores should be entered on the CDC in one of the following formats: 00 to 10 or 0 to 10 (00 to 10, double digits, is preferred). For currently admitted/open adult clients, the ACE Questionnaire shall be given at the next 6-month treatment update and reported on the CDC/PA 42 (6-month update/extension).

*Note: This questionnaire should only be given to adults ages 18 and older; it should not be given to children or youth under the age of 18.

**Exceptions: Due to the nature of some levels of care and program types, there are circumstances in which the ACE Questionnaire shall not be required. They are as follows:

- Community Living (CL) Level of Care (ex: Homeless, Housing, Residential Care)
- Service Focus- 11 (Homeless, Housing, Residential Care); 23 (Day School); 24 Medication Clinic Only; and 26 Mobile Crisis.

GIVING THE ACE QUESTIONNAIRE

The ACE Questionnaire is to be given at the time of clinical assessment (at initial clinical assessment for new clients, and for currently admitted/open clients- at clinical assessment update completed as a part of the service plan update process at 6-month treatment update). This is to ensure ready access to a therapist should one be needed to address any issue that might arise from revisiting childhood trauma.

It is a self-administered instrument and shall be completed by the individual seeking services without intervention from staff (ex: staff may not reframe the question or give explanation regarding the intent of the question). The only assistance that staff may provide is with regard to literacy or vision challenges, and in that instance the introduction statement and questions must be read aloud to the individual exactly as written on the questionnaire. To ensure a trauma informed process, it is important that the introduction statement on the questionnaire is either read by the client or read to the client.

Due to the sensitive nature of the questions, the individual completing the ACE Questionnaire should be given a confidential space in which to complete it. They may choose to have someone with them in the room for support (ex: Peer Support Specialist, family, friend).

Scoring

For each of the ten (10) questions on the questionnaire, the individual will give a Yes or No answer. When scoring, each “Yes” answer will be given one (1) point. These points will be tallied to determine the individuals ACE Score.

1.2.4 Worksheet

Developmental Milestones Assessments

This is a short list of websites to assess a child's developmental milestones and if a child is reaching their milestones. Do remember not every child will develop at the same rate, so always assess for any concerns about a child's development.

1. Infant Development & Milestones-
https://www.michigan.gov/mikidsmatter/0,9220,7-376-101357_101415---,00.html
2. CDC: Milestone Checklists-
https://www.cdc.gov/ncbddd/actearly/pdf/checklists/all_checklists.pdf
3. Pathways.org: Child Milestone Checklists For All Ages- <https://pathways.org/all-ages/checklists/>
4. A Simple Checklist to Track Your Child's Developmental Milestones-
<http://flintoclass.com/blog/child-developmental-milestones>
5. Child Mind Institute: Complete Guide to Developmental Milestones-
<https://childmind.org/guide/parents-guide-to-developmental-milestones/>
6. Kid Sense: Self Care Development Checklist-
<https://childdevelopment.com.au/resources/child-development-charts/self-care-developmental-checklist/>
7. Developmental Milestones and the Early Years Learning Framework and the National Quality Standards- <https://www.acecqa.gov.au/sites/default/files/2018-02/DevelopmentalMilestonesEYLFandNQS.pdf>
8. C.S. Mott Children's Hospital: Developmental Milestones-
<https://www.mottchildren.org/posts/your-child/developmental-milestones>
9. Children's Hospital of Philadelphia: Developmental Milestones-
<https://www.chop.edu/primary-care/developmental-milestones>
10. PBS SoCal: The ABC's of Child Development-
<https://www.pbs.org/wholechild/abc/index.html>

1.2.5 Child-Caregiver Attachment Styles

Caregiver “attachment” relationship is important protective factor emphasizing on bonding, mental health, and emotional growth for the child (Stygar & Zadroga, 2021)

What are the four different attachment styles?

- Secure attachment
- Avoidant attachment
- Resistant/dependent attachment
- Disorganized attachment

Why is attachment important?

- Understanding attachment style of the caregiver and child enhances mental health clinicians’ knowledge and awareness to facilitate the healing process to children under 5 years old
- The risk of developing an insecure, disorganized, and dissociated attachment style is related to severely impacting the neurophysiological development of the children, restricting of their ability to regulate (Pearlman & Courtois, 2005)

1.2.6 Parental Trauma

What is parental trauma?

- Understanding multigenerational transmissions of the family; mental health clinicians can understand how the child’s behaviors have been influenced by caregiver’s unresolved emotional attachments
- Working with the family is an important intervention to address the impact of trauma to help alleviate symptoms by having the support from the family in the healing process (Figley & Figley, 2009)
- Through the family healing process, the family as a unit helps with regulation within the relationship context to address the impact of trauma (Papero, 2017)

Group Activity #5: Watch video clips “Breaking the silence on Childhood Trauma” (13 mins) and “The Strange Situation- Mary Ainsworth” (3 mins)

Group Activity #6: Vignette on child-caregiver attachment styles/ role- play asking each other a parental trauma questionnaire (1 hour)

This is your first time seeing this family, a three-year old child with her 39-year-old mother, at your clinic. The mother has shared that the client was in foster care for one year due to physical abuse by biological father. The mother shared being in a domestic violence situation with her child’s father. The client

is displaying crying spells, she jumps when there are loud noises, and she cries every time her mother leaves to work. You notice the child always looking at her mother and she is afraid to approach you. The mother shares that the child will cry around men and will always look for her in need of comfort. The child is also having nightmares saying, “daddy scary.”

- What attachment style is being present in the vignette?
- How would you proceed with parental trauma?
- Why did you choose that specific parental trauma questionnaire?
- How comfortable were you using the parental trauma questionnaire and which one(s) would you use in your own practice?

Notes

1.2.5 Worksheet

Attachment Styles

These are the four different types of attachment styles for a dyad.

According to Ainsworth et al. (1978), the Strange Situation demonstrated three major attachment patterns between infants and primary caregivers (Huang, 2020).

- Group A: Avoidant Attachment**
- Group B: Secure Attachment**
- Group C: Ambivalent Attachment**
- Group D: Disorganized Attachment**

Avoidant Attachment <ul style="list-style-type: none">• Child avoids interacting with the caregiver and shows no distress• Children has internalized a belief that they cannot depend on caregiver, if caregiver has ignored intimate interactions with the child• Child shows signs of avoidance when reunited with caregiver	Secure Attachment <ul style="list-style-type: none">• Child can connect and feel secure in relationships• Child actively seeks and maintains proximity with caregiver• Child might be slightly distressed, but will rarely cry
Ambivalent Attachment <ul style="list-style-type: none">• Child is concerned about not receiving reciprocated desire of intimacy• Child has learned from caregivers being unreliable and inconsistent• Child want contact with caregiver, but are anxious of a caregiver's response	Disorganized Attachment <ul style="list-style-type: none">• Child not fitting in Groups A, B, or C• Child behaviors lack intention, displaying contradictory behaviors• Child has unresolved attachment-related traumas to caregivers• Child learns to depend on a caregiver who is scary, which is confusing

1.2.6 Worksheet

Parental Trauma Resources

These are some excellent assessments/questionnaires to use to gather parental trauma information, so you can have a better understanding how the child-caregiver relationship is being affected. Gathering parental trauma information helps the clinician stay attune to the family's relationship and emotional responses to the child.

