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Pediatric Trauma-Informed Care and Implications for Occupational Therapy Practitioners

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PEDIATRIC TRAUMA-INFORMED CARE AND IMPLICATIONS FOR OCCUPATIONAL THERAPY PRACTITIONERS

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Abstract

Occupational therapy practitioners are provided a wealth of knowledge through school and professional fieldwork experiences to understand and skillfully address the needs of children who have been exposed to trauma. Therapists are competently prepared to provide holistic and client-centered care that is dedicated to meaningful and volitional engagement (Lynch et al., 2021). However, many therapists still lack the confidence and awareness of their role related to trauma-informed care in the pediatric environment (Piller, 2022). Trauma compromises each domain of occupation (Lynch et al., 2021). As early intervention specialists, the lack of responsiveness to children's trauma can have devastating and enduring negative consequences on their occupational performance and well-being. When trauma-informed practices are integrated by pediatric OT service providers in the home, school and community settings, this vulnerable population will have an improved likelihood of developing more meaningful and secure relationships with their provider, family members, and other support systems. Additionally, it will expand their ability for safe-engagement in occupation and sensory-based interventions and reduce the opportunity for re-traumatization.

This doctoral capstone project aimed to fill a gap in the literature and investigate the perceptions and practices of pediatric occupational therapists' use of trauma-informed care. It examines disseminating childhood trauma-informed care education, targeting pediatric occupational therapy practitioners by the development of a professional continuing education presentation and a prospective twelve-week course entitled, "Pediatric Trauma-Informed Care and Implications for Occupational Therapy Practitioners." The attitudes of practitioners are assessed using pre and post-measures to determine the effectiveness of providing trauma-informed education that coincides with the exclusive contexts of the pediatric OT setting.

Acknowledgments

First and foremost, I would like to express my sincerest gratitude to my capstone committee. Thank you, Dr. Donna Costa and Dr. Janeene Sibla, for supporting me from beginning to end. I truly appreciate the overwhelming time and valuable input you have given to edit, give recommendations, and constructively critique my work during the different stages of this process. I also would like to thank Dr. Donnamarie Krause for your mentorship and assistance in providing me with the connections and access to present my project at the university and the suggested resources for the quality and integrity of my project.

I would like to thank Dr. Kaitlin Ploeger and the University of Nevada, Las Vegas OTD students for allowing me to present my capstone project. In addition, I would like to send a deep expression of gratitude to the Nevada Occupational Therapy Association for coordinating and allowing me to present my work to their members. The information I receive from both groups helps support my desire to continue to inform occupational therapy practitioners on this subject.

I also owe the hugest thank you to my friend and colleague, Dr. Jennifer Allison. I came to you searching for ideas that would be of interest and needed in our professional community, and you proposed trauma-informed care. Your inspiration led me to combine the two areas of interest that intrigue me the most, and I am forever grateful.

I cannot forget to acknowledge my classmates. Your support, encouragement, and reminders of deadlines and details helped me to meet to stay focused and on track to get my project completed.

Finally, I would like to express my gratitude and appreciation to my family and friends for their support and encouragement over the last 2 years.

Dedication

To my children, your existence and unconditional love have healed parts of me that I didn't know were broken. You have opened my heart to selfless love, to be a better and healthier person for you and to persevere through any obstacles. I hope this inspires you to always choose adventure and never stop learning. You can do hard things!

To my dear husband, thank you for never looking at me crazy or trying to talk me out of my goals. You know I wouldn't listen anyway. Thank you for your undeniable support, your words of encouragement, and for sending me to "my room," so I could focus and get my work done.

To my dad, this is my first graduation you won't be able to attend, but I know you're all smiles. Your love and fire live through me, so I'll continue to pursue my dreams and live as if you were still here. I miss you dearly.

To anyone who has experienced trauma and is attempting to break generational cycles, may you find healing, immense happiness, and wholeness along your journey.

Table of Contents

Chapter 1: Introduction

Healthcare professionals have integrated attitudes and etiquette related to trauma-informed practices well before the formal inception of the concepts and the current framework aligned with trauma-informed care (TIC). According to the National Center for Trauma-Informed Care (National Center for Trauma-Informed Care [NCTIC], 2012), trauma-informed services began between the 1960s and 1970s (NCTIC, 2012). The mindset and approaches to medical and mental health care were shifting in response to studies on the traumatic stress from survivors of war, veterans of the Vietnam War, and the movements related to domestic violence and feminist theory (NCTIC, 2012).

Early perceptions from mental health and medical professionals viewed traumatic stressors as a person's character flaw or weakness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The ideologies and practices within this social movement began transitioning as research indicated new, effective, and more humane models for treatment and therapy. The American Psychological Association (APA) also assisted in facilitating change by adding the diagnosis of Posttraumatic Stress Disorder to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. This supported the idea that the behaviors encountered by patients or clients were not flaws or weaknesses, but from external traumatic experiences (SAMHSA, 2014).

Research related to trauma and its effects continued to surge and be a heavy topic of interest in the mental health and medical communities. The antiquated thinking surrounding mental health was transforming from "What's wrong with you?" to "What happened to you?" (Bloom, 1994). An instrumental study was conducted by Anda and Felitti (2002), which included over 17,000 participants and began in 1995. The CDC Kaiser Permanente Adverse

Childhood Experiences study was one of the largest examinations of abuse and neglect, family challenges, and the effects on adult health and well-being (Centers for Disease Control and Prevention [CDC], 2021). The findings highlighted the critical correlation between childhood trauma and the long-term detrimental effects on medical and mental health, as well as mortality.

National agencies began to increase their attention on children, as interest and concern were increasing to circumvent and address trauma in this population as a strategy of early intervention. The U.S. Congress and SAMHSA instituted the Donald J. Cohen National Child Traumatic Stress Initiative and the National Child Traumatic Stress Network in 2001 (Wilson et al., 2013). These agencies integrated earlier research from trauma-informed care with adults and adopted trauma-specific interventions from pediatric settings to produce trauma-informed practices that could be incorporated with traumatized children and their families.

Maxine Harris and Roger Fallot were the pioneers to make the distinction between "trauma-specific services" (clinical treatments), and the culture transformation to what is now termed "trauma-informed care" (NCTIC, 2012). In 2005, NCTIC was formed by SAMHSA. The establishment of this organization gave rise to the development of a formal framework for trauma-informed care that can be applied by all health service systems (NCTIC, 2012). Fallot and Harris (2009) proposed that TIC has five core values: safety, trustworthiness, choice, collaboration, and empowerment.

Many established organizations have their own philosophies and definitions to describe TIC practices. Some of the common themes among them all include maximizing physical and mental safety; interventions should be collaborative with the client; identifying client trauma-related needs; promoting client well-being and resilience; and fostering family well-being and resilience (Wilson et al., 2013). Although occupational therapists (OTs) have a well-established

history in mental health and other therapeutic settings to address trauma in clients or patients, there has not been a clearly defined role or framework provided by the national occupational therapy organization or any other recognized professional occupational therapy agencies. The American Occupational Therapy Association (1998) has provided a statement regarding stress, trauma, and posttraumatic stress disorder. This statement encourages and advocates for occupational therapy practitioners to apply the mental health training and other skilled therapeutic interventions when working with clients experiencing or have experienced traumatic events.

With the expansion of research, ongoing studies, and the surge in traumatic events occurring in our daily lives, the prevalence and impact of the negative influence of trauma is now more widely accepted in both children and adults. Childhood trauma can have extensive, long-lasting harmful effects that trail into adulthood. The advocacy and implications for implementing trauma-informed care practices should be understood and competently enforced by all professionals who encounter and work with children in any given setting.

Chapter II: Literature Review and Problem Statement

Problem Statement

OTPs are not being adequately trained or provided with sufficient, evidence-based information and interventions to confidently and consistently implement trauma-informed care practices in the pediatric setting.

PICO (Population, Intervention, Control, and Outcomes) Question

Does education on pediatric TIC increase occupational therapist practitioners' awareness and perception of implementing evidence-based TIC practices in the pediatric setting?

Literature Review

Implementing evidence-based, trauma-informed care (TIC) practices in work environments and communities has become a priority topic in recent years and gaining more attention in the pediatric setting. Trauma-informed care is defined by the National Child Traumatic Stress Network (n.d.) as a child and family service system which recognizes and reacts to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Nearly half, or 34 million American children, 18 years or younger, have experienced at least one childhood traumatic event (Forkey et al., 2021). The Strategic Prevention Technical Assistance Center (SPTAC) (n.d.), highlights five out of the top ten factors leading to death are linked to traumatic childhood experiences. Based on these alarming statistics, providing awareness of TIC and incorporating the principles as a part of early intervention in pediatric settings, including occupational therapy, is essential.

Background

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aligned with trauma-informed care (TIC) (Wilson et al., 2013). According to the National Center for Trauma-Informed Care (National Center for Trauma-Informed Care [NCTIC], 2012), trauma-informed services began between the 1960s and 1970s (NCTIC, 2012). The mindset and approaches to medical and mental health care were shifting in response to studies on the traumatic stress from survivors of war, veterans of the Vietnam War, and the movements related to domestic violence and feminist theory (NCTIC, 2012).

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other recognized professional occupational therapy agencies. The American Occupational Therapy Association (2018) provided a statement regarding stress, trauma, and posttraumatic stress disorder. This statement encourages and advocates for OTPs to apply the mental health training and other skilled therapeutic interventions and techniques when working with clients experiencing or have experienced traumatic events.

Effects of TIC on Children and Professional Practice

Research has indicated that OTPs are still unclear about their role in TIC, and there is little evidence to guide them (Piller, 2022). Examination continues into the OTPs' role in addressing the concerns of people who have or are experiencing trauma (Piller, 2022). Studies have reinforced that trauma or ACEs negatively affect domains of occupational performance in adults, as well as children (Piller, 2022). Although OTPs are well-versed and educated in mental health, many are uninformed about TIC and its application in the pediatric setting. Evidence shows that when healthcare and educational providers implement early intervention TIC to children and their families, they can tackle and divert further issues and promote healthy childhood development and transition into adulthood (Chizimba, 2021). Hornor et al. (2019) described some negative effects on adolescence, which include self-esteem, the ability to build healthy relationships, school performance, self-regulation, critical thinking, and self-motivation. Pediatric TIC is a necessary tool for healthcare practitioners, including OTPs to understand and implement when interacting and working with children (Hornor et al., 2019). When OTPs can competently identify and implement evidence-based TIC strategies and interventions, we increase the probability of being able to effectively meet the needs of the children and families we serve and avert behaviors that adversely impact occupational performance.

