Perceptions of Early Childhood Teachers About How Trauma Impacts Young Children in the Classroom and the Adequacy of Their Preparation to Teach Young Children Who Have Experienced Trauma

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Abstract

Nearly every teacher will have contact with a child or family who has been impacted by trauma, and research has indicated that the intervention and support a young child receives can make a critical difference (Erdman, Colker, & Winter, 2020). Trauma in young children is a public health crisis (Erdman et al., 2020; Van der Kolk, 2014). While there is compelling research about the development of young children and the quality of early childhood education experiences, few studies have focused on early childhood care and education (ECCE) teachers' perceptions of how trauma impacts young children in center-based programs, the information and skills needed to meet the challenges of young children who have experienced trauma, professional development opportunities that are available to provide the knowledge and skills needed to work with young children who have experienced trauma, or the challenges related to accessing professional development. Ten ECCE teachers working directly with young children who may have experienced trauma participated in the study. All participants had two or more years of experience and were employed in a center-based ECCE classroom in Johnson County, Kansas, from January 2020 through July 2021. Four themes were identified from the data analysis: (1) teachers' perceptions of trauma in early care and education; (2) teachers' professional development needs working with young children who may have experienced trauma; (3) the resources and professional development opportunities available to ECCE teachers; and (4) the challenges of working with young children who may have experienced trauma. The need for collaboration among ECCE professionals and infant-toddler mental health practitioners and organizations to provide

relevant professional development for ECCE teachers and providers who work with young children and their families who have experienced trauma was identified in the current study.

Dedication

This dissertation is dedicated to my grandson, Bear, and all young children who have experienced trauma and who are triggered without warning and struggle with caregivers and teachers who have little or no awareness of the impact of trauma or have effective strategies to support them in self-regulation and healing. You are my inspiration.

These efforts are in remembrance of my late husband, William K. Hodapp, my mom, Virginia Northrop Ryan, and my dad, Charles "Chuck" Ryan. Each was generous with their time and talents and willing to share them with children of all ages. In addition, each demonstrated a love of learning and valued life-long education. I was aware of their presence and have had them in my thoughts and heart throughout this doctoral journey.

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Chapter 1

Introduction

Parents, caregivers, and teachers desire the best early childhood experiences for young children. Laughlin (2013) indicated that in 2011, over 20.4 million children under five years of age participated in early care and educational services. The workforce providing early care and education to our communities' youngest members is as diverse as the families they serve (Nicholson, Perez, & Kurtz, 2019; Rhodes & Huston, 2012). According to Concordia University St. Paul (2019), scores of women and men have aspirations to work in the education field. However, it demands an exceptional caliber of educator to work with young children during their first five years of life. These teachers are charged with fostering fundamental physical, social, behavioral, and cognitive growth and development.

The National Academies of Sciences, Engineering, and Medicine (2018) noted that well qualified ECCE staff are crucial in the delivery of exceptional ECCE services. Researchers have indicated that care providers' and teachers' education and training are critical factors in attaining and maintaining quality early childhood programs and practices. There is growing evidence that the caregivers and teachers who provide specific knowledge and skills to their position are the most highly qualified to deliver high-quality programs and resources to young children and their families (National Association for the Education of Young Children [NAEYC], 1993).

The Childcare Resource and Research Unit (2020) offered no single definition of quality in child care but identified several overall elements of child care critical to children's well-being. Several common human factors are associated with early care and

instruction. These include effective leadership; knowledgeable, competent, trained and nurturing staff; small group size and low staff-child ratios; positive interactions and relationships with adults; inclusion of children with special needs; diversity; positive relationships; effective parent communication; and parent involvement (Childcare Resource and Research Unit, 2020; Early Childhood Education, 2020; NAEYC, 2020; Sim, Belanger, Stancel-Piqtak, & Karoly, 2019). In addition, aspects of the early learning environment and curriculum encompass a safe, clean, and well-maintained environment; include developmentally appropriate practices and learning activities; address areas of child development (large and fine motor, social-emotional, language, and cognitive skills); provide a balanced schedule including opportunities for active play, quiet activities, rest, outdoor time, nutritious meals and snacks, and self-care; and engage young children in a variety of activities provided individually in a large group and small group (Child Care Resource and Research Unit, 2020).

McLoyd, Aikens, and Burton (2006) contended that the quality of children's ECCE experiences matters for long-term intellectual development, socio-emotional well-being, and health. A young child's social-emotional development is dependent on a secure, trusting relationship with a designated caregiver (Zero to Three, 2005). The early childhood teacher spends a significant amount of time with a child during waking hours. The Learning Tree Institute (2021) in *The 2020 Kansas Child Care Market Analysis Final Repor*t noted children in full-time care are with family child care providers or in child care centers 50 -55 hours per week

Lieberman, Chu, Horn, and Harris (2011) argued that children under age 5 are at exceptionally high risk for exposure to potentially traumatic events due to their

dependence on parents and caregivers. The American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents (2008) defined a traumatic event as "one that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs" (p. 2). Traumatic events include a serious illness that requires significant medical intervention; the loss or life-threatening illness of a close family member; witnessing natural disasters; domestic or community violence or threats of terrorism; homelessness; and neglect or physical or sexual abuse (National Child Traumatic Stress Network Schools Committee, 2008). Unfortunately, exposure to trauma is a widespread experience for our youngest children (Ippen, Harris, Van Horn, & Lieberman, 2011). Numerous researchers, Briggs-Gowan, Ford, Fraleigh, McCarthy, and Carter (2010) and Shahinfar, Fox, and Leavitt (2000) indicated that a significant number of children in the United States have been vulnerable to trauma, and the likelihood of experiencing trauma is highest for children in the early childhood years. Statman-Weil (2015) noted that 26 % of children in the United States would have witnessed or experienced trauma before age 4.

Reactions to traumatic events can be displayed in various behaviors and vary from child to child. The National Child Traumatic Stress Network Schools Committee (2008) reported, "Many behaviors seen in children who have experienced trauma are nearly identical to those of children with developmental delays, attention deficit hyperactivity disorder (ADHD), and other mental health conditions" (p. 7). Because of the types of trauma young children may have experienced, ECCE teachers may observe increased separation anxiety, increased irritability and frustration, difficulty playing and working with adults and other children, tantrums, aggressive behaviors, lack of interest or ability

to concentrate, detached, hyper-alert responses, or limited communication (American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, 2008; Buss, Warren, & Horton, 2015; Erdman, Colker, & Winter, 2020; Nicholson et al., 2019; Stone & Bray, 2015; Zero to Three, 2020).

Trauma experiences can have short-term and long-term impacts. According to the National Child Traumatic Stress Network Schools Committee (2008), trauma experienced in early childhood may result in learning or behavior challenges, poor school performance, and reoccurring physical and emotional distress. Researchers (Cleveland Clinic Pediatrics, 2020; Monnat & Chandler, 2015; Prevent Child Abuse America, 2020; Substance Abuse and Mental Health Services Administration, 2020) have indicated that long-term implications for multiple or repeated adverse childhood experiences may increase the risk of physical and emotional health problems in adult life. Childhood trauma may increase an individual's risk of anxiety, asthma, cancer, depression, diabetes, heart disease, obesity, post-traumatic stress disorder (PTSD), stroke, substance abuse, and suicide (Monnat & Chandler, 2015; Prevent Child Abuse America, 2020).

Van der Kolk (2005) stated, "Childhood trauma, including abuse and neglect, is probably the single most important public health challenge in the United States, a challenge that has the potential to be largely resolved by appropriate prevention and intervention" (p. 401). Teachers in early care and education programs can help a young child who has experienced a traumatic event. The National Child Traumatic Stress Network (2010) encouraged educators to report suspected abuse, work with parents and colleagues to address noticeable concerns, make a referral, and share *Trauma Facts for*

Educators (NCTSN, 2008) with other early childhood professionals. The American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents (2008) noted,

> Conveying information about common reactions to trauma can often be helpful to the child and the people around him or her, including parents, teachers, coaches, clergy, and community leaders. Knowing what to expect and what reactions are most common can relieve adults' worries that the child will not recover or will be damaged forever. If the individuals in a child's support system understand his or her behavior and distress as normal reactions to abnormal events, they can better support the child during the recovery period. (p. 4)

Nearly every educator will interact with a child or family who has been affected by trauma, and research has shown that the support and intervention a child receives when young can make a critical difference (Erdman et al., 2020).

Background

Historically, child care was intended to promote parental employment, and early childhood education was designed to facilitate child development. However, in practice, this distinction is artificial. Many early education programs enable parents to work and many child care settings are designed to promote learning and development (Rhodes & Huston, 2012).

Young children develop social-emotional competencies in the context of the relationships that exist between a small group of consistent caregivers and the child. Caregivers may include parents, child care providers, foster parents, grandparents, and other family members (Cohen, Onunaku, Clothier, & Poppe, 2005). Rhodes and Huston

(2012) reported that by the age of 5, most children had spent significant time in the care of adults other than their parents. Second only to the family, more than two million individuals in early care and education play a central role in children's development (Rhodes & Huston, 2012). The early years of childhood experiences build the foundation for physical and emotional well-being, intellectual development, and social competence (National Scientific Council on the Developing Child, 2007; Zero to Three, 2020).

The Institute of Medicine and National Research Council (2015) identified competencies for early childhood educators in its publication *Shared Knowledge and Competencies for Educators of Children Birth through Age 8.* The competencies related to young children's social-emotional development include:

- Ability to establish relationships and interactions with children that are consistent, nurturing, and use positive language.
- Ability to promote positive social development and self-regulation while mitigating challenging behaviors in ways that reflect an understanding of the multiple biological and environmental factors that affect behavior.
- Ability to recognize the effects of factors from outside the practice setting (e.g., poverty, trauma, parental depression, experience of violence in the home or community) that affect children's learning and development and to adjust practice to help children experiencing those effects. (p. 3)

From birth to age 5, young children are especially vulnerable to adverse effects of trauma due to rapid developmental growth, dependence on caregivers, and limited coping skills (Schonfeld, Demaria, & Kumar, 2020). Despite decades of statistical data, mental health professionals generally have limited knowledge about the impact of traumatic

events on younger children compared to older children and adolescents (De Young, Kenardy, & Cobham, 2011). "Children younger than five years of age typically experience rapid developmental changes that often are misinterpreted or not fully accounted for, which hinders proper diagnosis and intervention" (Buss et al., 2015, p. 266). Explanations for this disparity in knowledge include a historical resistance to the notion that early childhood mental health is critical. As a result, researchers have spent little time and effort investigating the effects of trauma exposure in early childhood. In addition, a widely held misconception has been that infants and young children lack the perception, cognition, and social maturity to remember or understand traumatic events (Buss et al., 2015; Cohen et al., 2005; Zeanah & Zeanah, 2019; Zero to Three, 2005).

Buss et al. (2015) indicated that early childhood mental health research had developed rapidly over the past 20 years. Practitioners and researchers who work with this population have contributed to understanding trauma and early childhood mental health. However, the information gained by mental health professionals has been slow to move into the field of ECCE, in part, because of the differences between the ECCE systems. Phillips and Lowenstein (2011) reported that current ECCE programs in the United States emerged from two major policy streams with different historical origins, goals, and funding sources.