1. Life Stressor Checklist-Revised (LSC-R)
2. PTSD Symptom Scale Interview (PSSI)
3. Center for Epidemiologic Studies-Depression Scale (CES-D)
4. GAD-7 Anxiety
5. What to Look for in Relationships

IMPORTANT

If the caregiver/family is currently experiencing trauma such as domestic violence, it should be your clinical judgment if you want to offer family therapy for the caregiver and child. It is highly encouraged for the clinician to recommend individual therapy for the caregiver to reduce emotional distress and learn coping skills to participate in family therapy. Furthermore, if you suspect the child is in any danger such as physical abuse, sexual abuse, and/or neglect follow through with mandated reporting obligations to ensure the safety of the child.

1.2.7 DC 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)

What is infant-early childhood trauma?

- “Traumatic experiences that occur to children aged 0-6 affecting their safety or the safety of their parents/caregivers” (NCTSN, n.d.)
- Children suffering from traumatic stress became easily frightened, stunt their developmental skills growth, dysregulation of their emotions, difficulty sleeping, and so on (NCTSN, n.d.)

What is the DC: 0-5?

- The DC:0-5 provides effective early intervention by identifying and classifying disorders (Simpson et al., 2016)
- DC: 0-5 allows for mental health clinicians to assess the “attachment” relationship in their different environments (Simpson et al., 2016)
- If mental health clinicians have knowledge of the *DC:0-5* diagnostic manual, mental health clinicians can identify if the caregiver knows how to be emotionally consistent, if the caregiver values the child as unique, and if the caregiver has the capacity to provide empathic care to the child (Zeanah & Lieberman, 2016)

Group Activity #7: Introduce and Teach the DC 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)

Instructor will pass out copies of the DC: 0-5 book and developmental milestones assessments to be used for group activity

Group Activity #8: Vignettes to help facilitate using the DC 0-5 for children; role play using a child developmental milestones assessment

Vignette #1

You are meeting with a 5-year-old male child and father for the first time. Child shares he does not like to be home because he is always getting in trouble when he picks on his sister. He shares he is always getting “mad” and his father tells him to calm down. He shares he has a hard time calming down, so he will start to throw and hit his father. Father shared child has tantrums and having restless sleep since the divorce. Father share child is having a hard time concentration in class, which is affecting his grades. Child shared he feels like it is his fault that his parents are not together because he would get mad all the time. Child shared he feels as a bad kid and wants his parents back together.

Vignette #2

You are meeting with your 4-year-old female child and mother for the first time. Child does not leave mother's side even though the room is filled with toys. Mother shared child becomes nervous around people and at new places. Child will start to cry when asked to say hi to strangers and will cling to mother's leg. You try to engage with the child, but the child continues to hide behind her mother. Mother shared client has not formed any new friends at pre-school and only plays with her 7-year-old brother. Mother shared she must stay at the pre-school with the child impeding mother from following up with her routine.

- How would you approach the family regarding the presented issue(s)?
- What diagnosis does the child have? And what made you choose that diagnosis?
- What other possible diagnoses did you consider?
- What treatment plan would you create for the child to address the symptoms and behaviors?

Notes

1.2.7 Worksheet

Infant-Early Childhood Trauma Resources

These are some excellent assessments/questionnaires to use to gather infant-early childhood trauma information, so you can have a better understanding on the child's symptoms and behaviors. Gathering infant-early childhood trauma information helps the clinician provide appropriate support for caregivers to understand the effects of trauma.

1. Traumatic Events Screening Inventory Parent Report Revised (TESI-PRR)
2. Traumatic Symptom Checklist for Young Children (TSCYC)*
3. Young Child PTSD Checklist (YCPC)
4. Ages and Stages Questionnaire (ASQ)**
 - a. ASQ-3 (Developmental screening tool)
 - b. ASQ: SE-2 (Socio-emotional health)
5. Child Behavior Checklist (CBCL, 1 ½-5 years old) *
6. Eyberg Child Behavior Inventory (ECBI, 2-16 years old)

IMPORTANT

If the caregiver/family is currently experiencing trauma such as domestic violence, it should be your clinical judgment if you want to offer family therapy for the caregiver and child. It is highly encouraged for the clinician to recommend individual therapy for the caregiver to reduce emotional distress and learn coping skills to participate in family therapy. Furthermore, if you suspect the child is in any danger such as physical abuse, sexual abuse, and/or neglect follow through with mandated reporting obligations to ensure the safety of the child.

*Must be purchased

**Multiple questionnaires for the different ages (1 month-60 months old)

1.2.7 Worksheet

Crosswalk from DC:0-5 to DSM-5 and ICD-10

1. https://aimhitn.org/images/DC_0_to_5_Crosswalk/DC_0_to_5_Crosswalk.pdf
2. <https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10>

Group Activity #9: Teach how to use the Crosswalk from DC: 0-5 to DSM-5 and ICD-10

Instructor(s) will provide copies of the DC: 0-5 book and DC: 0-5 Crosswalk to participants

Group Activity #10: Practice using the Crosswalk when diagnosing children in the infant-early childhood population to understand the common diagnoses referred in the DSM-5 from the previous vignettes on page 22

Notes

Phase 2:

Nondirective Play Therapy

2.1 Session Overview

Aim

The aim of this session is to learn and understand the importance of nondirective play therapy.

Learning Objectives

- Review & answer questions from Phase 1
- Learn nondirective play therapy principles from the treatment modality Child-Centered Play Therapy
- Realize appropriate play therapy toys
- Comprehend client-centered play techniques
- Techniques for Parents
- Understand socio-emotional techniques for infants to three-year-old children

Session Activities

- Viewing of videos about nondirective play therapy techniques
- Role plays
- Worksheets and vignettes to enhance clinical knowledge and awareness

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

2.1.1 Nondirective Play Therapy

What is nondirective play therapy?

- Nondirective play therapy is appropriate for children who are unable to express themselves verbally about their traumatic experiences
- Allows for self-expression in a positive way to regulate emotions, stimulate creative thinking, and encourage exploration (Association for Play Therapy, 1982)
- Encourage children to express their needs and heal from the trauma (Ahuja & Saha, 2016)

What are the eight principles of Child-Centered Play Therapy? (Moss & Hamlet, 2020)

- Developed by Virginia Axline (1969) blending person-centered therapy components: congruence, unconditional positive regard, and empathy
- Principle 1: Develop a warm, friendly rapport with the child as soon as possible.
- Principle 2: Accept the child just as they are.

- Principle 3: Allow the child to express themselves freely and completely by establishing a sense of permissiveness.
- Principle 4: Recognize the feelings the child expresses and reflects those them back to the client in a way that allows the client to gain insight into his/her own behavior.
- Principle 5: Maintain and communicate a deep respect for the child's ability to solve problems, make choices, and institute change.
- Principle 6: Allow the child to lead the way in all aspects of therapy, refraining from directing the child's play in any way.
- Principle 7: Allow the therapy process to develop at its natural pace without being hurried in any way.
- Principle 8: Establish limitations only when necessary to anchor the therapy to reality and with therapeutic benefit that provides insight into the child's aware of his/her responsibility in the relationship.

2.1.2 Appropriate Play Therapy Toys

What are some appropriate toys?

- University of North Texas (n.d.) recommends for an organized space and criteria for selecting toys and material:
 - Allows for exploration of cultural values, traditions, and roles
 - Gain the child's interest and engagement
 - Allows for limit setting
 - Allows for the development of self-control
 - Allows for exploration of others and self
 - Allows for symbolic expression
 - Provides opportunity to express range of emotions
 - Facilitates insight/self-understanding
 - Allows creative expression
 - Durable, simple, and easy toys

What are some recommended toys?