Early childhood trauma can have lifelong, damaging consequences. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) defines trauma as an event, series of events, or incidences that are experienced by someone as physically or emotionally harmful or threatening and that has lasting adverse effects on the person's ability to function, including their physical, social, emotional, or spiritual health. When these traumatic events take place during the child development period, they are considered adverse childhood experiences or ACEs. The types of ACEs that can occur can involve physical, sexual, and psychological abuse and neglect, natural disasters, terrorism, school violence and bullying, racism or discrimination, witnessing violence, human trafficking, serious accidents, lifelong illness, losing a loved one, war and refugee experiences, divorce, and military-life stressors (SAMHSA, 2014). Although most pediatric providers realize the harmful effects surrounding childhood trauma, many feel ill-equipped or have not been given sufficient education or guidance on how to address these detrimental circumstances (Forkey et al., 2021).

Professional Pediatric Roles and Responsibilities

Pediatric providers and educators are typically the first lines of defense for caring for and supporting the needs and concerns of children. OTPs are among the multitude of professionals included in this responsibility. However, there is very little evidence-based research that defines trauma-informed care in the pediatric occupational therapy setting (Piller, 2022). The role of the OTP has not been clearly defined, yet OTPs are well-prepared to address many of the domain areas that can be affected by trauma (Piller, 2022). Therapists are trained to be holistic and provide client and family-centered care. Pediatric OTPs are competent in the scope of practice to determine appropriate assessments, deliver instruction and interventions related to daily living skills, sensory and emotional regulation, school performance, social participation, family

education, and more. In a study conducted by Atchison (2007), 900 children were evaluated using the Sensory Profile. Nearly 42% had tactile sensitivity, 18.9% differences in taste and smell, 23.5% differences in movement sensitivity, and 24.4% differences in auditory and visual processing Atchison (2007). These statistics are an indication of the significant role practitioners can play when addressing the sensory needs of children who experience trauma. Additionally, OTPs are skilled in the ability to recognize and understand the value of addressing context and environment, performance skills and patterns, and client factors (Lynch et al., 2021). A systematic review completed by Lehr et al. (2023) reinforced the benefits of OTPs being a part of a multidisciplinary team to work with children using sensory-based and other trauma-informed practices. OTPs are positioned and have an opportunity to redefine how TIC is utilized and integrated into pediatric OT clinical methodologies. OTPs have a responsibility to competently understand their critical role in reducing the negative effects of trauma on children and provide care that has the potential to lead to positive outcomes.

Significance of TIC in OT Course Curriculum and in Practice

The focus of TIC in occupational therapy has mainly been on adults, but still very limited. Eighty-two online surveys were sent to OT programs to identify if TIC was a mandatory part of the curriculum (Merryfield et al., 2020). Only 12 programs completed the surveys and specified that it was a mandatory part of their curriculum (Merryfield et al., 2020). Examination continues into the OTPs' role in addressing the concerns of people who have or are experiencing trauma (Piller, 2022). Studies have reinforced trauma or ACEs negatively affect domains of occupational performance in adults, as well as children (Piller, 2022). Results from a study completed by Fraser et al. (2019) indicated 9 veteran OTPs acknowledged the following concerns regarding TIC and working with children and adolescents: the importance of family

involvement in care, interventions to address bottom-up interventions, advanced training to build a strong OT trauma practice, and building a stronger community of practitioners who work with this population. Pediatric trauma-informed care is a necessary tool for healthcare practitioners, including OTPs to understand and implement when interacting and working with children (Hornor et al., 2019). Evidence supports that when healthcare and educational providers implement early intervention TIC to children and their families, they can tackle and divert further issues and promote healthy described some negative effects on adolescence, which include self-esteem, the ability to build healthy relationships, school performance, self-regulation, critical thinking, and self-motivation. When OTPs can competently identify and implement evidence-based TIC strategies and interventions, we increase the probability of being able to effectively meet the needs of the children and families we serve and avert behaviors that adversely impact occupational performance. (CITE)

Models, Theories, and Frame of Reference (FOR) for Application

This project involved developing a pediatric TIC course for entry-level students and OTPs. It required several models, frames of reference (FOR), and frameworks to be utilized from educational, mental health, developmental, and sensory perspectives. These frameworks were intended to be implemented with future and present practitioners as part of the educational process and also disseminated and implemented with pediatric clients and their support systems.

The Model of Human Occupation (MOHO) will be used as the foundational model. It consists primarily of three components: volition, habituation, and performance. This model was essential for developing the framework for educating students and colleagues and facilitating healthy relationships and occupational performance for the child. Studies related to MOHO in mental health and general practice settings have recognized its benefits (Taylor et al., 2022).

This model has been shown to facilitate higher-level, client-centered therapeutic reasoning, and present a holistic view of client functioning, which is credited to OTPs' enhanced skills to understand patients, prioritize client needs, and the ability to identify patient progress due to the use of the theory (Lee et al., 2008; Taylor et al., 2022).

From the teaching perspective, MOHO is necessary because I will begin to explore and identify the connections between the role of pediatric OTPs, the meaningful relationships we strive to establish with children and their families, and how trauma and the social determinants of health can impact behavior and performance. OTs who work with children should make great efforts to understand how interactions within the complex dynamics of their lives impact performance in daily occupations (O'Brien et al., 2010). Kielhofner (2008) described volition as how children and adults view and reflect on their own feelings about their abilities and occupations that motivate them to participate in daily activities or occupations (O'Brien et al., 2010). Habituation refers to a person's daily routines, activity patterns, and expectations coupled with the patterns (Kielhofner, 2008). For OTPs, understanding their own roles as pediatric service providers and their work routines will offer the opportunity to understand how TIC is interwoven into their experiences and interactions with children. For children, understanding their habits will bring a diverse and individualized perspective into their day for the practitioner. Performance capacity includes underlying skillsets and one's own individual experience of those abilities (O'Brien et al., 2010). Therapists should be challenged to examine their performance capacity, as well as examine the ability of the child to provide services. Assessing one's own physical, processing, and communication skills leads to deeper insight into the need for self-reflection, change or adaptations, mentorship, or external support. Furthermore, evaluating the performance of children gives understanding of their functioning and self-awareness.

One study conducted involved occupational therapy graduate students being supervised by licensed OTPs. The MOHO model was used to structure and assist the graduate students with developing care plans and interventions for five girls, ranging from 8 to 12 years of age, in an after-school program (O'Brien et al., 2010). The school-age students completed at least 5-6, one-hour occupational therapy sessions. Using MOHO to guide the assessment and intervention process led to many advantageous responses and outcomes. Some of the positive results included it permitted client-centered practice, the use of theory-based assessment, and the ability to use one theory for a variety of clients (O'Brien et al., 2010). Moreover, using the model helped focus on the individualized needs and interests of each child when developing their care plans. MOHO also aided with recognizing physical and psychosocial factors affecting the school-age students' occupational performance.

Keponen and Launiainen (2008) explained that applying MOHO can foster an occupational focus during the clinical reasoning process for more skilled practitioners and can be instrumental in moving away from traditional impairment types of practice. The article described the steps to implement the approach, based on the authors' development of work at Helsinki Polytechnic for instruction related to clinical reasoning based on MOHO (Keponen & Launiainen, 2008; Kielhofner, 2008). The five-step process involves: (1) considering the context and client in order to select an assessment, (2) beginning to reflect with MOHO, (3) setting the problem, (4) searching for a convergence of meaning in treatment planning, and (5) concluding the reflection with MOHO (Keponen & Launiainen, 2008; Kielhofner, 2008). The first step involves determining the abilities of a client to choose the appropriate assessment tools. The second step is focused on ensuring that therapists have a sufficient working understanding of the MOHO concepts and are competent in choosing an assessment to administer and interpret the

information appropriately. The third step is to synthesize the information gathered to formulate a picture of the client and identify the problems. The fourth step involves developing goals based on the information learned in the previous step. The final step encompasses reflection on the experience, the MOHO concepts, and the phases involved in the therapeutic process. Incorporating this as a part of the instruction course would be valuable for both experienced and novice therapists to facilitate improved clinical reasoning skills when applying holistic pediatric TIC and care plan procedures.

According to much of the literature found, OTPs and other professionals are still uninformed on TIC, the formal practices, and how to implement them into their services. Using this model empowered practitioners to find motivating reasons to incorporate the TIC principles, and encourage them to practice modeling integration, hopefully leading to improved knowledge, competence, and consistency in use. Applying the five-step process can support and strengthen OTPs understanding of MOHO and improve their clinical reasoning skills (Kielhofner, 2008; Keponen & Launiainen, 2008).

The Occupation-specific Community Development Model (OCDM) will also be used for guidance to complete the project. This model centers on the client and their involvement in their community and their occupational functioning within this system (Scaletti, 1999). There are minimal studies and resources related to this model when considering children. Occupational therapy research presents a scarcity of information specific to children, adolescents and their families within a mental health community context (Scaletti, 1999).

The OCDM is used to evolve the roles of a family into healthier dynamics, incorporating stages of mental health (Hotheory, 2023). Scalletti (1999) recommended using this model in the pediatric OT community setting as a means for working with children, adolescents, and their

families, by which families may be motivated to work towards change before problems negatively influence their occupational roles. Children and adolescents who experience trauma may also experience social isolation because of poorly developed occupational role behavior (Scaletti, 1999). The five steps include developmental casework, mutual support, coalitions of mutual interest, pro-active community participation, and social movements (Hotheory, 2023). The OTP is initially active in focusing on occupational behaviors and having the client engage in relevant roles within their daily living skills. In the next step, clients and their families are empowered by the OTP to enable them to seek mutual support systems or groups. The OTP starts to relinquish power to the system or group chosen. The third part of the process encompasses the occupational therapists to actively listen and determine which problems have adequate support to create change (Scaletti, 2002). In the fourth and fifth steps, clients and their families are encouraged to invest and commit to positions within their designated group or support system to enable them to be a collective entity of direct change (Scaletti, 1999).

The concepts encompassed in this model are necessary to embed into the curriculum and education because children and families often adopt inadequate or inappropriate roles during or after experiencing trauma. This overlying concept can provide a means to teach and understand appropriate roles for children and provide client-centered interventions. The occupation-specific approach to community development presents one way through which occupational therapists can promote change and occupational justice, fill a needed gap in services, and support clients to use it for the development and broadening of their occupational roles (Scaletti, 1999).

The Sensory Integration Theory and FOR will be used to explain how trauma can impact the sensory systems. This FOR focuses on how the relationships between the sensory systems provide integrated information that impacts a child's ability to learn and utilize adaptive

behaviors (Bodison et al., 2018). It will also be used as part of the assessment process and as an intervention tool.