The movement for early education began in the 1800s in Europe with Friedrich Froebel's work (1782 – 1852) in Germany and Maria Montessori's (1870 – 1952) in Italy (Kamerman, 2006). Child care in the United States began with women moving into the workforce during WWII. Rhodes and Huston (2012) identified landmarks in the early care and education movement. Early education programs were initiated in the 1960s as

part of President Lyndon Johnson's War on Poverty. Several programs were created aimed at educational support and interventions for young children and their families living in poverty. They included: the Head Start Economic Opportunity Act of 1964, Sesame Street Workshop® (1969), and early childhood-focused research projects, among them the Perry Preschool Project (1962) in Ypsilanti, Michigan, and the Abecedarian Project (1972) in Chapel Hill, North Carolina.

It is recognized that the first three years of life are critical to optimizing brain growth and development and that this period of the lifespan has a lasting influence on an individual's life (Centers for Disease Control and Prevention, 2020b; Center on the Developing Child, 2007; National Research Council and Institute of Medicine, 2000). The use of imaging technology in neurobiology provided the opportunity to examine the developing brain. According to Halfon, Schulman, and Hochstein (2001), the years from 1990 to 2000 have been labeled the 'decade of the brain.' In this time frame, the scientific understanding of brain development accelerated aggressively.

The 1990s brought a resurgence in the focus on early care and education. The Head Start Expansion and Quality Improvement Act was passed in 1990. In 1995, Early Head Start, an expansion of Head Start, was created to support families with infants, toddlers, and pregnant women (Rhodes & Houston, 2012). In addition, state prekindergarten programs were initiated to prepare at-risk children for formal schooling (Barnett, 2011). Maxwell, Lim, and Early (2006) indicated that in 2002 President Bush sponsored the federal government passage of the early childhood initiative *Good Start, Grow Smart*, a companion to Public Law 107 – 110 No Child Left Behind (NCLB) Act of 2001. "Both sets of legislation emphasized quality and focused national attention on

the importance of 'highly qualified teachers in children's educational success" (Maxwell et al., 2006, p. 1).

Researchers have shown that a well-trained and knowledgeable workforce is a critical quality component of any ECCE program (Martinez-Beck, & Zaslow, 2006). Friedman-Krauss et al. (2019) found a wide diversity in the educational requirements for early childhood teachers. According to a joint statement by the NAEYC and the National Association of Child Care Resource and Referral Agencies (NACCRER, 2011), the professional development of the early childhood workforce varies considerably. Some are graduates of technical programs, while others take college courses or enroll in degree programs. Some teachers and administrators have college degrees in early education or related fields. Still, others have no prior related education. The majority of the early childhood workforce participates in yearly training (NACCRER, 2011).

Gerrity and Folcarelli (2008) reported that childhood trauma is a painfully common problem, both domestically and internationally. Although some children are at greater risk of experiencing trauma than others, traumatic events happen to children of all ages, socioeconomic groups, racial and ethnic groups, and geographic regions in the United States. According to Erdman et al. (2020) almost all teachers will work with a child or family who has been impacted by trauma, and research corroborates that the intervention and support a young child receives will make a-significant difference. Most educators, however, have not been educated in relevant strategies for managing traumatic reactions in young children (Early et al., 2007). Providers of professional development must respond to early childhood teacher needs. Limited research has focused on the

content and quality of training that improves ECCE teacher competencies (Early et al., 2007).

Statement of the Problem

Because early care and education teachers play a critical role in young children's social and emotional development, they are often on the front lines of observing children's behaviors and their interactions with peers, other adults, and the environment. ECCE personnel often recognize or identify a need, a challenge, or a red flag in a young child's development. The American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents (2008) indicated that most children and adolescents with traumatic exposure or trauma-related psychological symptoms are not identified and do not receive any help. While there is significant research about the development of young children and early childhood learning options, there is limited research focusing on how well early childhood teachers are prepared to work with students who have experienced trauma. Zero to Three (2021) reported that until recently, the efforts and funding to provide mental health training were focused on mental health professionals and clinicians, with limited training provided to ECCE providers.

Purpose of the Study

This qualitative study explored ECCE teachers' perceptions about the adequacy of the training they received to work with young children who have experienced trauma. Four purposes guided the current study. The first purpose was to investigate ECCE teachers' perceptions of how trauma has impacted young children in early childhood center-based programs. A second purpose was to explore ECCE teachers' perceptions

about the information and skills needed to meet the needs of young children who have experienced trauma. The third purpose was to identify ECCE teachers' perceptions about professional development opportunities available to them that provide preparation to meet the needs of young children who have experienced trauma. Finally, the fourth purpose was to examine the perceptions of ECCE teachers about the challenges they face in accessing professional development to aid them in working with young children who have experienced trauma.

Significance of the Study

There is limited research about the preparation of ECCE teachers related to working with young children who have experienced trauma. This study added to the body of literature on the professional development of ECCE teachers who work with young children who have experienced trauma. ECCE teachers may be interested in the current study results as they seek training and support for the challenges they experience when acquiring training and support for working with children who have experienced trauma. The study results may guide early childhood administrators to emphasize and provide professional development for ECCE educators that focuses on the impact of trauma on early childhood instruction. The study results may guide parents of young children to form partnerships with early childhood teachers to meet the needs of their children who have experienced trauma. Individuals and organizations who provide professional development to ECCE providers may be interested in the current study results as they design professional development opportunities for ECCE teachers of young children who have experienced trauma. Individuals and organizations that provide mental health services for children and families who have experienced trauma may be

interested in the current study results. State and national officials and policymakers who determine funding and policies for the well-being of young children and their families, quality early childhood care and education, including professional development, and infant-toddler mental health services, may be interested in the results of the current study. Individuals and organizations who advocate and support young children and their families, the early education workforce, and mental health professionals may also be interested in the current study results.

Delimitations

Lunenburg and Irby (2008) defined research delimitations as the self-imposed boundaries that the researcher determines. The sample for the current study was limited to ECCE teachers employed in early childhood center-based programs in Johnson County, Kansas, from January 2020 through December 2020. The sample was limited to ECCE teachers with two or more years of experience working directly with young children in an ECCE environment. Only teachers who had contact with young children who have experienced trauma were included in the study. The study sample included ECCE teachers who voluntarily chose to participate in personal interviews.

Assumptions

"Assumptions are postulates, premises, and propositions that are accepted as operational for purposes of the research" (Lunenburg & Irby, 2008, p. 135). The following assumptions were made regarding this study:

1. The sample was representative of ECCE teachers employed in center-based child care programs in Johnson County, Kansas.

2. The ECCE education teachers participating in personal interviews understood the questions and answered honestly.
3. All participants in the current study had contact with at least one child who had experienced trauma during their employment in an early learning center-based program between January 2020 and December 2021.

Research Questions

Creswell (2014) stated that research questions "narrow the purpose statement and become major signposts for the readers" (p. 151). Four research questions guided the current study:

RQ1. What are the perceptions of ECCE teachers about how trauma has impacted young children in early childhood center-based programs?

RQ2. What information and skills do ECCE teachers perceive they need to meet the challenges and needs of young children who have experienced trauma?

RQ3. What professional development opportunities do ECCE teachers perceive are available to them that provide knowledge and skills to work with young children who have experienced trauma?

RQ4. What challenges do ECCE teachers perceive they face in accessing professional development to aid them in working with young children who have experienced trauma?

Definition of Terms

Several definitions are provided in the following section to provide a common understanding of words and terms used throughout the current study. "Consistent

terminology and definitions have emerged as a critical issue for the early education field" (The NAEYC & NACCRRA, 2011, p. 3).

Center based. Research Connections (2020) used the term center-based to refer to child care provided in nonresidential group programs, such as public or private schools, churches, preschools, daycare centers, or nursery schools.

Early childhood education (ECE). Gwynedd Mercy University (2020) defined ECE as "the period of learning and care that takes place from birth to 8 years old" (para. 2).

Family child care. Rhodes and Huston (2012) and Research Connections (2020) used the term family child care to identify child care provided in a home setting. Family child care homes provide care for one or more children in the caregiver's home. Family child care may be paid or unpaid, regulated or unregulated, listed or unlisted.

In-service training. Research Connections (2020) referred to in-service training as professional development outside of a credentialing program that early childhood teachers attend to strengthen their skills and update knowledge and practices in the field. A specified number of in-service training hours are generally required for early childhood professionals to maintain program licensure or certification.

Professional development. Research Connections (2020) referred to professional development as a continuum of learning and support activities designed to prepare individuals for work with, and on behalf of, young children and their families and ongoing experiences to enhance this work. "Professional development encompasses education, training, and Technical Assistance (TA), which leads to improvements in the knowledge, skills, practices, and dispositions of early education professionals" (para.

139). Professional development may include workshops, conferences, onsite technical training and assistance, professional learning communities, online coursework, books, and professional journals (LeeKeenan & Chin Ponate, 2018).

Trauma. Bartlett and Sacks (2019) described trauma as one possible outcome of exposure to adversity. According to Bartlett and Sacks, trauma occurs when a person perceives an event or set of circumstances as extremely frightening, harmful, or threatening emotionally, physically, or both.

Traumatic event or experience. Buss et al. (2015) cited the National Library of Medicine (2013) when they described a traumatic event or experience as "one that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs" (p. 2). In addition, according to the National Child Traumatic Stress Network Schools Committee (2008), situations that can be traumatic include:

- Physical or sexual abuse
- Abandonment, betrayal of trust (such as abuse by a caregiver), or neglect
- Neglect
- The death or loss of a loved one
- Life-threatening illness in a caregiver
- Witnessing domestic violence
- Automobile accidents or other serious accidents
- Bullying
- Life-threatening health situations or painful medical procedures

- Witnessing or experiencing community violence (e.g., shootings, stabbings, robbery, or fighting at home, in the neighborhood, or at school)
- Witnessing police activity or having a close relative incarcerated
- Life-threatening natural disasters
- Acts or threats of terrorism (viewed in person or on television)
- Living in chronically chaotic environments in which housing and financial resources are not consistently available. (p. 7)

Young children. IGI Global (2020) provided three definitions of young children:

- Children birth to eight years.
- The age range of children who are typically age four to eight and are enrolled in pre-kindergarten through third grade in school.
- Children aged from birth to five years of age (p. 1).

Organization of the Study

This dissertation is organized into five chapters. Chapter 1 provided an introduction, including the background, statement of the problem, the purpose of the study, the significance of the study, delimitations, assumptions, the research questions, and definition of terms. Chapter 2 provides a review of the literature as it applies to the definition of ECCE; the history and development of ECCE; the description of the ECCE workforce and programs; the description of quality ECCE; the professional development of ECCE teachers; young children's social and emotional development; description of trauma experiences in young children; the history and development of mental health services; and mental health services for young children. Chapter 3 describes the methods used to conduct the study, including the research design, setting, sampling procedures,

instrument, data collection procedures, data analysis and synthesis, reliability and trustworthiness, researcher's role, and limitations. Chapter 4 presents the results of the data analysis. Chapter 5 provides a study summary, findings related to the literature, and conclusions.

Chapter 2

Review of the Literature

The purpose of this qualitative study was to examine ECCE teachers' perceptions of how trauma impacts young children in ECCE center-based programs and the training ECCE teachers receive to work with young children who have experienced trauma. Four purposes guided the current study. The first purpose was to investigate ECCE teachers' perceptions about how trauma has impacted young children in early childhood center-based programs. The second purpose was to explore ECCE teachers' perceptions about the information and skills needed to meet the needs of young children who have experienced trauma. The third purpose was to identify ECCE teachers' perceptions about professional development opportunities available to them that provide preparation to meet the needs of young children who have experienced trauma. The final purpose was to examine the perceptions of ECCE teachers about the challenges they face in accessing professional development to aid them in working with young children who have experienced trauma.