- Dollhouse
- Baby Dolls
- Diverse Family Sets
- Superheroes
- Soldiers
- Blocks
- Food
- Play Doh
- Paints
- Sand Box
- Musical instruments
- Books

ACCESS TO EXTENDED TOY LISTS ARE PROVIDED ON THE RESOURCE PAGE

Group Activity #1: Instructor(s) will demonstrate nondirective play therapy techniques for 15 minutes; Participants will engage in play for 1 hour so they can feel comfortable playing

Group Activity #2: Have participants engage in a group conversation about the importance of play

- What are the benefits of play?
- What are some play activities you engaged in as a child with a caregiver?
- What does play look like in therapy? In your family?
- What does play help children learn throughout the process?

Notes

2.1.1 Worksheet

Additional Play Therapy Treatment Models

These are some excellent play therapy treatment models for additional trainings.

1. Filial Play Therapy
2. Adlerian Play Therapy (AdPT)
3. Sandplay Therapy
4. Theraplay
5. Child Parent Relationship Therapy (CPRT)

Programs supporting play-based interventions

6. Child Parent Psychotherapy
7. Parent-Child Interaction Therapy
8. Incredible Years

IMPORTANT

If the caregiver/family is currently experiencing trauma such as domestic violence, it should be your clinical judgment if you want to offer family therapy for the caregiver and child. It is highly encouraged for the clinician to recommend individual therapy for the caregiver to reduce emotional distress and learn coping skills to participate in family therapy. Furthermore, if you suspect the child is in any danger such as physical abuse, sexual abuse, and/or neglect follow through with mandated reporting obligations to ensure the safety of the child.

2.1.3 Client-Centered Play Therapy Techniques (Landreth et al., 2009)

- Therapist must maintain empathy, unconditional positive regard, and congruence
- Important to be fully “present” in the play therapy session and entering the child’s world
- Nonverbal skills: playing genuineness and interest in the child’s play, congruent expressions, matching nonverbal skills with verbal skills
- Verbal skills: focusing on the responses to be tailored to the child’s age
 - Reflecting nonverbal play behavior (tracking)
 - Reflecting content
 - Reflecting feeling
 - Facilitating decision making/returning responsibility
 - Facilitating creativity/spontaneity
 - Esteem building/encouraging
 - Facilitating relationship
 - Limit-setting
- Reflecting content, feeling, and meaning facilitates the therapeutic relationship
- Therapeutic limit setting and choice giving
 - Feelings, desires, and wishes of child are accepted, but not all behaviors are acceptable
 - Acknowledge child’s feelings, wishes, and wants
 - Communicate the limit
 - Target acceptable alternatives (behaviors)

2.1.4 What Children Learn in Child-Centered Play Therapy (Landreth et al., 2009)

- To accept themselves
- To respect themselves
- Assume responsibility for themselves
- Be creative in problem solving
- Self-control and self-direction
- Make choices and be responsible for those choices

2.1.5 Techniques for Parents (Stygar & Zadroga, 2021)

- Understanding one’s own emotional states
- Reading and understanding emotional states in others
- Managing strong emotions and expressing these in a constructive manner
- Regulating one’s own behavior
- Developing empathy for others
- Establishing and maintaining relationships

Group Activity #3: Gather in a group of 4 people and grab some toys to practice nondirective play therapy; Instructor(s) will demo play therapy for 15 minutes

Group Activity #4: Participants will engage in experiential activity for 1 hour taking turns being a therapist(s), parent(s), and child to practice nondirective play therapy

Course instructor(s) will be joining groups for observation and guidance

Vignette #1

You are meeting with your 5-year-old male client and his caregiver for the fourth time. You are continuing to build a relationship with the family through play therapy. The child is in therapy because his father passed away two months ago. Child found father unconscious in the backyard when client arrived from school. 911 was called and the child watched the paramedics give father CPR before father was led to the ambulance. Mother shared child continues to ask for father and wanting to visit father in “heaven.” Child is afraid of the ambulance noise and does not sleep alone.

Vignette #2

You are meeting with your 3-year-old female client and her caregiver for the second time. The child cries every time mother leaves to work and calms down about two hours after. The mother shared the child was exposed to domestic violence and witnessed father hit mother. The child has been hitting and scratching when the mother comes back home but will not leave mother’s side. The mother shared she has a hard time soothing the child and does not want to leave her with her maternal grandparents. The child jumps when there is screaming and shuts her eyes.

- How would have you approached each vignette differently?
- What did you realized as you (therapist) were engaging in the nondirective play therapy?
- What are some play techniques that you used to address the presenting issue(s)?
- As “parents” did you find the play techniques useful to understand your “child?” Why or why not?

Notes

2.1.6 Socio-emotional techniques for infants to three-year-old children (Zero to Three, n.d.)

- Music
- Messy Play
- Puppets
- Slow down and observe
- Respond in productive manner
- Identify feelings
- Loving touches
- Encouraging words

Group Activity #5: Gather in a group of 4 people and grab some toys to practice socio-emotional techniques; Instructor(s) will demo socio-emotional techniques for 15 minutes

Group Activity #6: Participants will engage in experiential activity for 1 hour taking turns being a therapist(s), parent(s), and child to practice socio-emotional techniques

Course instructor(s) will be joining groups for observation and guidance

Vignette #1

You are meeting with your 4-month-old male client and his caregiver for the seventh time. The child was exposed to alcohol and methamphetamine in utero and had a positive drug test at birth. The client displays tremors and rigidity around his legs. Client has high pitch screams when he is in distressed. Foster parent shares client does not sleep more than three hours throughout the night and only calms down when he is being held. You are using socio-emotional techniques to support the relationship and regulate the family.

Vignette #2

You are meeting with your 2-year-old female client and her caregiver for the fifth time. The child witnessed domestic violence between mother and father as well as was hurt physically by mother. Client cries when her current caregiver tries to comfort her, but she also seeks physical touch from the caregiver. Client has issues with her language development and is only able to communicate through grunts, cries, and other noises. You are using socio-emotional techniques to help the relationship and regulate the family.

- How would have you approached each vignette differently?
- What did you realized as you (therapist) were engaging in socio-emotional techniques?
- What are some socio-emotional techniques that you used to address the presenting issue(s)?
- As “parents” did you find the socio-emotional techniques useful to understand your “child?” Why or why not?

Notes

Phase 3:

Reflective Practice and Mindfulness

3.1 Session Overview

Aim

The aim of this sessions is to learn and understand the importance of reflection practice and mindfulness in play therapy.

Learning Objectives

- Review & answer questions from Phase 1 & 2
- Learn how to use reflective practice
- Discuss secondary traumatic stress and burnout
- Discuss self-care
- Learn about mindfulness

Session Activities

- Viewing of videos about reflective practice and mindfulness
- Role plays
- Worksheets and vignettes to understand clinical techniques

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

3.1.1 Reflective Practice

What is reflective practice?

- A therapeutic skill a clinician uses to observe the family's interaction to promote attunement of the parent to the child's emotions (Ferreira et al., 2017)
- Reflective practice allows mental health clinicians to explore with caregivers "what happened" to the child instead of "what is wrong" with the child, who has experienced trauma
- Reflective practice often prevents mental health clinicians from secondary trauma and burnout if they have someone to consult about their trauma cases (Norona & Acker, 2016)

Group Activity #1: Gather in a group of 4 people and grab some toys to practice reflective practice in a play session; Instructor(s) will demonstrate reflective practice for 15 minutes

Group Activity #2: Participants will engage in experiential activity for 1 hour taking turns being a therapist(s), parent(s), and child to practice reflective practice in a play session

Course instructor(s) will be joining groups for observation and guidance

You are meeting with your 3-year-old female client and mother for the third time. You are guiding mother to follow the child's lead in play and to reflect on her play. You are observing the child play, but the child's mother is having a difficult time playing with the child in therapy. You decide to use reflective practice to help the mother follow the child's lead in play.