Neurological changes have been documented in the sensory cortex, altering the visual and auditory cortexes and the limbic system in children with early recurring trauma experiences or exposure (Joseph et al., 2021; Stein et al., 1997). Children who have been neglected or in a state of flight, fight, or fright with high or low arousal over periods of time may produce maladaptive responses in which the child may either misinterpret or not respond appropriately to key sensory information (Howard et al., 2020; May-Benson & Teasdale, 2019). Trauma-related stressors have a direct influence on children's ability to respond, adapt, and integrate sensory information. It affects the sensory modulation system, which allows for adaptive responses to the environment when stressors are detected (Joseph et al., 2021). OTPs providing Ayres Sensory Integration (ASI) intervention routinely address issues related to sensory regulation and motor performance in children with Sensory Processing Disorder (SPD) (May-Benson & Teasdale, 2020). Therapists also provide sensory strategies in a variety of settings, including early intervention programs, schools, and community-based programs.

There is limited evidence-based research within the occupational therapy profession available where sensory integration and pediatric trauma are the focal areas. In addition to the Atchison (2007) study, there are other investigations that support using the sensory-integration approach, with improvements in self-regulation in children with emotional disturbances who received sensory modulation intervention (Joseph et al., 2021). Positive results were also found using the ALERT program (Joseph et al., 2021). The program was developed by Williams and Shellenberger (1996) and is reviewed in 12 sessions and divided into three stages: how does your

engine run, experimenting with methods to change engine speeds, and regulating engine speeds (Joseph et al., 2021).

Chapter III: Capstone Plan and Process

The purpose of this doctoral capstone was to educate future and present OTPs on evidence-based practices of pediatric TIC, its relationship to the occupational therapy profession in the pediatric setting, and assess the participants' attitudes and perceptions based on the educational intervention. The PICO question formulated, “Does education on pediatric TIC increase occupational therapist practitioners’ awareness and perception of implementing evidence-based TIC practices in the pediatric setting?” One main objective was to develop a professional understanding and integrate the researched information and feedback from other OTPs, to teach and disseminate current evidence-based TIC frameworks and practices used in pediatric settings. Another aim was to synthesize the literature and bridge pediatric TIC practices with meaningful and relevant evidence-based OT interventions that can be integrated for practical use.

Capstone Goals:

1. By the end of this capstone project, a professionally applicable pediatric TIC presentation that can be shared with occupational therapist practitioners and students will be developed and disseminated into the professional community.
2. By the end of this capstone project, an assessment of practitioners' confidence and attitudes regarding the understanding and implementation of evidence-based TIC frameworks and practices in pediatric settings will be completed and statistically analyzed.
3. By the end of this capstone project, a 12-week course related to the content to include modules centered on evidence-based pediatric TIC practices and application to the

pediatric OT setting will be developed for use as an education institutional course or continuing education course.

Capstone Process

Table one provides details of the projected timeline for the development, implementation, and completion of the Capstone project process.

Table 1

Capstone Project Timeline

Date	Tasks
Dec. - January 2024	Get permission and gain access to the Attitudes Related to Trauma-Informed Care (ARTIC-35) evaluation tool, for data collection.
Jan. - February 2024	Develop a professionally applicable pediatric TIC presentation that can be shared with occupational therapist practitioners and students.
Feb. - March 2024	Complete the academic 12-week course, Present to entry-level students and OTPs in different settings
Feb. - April 2024	Collect and analyze data from the evaluation tools, continue to revise the capstone paper
April - May 2024	Complete final capstone paper Defend capstone project

Note. Timeline to complete the doctoral capstone project.

Chapter IV: Project Implementation

The capstone project entailed developing a 12-week course (See Table 2 and Appendix O for more details) for prospective occupational therapy collegiate-level students or to be used as a continuing education course for practitioners for future use. The course included weekly modules that encompassed thought-provoking and reflective discussions and assignments (See Appendix M and Appendix N) related to trauma, trauma-informed care, and pediatric occupational therapy. A course description, objectives, and competencies have also been created (See Appendix A). The course will require a final presentation that will capture the knowledge and application of information learned from the course (See Appendix B). The required readings for the course would include *Trauma, Occupation, and Participation: Foundations and Population Considerations in Occupational Therapy* (Lynch et al., 2021) and *The Body Keeps the Score* (van der Kolk, 2014)

This project also involved disseminating an educational presentation to numerous pediatric occupational therapy interest groups. Overall, three OTPs and 19 entry-level doctoral students participated in listening to the educational presentation (N=22). The educational presentation was given to entry-level doctoral students and a professor at the University of Nevada, Las Vegas (1 OTP and 19 students). Before the presentation started, the audience was given the assessment paper form of the ARTIC-10 (See Appendix C). The presentation's purpose (See Appendix D), outline (See Appendix E), and objectives (See Appendix F) were explained, and the details of pediatric trauma-informed therapy and its significance in OT were lectured to the audience. Upon conclusion of the educational session, the ARTIC-10 paper form was given again, with an additional self-made questionnaire (See Appendix G) to obtain further information from the audience. The ARTIC-35 was initially chosen as the standardized measure to assess the

participant's attitude and awareness. After reviewing the length of the form and discussing time constraints with my professional peers, the decision was made to switch to the ARTIC-10. The ARTIC-10 was a shorter form and a more feasible tool to administer due to time limitations.

The information was also presented to the state professional organization Nevada Occupational Therapy Association (NOTA) online via Zoom. There were approximately 15 OTPs who listened to the presentation. The ARTIC-10 and questionnaire were formatted for online use (with the Trauma Stress Institute's approval), and QR codes and web links were used to access the pre and post-assessment and post-presentation questionnaire (See Appendix H and I).

Table 2

Course Title: Pediatric Trauma-Informed Care and Implications for Occupational Therapy Practitioners

WEEK / MODULE	TOPIC	Multimedia Learning	ASSIGNMENTS
Week 1	Intro to Trauma-Informed Care	Course Intro ****All assigned readings in modules**** Videos: https://www.youtube.com/watch?v=xd72Rx32EK4 https://www.youtube.com/watch?v=-876Zw-NA94 Websites: https://americanspcc.org/take-the-aces-quiz/ https://acestoohigh.com/got-your-ace-score/	DB: Intro Video Check-In Assignment: Take the ACES quiz (Appendix F) and review Aces too High website Journal 1
Week 2	TIC, Adverse Childhood Experiences (ACES), & the significance in pediatrics	Video: https://youtu.be/8gm-lNpzU4g	DB 1
Week 3	Interrelationships of pediatric TIC and SDH	https://www.thedoctors.com/articles/pediatrics-addressing-social-determinants-of-health-and-adverse-childhood-experiences/ https://www.pacesconnection.com/blog/the-intersection-of-the-social-determinants-of-health-sdoh-and-trauma-informed-care-tic	DB 2 Journal 2
Week 4	Pediatric trauma and the body & types of trauma	Video: https://youtu.be/uQFLQNUVWrw?si=onwamd2sYTF72-95	DB 3 Journal 3
Week 5	OT and other frameworks, models and theories	Explore other frameworks and models that are relevant to pediatrics and TIC	DUE: Framework Application Assignment (See Appendix M)
Week 6	Resilience & Traumatic Stress	Review Website: https://www.nctsn.org/sites/default/files/resources/resilience_and_child_traumatic_stress.pdf Video: https://youtu.be/7APpG80XBSw?feature=shared	DB 4

Week 7	Trauma Screenings and OT Assessments	Review Assessments in class Review: Occupational Profile Child Template: *https://www.aota.org/~/media/Corporate/Files/Practice/Manage/Documentation/AOTA-Occupational-Profile-Template.pdf*	DB 5 Journal 4
Week 8	Occupational Therapist role as an educator and practitioner	Video: https://youtu.be/sYk_OleyRsE	DUE: Case Study/Care Plan Assignment (See Appendix N)
Week 9	Client & Family Centered Thinking & Practices	Video: https://youtu.be/3qyUdbe8mxE?feature=shared	DB 6 Journal 5 Assignment: Begin literature review for final presentation
Week 10	Trauma & Marginalized Populations	https://research.aota.org/ajot/article/75/6/7506150010/23098/Working-With-Marginalized-Populations Video: https://youtu.be/oC_MPCXs0Sw	DB 7
Week 11	OTP Wellness and Health Management	Review Website: https://www.aota.org/career/career-center/wellness-for-life-and-career https://tinybuddha.com/blog/45-simple-self-care-practices-for-a-healthy-mind-body-and-soul/ Video: https://youtu.be/w0iVTQS8ftg?feature=shared Work on Presentation	Journal 6
Week 12	Trauma-Informed Presentations		DB 8 DUE: Presentation uploaded to LMS

Note. Composition of weekly educational modules

Adverse Childhood Experiences Quiz

The students would complete the Adverse Childhood Experiences (ACEs) quiz during the first week of class (See Appendix J). The American Society for the Positive Care of Children

(2024) supports completing the quiz to help with awareness about prospective traumatic events on the person and external systems. When we understand and are more knowledgeable, we are more likely to address the issues concerning children and trauma. The purpose of completing the quiz would benefit students to be cognizant of the lasting impacts of trauma and develop the skills to provide appropriate interventions, prevent further trauma, and promote childhood wellness.

Weekly Online Discussions (See Appendix K)

The students would be required to engage and complete weekly discussion board assignments, eight in total. The discussion board assignments are a valuable tool to challenge the students' critical thinking, problem-solving skills, and reflective perspectives about the weekly topics. It would allow the opportunity to interact respectfully with their peers and gain insight into others' thoughts and experiences. When the expectations have been clearly defined, students will improve their engagement, learn to use valuable research and theoretical skills, and encourage students to be active who may not be as vocal face-to-face (Georgia Southwestern State University, n.d.). Furthermore, utilizing the discussion board for arduous topics pertaining to trauma and children may increase productive conversations and disclosure of relevant stories and experiences.

Journal Entries (See Appendix L)

The students would be required to complete 6 journal entries. Journaling would encourage and promote students' improvement in self-awareness and serve as a reflective method to integrate the concepts and information learned throughout the course. It would allow students the freedom to express their perceptions, thoughts, and feelings without judgment. Studies have supported the use of journaling for educational purposes. It can assist students in setting and

achieving goals, improving memory and understanding, increasing communication and organizational skills, and minimizing stress (Merrow, n.d.).

Chapter V: Evaluation and Results

Attitudes Related to Trauma-Informed Care (ARTIC)

The ARTIC was developed by Dr. Courtney Baker and the Traumatic Stress Institute. It was created as an objective measure to determine the degree of knowledge of individuals or systems related to TIC (Baker et al., 2015). The attitudes of staff members, including health and educational professionals, are crucial to the implementation effectiveness of TIC services. The ARTIC is available in three versions (i.e., ARTIC-45, ARTIC-35, and ARTIC-10), for use in human services/health and education settings (Baker et al., 2015). For the purposes of this study, the ARTIC-10 human/health services form was determined to be the best fit due to the time constraints of the participants. The ARTIC-10 is a short-form assessment consisting of ten questions. This condensed version is comprised of two items from each of the five primary subscales (i.e., underlying causes of problem behavior, responses to problem behavior, empathy and control, self-efficacy, and reactions to the work) (Baker et al., 2015).