Prior to the development of this study, an extensive review of the literature was conducted. The summary of the literature begins with a definition of ECCE, the history and development of ECCE; the description of the ECCE workforce and programs; and the description of quality ECCE. Next, an explanation of the professional development of ECCE teachers is provided. This section is followed by an overview of young children's social-emotional development and a description of trauma experiences in young children. Finally, the literature review concludes with the history and development of mental health services and mental health services for young children.

Definition of ECCE

According to White (1975), the care and education of young children have been the role and responsibility of families since the beginning of human time. Bornstein (2012) stated, "Some demands on parents are universal. For example, parents in all societies must nurture and protect their young" (p. 5). However, not all children have been nurtured and protected throughout history.

Cultures, historical events, scientific discoveries, and financial status determine who or what institutions assumed or were assigned the responsibilities associated with early child care. Heywood (2001) stated that any child's care and education were the fate of an era's religious, economic, political, and scientific beliefs. Phillips and Lowenstein (2011) and Michel (2011) indicated that families' socio-economic status has determined who will provide care for young children, the goals, and the quality of early care and education services throughout the centuries.

In the 21st century, the phrases *child care* and *early childhood education* have been used to describe young children's experiences in settings they were placed in while their parent or guardian managed work, school, or civic responsibilities (NAEYC, 2020). Rhodes and Huston (2012) stated that many child care environments are intended to promote development and learning, and many early education programs support parents while employed. Learning results from each one of a child's experiences. The profession has advocated defining such experiences for young children with comprehensive descriptions such as 'early learning' and 'early childhood care and education (NAEYC, 2020).

History and Development of ECCE

Heywood (2001) indicated that for centuries, the early years of development were viewed as the preparation for adulthood and only as a means to an end, becoming a productive member of society. In many cultures, there was little value placed on children before the age of 18. Demause (2002) stated that for hundreds of years infanticide was practiced due to economic burden, perceived lack of value, or religious sacrifices. Obladen (2016) stated that in the 300s, the emperors Constantine and Valentinian moved to outlaw infanticide. For hundreds of years, regardless of socio-economic status in the western world, a solid Christian belief was held that children were inherently evil. Beating and torture were implemented daily to purge wickedness or force submission (Grille, 2006; Heywood, 2001).

According to Heywood (2001), before the 19th century, the years prior to 17 years of age were given little attention. Children were viewed as miniature adults, biding time until the young human could be a productive member of the community. "The moment children could survive without the care and attention of their mothers or nannies, somewhere between the ages of 5 and 7, they were launched into the great community of men" (Heywood, 2001, p. 11). Children joined adults in their leisure activities and trades by living and working with fully trained people. By today's standards, the care and education of children prior to the 19th century are viewed as abusive and intolerable (Demause, 2002). As humankind's understanding of the world broadened, the status of children slowly evolved (Grille, 2006).

Before the 1500s, the care and education of children depended on the knowledge and wisdom of the elders' and wives' tales (Mechling, 2021). The term wives' tale (2021)

was defined as “a belief, usually superstitious or erroneous, passed on by word of mouth as a piece of traditional wisdom” (para. 4). As cultures emerged across the world and communities were established, the care and education of children continued to rely on elders' wisdom, family traditions, and old wives' tales. The reliance on experts occurred with the scientific revolution of the 16th century, the creation of universities, and the mass publication of the written word (Mechling. 2021). In addition, the artists, storytellers, and poets of the late 18th and early 19th centuries offered a romantic view of childhood that was an unrealistic portrayal of the status of children (Heywood, 2001).

Throughout most of human history, children have been apprentices and indentured servants in agriculture and the trades (Child Labor, 2020). Children were taught the skills and trades of their parents or caretakers. As the U.S. was being colonized, children were essential to the labor force. The founders of the 13 colonies believed in a Puritan work ethic, and they valued hard work over idleness. This mindset applied to children as well. As a result, child labor prevailed throughout history, reaching its peak during the Industrial Revolution (Child Labor, 2020).

Child care manuals flourished in the 19th century due to an upsurge in male pediatricians and obstetricians. At no time in antiquity had men of medicine held keen regard for the care of ordinary women and children. Instead, they produced books to prove themselves and justify being superior to the lowly midwife (Oneill, 2013).

ECCE programs in the United States developed with different goals, unique historical origins, and varied funding sources. “ECCE programs in the U.S. evolved out of diverse historical streams including child protection, early childhood education services for children with special needs, and services to facilitate mothers’ labor force

participation" (Kamerman & Gatenio-Gabel, 2007, p. 26). According to Michel, 2011), one stream provided interventions to enhance children's well-being and development. In the 19th century, the Industrial Age, early care emerged as the working classes needed places for their children to be housed while employed. Child care in America included an array of formal and informal arrangements commonly connected with immigrants, the poor, and minorities and was classified as custodial and charitable (Michel, 2011). According to Cahan (1989), the first efforts in early care were nurseries. These were charitable inventions to save or rehabilitate indigent children (Cahan, 1989). The first early education programs were nursery schools founded in Massachusetts in the 1830s. Later, kindergarten programs were established based on Froebel's work (Kamerman, 2006). Gradually, early education programs increased to offer an enhanced experience to middle-class families (Child Care Lounge, 2018; Kamerman & Gatenio-Gabel, 2007; Michel, 2011).

By the mid-1800s, the long-term consequences of child labor on children's education and health provoked reformers, labor groups, teachers, and churches (Paul, 2017). The University of Iowa Labor Center (2004) reported that child labor reform and union organizing were often intertwined. Their shared initiatives were undertaken by organizations directed by middle-class consumers and working women. During the Great Depression, the deep-rooted conventions of child labor were disrupted because Americans desperately needed jobs (Child Labor, 2020). The National Child Labor Committee's efforts to end child labor was integrated with endeavors to provide no cost required education for all children. This was

accomplished in the passage of the Fair Labor Standards Act in 1938 (University of Iowa Labor Center, 2004).

Beginning in the early and middle 19th century and emerging mainly after World War II a predominant theme was the transition from private charity to public responsibility (Kamerman, 2006). Government involvement moved from child labor protection to child care to support working families. Kiesling (2019) stated that during the Depression, the Works Progress Administration ran a federal and state collaborative program of nursery schools to create jobs. World War II moved women to the workforce, although women with young children were discouraged from participating in the war effort. Kiesling (2019) noted, "The official position of many people in government was that women with young children should be the last people brought into the labor force" (para. 9). Ertman (2019) reported that the U.S. Senate passed the first and only national child care program on June 29, 1943. $20,000,000 was allocated to provide public child care for employed women. With the end of World War II, government funding of child care services ended (Ertman, 2019).

According to the National Research Council and Institute of Medicine (2000), the structured study of infant behavior appeared in the early to the mid-20th century. At that time, researchers in both embryology and evolution posed critical questions about the origins and development during the lifespan of humans. By the 1920s, pediatricians, educators, and social workers were deepening their interaction with psychologists in the field of child studies which resulted in the creation of a dynamic, multidisciplinary, scientific discipline (Zeanah & Zeanah, 2019). Following World War II, technological advances marked the dawn of the Technological Revolution

(Doncaster, 2021). However, in 1958 few psychologists intentionally undertook research with children younger than three years old. Although somewhat mindful of infant care, society remained unfamiliar with any unique educational relevance of the early years (White, 1975).

Alleyne (2016) and the Center for Substance Abuse Treatment (2014) described the 1960s as an era of social revolution. African Americans, women, and individuals with disabilities advocated for rights and services. President Lyndon Johnson declared the War on Poverty. White (1975) summarized the role of early care and education through the 1960s. He stated that daycare was extensively established to meet the needs of parents instead of the child. The early care and education field weathered the roller coaster of government legislation proposed, ignored, passed, expired, and not reauthorized (First Five Years Fund, 2021a). Labor market policy, public (social) assistance policy, education policy, child welfare policy, and child development research expanded ECEC policies and programs (Kamerman & Gatenio-Gabel, 2007). Rhodes and Huston (2012) described numerous intervention programs targeting children of families living in poverty initiated through federal funding. Head Start, Sesame Street, and research demonstration models were created. All initiatives had a similar goal - to break the cycle of poverty by educating adults and children and improving living standards in lower socio-economic communities (Rhodes & Huston, 2012). In addition, Parents as Teachers (1981) emerged providing a home visiting program to young children and their parents regardless of socio economic status. The program goals included increase parent knowledge of early childhood development, enhance parenting skills,

identify developmental delays, aid in a child's school readiness and success, and prevent child abuse and neglect (Hackett, 2011; Parents as Teachers, 2021).

The 1990s brought a renewed focus on young children. Reid (2019) noted that in 1989 the United Nations ratified the Convention on the Rights of the Child, which guaranteed the protection of children's rights to grow and thrive. The movement gained momentum with the World Conference on Education for All in Jomtien, Thailand. According to Kamerman (2006), the Jomtien Declaration (1990) and Dakar Framework for Action (2000) launched a dynamic initiative to educate all. At the forefront was the tenet that access to preschool education was a lawful right.

Scientific advances in neuroimaging elevated the importance of the early years of child development (Shore, 1996). As a result, brain development became a new field of study. Hustedt and Barnett (2011) reported that with the growing recognition that poverty's disadvantages begin well before age 3 or 4, Early Head Start (EHS) was introduced in 1995. In addition, state pre-kindergarten programs were created. The goal was to prepare four-year-old children at risk of low achievement (e.g., from families with low incomes, children with special needs, or limited English proficiency,) for K -12 formal schooling (Hustedt & Barnett, 2011).

As the new millennium began, Congress passed Public Law 107 – 110, the No Child Left Behind (NCLB) Act of 2001. In addition, the added focus was placed on early care and education with the Bush administration's initiative *Good Start, Grow Smart* (The White House, 2002). Three major areas were addressed in the law and Bush initiative: strengthening Head Start, partnering with states to improve ECCE, and providing information to caregivers, teachers, and parents.

Kamerman and Gatenio-Gabel (2007) cited multiple factors in the expansion of ECCE programs. These included the increase of single and married mothers in the labor market, the welfare reforms that required mothers to work, and the focus on the impact of early learning and future school success. The National Academies of Sciences, Engineering, and Medicine (2018) noted, "Each purpose has been reflected in the evolution of early care and education over the past century and has been prioritized differently in various early childhood education policies over time" (p. 2). According to Kamerman (2006), the result has been a fragmented ECCE system. Multifaceted societal beliefs and explicit funding reinforced the differences. The last 25 years substantiated the need for a cohesive early care and education system. ECCE authorities and proponents are steadily more convinced of the need to incorporate all these program types (Kamerman, 2006).

Professional and consumer organizations and associations have struggled to raise public consciousness for quality ECCE and educational and financial resources for parents and providers. The efforts by NAEYC, the Children's Defense Fund, and Zero to Three have been critical in impacting public awareness and government policy. Moreover, as the world's population copes with the impact of the global pandemic, greater focus has been placed on the essential role of ECCE not only on the lives of children but the socio-economic well-being of the nation (Guarino, 2021).