- What are your thoughts on reflective practice? Have you practice this technique before in your clinical practice?
- What are some reflective practice questions did you come up with to help the therapeutic process?
- What other possible interventions could you use to help mother feel comfortable with the concept of play?

Notes

3.1.2 Secondary Traumatic Stress and Burnout

What is secondary traumatic stress and burnout?

- An emotional response to hearing firsthand trauma experience from another individual (NCTSN, n.d.)
- Professionals working with traumatized children are at high risk of developing secondary traumatic stress (NCTSN, n.d.)
- Burnout is an emotional, mental, and physical state of mind causing exhaustion by chronic stress (Smith et al., 2020)

What are some signs of burnout?

- Headaches
- Loss of motivation
- Isolation
- Sense of failure
- procrastination

3.1.3 Self-Care

What is self-care?

- A concept of having a healthy relationship with yourself by taking care of your mind, bodies, and souls through activities to reduce emotional distress (Activeminds, n.d.)

What are some self-care activities?

- Reading a book
- Listening to music
- Watching a favorite movie
- Exercising
- Mindfulness techniques

Group Activity #3: Discuss how to avoid secondary traumatic stress and burnout as a therapist working with the trauma population

Group Activity #4: Participants will engage in some self-care activities given by the instructors.

- What kind of self-care activities do you engage in to decompress after work?
- How do you view self-care in your life?
- How do you know if you are burnout? Or have experienced secondary traumatic stress?
- How did it feel to participate in a self-care activity during this training?

3.1.4 Mindfulness

What is mindfulness?

- The five core psychological processes of mindfulness (Williston et al., 2021)
- Mindfulness-based interventions regulate signals that are hyperarousal through relaxation instead of stress reactivity (Williston et al., 2021)
- Mindfulness provides an alternative intervention to treating trauma symptoms, but mindfulness allows for emotional regulation in an uncomfortable experience

What is mindfulness-based interventions?

- Breathing exercises
 - Balloon Breath
- Guided imagery
- Meditation
- Body Scan
- Mindful Strategies
 - Mindful Eating
 - Mindful Breathing
 - Mindful Walking
 - Mindful Words

Group Activity #5: Discuss the benefits of mindfulness as a therapist and for your clients; Instructor(s) will demonstrate for 15 minutes how to use mindfulness in therapy

Group Activity #6: Participants will engage in an experiential activity for 1 hour to practice mindfulness-based interventions

Vignette #1

You are meeting with your 4-year-old male client and his mother for the third time. He has been having a difficult time managing his emotions when his parents tell him no. Parents share that they have tried time outs, telling him to calm down, and ignoring him; but he just seems to get madder. You decide to play a game with him to understand his level of tolerance to the word “no.” But before you start to play a game with him, you want to introduce some mindfulness-based interventions to the family.

Vignette #2

You are meeting with your 5-year-old female client and her father for the 6th time. Client has started to share some parts of her trauma story through art, and you notice that she starts to rock back and forth as she is sitting on the floor. Father starts to share how client was left alone in the dark for three hours until he was able to come home finding the mother dead in the other room. Client starts to scribble aggressively while saying “mommy is dead, I was scared.”

- How were you able to regulate your clients in session?
- What mindfulness-based intervention did you use?
- Did you feel comfortable using mindfulness-based interventions in these scenarios? Why or why not?
- As “parents” did you find mindfulness-based interventions useful to understand your “child?” Why or why not?

Notes

*****IMPORTANT NOTE FOR INSTRUCTOR(S)*****

*****page should not be included among the participants' handouts*****

PowerPoints are developed based on the following topics of the curriculum and what needs to be reviewed during the booster session(s). PowerPoints are to be used during the booster sessions. Handouts include what topics will be reviewed and vignettes for role plays, while “notes” pages are for participants to write down notes from the PowerPoint presentations.

PowerPoint Topics Booster Session #1

- a. *Phase One: Psychoeducation on Infant-Early Childhood Mental Health and Trauma*
 - i. *Infant-Early Childhood Mental Health*
 - ii. *Neuroscience of Trauma*
 - iii. *Developmental Milestones*
 - iv. *DC 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)*
- b. *Phase Two: Nondirective Play Therapy*
 - i. *Child-Centered Play Therapy*
 - ii. *Child-Centered Play Therapy Techniques*
 - iii. *Socio-Emotional Techniques for Infants to Three-Year-Old Children*
- c. *Phase Three: Reflective Practice and Mindfulness*
 - i. *Reflective Practice*
 - ii. *Mindfulness*

PowerPoint Topics Booster Session #2

- a. *Phase One: Psychoeducation on Infant-Early Childhood Mental Health and Trauma*
 - i. *Developmental Milestones*
 - ii. *Child-Caregiver Attachment Styles*
 - iii. *Parental Trauma*
- b. *Phase Two: Nondirective Play Therapy*
 - i. *Appropriate Toys*
 - ii. *What Children Learn in Child-Centered Play Therapy*
 - iii. *Techniques for Parents*
- c. *Phase Three: Reflective Practice and Mindfulness*
 - i. *Reflective Practice*
 - ii. *Secondary Traumatic Stress and Burnout*
 - iii. *Self-Care*

Part IV: Booster Sessions

What you will learn

Booster sessions are designed to review important lecture material from the training course. There will be PowerPoints and experiential activities to strengthen participants' clinical knowledge and awareness.

Why the booster sessions are important

The booster sessions will help you feel competent to treat the infant-early childhood population. Since there is a need of trauma-informed care trainings and limited evidence-based practices focusing on infant-early childhood trauma, the booster sessions focus on reviewing lecture material and providing opportunities for experiential activities.

Who is this booster sessions designed for

The booster sessions are designed for pre-licensed (students and associates) and licensed mental health clinicians. Mental health clinicians are known as therapists, counselors, psychologists, and clinical social workers, who hold a Master degree and/or Doctoral degree and are trained to evaluate people's mental health. Pre-licensed (students and associates) and licensed mental health clinicians work in the following settings: hospitals, psychiatric facilities, and outpatient facilities such as community mental health agencies, schools, and private practices.

How are these booster sessions organized

These are one-day booster sessions consisting of a review of the four-day training course about infant-early childhood mental health and trauma and opportunities for experiential activities.

Booster sessions' ground rules

Some basic ground rules to follow:

1. Show respect towards others in the group
2. Actively participate
3. Ask encouraging questions for development
4. Personal disclosures should remain confidential and not shared outside of group

How to learn most effectively during this training course

This is an interactive training course, and every participant is encouraged to actively participate in the learning process. Participants are encouraged to ask questions throughout the course to gain understanding.

Phase 4:
Booster Session #1

4.1 Session Overview

Aim

The aim of this sessions is to review lecture material from Phase 1, 2, & 3 and continue with experiential activities to strengthen participants' clinical knowledge and awareness.