Each version of the ARTIC includes statements that are rated on a 7-point bipolar Likert scale containing a statement unfavorable toward trauma-informed care (e.g., *"Clients could act better if they really wanted to."*) and a statement favorable toward trauma-informed care (e.g., *"Clients are doing the best they can with the skills they have."*). To address response bias, some items are reverse coded (e.g., a favorable statement comes before a negative statement). After reverse scoring indicated items, subscale and total scores are computed as averages. Higher scores indicate more favorable attitudes toward trauma-informed care (Baker et al., 2015). Higher ARTIC scores have been shown to reflect positive relationships with decreased stress and work fatigue and increased satisfaction among providers and educators (Keesler et al, 2024).

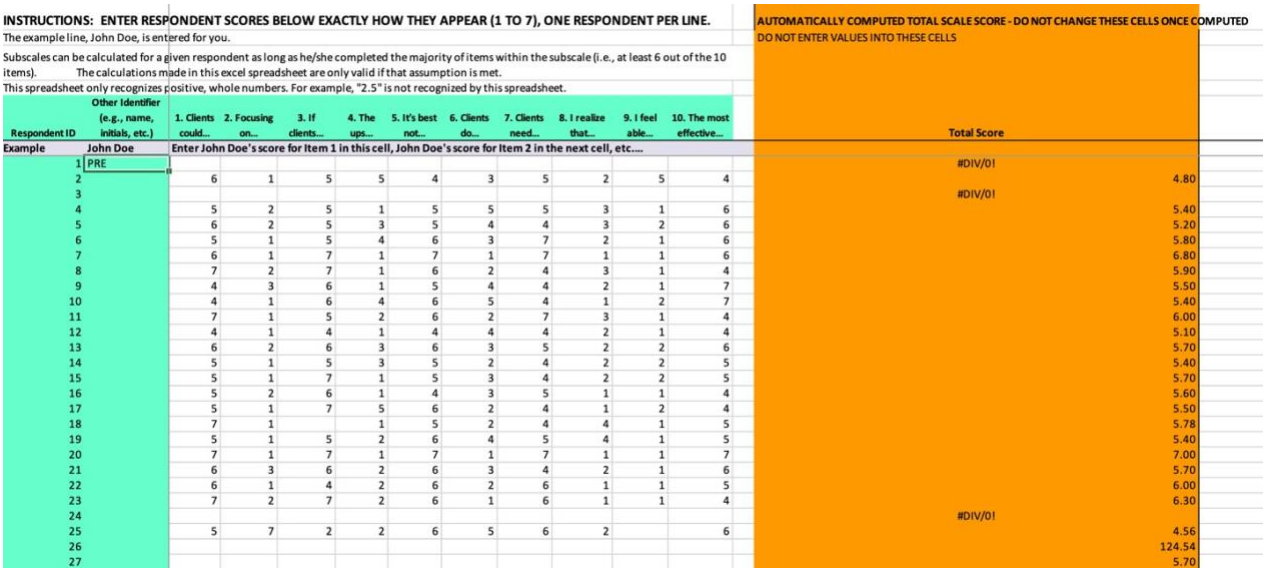
Internal consistency was found to be excellent for the ARTIC-45 (α _= .93) and ARTIC-35 (α _= .91), and very good for the ARTIC-10 (α _= .82) (Baker et al., 2015). Subscale alphas fluctuated from respectable to very good (Baker et al., 2015). All three tests had strong test-retest reliabilities (Baker et al., 2015).

ARTIC-10 Survey Results

There were 34 participants overall: 19 from the in-person academic presentation to students and staff and 15 from the online session to the state professional organization. Only 2 out of 15 online participants completed both the pre and post-tests. Three of the online participants did not complete both the pre and post-tests and their data was removed. The data was input into an Excel Spreadsheet developed and issued by the Trauma Stress Institute, with calculations embedded into the document. The complete details of data for the pre and post-surveys can be found in Table 3 and Table 4. A paired t-test analysis was conducted using GraphPad to compare the pre and post-attitudes (N=22) related to the pediatric TIC presentation. The results (See Appendix P) indicated a statistical significance (t-value = 2.6082 and two-tailed p-value = .0164) (See Appendix I and Appendix J for data input details). The pre-presentation surveys had a mean of 5.66 and the post-presentation outcome mean was 6.10. The increase in scores after the educational session indicated that the participants' attitudes showed a positive change and confidence regarding pediatric trauma-informed care and implementation for occupational therapy practitioners.

Table 3

Pre ARTIC Excel Score Sheet



INSTRUCTIONS: ENTER RESPONDENT SCORES BELOW EXACTLY HOW THEY APPEAR (1 TO 7), ONE RESPONDENT PER LINE.
The example line, John Doe, is entered for you.
Subscales can be calculated for a given respondent as long as he/she completed the majority of items within the subscale (i.e., at least 6 out of the 10 items). The calculations made in this excel spreadsheet are only valid if that assumption is met.
This spreadsheet only recognizes positive, whole numbers. For example, "2.5" is not recognized by this spreadsheet.

AUTOMATICALLY COMPUTED TOTAL SCALE SCORE - DO NOT CHANGE THESE CELLS ONCE COMPUTED
DO NOT ENTER VALUES INTO THESE CELLS

Respondent ID	Other Identifier (e.g., name, initials, etc.)	1. Clients could...	2. Focusing on...	3. If clients...	4. The ups...	5. It's best not...	6. Clients do...	7. Clients need...	8. I realize that...	9. I feel able...	10. The most effective...	Total Score
Example	John Doe	Enter John Doe's score for Item 1 in this cell, John Doe's score for Item 2 in the next cell, etc....										
1	PRE											#DIV/0!
2		6	1	5	5	4	3	5	2	5	4	4.80
3												#DIV/0!
4		5	2	5	1	5	5	5	3	1	6	5.40
5		6	2	5	3	5	4	4	3	2	6	5.20
6		5	1	5	4	6	3	7	2	1	6	5.80
7		6	1	7	1	7	1	7	1	1	6	6.80
8		7	2	7	1	6	2	4	3	1	4	5.90
9		4	3	6	1	5	4	4	2	1	7	5.50
10		4	1	6	4	6	5	4	1	2	7	5.40
11		7	1	5	2	6	2	7	3	1	4	6.00
12		4	1	4	1	4	4	4	2	1	4	5.10
13		6	2	6	3	6	3	5	2	2	6	5.70
14		5	1	5	3	5	2	4	2	2	5	5.40
15		5	1	7	1	5	3	4	2	2	5	5.70
16		5	2	6	1	4	3	5	1	1	4	5.60
17		5	1	7	5	6	2	4	1	2	4	5.50
18		7	1		1	5	2	4	4	1	5	5.78
19		5	1	5	2	6	4	5	4	1	5	5.40
20		7	1	7	1	7	1	7	1	1	7	7.00
21		6	3	6	2	6	3	4	2	1	6	5.70
22		6	1	4	2	6	2	6	1	1	5	6.00
23		7	2	7	2	6	1	6	1	1	4	6.30
24												#DIV/0!
25		5	7	2	2	6	5	6	2		6	4.56
26												124.54
27												5.70

Table 4

Post ARTIC Excel Score Sheet

INSTRUCTIONS: ENTER RESPONDENT SCORES BELOW EXACTLY HOW THEY APPEAR (1 TO 7), ONE RESPONDENT PER LINE.
The example line, John Doe, is entered for you.
Subscales can be calculated for a given respondent as long as he/she completed the majority of items within the subscale (i.e., at least 6 out of the 10 items). The calculations made in this excel spreadsheet are only valid if that assumption is met.
This spreadsheet only recognizes positive, whole numbers. For example, "2.5" is not recognized by this spreadsheet.

AUTOMATICALLY COMPUTED TOTAL SCALE SCORE - DO NOT CHANGE THESE CELLS ONCE COMPUTED
DO NOT ENTER VALUES INTO THESE CELLS

Respondent ID	Other Identifier (e.g., name, initials, etc.)	nts ...	2. Focusing on...	3. If clients...	4. The ups...	5. It's best not...	6. Clients do...	7. Clients need...	8. I realize that...	9. I feel able...	10. The most effective...	Total Score
Example	John Doe	John Doe's score for Item 1 in this cell, John Doe's score for Item 2 in the next cell, etc....										
1	POST	7	1	6	2	6	2	6	2	2	6	6.20
2												#DIV/0!
3		6	1	7	2	6	6	6	2	2	6	5.80
4		7	1	2	2	7	1	6	1	1	7	6.30
5		7	1	5	1	5	4	4	5	1	6	5.50
6		7	1	7	1	7	1	7	1	1	7	7.00
7		6	2	7	1	6	1	6	1	1	6	6.50
8		7	1	7	1	6	1	6	1	2	6	6.60
9		5	2	7	1	7	2	7	1	1	7	6.60
10		7	1	7	2	7	1	7	1	1	5	6.70
11		6	1	6	1	5	2	6	4	1	5	5.90
12		5	1	7	3	7	3	5	1	3	6	5.90
13		6	1	4	1	4	6	7	4	1	4	5.20
14		7	1	7	1	7	1	7	1	3	7	6.80
15		7	5	6	5	6	4	3	3	1	3	4.70
16		5	2	6	3	5	4	5	2	2	5	5.30
17		7	1	7	1	7	1	7	1	1	7	7.00
18		7	1	7	1	7	1	7	1	2	7	6.90
19		7	1	6	1	6	1	7	7	1	7	6.20
20		6	2	6	1	6	2	6	2	2	3	5.80
21		6	1	7	3	2	5	6	1	3	4	5.20
22		7	1	7	1	6	1	4	2	2	4	6.10
23		6	1	6	2	5	2	4	2	1	3	6.13
24												135.03

Post Trauma-Informed Education Questionnaire

An online form was developed to include ten mixed open-and-closed questions as part of the post-test session to better understand occupational therapy students' and practitioners' attitudes after the presentation, TIC usage in their current area of practice, barriers, and incorporation of self-health management (See Appendix E) (N=22 respondents). The feedback indicated all participants found the educational presentation helpful and informative. Fifteen respondents were familiar with TIC practices, and seven were not. Ten of the contributors specified they used TIC in their workplace. Some of the documented practices noted were: using sensory regulation techniques to increase body awareness, including Zones of Regulation, use of coping strategies, practicing empathy and not taking things personally, collaboration with other interdisciplinary groups, creating safe spaces, cultural sensitivity, humility, and building rapport with children/clients, and using active listening skills.