Description of ECCE Workforce and Programs

A joint statement by NAEYC and NACCRRA (2011) described the ECCE workforce as individuals:

> working with young children (infants, toddlers, preschoolers, and school-age children in centers, homes, and schools) and their families or on their behalf (in agencies, organizations, institutions of higher education, etc.), with a primary mission of supporting children's development and learning. (p. 5)

According to the Institute of Medicine and National Research Council (2012), "Terminology can be problematic with such a wide spectrum of work represented, even among the members of the workforce themselves" (p. 6). Rhodes and Huston (2012) stated, "Labels for people who work in this field include 'teacher,' 'child care worker,' 'daycare provider,' and 'babysitter,' among many others" (p. 11). NAEYC (2009) stated that the term *teacher* is always intended to refer to any adult responsible for the direct care and education of a group of children in any early childhood setting. Teachers are not only individuals in a classroom but also include family providers, infant/toddler caregivers, and specialists in other disciplines who fulfill the teacher's role.

Maroto and Brandon (2011) estimated that the employed ECCE workforce includes 2.2 million individuals who comprise 31% of the total U.S. teaching workforce for all age groups (infants and toddlers through college-level students). Fifty-one percent work in center-based programs, 27% are paid relatives, 12 % are nonrelatives in family child care settings, and 11% are individuals working in the child's home (Maroto & Brandon, 2011). The Institute of Medicine and the National Research Council (2012) noted that researchers in the field have indicated that the definitions of child care workers and preschool teachers do not reflect the reality of their work, especially the overlap in their respective roles. Erdman et al. (2020) acknowledged, "All educators who work with children and their families are professionals" (p. 1).

Administrative organization and the funding stream determine the setting or function of an early care and education program (Rhodes & Huston, 2012). Vandell (2004) stated that early care and education settings might be grouped into three wide-range categories: center-based, family child care, and in-home care. Multiple funding streams finance early care and education services. They include family fees, federal and state allocations, and independent financial resources (National Academies of Sciences, Engineering, & Medicine, 2018).

Cui and Natzke (2020) reported that young children participate in multiple kinds of early care and education settings before they enroll in kindergarten. Several children attend center-based environments such as Head Start programs, child care centers, or preschools. Others are looked after in relatives' or nonrelatives' homes or are regularly taken care of only by their parents (Cui & Natzke, 2020). DeBord (n.d.) stated that group care for two or more children is usually provided in child care centers. A program may be established in a facility planned explicitly for the care of multiple children or a church, school, or home. ECCE centers may be identified as community-based, Early Head Start, faith-based, Head Start, military child care, nursery school, preschool, public preschool, therapeutic preschool, and corporate care (Child Care Aware of Kansas, 2019; Kamerman & Gatenio-Gabel, 2007). The faith-based programs are part-time or full-time early childhood programs affiliated with or supported by a church or other religious organization (DeBord, n.d.). Military Child Care is ECCE available to families serving in the armed services. Programs were regulated and supported by the Department of Defense (Research Connections, 2020).

According to Research Connections (2020) and Rhodes and Huston (2012), Head Start and Early Head Start are federally funded programs that provide comprehensive services to low-income families. Services included early childhood education, health and nutrition, mental health, and parent engagement. In addition, early Head Start targets pregnant women and families with infants and toddlers to support optimal child development while helping parents/families move toward economic independence. Federal grants that support ECCE are awarded to local public or private agencies (Research Connections, 2020).

Before attending kindergarten, children 2 ½ to 5 years of age participate in early care and education in preschool. DeBord (n.d.) reported that originally preschools were half-day programs. As early care and education services were expanded, long-standing programs offered full-day activities and retained 'preschool' or 'nursey' in their business name. Preschools may be publicly or privately operated and may receive public funds (DeBord, n.d; Research Connections, 2020). Publicly-funded preschool programs typically serve children from disadvantaged families. In contrast, private preschool programs supported by parent fees are more likely to serve children from all backgrounds, and the focus is more on the child than on providing support to the family (Kamerman & Gatenio-Gabel, 2007). Therapeutic preschools and special needs services meet the unique needs of children who have identified disabilities and learning challenges as determined by the Individuals with Disabilities Education Act (IDEA, 1975), Part B & C. Special education, individualized instruction, and support services occur in the classroom, at home, in medical facilities, or other settings (Research Connections, 2020).

Family child care is offered in a home environment for a small group of children in the provider's home (Research Connections, 2020). Per state regulations, programs may be licensed, regulated, or not licensed or regulated. The caregiver may or may not be trained in child care and development. In rural areas, the primary setting of available child care is provided by relatives or family child care homes (DeBord, n.d.). In-home providers **(**identified as babysitters, nannies, and extended family) provide care for children in the child's place of residence and may or may not be trained in child development or child care (DeBord, n.d.).

The National Academies of Sciences, Engineering, and Medicine (2018) stated that early care and education fulfilled numerous functions in the United States: facilitating child development, supporting parental employment, and encouraging investment in the future workforce. According to Kamerman and Gatenio-Gabel (2007), in the United States, excluding the government, there are many foundations, private advocacy, public policy, research, think-tank, and university organizations-focused on early childhood education and care policies. With the vast number of stakeholders and multiple objectives of ECCE programs it may be challenging to succinctly describe the ECCE workforce.

Definition of High-Quality ECCE

High-quality ECCE dramatically impacts a child's development and well-being (First Five Years Fund, 2021b). One of the more constant and prevalent findings in the research connects the quality of child care that children are provided to nearly every assessment of development that has been investigated (National Research Council and Institute of Medicine, 2000). Zeanah and Zeanah (2019) reported that language and

cognitive outcomes in young children, along with behavior and social outcomes, are linked with the quality of care. Van der Kolk (2014) stated that the quality of early caregiving is highly critical in thwarting mental health problems, distinct from other traumas.

All ECCE programs, nonprofit and for-profit child care centers, public schools, and family care providers can provide high-quality early childhood education for children. In the United States, there are considerable differences between early education settings. The approach to quality is not-one size fits all, and quality is not limited to one type of program (Workman & Ullrich, 2017). Kamerman and Gatenio-Gabel (2007) stated that across school-based pre-kindergarten, Head Start, and center-based programs, there is no consensus on the definition of or standards regarding the quality of the ECCC settings.

The National Research Council and The Institute of Medicine (2000) provided a joint statement that indicated that when studies of child care quality are reviewed, three categories emerge: the child-provider relationship, the established nuances and procedures for care, and the local policy framework. Kamerman and Gatenio-Gabel (2007) stated that subjective and quantifiable variables are used when assessing quality in centers. Subjective variables require direct observation of indicators such as staff-child interactions and relationships. Quantifiable variables include adult-child ratios, group size, staff qualifications (education and training), salaries, and turnover rates. These dimensions of quality can be regulated and counted.

NAEYC (2020), Research Connections (2020), and Early Childhood Education (2020) identified additional characteristics of high-quality ECCE programs, which included:

- A clear statement of goals and philosophy that is comprehensive and addresses child development areas.
- A safe, nurturing, and stimulating environment, with the supervision and guidance of competent, caring adults.
- A strong foundation in language development, early literacy, early math, and each child's family background.
- Developmentally appropriate practices include environments, activities, and adult-child interactions adapted to meet a specific group of children's age, characteristics, and developmental needs.

Burchinal, Kainz, and Cai (2011) described factors of quality child care that included close teacher-child relationships, frequent sensitive interactions between the child and the teacher, respectful and effective behavior management, well-designed instruction, and a rich physical learning environment. Boothe Trigg and Keyes (2019) included an additional factor, "Quality child care demands individualized care of infants and young children, which translates into low teacher-student ratios" (p. 604). Meeting the physical and emotional needs of very young children, such as feeding, diapering, comforting, and carrying a non-mobile child, requires engaging one child at a time rather than small or large group activities.

Research Connections (2020) stated that consistency and limiting transitions in a child's early years promote the profound human connections that young children require

for optimum early brain development, self-regulation, and learning. The caliber of care fundamentally depends on the quality of the relationship between the early care and education staff member and the child (The National Research Council and The Institute of Medicine, 2000). An enticing environment and a phenomenal curriculum can be compelling. However, positive development will not be fostered without adept and consistent child care providers (The National Research Council and The Institute of Medicine, 2000).

ECCE Teacher Professional Development

The National Research Council and The Institute of Medicine (2000) jointly stated that a teacher's level of preparation and currently focused education in child development had been repeatedly linked with high-quality interactions and children's development in all early care and education settings. Professional development refers to a range of educational and resource activities developed to prepare individuals to care for, work with, and advocate for young children and their families, as well as improve practices in the field. Professional development includes education, training, and technical assistance (TA), which results in better knowledge, skills, strategies, and qualities for early education professionals (Research Connections, 2020).

Rhodes and Huston (2012) stated, "Professional development and institutional supports are needed to foster a strong ECCE profession and high-quality ECCE" (p. 4). However, there are discrepancies in the education requirements for ECCE teachers across programs in the United States. Rhodes and Huston (2012) indicated: "The ECCE workforce is highly diverse and some characteristics, particularly educational attainment and qualifications, vary by sector" (p. 5). The Institute of Medicine and The National

Research Council (2012) jointly identified the ECCE workforce as a range of people who, on one end of the continuum, have minimal training and primarily provide child care devoid of a focus on educational aims. On the other end, individuals with concentrated advanced degrees provide well-designed learning activities, with many others in the middle. Kamerman and Gatenio-Gabel (2007) reported that in 10 states, no special training is required for ECCE teachers, and in 20 states, a bachelor's degree is not required of pre-kindergarten teachers.

State licensing, regulatory bodies, and organization administrators determine the employment and education requirements for ECCE teachers. For example, the Kansas Department of Health and Environment (KDHE, 2020) identified the education and training requirements for all staff working in licensed preschool and child care programs in the state (see Appendix A). The minimum educational requirement for staff members working with children is a high school diploma or the equivalent. Within Kansas licensing, there are variations in education and experience that allow teachers to be lead teachers in classrooms of infants, toddlers, two-year-olds, and preschoolers (KDHE, 2020).

According to the KDHE (2020), regardless of the new staff member's background, the individual must participate in orientation or pre-service training. Research Connections (2020) described pre-service training as the educational experiences that an ECCE "staff member may undergo prior to assuming a particular role or position within a child care program" (para. 135). KDHE (2020) child care licensing requires that each employee or volunteer working with children shall complete orientation within seven calendar days of the start date. Orientation topics include

licensing regulations, the policies and practices of the early care and education program, including emergency procedures, behavior management and discipline, the schedule of daily activities, care and supervision of children in care (including any special needs and known allergies), health and safety practices, and confidentiality. Pre-service training or orientation is usually provided by the employer or hiring body (Child Care Aware® of America, 2016; KDHE, 2020)

When early education programs were part of the public school system, the criteria for educational requirements and compensation for the preschool teacher were similar to K-12 teachers (Rhodes & Huston, 2012). Unlike the requirements for teachers in public education systems, state teacher certification is not a requirement for most ECCE teachers (Institute of Medicine and National Research Council, 2015). In addition, many positions do not require a bachelor's degree. Schonert-Reichl, Kitil, and Hanson-Peterson (2017) indicated, "Courses on child and adolescent development can be found in the majority of colleges of education in almost all U.S. states" (p. 12). According to Schonert-Reichl et al. (2017), research suggested a modicum of evidence that college students in teacher preparation programs are informed about children's and adolescents' social and emotional development.

Federal funding often carries requirements for qualifications and credentials. For example, in the reauthorization of Head Start (Improving Head Start for School Readiness Act of 2007), provisions were included to require higher qualifications for the Head Start teaching workforce (Rhodes & Huston, 2012). In addition, Kamerman and Gatenio-Gabel (2007) reported that the adaptation of comprehensive learning standards in

many states had improved preschool quality. However, variation in early education quality continues across the country.