Learning Objectives

- Review & answer questions from Phase 1, 2, & 3
- Experiential activities

Session Activities

- Video case examples
- Role plays
- Vignettes to understand clinical techniques

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

4.1.1 Review Lectures

- a. Phase One: Psychoeducation on Infant-Early Childhood Mental Health and Trauma
 - a. Neuroscience of Trauma
 - b. Developmental Milestones
 - c. DC 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Zero to Five (DC:0-5)
- b. Phase Two: Nondirective Play Therapy
 - a. Child-Centered Play Therapy
 - b. Child-Centered Play Therapy Techniques
 - c. Socio-Emotional Techniques for Infants to Three-Year-Old Children
- c. Phase Three: Reflective Practice and Mindfulness
 - a. Reflective Practice
 - b. Mindfulness

4.1.2 Vignettes for role plays

Vignette #1

You are meeting with your 2-year-old female child and mother for the first time. Child leaves mother's side to play with the toys in the room. Mother shared child starts to cry if she is not in the same room and will come looking for her mother frantically. The child will also hit mother when they are reunited, while trying to hug mother when she is in distress. You try to engage with the child, but the child

continues to hit mother and tries to hit you. Mother shared child has a hard time in daycare and will cry for hours before she is able to calm down with her favorite daycare worker. Child will be extremely upset with mother when she comes to pick her up from the daycare.

Vignette #2

You are meeting with your 4-year-old male child and mother for the first time. Child does not leave mother's side even though the room is filled with toys. Mother shared child will hide in the closet or under the table when there is a loud noise. Child will start to cry asking "why is daddy throwing stuff again and why is he back?" You try to engage with the child, but the child continues to hide behind her mother. The child starts to look around the room, seems nervous as he starts to suck on his thumb, and rocks back and forth. Mother shared client will sit in a corner of the room when he is in pre-school and will only play when the teacher allows him to take his safety blanket with him. Mother shared she must stay at the pre-school with the child impeding mother from following up with her routine.

Vignette #3

You are meeting with your 9-month-old female client and her father for the seventh time. The child was exposed to alcohol and methamphetamine in utero and had a positive drug test at birth. The client displays tremors and rigidity around her legs. Client has high pitch screams when she is in distressed. Father shares client does not sleep more than five hours throughout the night and only calms down when she is being held or bundled up in tight blankets. Father shared he has noticed that the child has not started to crawl, and he has a difficult time holding her head up when she is on tummy.

Vignette #4

You are meeting with your 3-year-old male client and her mother for the second time. The child cries every time mother leaves child with any male caregiver including the child's uncle and maternal grandfather. Child will run towards any female caregiver for comfort and will hide away from any male. Mother shared the child was exposed to domestic violence and was hit by father several times. Child is hardly verbal and usually communicates with sounds or screams when he wants his needs met. The mother shared she has a hard time soothing the child when she cannot understand his nonverbal communication. The child jumps when there is screaming and shuts his eyes.

Notes

Notes

Phase 5:

Booster Session #2

5.1 Session Overview

Aim

The aim of this sessions is to review lecture material from Phase 1, 2, & 3 and continue with experiential activities to strengthen participants' clinical knowledge and awareness.

Learning Objectives

- Review & answer questions from Phase 1, 2, & 3
- Experiential activities

Session Activities

- Video case examples
- Role plays
- Vignettes to understand clinical techniques

The following pages include worksheets that will be used during the activities listed above. Your instructor will guide you in the proper use of the worksheets.

5.1.1 Review Lectures

- d. Phase One: Psychoeducation on Infant-Early Childhood Mental Health and Trauma
 - a. Developmental Milestones
 - b. Child-Caregiver Attachment Styles
 - c. Parental Trauma
- e. Phase Two: Nondirective Play Therapy
 - a. Appropriate Toys
 - b. What Children Learn in Child-Centered Play Therapy
 - c. Techniques for Parents
- f. Phase Three: Reflective Practice and Mindfulness
 - a. Reflective Practice
 - b. Secondary Traumatic Stress and Burnout
 - c. Self-Care

5.1.2 Vignettes for role plays

Vignette #1

You are meeting with your 5-year-old female client and her caregiver for the fourth time. You are continuing to build a relationship with the family through play therapy. The child is in therapy because her grandfather (a primary caregiver) passed away two months ago. Child found grandfather lying on the floor having a difficult time breathing. 911 was called and the child watched the

paramedics give grandfather CPR before father was led to the ambulance. Mother shared child continues to ask for grandfather and wanting to visit grandfather in the hospital. The caregiver does not know how to tell the child that her grandfather has passed away. The caregiver is hoping the therapist can discuss death and let the child know about her grandfather.

Vignette #2

You are meeting with a 5-year-old female child and her father for the first time. Child shares she does not like school because she is always getting in trouble for getting up from her chair. She shares she feels butterflies in her stomach when the teacher asks the class to work with their peers in their group table. She shares she does not have friends and her peers do not talk to her. Father shares child plays with the neighborhood children, but he does find her crying sometimes when they stop playing with her. Child feels that she needs to be a better friend so she can keep her friends.

Vignette #3

You are meeting with your 4-year-old male client and his father for the third time. He has been having a difficult time managing his emotions after mother left the family. Father shared that he has tried to give him hugs and continue his normal routine, but it has become difficult since father must work. The client has been asking about his mother and when is she coming back home. Father started to cry and feels trapped not knowing how to make his son feel better. Father shared client cries himself to sleep and wakes up in the middle of night to sleep with father. In the morning the client will throw tantrums before attending daycare.

Vignette #4

You are meeting with your 2-year-old male client and his mother for the fifth time. Child has been in four different foster homes before he was reunited with his mother. Mother shared she has a difficult time attaching to her son because he is constantly running around and asking for his last foster mother. Mother shared she has play dates with the foster mother and other foster children and her son seems so happy. It has been three months since the child came back home and mother has tried everything to make him feel loved. Mother starts to cry and the child approaches mother to pat her back, but soon turns to the toys in the room.

Notes

Notes

Certificate of Completion

This certifies that

*has completed the “Introduction to
Infant-Early Childhood Mental Health
Trauma Training”*

Date: _____

Appendix B: RESOURCE LIST

- Active Minds- Self Care
 - <https://www.activeminds.org/about-mental-health/self-care/>
- Ages & Stages Questionnaires (ASQ-3)
 - <https://www.michaeltaymormd.com/storage/app/media/forms/master-set-asq.pdf>
- Ages & Stages Questionnaires: Social- Emotional (ASQ:SE-2)
 - https://www.delnortekids.org/uploads/8/2/8/1/82819108/master_set.pdf
- California Department of Education- Ages and Stages of Development
 - <https://www.cde.ca.gov/sp/cd/re/caqdevelopment.asp>
- Centers for Disease Control and Prevention (CDC)- Child Developmental Milestones
 - <https://www.cdc.gov/ncbddd/actearly/milestones/index.html>
- Centers for Disease Control and Prevention (CDC)- Positive Parenting Tips
 - <https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html>
- Center for Epidemiologic Studies-Depression Scale
 - https://www.dropbox.com/sh/j1uom63d86atwun/AACE7ncIFLzoB1YKGovtSjNca/PPP%20Evaluation%20and%20Assessment%20Toolkit/Caregiver%20instruments/Caregiver%20Depression?dl=0&preview=CES-D+English.pdf&subfolder_nav_tracking=1
- Center of Excellence for Infant & Early Childhood Mental Health Consultation
 - <https://www.iecmhc.org>
- Child Behavioral Checklist
 - <https://aseba.org/preschool/>
- Child Mind Institute- Child Books on Mental Health
 - <https://childmind.org/article/best-childrens-books-about-mental-health/>
- Child Parent Psychotherapy- CPP Suggested Toy List
 - <https://childparentpsychotherapy.com/wp-content/uploads/2019/01/PPP-Toy-List.pdf>
- Children’s Health of Orange County (CHOC)- Child Development Guide: Ages and Stages
 - <https://www.choc.org/primary-care/ages-stages/>