Five attendants indicated that there were barriers in their place of work. The barriers identified were a lack of resources, a heavy workload, a lack of time and demand to complete documentation, and a limited focus on TIC in the environment. Thirteen selected "No" for barriers, and three did not make a selection. Twenty participants responded they felt encouraged to remove or reduce the barriers at work to use TIC practices in the pediatric setting and two did not mark anything. In terms of incorporating health management, ten practitioners indicated they do use self-care techniques to reduce burnout and secondary trauma. Ten indicated they do not and two did not make a selection. Of the participants that initially marked "No", they said "Yes", they felt encouraged to start integrating health management into their lives.

Four main themes emerged related to what the participants thought was informative or useful. These included incorporating specific intervention strategies related to the pediatric

occupational therapy setting, exploring self-awareness of one's own trauma, real-life application of TIC principles integrated with occupational domains and pediatric OT concepts, and better understanding of childhood trauma and its impact on sensory systems and applicable interventions. One participant highlighted concern over the need to expand trauma-informed spaces in communities to increase awareness. Some constructive feedback entailed more information on how to use TIC language when communicating with children and their families, including more specific intervention ideas and clinical scenarios.

Chapter VI: Discussion and Impact

The purpose of this capstone project was to educate future and present occupational therapist practitioners (OTPs) on evidence-based practices of pediatric TIC, the relevancy and connection to the pediatric setting, and to evaluate the participants' knowledge and attitude based on the educational presentation. Moreover, the project was a catalyst for developing an informed understanding of evidence-based trauma-informed care (TIC) frameworks and practices used in pediatric occupational therapy settings and within other disciplinary groups. The ARTIC-10 was used to determine the effectiveness of the educational course. A statistically significant increase was revealed (pre-score mean = 5.66, post-score mean = 6.10) using a t-score measure of the attendees' post-test ARTIC-10 evaluation scores. The statistical outcomes from the pre and post-test scores (two-tailed P-value score = .0164) and information gathered from the questionnaire confirmed that the educational session improved the participants' attitudes and perceptions regarding pediatric TIC and supported an enhanced self-perceived level of competency.

The increase in the total subscale scores for the ARTIC-10 suggested the pediatric TIC course changed the participants' attitudes and improved their perception of trauma, its impact on the pediatric population, self-efficacy, and reactions to the work environment. This study supported previous studies, such as Cerny et al. (2023), which achieved similar results when educating licensed clinicians, including audiologists, behavioral/mental health specialists, nurses, occupational therapists, physical therapists, physician assistants, and other healthcare providers. Providing an educational TIC course, particularly including specific evidence related to pediatric occupational therapy practitioners, illustrated the significance of the impact of trauma on children and the critical role OTPs play in early intervention to reduce the negative effects.

The qualitative data from the questionnaire presented rich insight into the participants' perspectives and impressions post-presentation. The practitioners gave very positive, informative, and enlightening feedback. There was an overwhelming optimistic response related to the evidence-based application and integration of specific OT pediatric concepts and occupation-based examples and interventions. About 68% of the course participants were familiar with TIC prior to the presentation. However, they stated none of the courses had been exclusive to pediatric occupational practice or as detailed to feel comfortable with competency for a full application of the TIC principles. The shift in feeling prepared and competent to execute the practices in their work environments corroborates the necessity of the educational course. Reviewing the data, the participants gained a sense of compassion and empathy, learned to be more client and family-centered, and recognized the need for healthy self-management skills.

The practitioners identified similar barriers to those in previous studies (Cerny et al., 2023; MacLeod et al., 2023). Some of the common limitations included lack of time, lack of resources and opportunities to engage in TIC awareness and competency, and the need for safe spaces in the work environments and communities. Providing the participants with an exclusively designed TIC course for pediatric occupational therapists aided in the practitioners' being empowered to become active in implementation and addressing the barriers in their work environments or fieldwork settings.

Pediatric TIC and OT Curriculum

Determining the topics and activities to be included in the curriculum presented its challenges yet became edifying and broadened my personal and professional understanding of pediatric TIC and even concepts related to frameworks and theory, neuroscience, and other OT-

related subjects. As I provided the pediatric TIC presentation to the OT doctoral students, it was evident the topic as it relates to the pediatric population may have been pivotal in their learning experience. The initial responses from the surveys exposed how narrow their views and beliefs were prior to the presentation, and even those who were aware of TIC still did not have the knowledge necessary for consistent application and understanding in the pediatric setting. Including the 14-week course would be instrumental as an additional course elective for students to gain awareness and become confident and competent in applying the principles in practice.

Implications for Practice

The development and implementation of this TIC presentation designed for pediatric OTPs supported the need for a curriculum designated for this specific setting and area of interest. The ARTIC-10 metrics continued to support the effectiveness of providing educational courses to practitioners to transform their attitudes, perceptions of preparedness and competency to implement TIC practices with children and their families. The PowerPoint was modified to differentiate between students and active, licensed practitioners. Some information was more detailed for students but reduced due to the time constraints of a 1-hour online presentation and the foundational knowledge already established by practicing therapists. Both are essential to instructing OTPs, and accommodations should be made for each to maximize the educational experience.

Trauma-informed practices in pediatric settings continue to be a growing and vital topic in general and in the occupational therapy community. Future studies and projects should continue to focus on pediatric occupational practitioners, using larger samples and a variety of settings. In addition, using one of the other two ARTIC-Scale assessments may offer more detailed information and insight into therapists' attitudes and perspectives. Future projects must

be cognizant of how the data is collected, particularly in online platforms. Critical data was missed due to participants not completing the forms, and the instructor was unaware. Extra steps should be taken to ensure participants are aware of all the forms requested to be completed and have visible access throughout the presentation during their attendance. Evidence-based research in this area continues to be essential to providing educational resources and appropriate interventions for children and families, as well as shifting OTPs attitudes and their willingness to implement pediatric TIC information and relevant interventions and plans of care. Expanding on this study would result in more reliable and generalizable data and strengthen the quality of information available to the occupational therapy community and pediatric area of practice.

Limitations

This capstone project had several limitations. The evidence-based research related to TIC, pediatrics, and occupational therapy is very limited in resources to assist with guidance on these topics. The matter of TIC and its significance in the pediatric occupational therapy environment should continue to be investigated for the betterment of OTPs to provide higher quality care and improve child and familial relationships while delivering services. Another limitation was the version of the assessment chosen. The ARTIC-10 has very good internal consistency and strong test-retest reliability (Baker et al., 2015). However, the short form only offers a total score. Using one of the other ARTIC assessments with full subscales could provide more enriched information. A final constraint to my project is the inability to implement the constructed 12-week course. Being able to present and execute the coursework to students would have offered some in-depth feedback and experience as an instructor.

Impact of the Capstone Experience

The magnitude to which this experience has changed the way I view myself as a student, practitioner, instructor, and a part of the occupational therapy community has been complex and enlightening. Developing a presentation with limited evidence-based research and resources made synthesizing the pieces frustrating and anxiety-driven, nevertheless intriguing, when I stumbled across a book or article that added a relevant layer of information. I achieved a deeper level of understanding of neuro concepts, such as the Polyvagal Theory and other trauma effects and their relationship to behavior and occupational domains as they relate to children. Investigating theories and frameworks aided my understanding of the models and their continued relevance when working with the pediatric population and their families. MOHO extended a wealth of information about the child profile and performance when addressing the subsystems and environment. This construct broadened my lens to be mindful of these concepts when working with children and using trauma-informed principles.

As a practitioner passionate about mental health and children, I wanted to have an insightful and reflective impact on the intended audience. We learned about different teaching styles and theories in one of our OTD courses: Teaching Adult Learners or Evidenced Base Education. For the purposes of constructing my presentation and coursework, I was mindful to focus on the transformative learning theory. Transformative learning involves a heightened level of awareness of the perspective of one's beliefs and feelings, a critique of their assumptions, an assessment of other perspectives, a decision to refute past perspectives in support of a new one or to make a synthesis of old and new, an ability to take action based upon the new perspective, and a desire to merge the new views into the wider context of one's life (Merriam & Bierema, 2014).

I tend to be reflective and conscious about my learning experiences, beliefs, and cultural systems during my interactions with others. I aspired to challenge the participants to do the same. By having the audiences review or take the ACEs quiz, providing videos from relevant trauma-informed resources, and evidence-based research on the impact of trauma and ACEs on children, it appeared to have a significant and positive impression on their views. When we examine our own frames of reference and open our minds to think outside of ourselves, we are able to provide a higher-quality level of care.

Completing this project helped contribute to my foundation as a knowledgeable authority figure in this area of practice. One of my biggest fears is public speaking, but putting myself in a position to challenge my anxiety has led to greater confidence and humility. When I presented in front of the university students, they were extremely quiet, and it was quite challenging to get them to interact and engage. The class instructor informed me at the end that they were her quietest class. Some of the students came up after class to ask questions and thanked me for my time and the information. I was worried about their overall response to my presentation, but based on the scores and qualitative data, I was effective in reaching them to shift their attitudes on how they view trauma in children and even improved self-awareness. I also developed a sense of community with the Nevada Occupational Therapy Association. When I reached out to the leadership of the organization, they quickly responded to my email and organized the schedule for me to be able to speak with their members via Zoom. I was just as anxious during this session as well. I had practiced my presentation several times the day before and the day of. During the start of the session, my PowerPoint corrupted and didn't look anything like I had revised. I closed it, tried to reopen it and it corrupted. Fortunately, I had several older copies, and because I had practiced the presentation so many times, I was able to recall the revised areas and transition

smoothly to finish successfully. The leadership explained they rarely have pediatric continuing education, so everyone was excited about the presentation. Their response to my project helped me contribute to the professional community and be of service to my colleagues.

Chapter VII: Conclusion

This capstone project has opened the door for an indispensable area of interest and study for pediatric OTPs. Children have the right to have healthy relationships, navigate through development without the extended burdens of trauma, and reach their full potential in every area of occupation. Delivering TIC in conjunction with pediatric OT practices is essential to providing the best quality levels of care and ensuring that re-traumatization is prevented. Furthermore, when trauma-informed principles and frameworks are utilized, we create healthier body and mental systems for children, their families, and OTPs.

Based on the data collected, providing education on TIC and its significance to the pediatric occupational therapy community is effective and has positive outcomes. When pediatric OT providers are trauma-informed and presented with specific interventions and relevant information to their clinical setting, they can transform their thinking and adapt to applying new and synthesized evidence-based practices.

How I think, practice, and interact with children and their families, as well as other professionals, have evolved. I am more confident in myself in terms of giving presentations and using a variety of methods to engage the audience. This project has encouraged me to seek a part-time teaching position in the future. Although I have anxiety regarding public speaking, I find myself also excited about educating others and hopefully changing their views and outlook for the better. It is also my goal to complete a pediatric TIC video that can be used for continuing education purposes to disseminate the information to a broader audience. The completion of this Capstone project continues to ignite my passion for learning and creating pathways for occupational justice.