ECCE professional development occurs through various venues in a variety of environments. Educational opportunities are provided through two-year and four-year higher education institutions to earn bachelor's or associate degrees and specialty certificates. In addition, professional organizations and child care resource and referral agencies offer credentials, certifications, and continuing education. In-service or ongoing training is professional development that early childhood professionals participate in to gain up-to-date knowledge and practices to augment their skills in the field. An ECCE program may require in-service training hours to continue employment (Research Connections, 2020). KDHE (2020) identified that 16 clock hours were needed to meet annual in-service requirements for each licensure year following 2020.

Child Care Resource and Referral Agencies (CCR&R) are local and statewide organizations, usually funded by the Child Care and Development Fund (CCDF). The agencies provide many services to the families and the ECCE professionals that serve them. Resources offered include referrals and guidance to parents seeking child care, professional development and training for early childhood professionals, mental health services, and additional educational resources for families (Research Connections, 2020). The Family Conservancy is the local resource and referral agency serving 18 countries across eastern Kansas and western Missouri. The agency's mission is to help children and families achieve a lifetime of success (The Family Conservancy, 2021). It offers families resources in early childhood care and education resources, individual and family counseling, and community-based family support services. The early care and education

workforce is supported with professional development opportunities and infant-toddler mental health consultation,

Although many individuals in the ECCE workforce are skilled and committed, their ability to provide high-quality experiences for young children is hindered by a lack of shared objectives and identity, lack of institutional support, insufficient or ineffective training, and inadequate compensation (Rhodes & Huston, 2012). The National Research Council and The Institute of Medicine (2000) jointly indicated that as the quickly emerging science of early childhood development expands, its complexity will rise, and the gap between the working knowledge of service providers and state-of-the-art science will be startling. The professional dilemmas that this creates for the early childhood field are daunting.

Young Children's' Social and Emotional Development

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (2009) stated, "Development is a window into the life of a child and lays the foundation for the life course of the mature adult" (p. 4). Human development is contingent on and stimulated by the quality of our connections with one another (Bailey, 2017). According to the National Research Council and The Institute of Medicine (2000), the foundation of healthy development is human relationships and the outcome of social connections on relationships.

Child development is defined as the *stages* by which children gain skills in the domains of physical, social-emotional, speech and language, and cognitive (Research Connections, 2020). Zeanah and Zeanah (2019) stated that among the most significant factors of the cultural framework of infant development are family beliefs,

interpretations, and explanations of a child's behavior. According to the National Research Council and The Institute of Medicine (2000), early growth involves the steady progression from total dependence on others to handling the world for us to gain the abilities required to succeed independently.

The domains of child development are not clearly defined and often overlap. The number of developmental domains identified and described is based on the field of study in which a professional is engaged (medicine, psychology, education, or mental health). Research Connections (2020) noted that developmental domains are-intertwined. What occurs in one domain impacts growth in the other domains. For this study, the researcher grouped the domains of child development into the following categories:

- Physical: the growth of the child's body, muscles, and senses and development of gross motor and fine motor skills.
- Cognitive: the ability to remember, focus, learn, problem-solve, reason, understand, and adapt.
- Receptive Language: the ability to listen and respond.
- Expressive Language: the ability to communicate non-verbally and verbally.
- Social-emotional: the expression of feelings, relationships with adults and children, and the ability to self-regulate.

Rosenblum, Dayton, and Muzik (2019) recognized that learning domains are frequently investigated separately, yet social and emotional development are inherently interwoven with all other domains. Social and emotional development is a growth process whereby children gain the competencies to recognize and identify their feelings/emotions; express and manage their own positive and negative emotions in a

constructive way; develop relationships and empathy with other children and adults; discover their environment; and self-regulate (Bailey, 2011; Niemi, 2020; Research Connections, 2020; Zero to Three, 2005). The cornerstone of early childhood development is self-regulation. It transects all domains of learning (The National Research Council and The Institute of Medicine, 2000). Conscious Discipline (2021) indicated that more than any other indicator, social-emotional skills, such as self-regulation, are a greater predicator of life success.

Healthy social-emotional development is equivalent to infant mental health (Zero to Three Infant Mental Health Task Force Steering Committee, 2001). Zeanah and Zeanah (2019) stated that behavioral indicators of infant mental health include the ability to communicate emotions to parents and teachers, independent engagement with the environment, and self-regulation. The National Research Council and The Institute of Medicine (2000) noted that the extensive array of individual characteristics among young children frequently makes it challenging to discern normal variations and developmental delays from temporary disorders and ongoing disabilities. Boothe Trigg and Keyes (2019) cited Egger and Angold (2006) who reported that approximately 12% of preschool-age children, ages 2 to 5 have social-emotional or mental health problems that contribute to perilously challenging behaviors.

Developmental milestones are age-specific tasks or a set of functional skills that experts recognize that most children should demonstrate within a certain age range (Moodie et al., 2014; NAEYC, 2020). Professionals and families may use milestones to track a child's development, behavior, and learning. Not demonstrating a specific milestone may identify a reason for concern or a possible developmental delay (Research

Connections, 2020). According to Godoy et al. (2019) a considerable number of parents of young children reported high incidences of disruptive behavior but they are more concerned about their child's delays in social-emotional development. According to Zeanah and Zeanah (2019), early child care providers are one example of a worldwide setting for enhancing social-emotional and cognitive development. Social and emotional learning is an integral part of human development and education.

Trauma Experiences in Young Children

According to Van der Kolk (2014), trauma impacts those who are closely involved and the people associated with them. Furthermore, the American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents (2008) explained that a traumatic event is a situation that threatens injury, the physical integrity of self or others, or death. In addition, it may cause helplessness, terror, or horror at the time of the occurrence.

Significant sources of childhood trauma are adverse childhood experiences (ACE). Bartlett and Sacks (2019) noted that the term ACE was conceived by researchers Vincent Felitti, Robert Anda, and their colleagues in their influential study undertaken from 1995 to 1997. Adverse childhood experiences are described as all types of abuse, neglect, and possibly other trauma experienced by children younger than 18 years of age (Bartlett & Sacks, 2019). Specific examples of ACEs include exposure to physical, emotional, or sexual abuse; physical and emotional neglect; and witnessing violence, severe mental illness, or substance misuse in the home (Centers for Disease Control and Prevention, 2020b; Houry, 2019). In addition, the National Child Traumatic Stress Network (2010) identified traumatic events that included suicides and other deaths or

losses, domestic or sexual violence, community violence, medical trauma, vehicle accidents, war experiences, and natural and human-made disasters.

Van der Kolk (2014) noted that trauma is specifically an event that overwhelms the central nervous system altering how individuals process and recall memories. High levels of chronic stress may rewire the brain's developing architecture. "Trauma is not the story of something that happened back then. It's the current imprint of that pain, horror, and fear living inside people" (Psychotherapy Networker, 2014). According to Bartlett and Sacks (2019) toxic stress can occur when a child encounters persistent and intense adversity (e.g., domestic violence, chronic neglect, severe economic hardship) without sufficient support from a care-providing adult. Van der Kolk (2014) indicated that being traumatized means chronically managing life as if the trauma were ongoing, enduring, and inflexible. The past taints each new experience or situation. A traumatic experience may be triggered by upsetting emotions or abrupt or aggressive actions. At the inkling of threats, the activated disturbed brain networks release vast amounts of cortisol which generates distressing reactions, acute physical sensations, and unpredictable and hostile behaviors (Van der Kolk, 2014).

According to Van der Kolk (2014), the feeling of being safe with other people is probably the most critical aspect of mental health. Safe connections are fundamental to meaningful and satisfying lives. Furthermore, numerous researchers have demonstrated that having a positive support system establishes the sole most robust safeguards against becoming traumatized (Van der Kolk, 2014).

History and Development of Mental Health Services

Van der Kolk (2014) indicated that society frames the interpretation of traumatic stress. Mental health treatment requires examining the cultural perspective of mental illness and the social evolution of mental health. During the nineteenth century, individuals experiencing mental illness were viewed as possessed (Doncaster, 2021). The Greek physician Hippocrates recommended that people change environments. Persons afflicted with mental illness were isolated from the community. In 1407 the first mental health facility opened in Spain (Doncaster, 2021).

Doncaster (2021) indicated that Burton wrote *The Anatomy of Melancholy*, the first medical discourse on mental welfare, in 1621. Asylums to house the mentally insane were opened in the 18th century. As early as 1780, Pinel advocated for the humane treatment of individuals with mental illness. Writings by Dorothea Dix and Nelly Bly in the mid to late 1800s created public awareness of the mistreatment and squalor found in institutions caring for the mentally ill. Treatment of patients was tortuous or nonexistent, and many practices continued through the 1960s (Doncaster, 2021; Foundation Recovery Network, 2021; Samels & MacLowry, 2002).

In the 20th century, the first scientific studies of mental illness were undertaken by Emil Kraspelin (Samels & MacLowry, 2002; Tracy, 2019). After being a patient and subjected to abuse in state mental hospitals, Clifford Beers founded Mental Health America in 1909 (Mental Health America, 2020; Samels & MacLowry, 2002). The organization proved to be a driving force in care and advocacy for mental health services. Freud (1856-1939) and Jung (1875-1961) contributed psychoanalytic theories and

therapies (Samels & MacLowry, 2002). The 1930s introduced electroshock and cold water therapies (Foundation Recovery Network, 2021).

President Truman signed the Mental Health Act in 1947, which created the National Institute of Mental Health. Treatment of the mentally ill changed in the 1950s (Foundation Recovery Network, 2021). State hospitals were deinstitutionalized, and the first antipsychotic drugs were available. The care and treatment of individuals in need of mental health services moved to community mental health centers, psychiatric hospitals, correctional facilities, and homelessness (Foundation Recovery Network, 2021; Lumen Learning, n.d.).

The experiences of WWI and WWII veterans brought to light the impact of trauma on human behavior. Psychologists and psychiatrists studied and recorded the accounts of soldiers returning from wars. Van der Kolk (2014) reported that in 1941 Kardliner-wrote *The Traumatic Neuroses of War,* describing the *shell shock* experienced by WWI veterans. Today, veterans' traumatic experiences are referred to as post-traumatic stress disorder (PTSD). Before the 1960s, studies and publications reporting PTSD were not frequently published (Van der Kolk, 2014).

Mental Health America (2020) indicated that Congress and advocacy groups paved the way for mental health treatment and services offered in the 21st century. In 1955 Congress created the Commission on Mental Illness and Mental Health, followed by the Community Mental Health Act in 1963 (Mental Health America, 2020). Consumers founded the National Alliance for the Mentally Ill in 1979 (Samels & MacLowry, 2002). Through the 1970s and 1980s, the mental health needs of men and women returning from the Vietnam War precipitated professional and public

acknowledgment of the behaviors associated with trauma (Magruder et al., 2015; Tull, 2020). According to Van der Kolk (2014), 1980 was a turning point when a group of Vietnam veterans, assisted by the New York psychotherapists Robert J. Lifton and Chaim Shatan, successfully lobbied the American Psychiatric Association to establish a new diagnosis: post-traumatic stress disorder (PTSD). PTSD was defined as common characteristics experienced, to some degree, by all veterans. Concurrently, health professionals, psychiatrists, and therapists provided therapy and counseling to women who revealed they were sexually abused as a child (Van der Kolk, 2014). Individuals having experienced physical, emotional, and sexual abuse as children were heard. Their behaviors were recognized and identified, and efforts were made to provide support and therapy (Center for Substance Abuse Treatment, 2014; Van der Kolk, 2014). Congress passed the Protection and Advocacy for the Mentally Ill Act in 1985, and in 1990 the Americans with Disabilities Act (Mental Health America, 2020).