- Children's Therapy & Family Resource Centre- Infant Developmental Milestones
 - <http://www.kamloopschildrenstherapy.org/social-emotional-infant-milestones>
- Eyberg Child Behavior Inventory (ECBI)
 - <https://clas.uiowa.edu/sites/clas.uiowa.edu.nrcfcp/files/Eyberg%20Instrument.pdf>
- GAD-7 Anxiety
 - https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf
- Head Start Early Childhood Learning & Knowledge Center
 - <https://eclkc.ohs.acf.hhs.gov/family-support-well-being/article/early-childhood-mental-health-consultation-materials-families>
- Help Me Grow- Ways to Encourage Social and Emotional Development
 - <https://helpmegrowmn.org/HMG/HelpfulRes/Articles/WayEncourageSocialDev/index.html>
- Life Stress Checklist-Revised
 - https://www.dropbox.com/sh/j1uom63d86atwun/AAA8eRpxOtJpQqcfHDTyC5qSa/PPP%20Evaluation%20and%20Assessment%20Toolkit/Caregiver%20instruments/Caregiver%20Trauma%20History?dl=0&preview=LS-C-R.v2010+English.pdf&subfolder_nav_tracking=1
- Mental Health America- Taking Good Care of Yourself
 - <https://mhanational.org/taking-good-care-yourself>
- National Association for the Education of Young Children- Building Social and Emotional Skills at Home
 - <https://www.naeyc.org/our-work/families/building-social-emotional-skills-at-home>
- Nebraska Early Development Network- Social Emotional Development Resources
 - <https://edn.ne.gov/cms/social-emotional-development-resources>
- Pathways.org- Social-Emotional
 - <https://pathways.org/topics-of-development/social-emotional/>
- PESI- Your Brain on Trauma
 - <https://www.pesi.com/blog/details/1635/this-is-your-brain-on-trauma>
- Positive Psychology.com- 50 Play Therapy Techniques, Toys and Certification Opportunities
 - <https://positivepsychology.com/play-therapy/>

- PTSD Symptom Scale Interview (PSSI)
 - https://www.dropbox.com/sh/j1uom63d86atwun/AAAKr-IRf1tpKBhzGew52npHa/ CPP%20Evaluation%20and%20Assessment%20Toolkit/Caregiver%20instruments/Caregiver%20PTSD%20symptoms?dl=0&preview=PSS-I+English.pdf&subfolder_nav_tracking=1
- Raising Children Network (Australia)- Emotions and play: babies
 - <https://raisingchildren.net.au/babies/play-learning/play-baby-development/emotions-play-babies>
- Substance Abuse and Mental Health Services Administration
 - <https://www.samhsa.gov>
- Trauma Symptom Checklist for Young Children (TSCYC)
 - <https://www.parinc.com/products/pkey/463>
- Traumatic Events Screening Inventory Parent Report Revised (TESI-PRR)
 - <https://www.dropbox.com/s/26h7cbdfmhd5lge/TESI%20-%20PRR%20-%20%20v2013.pdf?dl=0>
- The National Child Traumatic Stress Network (NCTSN)
 - <https://www.nctsn.org>
- The National Child Traumatic Stress Network (NCTSN)- Secondary Traumatic Stress
 - <https://www.nctsn.org/trauma-informed-care/secondary-traumatic-stress>
- Trying Together- Strategies to Support Social-Emotional Development: A Guide for Families
 - <https://tryingtogether.org/dap/social-emotional-guide/>
- Understood For All Inc.-5 social-emotional learning games to play with your child
 - <https://www.understood.org/articles/en/social-emotional-activities-for-children>
- University of Missouri System
 - https://www.umsystem.edu/totalrewards/wellness/mindfulness/mindfulness_practices
- University of North Texas- Recommended Toy List
 - <https://cpt.unt.edu/recommended-toy-list>
- Virtual Lab School- Social-Emotional Development: Infants and Toddlers
 - <https://www.virtuallabschool.org/infant-toddler/social-emotional/lesson-2>

- What to Look for in Relationships
 - <https://childparentpsychotherapy.com/wp-content/uploads/2020/09/The-Relationship-Scale-w-updated-Cover-Sheet-REVISED-Final.11.2019.pdf>
- Young Child PTSD Checklist (YCPC)
 - <https://www.midss.org/sites/default/files/ycpc.pdf>
- Zero to Three
 - <https://www.zerotothree.org>
- Zero to Three-Crosswalk from DC:0-5 to DSM-5 and ICD-10
 - <https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10>
- Zero to Three- Mindfulness Practice for Families
 - <https://www.zerotothree.org/resources/3406-mindfulness-practices-for-families>

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CHAPTER SIX

SUMMARY AND APPLICATIONS

Summary of Project Outcomes

The project outcome is to provide a training manual for mental health clinicians who are seeking to expand their infant-early childhood mental health knowledge and skills to appropriately treat children and families with traumatic experiences. The training manual is for mental health clinicians, who are either pre-licensed (students and associates) or licensed therapists to receive the training in infant-early childhood trauma. The Introduction to Infant-Early Childhood Mental Health and Trauma Training program's next step is to implement the training at the clinical level. The organizations I will contact are the Los Angeles County Department of Mental Health (LACDMH), National Alliance on Mental Health, National Child Traumatic Stress Network (NCTSN), the Child Mind Institute, Zero to Three organization, and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). It would be important to build networking connections with the above organizations to start promoting the significance of infant-early childhood mental health and trauma awareness.

By contacting the organizations, I will advertise my trauma-informed care training program by targeting my defined audience, which are pre-licensed or licensed mental health clinicians. Furthermore, advertising the experts of the trauma-informed training program allows for participants to be aware of the professionals' expertise. The Introduction to Infant-Early Childhood Mental Health and Trauma Training will have a website for mental health clinicians to visit to have a better understanding of what the

trauma-informed care training addresses. With the support of the organizations, it is my hope to advertise through social media posts to promote interaction. At the end, I believe it is significant to have a marketing strategy to promote the trauma-informed care training to mental health professionals. The Introduction to Infant-Early Childhood Mental Health and Trauma Training Program is an “in-person” training for an effective process and to give mental health clinicians opportunities to ask questions in the moment. The goal of the trauma-informed care training program is to provide a “live” training due to the “on-hands” experiential activities of the manual; yet that could be a limitation due to the current mandated guidelines of California regarding the COVID-19 pandemic.

To fund the Introduction to Infant-Early Childhood Mental Health and Trauma Training program, I will apply to the Introduction to Infant and Early Childhood Mental Health Grant Program from the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant program under SAMHSA supports programs whose services focus on children from birth to 12-years-old, who are at risk or have early signs of a serious emotional illness (SAMHSA, 2018). Lastly, it is my hope to make the trauma-informed care training program affordable for mental health clinicians at the cost of \$100 for the four-day training and two booster sessions.

On the other hand, a team of four licensed mental health clinicians are recruited, who are experts in the field of infant-early childhood mental health for the four-day training and boosters. At least two licensed mental health clinicians will have either nondirective play therapy skills from Client Centered Play Therapy (CCPT) or reflective practice skills from Child Parent Psychotherapy (CPP) to have knowledge of infant-early childhood trauma. As a mental health clinician that practices CPP, I can inquire previous

colleagues who use CPP to co-facilitate the trauma-informed training with me.

Furthermore, to have a play therapy therapist, I would recruit a mental health clinician who is registered as a play therapist from the Association for Play Therapy. As I bring on board the team of mental health clinicians, I will train them how to facilitate the four-day training course and the booster sessions. It is crucial for the mental health clinicians to comprehend the flow and the goals for the trauma-informed care training to provide an effective educational program.