Appendix A

PEDIATRIC TRAUMA-INFORMED THERAPY AND IMPLICATIONS FOR OCCUPATIONAL THERAPY PRACTITIONERS COURSE

Course Description:
This course will examine the impact of trauma and the significance of integrating trauma-informed care practices in the occupational therapy pediatric setting. The course will focus on research-based practices and ideologies to include problem-solving, critical reasoning, and self-reflection to address issues that impact the physiological, cognitive, mental health, social justice, and development of children. The contextual, cultural, social, and economic factors that impact the welfare of the pediatric population will be explored. Strategies will be identified for understanding and providing specific and appropriate interventions for teaching purposes, for entry-level educational programs, and to other organization stakeholders.

Course Competencies:
- Develop a care plan focused on trauma-informed care in occupational therapy practice using the information gathered from performing a literature review and information learned during the course.
- Present a 15-20 minute educational lecture/module on trauma-informed care and pediatric occupational therapy
- Develop communication skills related to reflective thinking, self-awareness, and communicating with peers and diverse audiences

Learning objectives:

1. Summarize and describe trauma-informed care (TIC) and its significance in occupational therapy and the pediatric setting
2. Identify the six core trauma-informed principles and explain how to utilize them in practice
3. Apply trauma-informed elements skillfully into intervention and treatment planning when working with children and their families
4. Demonstrate knowledge and awareness of the signs and symptoms of children experiencing or who have experienced trauma within different developmental age groups
5. Synthesize the knowledge learned from the course to demonstrate understanding and disseminate the information to relevant stakeholders.

Required reading:

1. Lynch, A., Ashcraft, R., & Tekell, L. (2021). *Trauma, occupation, and participation: Foundations and Population Considerations in Occupational Therapy*. American Occupational Therapy Association.

2. Van Der Kolk, B. (2014) *The Body Keeps the Score*, Viking: New York, NY.

Required video: All videos will be posted in the modules

Evaluation Methods

Assignments	Points	%
1. Assignments • Care Plan (50 points) • Literature Review (50) • Case Study (50)	150	30%
2. Discussion board (8)	80	25%
3. Journal (6)	60	20%
4. Teaching presentation	50	25%

Appendix B

Pediatric TIC Presentation Assignment

Learning Objectives

1. Apply knowledge to solution-oriented interventions that promote incorporating trauma-informed care practices for the mental health and well-being of children in the pediatric setting.
2. Communicate complex material in a manner that is engaging and enlightening
3. Synthesize key information into a trauma-informed presentation
4. Demonstrate leadership skills by creating a presentation centered on the course learning objectives and disseminating the information to a broader audience

Assignment Requirements

Now that you have been given the tools and resources to understand TIC and its relevance in the pediatric OT setting, it is your turn to teach. Develop a presentation using PowerPoint, Prezi, or Canva that best relates or would be beneficial to your pediatric fieldwork placement or work environment using the information learned during this course and information found conducting a literature review (i.e. Bullying, racism, foster care, abuse, medical trauma, etc.). Your audience will be your pediatric fieldwork placement or pediatric work setting.

Grading Rubric

Points	Points Possible	Presentation Rubric
	30	**Presentation content** 1. Identify at least 3 learning objectives using Bloom's revised taxonomy 2. Include each of the following within your presentation: • Summary of the main points of the 3 articles in your literature review • Summarize the topics related to pediatric trauma-informed care that are impacting the OT population selected • Identify at least (3) action-oriented solutions/interventions that illustrate the value of OTs role in reducing trauma to children and their families • Conclude with a mini case study from a child in the setting that has experienced trauma or one found in the media. Include a brief description of the child or adolescent, history, the problem and solutions,

	10	**Delivery and Presentation** ◆ Delivery techniques (tone and vocal expressiveness) make the presentation compelling ◆ Presentation should be catered to an audience of varying types (Be mindful of using in language that would possibly be perceived as too scholarly, too formal, etc.) ◆ Media is appropriately utilized ◆ Evidence of integrative teaching during topic activity ◆ Slides are professionally formatted and engaging ◆ Excellent details are provided on slides ◆ Slides free of APA grammar, syntax, punctuation, or spelling errors
	5	**Organization and Timing** ◆ Organization of content is logical and presentation is cohesive • Presentation is 15-20 minutes in length
	5	**References** ◆ Presentation includes a minimum of 5 references ◆ References are relvant and applicable to topic ◆ References provide support of rationale for utilization and application
50 points total	**XX points earned**	**Comments:**

Appendix C

In-Person Pre/Post ARTIC-10

ARTIC | *Attitudes Related to Trauma-Informed Care Scale*
VERSION: ARTIC-10 HUMAN SERVICES

TRAUMATIC STRESS INSTITUTE

People who work in human services, health care, education, and related fields have a wide variety of beliefs about their clients, their jobs, and themselves. The term "client" is interchangeable with "student," "person," "resident," "patient," or other terms to describe the person being served in a particular setting.

Trauma-informed care is an approach to engaging people with trauma histories in human services, education, and related fields that recognizes and acknowledges the impact of trauma on their lives.

INSTRUCTIONS

For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

Sample

	1	2	3	4	5	6	7	
Ice cream is delicious	○	●	○	○	○	○	○	Ice cream is disgusting.

Note: *In this SAMPLE ITEM, the respondent is reporting that he/she believes that ice cream is much more delicious than disgusting.*

I believe that...

		1	2	3	4	5	6	7	
1	Clients could act better if they really wanted to.	○	○	○	○	○	○	○	Clients are doing the best they can with the skills they have.
2	Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	○	○	○	○	○	○	○	Rules and consequences are the best approach when working with people with trauma histories.
3	If clients say or do disrespectful things to me, it makes me look like a fool in front of others.	○	○	○	○	○	○	○	If clients say or do disrespectful things to me, it doesn't reflect badly on me.
4	The ups and downs are part of the work so I don't take it personally.	○	○	○	○	○	○	○	The unpredictability and intensity of work makes me think I'm not fit for this job.
5	It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	○	○	○	○	○	○	○	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.
6	Clients do the right thing one day but not the next. This shows that they are doing the best they can at any particular time.	○	○	○	○	○	○	○	Clients do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to.
7	Clients need to experience real life consequences in order to function in the real world.	○	○	○	○	○	○	○	Clients need to experience healing relationships in order to function in the real world.
8	I realize that clients may not be able to apologize to me after they act out.	○	○	○	○	○	○	○	If clients don't apologize to me after they act out, I look like a fool in front of others.
9	I feel able to do my best each day to help my clients.	○	○	○	○	○	○	○	I'm just not up to helping my clients anymore.
10	The most effective helpers find ways to toughen up – to screen out the pain – and not care so much about the work.	○	○	○	○	○	○	○	The most effective helpers allow themselves to be affected by the work – to feel and manage the pain – and to keep caring about the work.

Thank you for your participation.

Appendix D

Presentation Purpose

1. Develop an informed understanding of evidence-based trauma-informed care (TIC) frameworks and practices used in pediatric occupational therapy (OT) settings and within other disciplinary groups.
2. Educate future and present occupational therapist practitioners (OTPs) on evidence-based practices of pediatric TIC, its relationship to the OT profession in the pediatric setting, and to assess the participants' knowledge based on the educational intervention.

Appendix E

Presentation Outline

- Background and Need Trauma-Informed Practices
- Reactions and behaviors related to trauma
- Trauma's impact on mental and physical health
- Primary and secondary trauma diagnoses
- Trauma-Informed Care (TIC) Principles to support clients/patients in the pediatric setting
- OTPs role and implications
- OTP Wellness

Appendix F

Presentation Objectives

1. Summarize and describe trauma-informed care (TIC) and its significance in occupational therapy and the pediatric setting
2. Identify the six-core trauma-informed principles and explain how to utilize them in practice
3. Apply trauma-informed elements skillfully into intervention and treatment planning when working with children and their families.
4. Demonstrate knowledge and awareness of the signs and symptoms of children experiencing or who have experienced trauma within different developmental age groups

Appendix G

In-person Post Educational Trauma-Informed Education Questionnaire

Post Educational Trauma-Informed Education Questionnaire

Please fill out the following questionnaire. Your responses will remain confidential.

Gender

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Non-binary
- ◯ Other

Are you a student, COTA, or OT?

If an OTP, how many years?

Were you familiar with pediatric TIC before this video?

- ◯ Yes
- ◯ No

Did you find this educational presentation helpful?

- ◯ Yes
- ◯ No

Please explain what was informative or what would you like more information about?

Do you currently use the TIC principles and interventions discussed in your pediatric practice?

- ◯ Yes
- ◯ No

If yes, how have you integrated them into practice. Provide details.

If no, did this presentation help with feeling more competent and comfortable with incorporating them into your professional practice now? If yes, please explain.

Do you perceive there have been limitations to applying pediatric TIC practices in your setting?

- ◯ Yes
- ◯ No

If yes, please explain...

Did the presentation encourage you to remove or reduce those barriers?

- ◯ Yes
- ◯ No

Do you feel more prepared and competent to utilize pediatric TIC practices as an OTP when working with children and their families now?

- ◯ Yes
- ◯ No

Are you currently incorporating health management techniques in your professional practice to reduce secondary trauma?

- ◯ Yes
- ◯ No

If no, did the information presented help to change how you will prioritize yourself?

◯ Yes
◯ No

Additional Comments or Information

Submit

Appendix H

Online Pre/Post ARTIC-10 Form

PRE ARTIC-10

PRE ARTIC SCALE-10

For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

1

1 Clients could act better if they really wanted to. Clients are doing the best they can with the skills they have.

1 2 3 4 5 6 7

2

2 Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories. Rules and consequences are the best approach when working with people with trauma histories.

1 2 3 4 5 6 7

3

3 If clients say or do disrespectful things to me, it makes me look like a fool in front of others. If clients say or do disrespectful things to me, it doesn't reflect badly on me.

1 2 3 4 5 6 7

4

4 The ups and downs are part of the work so I don't take it personally. The unpredictability and intensity of work makes me think I'm not fit for this job.

1 2 3 4 5 6 7

5

5 It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job. It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.

1 2 3 4 5 6 7

6

6 Clients do the right thing one day but not the next. This shows that they are doing the best they can at any particular time. Clients do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to.

1 2 3 4 5 6 7

7

7 Clients need to experience real life consequences in order to function in the real world. Clients need to experience healing relationships in order to function in the real world.

1 2 3 4 5 6 7

8

8 I realize that clients may not be able to apologize to me after they act out. If clients don't apologize to me after they act out, I look like a fool in front of others.