Van der Kolk (2014) reported that since the 1990's brain imaging tools have shown what happens inside the brains of traumatized people. These scans proved essential in understanding the damage inflected by trauma and influenced the development of entirely new avenues of recovery and healing. De Young et al. (2011) found that despite decades of statistical data, counselors generally have limited knowledge of the impact of traumatic events on younger children compared to older children and adolescents. Zeanah and Zeanah (2019) reported that the DSM-5 (American Psychiatric Association, 2013) has made a definitive endeavor to be more developmentally responsive and included a sub classification of post-traumatic disorder defined for preschool children. Generally, the revisions are comparatively small. In

comparison, Zero to Three (2016) published *DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, and in 2021 released *DC:0–5™ Version 2.0*. These publications focused significant attention on the mental health and disorders of children from birth through 5 years of age. Over the past 20 years, research in early childhood mental health has advanced expeditiously. Researchers and practitioners who work with young children offer insights into trauma and early childhood mental health (Buss et al., 2015)

Mental Health Services for Young Children

Throughout the ages, little attention has been given to children's mental health needs (Zeanah & Zeanah, 2019). In 1910, Mental Health America facilitated the opening of over 100 Child Guidance Clinics aimed at preventing mental health issues, early intervention, and treating children (Mental Health America, 2020). In the years that followed, limited information on infant mental health was available. In 1975 Dr. Burton White wrote that he could not recommend anyone for children's mental health issues. Instead, White recommended Dr. Spock or a pediatrician or personal family physician when it was a matter of physical health issues. White explained that child psychiatrists usually do not work with children younger than three years of age, although programs may be identified for the treatment of emotional disabilities. According to White, sometimes a program for the early treatment of emotional disabilities or potential emotional handicaps may be found. Regrettably, there is little to offer parents beyond emotional support and recommendations in areas of young children's mental health. Woefully, little was available regarding well-versed or skilled professionals in managing behavior disturbances (White, 1975).

Van der Kolk (2014) stated, "Until 2001, there was no comprehensive organization dedicated to the research and treatment of traumatized children" (p. 157). Congress established the NCTSN as part of the Children's Health Act (2000). Its mission was to raise the standard of care and improve access to services for children and families who experience or witness traumatic events throughout the United States (NCTSN, 2010). Barwick and Urajnik (2021) reported that socio-demographic research corroborated that many children with mental health disorders were not provided the therapy they require. Approximations gleaned from an amalgamation of epidemiological studies indicated that in the U.S only 20% of children with mental health problems receive specialized services (Barwick & Urajnik, 2021; Brinkman, 2022; Centers for Disease and Control Prevention, 2022). According to Buss et al. (2015), Scheeringa and Haslett (2010), and Zeanah and Zeanah (2019), there are several reasons for the lack of early childhood treatment options, including:

- Historically, researchers have spent little time and effort studying the impact of trauma on young children.
- Resistance to the idea that early childhood mental health is critical.
- Apprehensions in diagnosing young children with mental disorders.
- Awareness of the stigma that a trauma-related mental illness diagnosis may plague young children.
- The misconception that young children lack the cognitive skills and social maturity to understand or remember traumatic events.
- Young children may not comprehend the vocabulary or the directions used in specific assessment tools.

- Diagnostic criteria, tools, and assessments for older children and adults were not developmentally appropriate for young children.

Van der Kolk (2014) indicated the advancement of mental health services for children and adults has emerged from three branches of science. Each has led to increased knowledge about the effects of abuse, neglect, and psychological trauma. These new fields are neuroscience, the study of how the brain supports mental processes, developmental psychopathology, the study of the impact of adverse experiences on the development of the mind and brain, and interpersonal neurobiology, the study of how our behavior influences the emotions, biology, and mindset of those around us (Van der Kolk, 2014).

Infant mental health is a multidisciplinary and aggregate field of study, services, and policies regarding emotional and psychological wellness of young children from before birth to 5 years of age (Lieberman et al., 2011). The U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2020) identified mental health services as activities that address matters negatively influencing development, learning, or socialization or involve emotional disorders or dysfunctional behavior. Mental health services are usually provided by private or public mental health agencies and include residential and non-residential activities. Zeanah and Zeanah (2019) indicated that the goals of infant mental health treatment are to decrease or remove-hardship, to impede adverse outcomes (developmental delays and deviance, delinquency, school failure, psychiatric morbidity, interpersonal, isolation or conflict), and to develop healthy outcomes by improving resilience and social competence.

Children younger than five typically experience rapid developmental changes that are often misinterpreted or not fully accounted for, which hinders proper diagnosis and intervention (Zero to Three, 2005). Diagnosing young children who have experienced trauma is a complicated process. Lieberman et al. (2011) identified multiple challenges:

- the transitory developmental growth in the first 5 years of a child's life,
- the inabilities in preverbal and nonverbal children to self-report,
- the impact of empirical experience on the young child's behavior,
- the extensive amount of time required to observe current unhindered appropriate developmental milestones,
- the inaccuracies of parents and caregivers as-observers and reporters,
- and the required time and cost in observing young children in various environments.

Zeanah and Zeanah (2019) indicated that the most unique characteristic of the first years is the distinct significance of the numerous interconnected contexts (e.g., family caregiver-infant relationship, social, cultural, historical) within which young children grow. According to Boothe Trigg and Keyes (2019), many infants experience care for extended periods outside of their homes. With that in mind, out-of-home child care for infants and young children must be examined when contemplating the mental health of infants and young children. Essential topics to be considered are the quality of the care provided, the attachment to nonparent caregivers, and the focus on the quintessential social-emotional development of young children. ECCE teachers and administrators observe red flags in development or challenging behaviors (Sorrels, 2015). Kaiser and Rasminsky (2021) stated that the phrase *challenging behaviors* can refer to

several actions. Challenging behavior is any action that impedes a child's social-emotional or cognitive development; is detrimental to the child, other children, or adults; or puts a child in jeopardy for later social struggles or academic failure.

Researchers have corroborated that traumatic events can affect children. Yet, the wide-ranging counselor community appears unfamiliar with infant mental health which deters referrals for this at-risk group of young children. A counselor may not offer support services for a child in a family where domestic violence is witnessed because the clinician lacks knowledge and training to determine trauma-related mental illness in young children (Buss et al. (2015). Van der Kolk (2014) indicated that the intellectual, psychological, biological, or ethical development of children who have experienced trauma was not systematically taught to pediatricians, child-care workers, or part of graduate social work or psychology schools.

Young children access mental health services through a referral from social services, pediatricians, and ECCE professionals. Infant and Early Childhood Mental Health Consultation (IECMHC) is a strategic intervention that partners mental health professionals with early childhood professionals and families to support a young child's social and emotional development and addresses behavior and mental health concerns in ECCE programs (Raine Group, 2014; Research Connections, 2020). Support and services may include an individualized education and care plan for the child, classroom resources, coaching/mentoring with the teacher for all children, or consultation with administrators to develop policies and procedures to benefit children, families, and staff.

Prevent Child Abuse America (2020) offered strategies to reduce or prevent traumatic or adverse experiences that included:

- Providing environments for safe, stable, nurturing relationships for children, families, and communities.
- Providing high-quality early care and education and home visiting programs.
- Assisting adults and children in gaining skills to manage and respond to stress and challenges.
- Accessing screening, referrals, and support for early interventions.

Many of the recommendations may be implemented without direct services of mental health clinicians and are included in the array of services provided by ECCE programs. Within the last five years, the need for mental health services for young children began to be seriously addressed by policymakers and mental health clinicians (Zero to Three (2021). The National Center for Children in Poverty, the Substance Abuse and Mental Health Services Administration (SAMHSA), and Zero to Three worked to administer infant mental health policy initiatives to support mental health professionals and clinicians, families, and young children (Zero to Three, 2021).

Van der Kolk (2014) pointed out that, unfortunately, the educational system and several methods that proclaim to care for trauma are inclined to circumvent the emotional-engagement system and concentrate instead on employing the brain's cognitive capacities. According to Lieberman et al. (2011), the impact of trauma on infant mental health problems is starting to be focused on the care strategies that demonstrate practical evidence of the effectiveness, such as cognitive behavioral therapy and child–parent psychotherapy.

Zeanah and Zeanah (2019) identified multiple challenges in providing infant mental health services. The challenges include the shortage of trained therapists and

professionals, the lack of optimal continuity of service to focus on the complete spectrum of needs of young children and their families, and funding. The parent, as the primary caregiver, and the young child are the primary recipients of professional and community mental health efforts. Early care and education personnel are viewed as allied professionals and not central to the plans (Zero to Three, 2021). According to Van der Kolk (2014), social support is not a choice. It is biologically essential, and this truth should be the foundation of all prevention and treatment.

Summary

Chapter 2 provided an overview of literature related to the definition of ECCE; the history and development of ECCE; the description of the ECCE workforce and programs; the definition of quality ECCE; professional development for ECCE professionals; young children's social and emotional development; a description of trauma experiences in young children; the history and development of mental health services; and mental health services for young children. Chapter 3 describes the methods used to conduct the current study. This chapter includes the research design, setting, sampling procedures, instrument, data collection procedures, data analysis and synthesis, reliability and trustworthiness, researcher's role, and study limitations.

Chapter 3

Methods

Early childhood educators regularly encounter young children who have experienced trauma. The purpose of this qualitative phenomenological study was to examine ECCE teacher perceptions of how trauma impacts young children in ECCE center-based programs and the adequacy of the training ECCE teachers receive to work with young children who have experienced trauma. Four purposes guided the current study. The first purpose was to investigate ECCE teachers' perceptions about how trauma has impacted young children in early childhood center-based programs. A second purpose was to explore ECCE teachers' perceptions about the information and skills needed to meet the needs of young children who have experienced trauma. The third purpose was to identify ECCE teachers' perceptions about professional development opportunities available to them that provide preparation to meet the needs of young children who have experienced trauma. The fourth purpose was to examine ECCE teachers' perceptions about challenges they face in accessing professional development to aid them in working with young children who have experienced trauma. Chapter 3 describes the research design, setting, sampling procedures, instrument, data collection procedures, data analysis and synthesis, reliability and trustworthiness, researcher's role, and limitations of the current study.

Research Design

A qualitative phenomenological research design was selected for this study. In qualitative studies, the researcher "is considered by many within the field of qualitative inquiry to be the primary *instrument* of the endeavor" (Saldana, 2011, p. 22).

Creswell (2014) described qualitative research as “an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem” (p. 4). According to Bloomberg and Volpe (2012), phenomenological research occurs within natural contexts. Therefore, real-world situations are studied as they naturally unfold (Bloomberg & Volpe, 2012). The phenomenon investigated in the current study was the perceptions of ECCE teachers about how trauma impacts young children in ECCE center-based programs and the adequacy and accessibility of training by ECCE teachers in centered-based programs who are teaching young children who have experienced trauma.