Lastly, some anticipated challenges with implementing the Introduction to Infant-Early Childhood Mental Health and Trauma Training program are insufficient funding, lack of interest in infant-early childhood mental health and trauma from mental health clinicians, and lack of support from LACDMH and other professional organizations. If there is not enough funding for the program, it will be impossible to purchase the necessary resources such as the training program curriculum, *DC: 0-5* diagnostic manuals, play therapy toys, and evaluation assessments. Furthermore, if there is a lack of interest in the trauma-informed care training because there is not enough awareness of infant-early childhood mental health and trauma then it will become difficult to motivate participation and commitment from mental health clinicians. Lastly, a lack of support from LACDMH and other professional organizations will be a huge barrier to implementing the trauma training program because it interrupts the capability to reach mental health clinicians through social media posts, newsletters, and other electronic means of communication.

Filling the Gap in the Mental Health Field

Research demonstrates that mental health clinicians have difficulty with applying guidelines to complex trauma, while having untrained supervisors who do not have appropriate infant-early childhood mental health and trauma knowledge. Furthermore, there are multiple barriers to becoming a competent trauma clinician due to the lack of trauma-informed care training, which includes a lack of focus on infant-early childhood trauma. The Introduction to Infant-Early Childhood Mental Health and Trauma Training program provides the opportunity to fill in the gap on the lack of focus on infant-early childhood trauma. Kumar et al. (2019) recognize the significance of needing more trauma trainings to avoid mistakes while treating patients with trauma. Various researchers concluded there are multiple barriers to creating a trauma training program and consequences for failing to have basic competent knowledge in trauma.

The trauma-informed care (TIC) movement introduces the idea that infant-early childhood trauma impacts the child and the family, but there is still a lack of competent skills to treat the infant-early childhood population (Cutuli et al., 2019). Furthermore, some evidence-based practices do not focus on early childhood trauma such as cognitive-behavioral therapy (CBT) (NAMI, n.d.), but there are some interventions that focus on the healing process of the child-caregiver relationship (NCTSN, n.d.). Unfortunately, evidenced-based treatment models do not appropriately treat trauma effects (Amaya-Jackson & DeRosa, 2007) and do not treat trauma systemically (Figley & Figley, 2009). There are limited interventions that have been evaluated for effectiveness, but current focus on prevention and intervention programs treating parent-child relationships have shown successful results (Harden et al., 2016). Therefore, the Introduction to Infant-Early

Childhood Mental Health and Trauma Training program addresses the gap of not having appropriate trauma-informed care training programs for mental health clinicians.

Limitations of the Training Program

A few limitations of the Introduction to the Infant-Early Childhood Mental Health and Trauma Training curriculum are the time commitment to complete a four-day training and two booster sessions, curriculum is not based on a specific evidence-based treatment model, and the trauma-informed care training is not available for continuing education units (CEUs). As mentioned above, a limitation is having a “live” training program due to the current COVID-19 pandemic in California and the rising rates of infected COVID-19 cases.

The first limitation is the time commitment to a four-day training and two booster sessions that mental health clinicians need to complete. It is a year commitment to follow through with the trauma-informed care training and the curriculum. It is unclear whether mental health clinicians are willing to commit to a year of training. Along with this limitation, there is a probability that mental health clinicians will not follow through with the booster sessions. Since the four-day training provides all the important information to understand and treat infant-early childhood mental health and trauma, there is uncertainty if mental health clinicians will be interested in the booster sessions.

The second limitation is the fact that the treatment manual is not based on a specific evidenced-based treatment model but instead uses multiple theories and treatment models to introduce infant-early childhood mental health and trauma. Currently, evidence-based treatment models are highly prioritized to teach effective

therapeutic skills to treat mental health issues. The trauma-informed care training discusses theories that address the family system, family's attachment styles, neurobiology, and mindfulness to support mental health clinicians' clinical development.

The third limitation is the trauma-informed care training will not be providing continuing education units (CEUs) to help mental health clinicians maintain their licensure. CEUs facilitate professionals to gain new knowledge or review necessary material to renew their licenses. In addition, CEUs allow for professionals to gather certifications to keep as proof just in case their professional organizations ask for clarification of their participation in the courses. Furthermore, the Introduction to Infant-Early Childhood Mental Health and Trauma Training program is not structured to be taken as a CEU course due to the experiential aspect of the curriculum.

The fourth limitation is the "live" preference of the trauma-informed care training program due to the experiential activities attached to the curriculum. During the four-day training, mental health clinicians engage in 22 group activities to reinforce the information they have learned about infant-early childhood mental health and trauma. The significance of the experiential activities is to cultivate a "hands-on" clinical experience, especially when the mental health clinicians are learning to recognize for infant-early childhood trauma and parental trauma, while attaining appropriate clinical knowledge and awareness about play therapy techniques. Furthermore, during the booster sessions mental health clinicians are engaging in four role play vignettes to enhance their clinical knowledge and awareness about the infant-early childhood population.

Even though there are a few limitations to the Introduction to Infant-Early Childhood Mental Health and Trauma Training program, this trauma-informed care

training addresses the need of focusing on infant-early childhood mental health and trauma. The curriculum provides excellent guidance through resources, handouts, worksheets, and experiential activities to enhance clinical skills. Moreover, some modifications can be made to reduce the limitations associated with the Introduction to Infant-Early Childhood Mental Health and Trauma Training program.

Modifications of the Trauma Training

One appropriate modification would be to execute the trauma-informed care training as a virtual program due to the COVID-19 pandemic. Despite the significance of “in-person” experiential activities, the curriculum can be flexible and adaptable to fit the need of the COVID-19 protocol. Using Microsoft Teams, Google Workspace, or Spike to provide the training program through a virtual platform allows for an acceptable modification. To keep the mental health clinicians engaged and committed to the virtual program some adjustments to the 22 group activities would be needed. In addition, the instructor(s) would have to be creative to ensure the mental health clinicians are engaging in the experiential activities while participating in the virtual program.

In addition, if there is an issue gathering key stakeholders or convincing LACDMH and other professional organizations to implement the trauma-informed care training, then approaching my current employer would be a modification. Currently I am employed at LifeStance Health, which provides the opportunity to present on any mental health topic to other mental health clinicians from the company. LifeStance Health allows for their mental health clinicians to present for one hour, so I can use that opportunity to make a short introduction to infant-early childhood mental health and trauma in hopes to

increase awareness. Allowing myself the opportunity to start with my employer not only increases infant-early childhood mental health and trauma awareness but provides the possibility to start implementing my program among mental health clinicians.

Relevance to the Field of Marriage and Family Therapy

The Introduction to Infant-Early Childhood Mental Health and Trauma Training program is relevant to the field of Marriage and Family Therapy because addressing the infant-early childhood population provides effective knowledge and awareness on infant-early childhood mental health. As the Zero to Three organization (n.d.) states, understanding infant-early childhood mental health is crucial to preventing mental health issues for children into adulthood. Furthermore, addressing mental health needs and concerns at an earlier age supports the development of healthy socio-emotional behaviors. The implementation of the trauma-informed care training program focuses on a change of knowledge, awareness, and attitude towards the significance of infant-early childhood mental health and trauma.

Through research it has been stated that the first five years of a child are crucial as they are building warm and responsive relationships with caregivers, learning to co-regulate with their caregivers, and achieving their developmental milestones to flourish and thrive. The Introduction to Infant-Early Childhood Mental Health and Trauma Training program allows for mental health clinicians to respond accordingly to the child and family's needs when coping with traumatic experiences. The trauma-informed care training encompasses the significance of realizing the impact of the adverse childhood experiences (ACEs) in hopes to reduce child maltreatment and the cost of sustaining a

child abuse case and utilizing services from child welfare agencies (Loudenback, 2017).