1 2 3 4 5 6 7 8

9

9 I feel able to do my best each day to help my clients. I'm just not up to helping my clients anymore.

1 2 3 4 5 6 7

10

10 The most effective helpers find ways to toughen up – to screen out the pain – and not care so much about the work. The most effective helpers allow themselves to be affected by the work – to feel and manage the pain – and to keep caring about the work.

1 2 3 4 5 6 7

Submit

Never share any password-related information in this survey

Appendix I

Post Educational TIC Questionnaire

Post Education Pediatric TIC Questionnaire

Please fill out the following questionnaire. Your responses will remain confidential.

Gender

- [ ] Male
- [ ] Female
- [ ] Transgender
- [ ] Non-binary
- [ ] Other
- [ ] Prefer Not To Say

Are you a...

- [ ] Student
- [ ] OTA
- [ ] Occupational Therapist

If an OT Practitioner, how many years?

Were you familiar with pediatric TIC before this video?

- ◯ Yes
- ◯ No

Did you find this educational presentation helpful?

- ◯ Yes
- ◯ No

Please explain what was informative or what you would like more information about.

Do you currently use the TIC principles and interventions discussed in your pediatric practice?

- ◯ Yes
- ◯ No

If yes, how have you integrated them into practice? Provide details.

If no, did this presentation help with feeling more competent and comfortable with incorporating them into your professional practice now? If yes, please explain.

Do you perceive there have been limitations to applying pediatric TIC practices in your setting?

- ◯ Yes
- ◯ No

If yes, please explain...

Did the presentation encourage you to remove or reduce those barriers?

- ◯ Yes
- ◯ No

Do you feel more prepared and competent to utilize pediatric TIC practices as an OTP when working with children and their families now?

- ◯ Yes
- ◯ No

Are you currently incorporating health management techniques in your professional practice to reduce secondary trauma?

- ◯ Yes
- ◯ No

If no, did the information presented help to change how you will prioritize yourself?

◯ Yes ◯ No

Additional Comments or Information...

Appendix J

ACE Quiz

Finding Your ACE Score

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

1. Did a parent or other adult in the household often or very 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 If yes enter 1 _____

2. Did a parent or other adult in the household often or very often…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?

   Yes No If yes enter 1 _____

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 If yes enter 1 _____

4. Did you often or very 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 If yes enter 1 _____

5. Did you often or very 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 If yes enter 1 _____

6. Were your parents ever separated or divorced?

   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

   Yes No If yes enter 1 _____

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

   Yes No If yes enter 1 _____

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

   Yes No If yes enter 1 _____

10. Did a household member go to prison?

    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

Adapted from: http://www.acestudy.org/files/ACE_Score_Calculator.pdf, 092406RA4CR

Appendix K

Discussion Rubric

10 points	Exceeds 2	Meets Expectations 1.66	Fair 1.33	Needs Work .66
Content	Information written is relevant and provides exceptional insight and thought into the topic	Information written is relevant and provides good insight and thought into the topic	Information written is relevant and provides some insight and thought into the topic	Information written is not relevant and off topic
Clarity	Expresses ideas with rich details, using multiple sources of evidence for exceptional understanding	Expresses ideas with good details and uses some relevant sources understanding	Difficult to understand more than half of the content.	Entry is difficult to understand and poor written
References	Uses at least 3 relevant references	Uses at least 2 relevant references	Uses at least 1 relevant reference	Doesn't use any references
Peer Response	Responds to at least 2 peers with reflective, well thought out, respectful and relevant information	Responds to at least 2 peers with good ideas, respectful and relevant information	Responds to at least 1-2 peers with fairly organized ideas, respectful and some relevant information	Doesn't respond or responds to at least 1 peer with poorly organized ideas, respectful and off topic information
Grammar & Mechanics	No grammar or spelling errors.	Maximum of one to two grammar or spelling errors.	Writing is adequate; maximum of three to four grammar or spelling errors.	Inadequate; more than four spelling or grammar errors.

Appendix L

Journal Writing Rubric

10 points	Exceeds 2	Meets Expectations 1.66	Fair 1.33	Needs Work .66
Content	Information written is relevant and provides exceptional insight and thought into the topic	Information written is relevant and provides good insight and thought into the topic	Information written is relevant and provides some insight and thought into the topic	Information written is not relevant and off topic
Clarity	Expresses ideas with rich details, using multiple sources of evidence for exceptional understanding	Expresses ideas with good details and uses some relevant sources understanding	Difficult to understand more than half of the content.	Entry is difficult to understand and poor written
Organization	Journal entry is well thought out and flows logically	Journal entry is generally logical and effective with a few minor errors.	Journal entry is difficult to understand in some areas, but still the general organization is okay.	Journal entry lacks logical order and organization.
Effort	Exceeds the requirements of the assignment and have extra effort into the process.	Fulfills all of the requirements of the assignment.	Fulfills some of the requirements of the assignment.	Fulfills few of the requirements of the assignment.
Grammar & Mechanics	Journal is has no grammar or spelling errors.	Journal has a maximum of one to two grammar or spelling errors.	Journal is adequate; maximum of three to four grammar or spelling errors.	Inadequate; more than four spelling or grammar errors.

Appendix M

Framework Application and Pediatric TIC Assignment

Assignment name: Framework Application and Pediatric Trauma-Informed Care
Purpose: To reflect, identify, and apply relevant frames of reference and model concepts, critical thinking skills, and interventions related to pediatric trauma-informed care (TIC).
Directions: Think of a child or family on your current caseload or from fieldwork or previous work experiences who have experienced trauma. Present their information in a case study, including their history, present levels of performance, and any pertinent information to give a full depiction. Choose a frame of reference or model and describe how you would implement its concepts with the child or family member(s). The FOR or model can be one discussed in class or another that is applicable to the pediatric population. This should be 3-5 pages in length and follow 7th edition APA format.

Grading criteria rubric

Criterion	**Exceeds (10)**	**Meets (8)**	**Needs Improvement (5)**
Content	Student includes an organized and well-thought-out synthesis and understanding of all the fundamental concepts.	Student answers the questions using the concepts discussed.	Student does not answer the questions.
Application	Student has exceptional ability to apply the TIC terms and principles and provide significant intervention responses.	Student has a good understanding to apply the general terms, principles, and interventions.	Student does not adequately apply relevant terms, principles, or intervention responses.
Punctuation and spelling	Student uses concise and clear language, correct grammar, punctuation, and spelling.	Student has one to two errors, but general grammar, punctuation, and language are	Student's grammar, punctuation, and language usage is poor.
Clarity	Expresses ideas with rich details, using multiple sources of evidence for exceptional understanding	Expresses ideas with good details and uses some relevant sources understanding	Difficult to understand more than half of the content.
Organization	Information is well thought out and flows logically	Information is generally logical and effective with a few minor errors.	Information is difficult to understand and follow in some areas, but still the general organization is okay.
			Total Points 50

Appendix N

Pediatric TIC Case Study/Care Plan Assignment

Assignment name: Pediatric TIC Care Plan Development

Purpose: To identify how trauma impacts functioning and use applicable concepts, critical thinking skills, synthesizing pediatric occupational therapy interventions, and related principles of trauma-informed care (TIC).

Directions: Using one of the three children identified at the beginning of Chapter 10 in van der Kolk, 2014, answer the following:

1. Identify 3-5 performance or behavior concerns with the child or family member.

2. Identify relevant assessment(s) you may use.

3. Develop three client-centered goals for the child and/or family.

4. Identify at least two interventions to address the identified concerns.

Grading criteria rubric

Criterion	**Exceeds (10)**	**Meets (8)**	**Needs Improvement (5)**
Content	Student includes an organized and well-thought-out synthesis and understanding of all the fundamental concepts and meets stands of direction criteria.	Student answers the questions using the concepts discussed with good use of course information. May be missing 1 criteria expectation.	Student does not answer the questions.
Application	Student has exceptional ability to apply the TIC terms and principles and provide significant intervention responses.	Student has a good understanding to apply the general terms, principles, and interventions.	Student does not adequately apply relevant terms, principles, or intervention responses.
Punctuation and spelling	Student uses concise and clear language, correct grammar, punctuation, and spelling.	Student has one to two errors, but general grammar, punctuation, and language are	Student's grammar, punctuation, and language usage is poor.
Clarity	Expresses ideas with rich details, using multiple sources of evidence for exceptional understanding	Expresses ideas with good details and uses some relevant sources understanding	Difficult to understand more than half of the content.
Organization	Information is well thought out and flows logically	Information is generally logical and effective with a few minor errors.	Information is difficult to understand and follow in some areas, but still the general organization is okay.
			Total Points 50

Appendix O

Weekly Modules

Required Texts: *Trauma, Occupation, and Participation: Foundations and Population Considerations in Occupational Therapy* (Lynch et al., 2021) and *The Body Keeps the Score* (van der Kolk, 2014) (see References)

Week 1: Introduction

- Trauma-Informed Care (TIC)
- Principles
- History of TIC
- Types of general trauma
- Epigenetics

Assignments: Take the ACE quiz and explore the posted website

Journal Entry 1: What does TIC mean to you?

Read: (Lynch et al., 2021) - pages 3-7, (van der Kolk, 2014) – Ch. 1

Watch:

https://www.youtube.com/watch?v=xd72Rx32EK4

https://www.youtube.com/watch?v=-876Zw-NA94

Week 2: Adverse Childhood Experiences

- What are ACEs?
- Review Kaiser Permanente Study
- General Health Impact of Trauma
- Types of Childhood Trauma
- Childhood Traumatic Affects

DB 1 – (Part 1) What did you learn from taking the ACE quiz? What was surprising? How do you think this information is relevant to how you would practice? (Part 2) Identify 3 pieces of information you found interesting and how they can be applied in your practice.

Watch: https://youtu.be/8gm-lNpzU4g

Read: (van der Kolk, 2014) – Ch. 7 (pgs. 164-178), Article by Straight & Meagher (2020) - Trauma-Informed Care in Pediatrics: A Developmental Perspective in Twelve Cases with Narratives.

Week 3: TIC and Social Determinants of Health (SDH)

- Relationship between trauma-informed care and SDH
- Review SDH
- Population Health, TIC and role of OT

DB 2 - Identify and describe the levels of prevention in population health. Include a research-based article related to pediatric occupational therapy that gives an example of one of the levels and explains its findings.

Assignment: Journal 2: What information has surprised you most so far? How do you think these new discoveries will help your clinical skills?

Read: (Lynch et al., 2021) – Chapter 5

Watch:

https://www.thedoctors.com/articles/pediatrics-addressing-social-determinants-of-health-and-adverse-childhood-experiences/

https://www.pacesconnection.com/blog/the-intersection-of-the-social-determinants-of-health-sdoh-and-trauma-informed-care-tic

Week 4: Pediatric Trauma and the Body

- Neurological Affects
- Window of Tolerance
- Common Signs and Symptoms of Childhood Trauma
- Common childhood trauma-related diagnoses

DB 3: Explore and find the evidence research and correlation between trauma, motor coordination, and sensory processing. Explain the outcomes and how this can impact a child's areas of occupation.