Setting

The setting for this qualitative study was center-based ECCE programs serving young children in Johnson County, Kansas. The NAEYC (1993) noted,

> Early childhood professionals who work directly with young children typically are employed in a variety of settings, including public schools; part-day and full-day centers, whether for-profit or nonprofit; public and private prekindergarten programs, including Head Start; before- and after-school programs; and family child care. (p. 9)

Center-based early learning programs in Johnson County, Kansas were selected as the current study setting because of the availability of numerous ECCE programs located in that geographic region of the state. In addition, center-based programs must meet the same Kansas Department of Health and Environment licensing requirements for teacher qualifications and professional development. The center-based ECCE classrooms in the current study were licensed to serve children birth to 5 ½ years of age.

Sampling Procedures

The population for the current study included all early childhood teachers in the U.S. A purposive criterion sampling procedure was employed to identify the sample for the current study. "The logic of purposeful sampling lies in selecting information rich cases, with the objective of yielding insight and understanding of the phenomenon under investigation" (Bloomberg & Volpe, 2012, p. 104).

The researcher selected 10 participants to participate in the study using criterion sampling. Bloomberg and Volpe (2019) defined criterion sampling as a purposeful strategy in which participants are selected based on specific criteria identified by the researcher. The criteria for inclusion in the sample for the current study included individuals who had two or more years of experience working directly with young children and were employed in a center-based ECCE classroom in Johnson County, Kansas from January 2020 through December 2020. In addition, participants had contact with one or more young children in the center-based ECCE classroom who had experienced trauma.

Instrument

An original semi-structured interview protocol was developed for the current study. The instrument was developed based upon the researcher's education and experience in ECCE and infant mental health. In addition, three subject matter experts (SMEs) also provided expertise in developing the instrument for the current study. One SME was an Early Care & Education Program Manager from the area child care resource and referral agency. The second SME was a Master Instructor of Conscious Discipline. The third SME was an early childhood faculty member at a university in the Kansas City

region. The interview protocol included eight descriptive and demographic and 12 semi-structured interview questions aligned with the research questions. The descriptive and demographic questions included the following:

1. If you are willing, please identify your age.

2. What is your highest level of education?

3. How long have you worked in the early childhood care and education field?

4. During the time you have worked in ECCE, what positions have you held?

5. How long have you been employed in your current ECCE teaching role?

6. What is the early childhood care and education program's licensed capacity where you currently work?

a) 60 or fewer children

b) 61 - 99 children

c) 100 - 159 children

7. What is the age range of the children in your classroom?

8. Please describe other classrooms where you have worked and the age range of the children in those classrooms.

The semi-structured interview questions aligned with four research questions included the following:

RQ1. What are the perceptions of ECCE teachers about how trauma has impacted young children in early childhood center-based programs?

IQ9. This research study looks at behaviors of young children who may have experienced trauma and the teachers' perceptions of being adequately prepared to work with those children who may have experienced trauma. How do you define trauma?

IQ10. What characteristics of a child who has experienced trauma in your classroom have you observed?

IQ11. How have the behaviors of the traumatized child impacted other children in your classroom or the early education program?

IQ12. How have the behaviors of the traumatized child impacted your ability to manage classroom experiences and learning activities?

RQ2. What information and skills do ECCE teachers perceive they need to meet the challenges and needs of the young children who have experienced trauma?

IQ13. What are the most significant challenges early childhood teachers face when working with young children who have experienced trauma?

IQ14. As you reflect on your experiences working with young children who express challenging or problem behaviors associated with trauma, what information do you need to provide quality early care and education?

IQ15. As you reflect on your experiences working with young children who express challenging or problem behaviors associated with trauma, what skills do you need to provide quality early care and education?

RQ3. What professional development opportunities do ECCE teachers perceive are available to them that provide knowledge and skills to work with young children who have experienced trauma?

IQ16. Please describe how you have gained information about young children's social-emotional development and the characteristics of young children who have experienced trauma.

IQ17. Please describe how you have gained information about instructional strategies for effectively teaching young children who have experienced trauma.

IQ18. How has the professional development you have participated in been delivered in-person, online, or in some other format?

RQ4. What challenges do early childhood teachers perceive they face in accessing professional development to aid them in working with young children who have experienced trauma?

IQ19. What challenges do you face in accessing professional development that would help you effectively teach young children who have experienced trauma?

IQ20. Do you have any additional thoughts or concerns regarding accessing professional development that would assist you in effectively teaching young children who have experienced trauma?

Two pilot interviews were conducted before using the interview protocol with study participants. The two individuals participating in the pilot interviews were teachers working in two different ECCE programs. The pilot interviews offered the researcher of the current study the opportunity to refine interview and observation techniques. As a result of the pilot interviews, an additional question was included in the interview that asked the participant to define the term trauma.

Data Collection Procedures

Prior to conducting research, the researcher submitted a proposal to conduct the study to the Baker University Institutional Review Board on June 7, 2021. Approval to conduct the study was received on June 9, 2021 (see Appendix B). Once approval to conduct the study was received, the researcher recruited participants using professional

and social messaging boards (see Appendix C). Requests for posting the social messaging information (Appendix C) about the study were sent to administrators of Facebook groups: the Family Conservancy, Kansas Infant Toddler Mental Health, and ECCE center-based programs in Johnson County, Kansas. The social media posts were followed by individual emails to 40 ECCE center directors that included an invitation to participate (see Appendix D). In addition, packets of invitation to participate letters (see Appendix D) were personally delivered to center directors at 20 ECCE programs in Johnson County, Kansas, for distribution to program staff. The invitation to prospective interviewees (see Appendix D) provided an overview of the study. It was stated that participation would be voluntary and that there were no risks, discomfort, or compensation associated with the study, the option to withdraw from the study at any time or not answer any question without penalty, the assurance that the interviewee's anonymity and confidentiality would be maintained, the time required for the interview, and the opportunity to review the transcript for accuracy. Within 24 hours of an indication of interest in participating in the study, the researcher contacted the individual by phone or email to answer questions about the study and confirm participation in the study. Following the initial contact, the researcher sent an email to the willing participant, including a confirmation letter (see Appendix E), research questions, tentative date for the Zoom interview, and the consent form (Appendix F). The confirmation letter included similar information to that included in the invitation to participate (Appendix D). The consent form (see Appendix F) included the same information as that included in the invitation to participate (see Appendix D). In addition, the consent form (see Appendix E) explained the participant was providing

permission to audio-video record the interview and indicated the researcher would be taking notes during the interview. Using criterion sampling (Bloomberg & Volpe, 2012), 10 participants were selected to participate in interviews for the study.

The researcher asked each participant to sign and return a consent form (see Appendix F) prior to participation in the study. Twenty-four hours before the scheduled interview, the researcher sent a confirmation email containing the date and time and the instructions to access Zoom to each participant. The researcher used Zoom video conferencing to conduct the semi-structured interviews. Video conferencing was used because of the interviewees' geographic locations and to follow the Centers for Disease Control and Prevention (2020a) safety recommendation during the COVID-19 pandemic.

Rubin and Rubin (2005) indicated that in a qualitative research study the interviewee is not a test subject but rather is a partner. Valenzuela and Shrivastava (2002) described the general interview guide approach. According to these researchers, the interview should be designed to guarantee that the same broad range of data are collected from each interviewee. It offers greater focus than the conversational approach yet provides an amount of flexibility and versatility in capturing-the participant's information.

As the Zoom interview began, the researcher welcomed the participant and thanked her for participation in the current study. The researcher reiterated that the interviewee could withdraw from the study or indicate a desire not to answer any question during the interview. The participant was reminded that the consent form permitted the interview to be audio-video recorded and for notetaking to occur. Participants were reassured that their identity and the interview would be kept

confidential using an anonymizing code (e.g., Participant 1, Participant 2, etc.) known only to the researcher.

According to Kvale and Brinkman (2009), the first few minutes of an interview are critical. A positive connection is initiated by attentive listening, with the interviewer demonstrating empathy, and respect for what the participant says. The interviewer is relaxed and is certain about what information he or she will seek. During the interview the researcher was aware of the pacing of the questions, her body position and breathing, and remained focused on the questions being asked.

The interview questions began with eight descriptive and demographic questions, which allowed the interviewees and researcher to engage in conversation and become comfortable sharing information. Descriptive and demographic questions were followed by 12 semi-structured interview protocol questions aligned with the research questions. All participants were asked the same interview protocol questions in the same order. Follow-up questions and probes were used as needed to encourage participants to be as thorough in their responses as possible. This procedure expedites interviews that can be efficiently analyzed and compared (McNamara, n.d). The researcher listened carefully, observed and took notes about nonverbal cues, attended to the conversation flow, asked probing questions as needed, and allowed the participants to speak without interrupting. When necessary, the researcher asked a follow-up question to fully understand the interviewee's response. At the conclusion of each interview, the researcher thanked the participant and ended the Zoom meeting. The researcher emailed a thank you note to the interviewee for their participation the day following the interview.

Interviews were scheduled from July 25 to October 5, 2021. Each interview lasted 30-45 minutes. Participant interviews were scheduled at the interviewee's convenience to provide adequate time for the Zoom meeting without distractions and interruptions. Once each interview was completed, the researcher assigned each recording an identification code known only to the researcher (e.g., Participant 1, Participant 2, etc.) to maintain confidentiality and protect anonymity. This identification code was also used to identify interview transcripts during the data analysis, the presentation of results, and the summary of results. Data were kept for five years on a secure drive accessible only to the researcher and then destroyed.

Data Analysis and Synthesis

Qualitative data analysis is the mechanism of creating structure, organization, and significance to the volumes of data compiled (Bloomberg & Volpe, 2012). Rubin and Rubin (2005) described qualitative data analysis as the process of moving from raw interviews to evidence-based interpretations that are the groundwork for published documents. Creswell (2014) stated that analysis occurs in several overlapping stages. According to Creswell and Plano Clark (2011) qualitative data analysis entails coding the data, subdividing the text into phrases, sentences, or paragraphs, designating a label to each grouping, and then organizing the codes into themes. The researcher applied Creswell's (2014) five general steps for data analysis in qualitative research: (a) organize and prepare the data for analysis; (b) read or look at all the data; (c) code the data; (d) generate descriptions, categories, and themes; and (e) interpret the findings.

Applying Creswell's (2014) first step of data analysis, the researcher organized and prepared the data collected during each interview. The researcher reviewed each

audio-video recording after each interview was completed to confirm that the recording was intact. The researcher labeled the interview and audio-video-recording with an identification code (e.g., Participant 1, Participant 2, etc.) to ensure anonymity. All data and notes the researcher had written during each interview were secured in the corresponding participant's file and stored chronologically.

The researcher initiated the transcription of the Zoom interviews by using the online app, Otter.ai (Fu & Sam Liang, 2020). The app provided efficient and precise documentation of the interview transcripts. First, each Zoom interview was uploaded to Otter.ai. After completing the Otter.ai processing, the researcher downloaded the interview transcript. Next, the researcher reviewed the copy while watching and listening to the recording to ensure that the document was transcribed verbatim. In addition, any errors or omissions were corrected.

Once the interview transcript was reviewed, the researcher emailed the appropriate transcript to each participant. Each participant was asked to review the transcript and note clarifications, corrections, omissions, and additional insights. The researcher instructed the participant to accept or return the amended transcript within a week. The participant's review of the transcript ensured the accuracy of the transcription. Bloomberg and Volpe (2012) referred to this process as member checking. After the participants' responses were received or the deadline had passed, the researcher highlighted any participant corrections to the transcript in a specific colored font.