Lastly, the trauma-informed care training allows for children and families to heal and create hope together.

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APPENDIX A

EVALUATION MEASURES

Commitment to Trauma Informed Care Survey

Section I. The first section of the survey asks about implementation of TIC within your organization. Your organization may be at any stage in a change to Trauma Informed Care (implementing it, thinking about implementing it, or not even considering it). Further, TIC will look different at each organization. Do your best to imagine TIC at your organization.

1=Strongly Disagree 2=Moderately Disagree 3=Mildly Disagree 4=Neither Agree/Disagree 5=Mildly Agree 6=Moderately Agree 7=Strongly Agree

- _____ 1. I believe in the value of Trauma Informed Care.
 - _____ 2. Trauma Informed Care is a good strategy for my organization.
 - _____ 3. I think that management is [or would be] making a mistake by introducing Trauma Informed Care.
 - _____ 4. Implementing Trauma Informed Care serves an important purpose.
 - _____ 5. Things would be better without Trauma Informed Care.
 - _____ 6. Trauma Informed Care is not necessary.
-
- _____ 1. Most of my respected peers have embraced Trauma Informed Care.
 - _____ 2. The top leaders in this organization are “walking the talk”.
 - _____ 3. The top leaders support Trauma Informed Care.
 - _____ 4. The majority of my respected peers are dedicated to making Trauma Informed care successful.
 - _____ 5. My immediate manager encourages me to support Trauma Informed Care.
 - _____ 6. My immediate manager is in favor of Trauma Informed Care.
-
- _____ 1. I do not anticipate any problems adjusting to the work I will have when Trauma informed Care is adopted.
 - _____ 2. There are tasks that will be required with Trauma Informed Care that I don’t think I can do well.
 - _____ 3. When we implement Trauma Informed Care, I feel I can handle it with ease.
 - _____ 4. I have the skills that are needed to make Trauma Informed Care work.
 - _____ 5. I have the knowledge that is needed to make Trauma Informed Care work.
 - _____ 6. When I set my mind to it, I can learn everything that will be required when Trauma Informed Care is adopted.
 - _____ 7. My past experiences make me confident that I will be able to perform successfully after Trauma Informed Care is adopted.
-
- _____ 1. Many of the clients served by our agency have experienced psychological trauma.
 - _____ 2. Many of the staff in our agency have experienced psychological trauma.
 - _____ 3. Many problematic behaviors (such as substance abuse) start as a way to cope

with emotionally traumatizing experiences.

- _____ 4. Past experiences of psychological trauma (for instance in childhood) cannot be linked to current problematic behavior in adulthood.
- _____ 5. When service recipients have experienced psychological trauma (current or in the past), this can influence their current behavior.
- _____ 6. When staff have experienced psychological trauma (current or in the past), this can influence their current behavior at work.
- _____ 7. Seeking and receiving services from our agency can be re-traumatizing for trauma survivors.
- _____ 8. Our service setting does not create psychological trauma for our service recipients.
- _____ 9. Our programs and services do not create psychological trauma for our service recipients.
- _____ 10. Working with trauma survivors can result in work related stress such as vicarious trauma.

Section II. The following questions ask about your knowledge of trauma, the impact of trauma, and Trauma Informed Care (TIC). Please select the answer that most closely represents your knowledge.

- | | | | |
|--------------------------------|------------------------------|----------------------------|-------------------------------|
| 1=Completely
Untrue | 2=Somewhat
Untrue | 3=Somewhat
True | 4= Completely
True |
|--------------------------------|------------------------------|----------------------------|-------------------------------|
-
- _____ 1. I understand the signs and symptoms of work related stress including secondary traumatic stress, vicarious trauma, compassion fatigue, and burnout.
 - _____ 2. I can tell the difference between secondary traumatic stress, vicarious trauma, and burnout.
 - _____ 3. I can explain to others, the difference between secondary traumatic stress, vicarious trauma, and burnout.
 - _____ 4. I know the importance of self-care for the workforce.
 - _____ 5. I know the principles of Trauma Informed Care.
 - _____ 6. I can explain, to others, the principles of Trauma Informed Care.
 - _____ 7. I know how to review policy, practice, and procedures using a trauma lens.
 - _____ 8. I can identify strategies to be more trauma informed in my agency.
 - _____ 9. I understand the difference between trauma specific services and trauma informed care.
 - _____ 10. I understand the reasons why individuals respond to trauma differently.
 - _____ 11. I can explain, to others, the reasons why individuals respond to psychological trauma differently.
 - _____ 12. I understand that a stress response can be activated in the absence of real threat.
 - _____ 13. I understand how psychological trauma can affect cognitive process such as memory, attention, and perception.
 - _____ 14. I can explain, to others, how psychological trauma can affect cognitive process such as memory, attention, and perception.
 - _____ 15. I understand how psychological trauma can affect relationships and

attachment.

- _____ 16. I understand how psychological trauma can affect emotional regulation.
- _____ 17. I know the signs of an acute stress response.
- _____ 18. I know what is happening in the mind and body during an acute stress response.
- _____ 19. I understand why unresolved psychological trauma exposure has a cumulative impact over time on individual, family, organizational, and community functioning.
- _____ 20. I know about the Adverse Childhood Experiences (ACE) study conducted by Kaiser Permanente and the CDC.
- _____ 21. I know which types of trauma experiences were included in the ACE study.
- _____ 22. I understand the dose-response relationship between adverse experiences and negative outcomes.
- _____ 23. I can explain, to others, the findings from the ACE study.
- _____ 24. I am familiar with the ACE pyramid and how adverse childhood experiences influence health and well-being.
- _____ 25. I understand how vulnerability to psychological trauma can be transferred from one generation to the next.
- _____ 26. I know one method of transferring vulnerability to psychological trauma from one generation to the next is biologically through altered DNA.
- _____ 27. I understand how economic inequities influence experiences of trauma and adversely affect access to resources that facilitate resilience and recovery.
- _____ 28. I understand how race, class, gender, sexual orientation, religion, and national origin can result in disproportionate trauma exposure.
- _____ 29. I understand how vulnerable and marginalized people and their communities can be differentially impacted by trauma.
- _____ 30. I understand how historical and structural oppression may create traumatic conditions and psychological trauma.

Child Trauma Clinical Beliefs Scale

0	1	2	3	4
Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Instructions: The following questions pertain to the treatment of a child who developed emotional and/or behavioral problems after experiencing psychological trauma. Please describe the extent to which you agree or disagree with each of the following statements using the above scale:

1. ____ The direction of treatment should be dictated by the child who experienced the trauma.
2. ____ Clinicians should direct children to describe their trauma in treatment.
3. ____ The direction of treatment should be dictated by the clinician.
4. ____ Children are generally capable of discussing their trauma when directed by a clinician.
5. ____ Children often lack the verbal ability to describe their feelings and thoughts about the trauma.
6. ____ Children should be allowed to discuss their trauma in their own time, when they are ready.
7. ____ Children often possess adequate verbal ability to describe their thoughts and feelings about the trauma.
8. ____ Children who experienced trauma should be allowed to select the activities of treatment sessions.

Attitudes Related to Trauma Informed Care (ARTIC) Scale

The ARTIC scale can be purchased online through the website, traumaticstressinstitute.org, either as an electronic or paper version.