Assignment: Journal 3 – Considering how trauma affects the body, how has trauma affected you or a family member or friend? What behaviors or physical symptoms have you recognized, felt, or observed in yourself currently or observed in your family or friend? Have you identified your triggers? If so, what are they? What have you, your family member, or your friend done to address the trauma?

Read: (van der Kolk, 2014) – Chapters 3 & 4

Week 5: Frames of References, Models, Theories, and other TIC Frameworks

- MOHO
- Sensory Integration
- Occupation-specific Community Development
- Other FOR and models in the TIC Community

Assignment: Think of a child or family on your current caseload or from fieldwork or previous work experiences who have experienced trauma. Present their information in a case study,

including their history, present levels of performance, and any pertinent information to give a full depiction. Choose a frame of reference or model and describe how you would implement it's concepts with the child or family members. The FOR or model can be one discussed in class or another that is applicable to the pediatric population. This should be 3-5 pages in length and follow 7th edition APA format.

Week 6: Resilience and Traumatic Stress

- Neuroplasticity
- Signs of resilience
- Factors that promote resilience
- Strength-based model

DB 4: Explore the literature, research, and other virtual mediums to find practical solutions and applications that OTPs can use to promote resilience in children and their families. Discuss your findings.

Read: (Lynch et al., 2021) - pgs. 106-108 (Resilience sections only on pg. 108),

Resilience and Child Traumatic Stress:

https://www.nctsn.org/sites/default/files/resources/resilience_and_child_traumatic_stress.pdf

Watch video: https://youtu.be/7APpG80XBSw?feature=shared

Week 7: Trauma Screenings and Assessments:

- ACE Screening
- Interview
- Canadian Occupational Performance Measure

- Occupational Profile
- Kawa Model
- Sensory Profile
- Sensory Processing Measure

DB 5: Choose an assessment (can be one discussed or not) and explain why you think it is the most effective tool for extracting information when working with children experiencing trauma. Fine one evidence-based article to support your reasoning.

Assignment: Journal 4 - Reflect on a time when you felt unheard or invalidated as a child. How do you validate your feelings and experiences now? What steps would you take to validate a child's feelings and experiences that you're working with now?

Week 8: OT role as an educator and practitioner

- Trauma's effects on children's occupational performance
- Identified OT roles
- Addressing specific occupational domains and interventions using TIC principles
- Developing intervention goals addressing areas affected by trauma

Read: (van der Kolk, 2014) – Chapter 10

Watch video: https://youtu.be/sYk_OleyRsE

Assignment: Using one of the three children identified at the beginning of Chapter 10 in van der Kolk, 2014, answer the following:

1. Identify 3-5 performance or behavior concerns with the child or family member.

2. Identify relevant assessment(s) you may use.
3. Develop three client-centered goals for the child and/or family.
4. Identify at least two interventions to address the identified concerns.

Week 9: Client and Family-Centered Practices

- Taking the Child's Lead
- Teaching and Mirroring Regulation
- Modeling
- Who is the expert?
- Active Listening

Read: (van der Kolk, 2014) – Chapter 13, Family Centered Care (FCC): https://s18798.pcdn.co/cjacobsot/wp-content/uploads/sites/11053/2020/08/Parent-Handout-on-Family-Centered-Care.pdf

Watch: https://youtu.be/3qyUdbe8mxE?feature=shared

DB 6: Research family-centered care and use the posted online reading for this week to explain how you incorporate FCC into your practice.

Assignment: Journal 5- Write a letter to your younger self, talking about mental health. What would you tell them? How can you use this information in professional practice?

Begin your literature review for your final presentation. It must include 3 research-based articles related to your project (see Pediatric TIC Final Presentation description)

Week 10: Trauma and Marginalized Populations

- Definition
- Historical Trauma
- SDH

- Racism
- LGBTQIA
- Children
    - Children with mental and physical disabilities, foster care

Read: (Lynch et al., 2021) – Ch. 12 & 13, (van der Kolk, 2014) – Chapter 17

AJOT: https://research.aota.org/ajot/article/75/6/7506150010/23098/Working-With-Marginalized-Populations

Watch: https://youtu.be/oC_MPCXs0Sw

DB 7: Using the AJOT article and any other sources, discuss habits, strategies, and interventions that you can use to improve your relationships and how you work with marginalized populations.

Week 11: Practitioner Wellness & Health Management

- Importance of Practitioner Health & Well-being
- Self-Awareness
- Secondary Triggers
- Strategies for Self-Care
- Meditation & Relaxation Practice

Read: (van der Kolk, 2014) – Epilogue

AOTA- https://www.aota.org/career/career-llcenter/wellness-for-life-and-career,

Self-Care Practices- https://tinybuddha.com/blog/45-simple-self-care-practices-for-a-healthy-mind-body-and-soul/

Watch: https://youtu.be/w0iVTQS8ftg?feature=shared

Assignment: Journal 6 – (Part 1) Are you making professional self-care a priority? What does your self-care look like? If you do not have a routine, develop your ideal practices that could be

put in place. What are the benefits and barriers to your self-health management routine? (Part 2) Have your beliefs and perceptions about trauma-informed care in the pediatric setting changed? Please explain. How do you feel about implementing these practices with children and their families? How do you feel about teaching them others what you now know?

Week 12: Trauma-Informed Presentations

DB 8: You will constructively critique your assigned peer's presentation. You will also answer the following: What was your biggest takeaway from this course? What challenged you the most? For future courses, what do you think should be added or changed?

Assignment: Now that you have been given tools and resources to understand Pediatric TIC and it's relevance in OT, it is your turn to teach. You are to develop a presentation using PowerPoint or your media of choice. Your audience will be your pediatric fieldwork placement or pediatric work setting. (See Appendix B).

Appendix P

ARTIC-10 Paired T-test Results

Paired *t* test results

P value and statistical significance:

The two-tailed P value equals 0.0164

By conventional criteria, this difference is considered to be statistically significant.

Confidence interval:

The mean of Pre ARTIC Survey minus Post ARTIC Survey equals -0.4405

95% confidence interval of this difference: From -0.7916 to -0.0893

Intermediate values used in calculations:

t = 2.6082

df = 21

standard error of difference = 0.169

Review your data:

Group	Pre ARTIC Survey	Post ARTIC Survey
Mean	5.6609	6.1014
SD	0.5620	0.6496
SEM	0.1198	0.1385
N	22	22

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Van Der Kolk, B. (2014). *The Body Keeps the Score*, Viking: New York, NY.

Curriculum Vitae

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Education

OTD University of Nevada Las Vegas, Occupational Therapy May 2022-Present

BS/MS Brenau University, Occupational Therapy June 2001- May 2004
Thesis: "The effectiveness of occupational therapy in improving life skills and satisfaction in female high school adolescents."
Advisor: Dr. Barbara Boyt Schell

BS Texas Tech University, Psychology August 1997-May 2001
Minored in Childhood Development

Honors and Awards

Pediatric Post-Concussion badge -National Board for Certification in Occupational Therapy – (NBCOT), 2022

School-based practice badge (NBCOT), 2010 - Present

Brenau University Merit List, 2001-2004
Scholarly honor from academic excellence

Texas Tech University Dean's List, 1999-2001
Scholarly honor from academic excellence

Research Experience

Thesis, Brenau University, Gainesville, Georgia, 2004
Advisor: Dr. Barbara Schell, PhD

- Collaborated with co-authors to develop a target research question and with a specified population, developed a comprehensive research methodology, completed intervention and assessments with participants, data collection, and critical analysis of the results
- Collaborated with co-authors to interpret, synthesize, and write a research paper. Presented findings to the institutional review board.

Teaching Experience

Occupational Therapist Fieldwork Educator, Las Vegas, NV January 2018-Present

- Taught and supervised 2-3 Level I or Level II occupational therapy students per semester.
- Educate students on the pediatric and other frames of references, various formal assessments and evaluation methods utilized in the school setting. Model appropriate interactions with

students and other support team members. Develop critical thinking skills to identify and develop appropriate clinical skills and interventions for students aging 3-21.

Northside Independent School District, San Antonio, TX June 2015, 2016, 2017

- Collaborated with developing and teaching summer workshop titled, "Fine Motor Tools You Can Use" for 100-150 teachers and support staff, covering the following topics: fine motor development, proper postural positioning, fine motor interventions for early development and older students, "take-home" items to use in the classroom

Gwinnett County Public Schools, Suwanee GA August 2009 and 2010

- Taught "How Does Your Engine Run", to 30-40 educational staff an undergraduate covering the following topics: sensory processing, sensory behaviors, developing appropriate interventions
- Developed a quiz for the "How Does Your Engine Run" course
- Developed a sensory room for students and educated 30-40 plus staff, integrating information taught from "How Does Your Engine Run."

Texas Tech University Student Counseling Services, Lubbock TX Aug 2000 May 2001

- Educated 50-75 students on the importance of mental health, time management skills, relaxation tools, and identifying when to seek campus or professional assistance.

Publications

Hoskin, Q., Ray, M., Swena, R. (2004). The effectiveness of occupational therapy in improving life skills and satisfaction in female high school adolescents. Master's thesis. Brenau University. Gainesville. (Submitted for publication)

Pediatric Trauma-Informed Care and Implications for Occupational Therapy Practitioners, University of Nevada, Las Vegas, In Progress May 2024

Professional Training

Trauma-Informed Pediatric Practice
Summit Education, Las Vegas, NV, February 2024

Improving Visual and Fine Motor Skills Using Neuroplasticity
Summit Education, Las Vegas, NV, November 2022

Trauma-Informed Rehabilitation
Summit Education, Las Vegas, NV, October 2022

Resolving Modulation Disorders in Children with ADD and Autism
Summit Education Las Vegas, NV, April 2021

Complex Feeding Issues: Sensory, Motor, and Behavior for Autism, Cerebral Palsy, and other Developmental Delays, Austin, TX, 2016

How Does Your Engine Run course, Atlanta, GA, 2006

Mental Health Disorders in Children and Adolescents course, Atlanta, GA, 2005

Fieldwork educator workshop, Brenau University, Gainesville, GA, 2005

Professional Presentations

"Pediatric Trauma-Informed Care and Implications for Occupational Therapy Practitioners," Speaker, University of Nevada, Las Vegas, February 2024.

"Pediatric Trauma-Informed Care and Implications for Occupational Therapy Practitioners," Virtual Speaker, Nevada Occupational Therapy Association, February 2024.

Professional Affiliations

American Occupational Therapy Association, Member, 2002-Present
National Board of Certification in Occupational Therapy (NBCOT), Member, 2001- Present
Nevada Occupational Therapy Association, Member, 2024