The researcher in this study recognized that stages in data analyses overlap. Creswell (2014) included the use of computers as a step in data analysis. The use of computer software in qualitative analysis is now standard acceptable practice. It

increases the efficiency in handling large amounts of data and supports transparency in the research (Bloomberg & Volpe, 2019; Ho & Limpaecherm, 2020). It is important to note that software supports analysis, but the work remains in the investigator's hands (Bloomberg & Volpe, 2019; Creswell, 2014; Ho & Limpaecherm, 2020; Saldana, 2016).

To apply Creswell's (2014) second data analysis step, read or look at all the data, the researcher read each transcript several times to get an overall impression of the data. After the first readings, the researcher included impressions about the interviews in a research journal. Next, the researcher selected one transcript during the second step and contemplated the question, "What is this about?"(Creswell, 2014, p. 198). Finally, the researcher added notes related to the question in the research journal. Saldana (2016) referred to this process as preliminary jottings. These include anecdotal notes, phrases for codes, memos made on documents, transcripts, or written in a research journal which are all available for future reference.

The next step taken by the researcher of the current study was Creswell's (2014) third data analysis step, coding the data. Coding requires methodically labeling concepts, events, themes, and topical markers so that the researcher can easily locate and review all of the data that relate to the same topic across all the study interviews (Creswell, (2014). According to Saldana (2016) coding is a cyclic undertaking. The researcher began coding with the initial reading of transcripts. Throughout the analysis, the researcher reexamined transcripts to refine, filter, or delete codes. The researcher utilized a streamlined code to theory model, moving from raw data to codes, categories and subcategories, themes, and assertions (Saldana, 2016).

Five transcripts were selected to begin the researcher's first efforts at coding. Initial codes were identified from the first grouping of transcripts. The researcher highlighted common words and phrases across all transcripts and made notes in the page margins. In the data analysis, the researcher transferred manually coded files to a Word Document file. Saldana (2016) recommended that when the researcher is satisfied with initial codes, the codes are moved to a digital file. The right-hand margin was expanded to provide room for coding and researcher comments. Different colored fonts were used to denote commonalities, differences, and unique responses provided by interviewees. The initial codes from the first grouping of transcripts were applied to the second grouping. The researcher found that additional codes emerged. The researcher drafted a codebook added to the researcher's journal from these codes.

Continuing the coding process, the researcher designated the most meaningful wording for the codes and transferred the terms to categories. Next, the researcher merged codes and categories to form themes. This action reduced the entire list of categories. Next, the researcher created abbreviations for each category, and the topics were alphabetized. The researcher then generated a comprehensive list of the codes and categories.

The researcher then conducted a preliminary analysis of the data. The purposes of initial data analysis are to refine the data and organize it for further analysis, define the major characteristics of the data, and summarize the findings (Blischke, Rezaul, & Prabhakar Murthy, 2011). Analyses entailed classifying, comparing, weighing, and combining interview material to glean the intention to reveal patterns or intertwine descriptions of events into a meaningful narrative (Rubin & Rubin, 2005). During this

step, the researcher of the current study drafted figures that illustrated the relationships between the categories across all participants. Next, the researcher created multiple spreadsheets that detailed all keywords and phrases for a specific research question for each respondent to be viewed. The researcher examined the composite of participants' responses to identify common themes, Creswell's (2014) fourth step. With preliminary analysis completed, the research proceeded with the final step of data analysis, interpreting the findings (Creswell, 2014). According to Creswell and Plano Clark (2011) the interpretation of findings entails carefully contemplating specific results and expanding the context in view of the study problems, research questions, the extant literature, and possibly personal history. The researcher recorded personal insights and reflections in a research journal throughout the current study. In addition, the descriptions of how the coding process evolved and themes were developed were documented, providing an audit trail (Bloomberg & Volpe, 2019). The researcher conducted a coding process audit to affirm the accuracy and credibility of the findings for this study. The researcher enlisted one external reviewer to review audio-video recordings and transcripts for accuracy and coding for common themes. The external reviewer holds a doctorate in Educational Leadership in Higher Education and conducted a qualitative research study to complete doctoral requirements. The external reviewer concurred with the themes identified by the researcher conducting the current study.

Reliability and Trustworthiness

Creswell (2014) indicated that reliability and trustworthiness could be established as the researcher reviews the accuracy of the results by implementing distinct protocols. The criteria identified by Lincoln and Guba (1985) to establish trustworthiness are

accepted and recognized by many qualitative researchers. These criteria include credibility, dependability, confirmability, and transferability (Bloomberg & Volpe, 2014; Creswell, 2014; Creswell & Plano Clark, 2011; Lincoln & Guba, 1985). Bloomberg and Volpe (2014) described trustworthiness criteria with corresponding research strategies. The researcher used five techniques to ensure the reliability and trustworthiness of the findings in the current study: peer examination of the interview protocol, two pilot interviews, member checking, journaling or narrative analysis, and an audit trail.

During the interview process the significance of the research's integrity is intensified because the interviewer is the primary instrument for gaining information (Kvale & Brinkman, 2009). Peer review of the interview questions was conducted by the researcher's major advisor, research analyst, and subject matter experts (SME) to ensure alignment with the purposes of the study, clarity, and determination that the questions were mutually exclusive and exhaustive. Three subject matter experts (SMEs) provided expertise in developing the instrument for the current study. The SMEs were asked to comment on the language of the interview questions, the understandability of the wording, and the relationship of the interview questions to the research questions. As a result, two changes were made in the wording of interview questions. The researcher conducted two pilot interviews to rehearse and ascertain the interview process's efficacy and questions and improve the researcher's interviewing skills.

After the interviews were conducted, the researcher used member checking to allow study participants to verify the truthfulness and accuracy of interview transcripts. Member checking is a method in which the investigator sends the narrative back to the interview participants requesting they review the information for accurate documentation

of their experiences (Creswell & Plano Clark, 2011). Participants reported that the transcriptions were accurate.

According to Creswell (2014) the function of the researcher as the principal data collection instrument requires the identification of personal beliefs, biases, and assumptions at the beginning of the research. Therefore, the researcher chose to journal and write a narrative analysis to address those matters. The narrative analysis included the researcher's description of the research process, synopsis of interview notes, explanation of the coding process, and interpretation of the results of the qualitative research. In addition, the narrative analysis incorporated personal reflections of what the researcher learned and interpretation of the research findings. Throughout all aspects of this study, the researcher engaged in self-reflection, noting impressions, and recording activities in a research journal.

The researcher conducted an audit trail to affirm the accuracy and credibility of the findings for this study. The researcher enlisted one external reviewer to review audio-video recordings and transcripts for accuracy and coding for common themes. According to Creswell (2014) the overall validity of qualitative research is strengthened when a nonpartisan examiner reviews multiple aspects of the study such as the veracity of the transcription, the links between the research questions and the data, the depth of analysis from the raw data through interpretation.

Researcher's Role

The researcher is the data-gathering instrument. The investigator's ability to observe, listen, and understand are crucial in the study's exploration (Rubin & Rubin,

2005). According to Creswell (2014), the researcher is also responsible for collecting and analyzing data obtained in a qualitative study.

The researcher's role in the current qualitative study was to produce unbiased research. Throughout qualitative research attention must be paid to identify possible prejudices that might exist in the design, implementation, and analysis of the study (Bloomberg & Volpe, 2012). The researcher in the current study acknowledged that biases might have been brought to this study due to her role as an administrator, educator, and consultant in ECCE programs. In addition, the researcher knew and had encountered participants who have worked with young children with challenging behaviors or experienced trauma.

The researcher for this study had experienced educational preparation at the University of Kansas. She earned a Master's Degree in Human Development and Family Life, with an emphasis in ECCE. The researcher was employed as a director and teacher in various ECCE programs and, at the time of the current study, was employed in ECCE as a consultant, educator, and substitute teacher across the Kansas City metropolitan area. The researcher was a foster parent and was the grandmother of an adopted young child who had experienced trauma. The researcher had the experience and background to have a solid foundation to discern the educational needs and challenges of early childhood teachers working with young children who have experienced trauma.

It was imperative to the researcher that the study be credible and trustworthy. These elements and roles required the investigator to recognize the potential for bias and continually exercise awareness, intentionality, and objectivity to maintain the research integrity throughout the study. The researcher of the current study kept a research journal

that provided a narrative of analysis of critical steps and insights that occurred throughout the study. The researcher employed attentive listening, careful observation, conscientious notetaking, and objective reflection on participant responses during the data collection phase. The interviews were recorded and transcribed. Member checking and independent audits of the results from interview transcripts assured the integrity of the data analysis. Throughout the current study, the researcher engaged in the process of reflexivity. Reflexivity necessitates the researcher to contemplate and clearly state their point of view, biases, and perspective so that readers are better able to comprehend the filters through which questions were asked, data were collected and analyzed, and results were reported (Sutton & Austin, 2015).

Limitations

Limitations are elements that may influence the analysis of the research or the determination of the outcome (Lunenburg & Irby, 2008). This study had the following limitations:

1. The interview participants may not have provided a representative sample of ECCE teachers resulting in limited validity.
2. The researcher did not verify the training opportunities described by the interview participants. As a result, recollections about training related to trauma in young children may have been inaccurate.
3. All participants were encouraged to be forthcoming and to go into detail when answering questions. However, Creswell (2014) stated, "Not all people are equally articulate and perceptive" (p. 190). Some participants may not have

clearly understood the interview questions or been able to articulate their responses verbally.

Summary

Using a qualitative phenomenological research design, the current study explored the perceptions of ECCE teachers about how trauma has impacted young children in early childhood centered-based programs and the adequacy of preparation to teach young children who have experienced trauma. Chapter 3 described the qualitative methodology employed in this research. The research design, setting, sampling procedures, instrument, data collection procedures, data collection procedures, data analysis and synthesis, reliability and trustworthiness, researcher's role, and limitations were explained. Chapter 4 presents the results of the data analysis.

Chapter 4

Results

This qualitative study was conducted to explore ECCE teachers' perceptions of how trauma impacts young children in ECCE-center-based programs and the adequacy of the training ECCE teachers receive to work with young children who have experienced trauma. Four purposes guided the current study. The first purpose was to investigate ECCE teachers' perceptions about how trauma has impacted young children in early childhood center-based programs. A second purpose was to explore ECCE teachers' perceptions about the information and skills needed to meet the needs of young children who have experienced trauma. The third purpose was to identify ECCE teachers' perceptions about professional development opportunities available to them that provide preparation to meet the needs of young children who have experienced trauma. The fourth purpose was to examine the perceptions of ECCE teachers about challenges they face in accessing professional development to aid them in working with young children who have experienced trauma. Chapter 4 includes the results of the qualitative analysis of transcripts of interviews with 10 early childhood teachers.

Descriptive Demographics and Participant Background

Eight demographic questions were asked to obtain an understanding of the backgrounds of the participants. Ten ECCE teachers employed in early childhood center-based programs in Johnson County, Kansas, with two or more years of experience working directly with young children who may have experienced trauma participated in the study. Each participant engaged in a face-to-face Zoom interview. The interview responses of the 10 participants were analyzed for this study.

All 10 study participants were teachers in KDHE licensed early care and education centers in Johnson County, Kansas. Five of the respondents had worked as float or assistant teachers before taking on the responsibilities of a teacher. Participant ages ranged from 23 to 59 years of age. One participant was younger than 25. Six study respondents were in their late twenties and thirties. Three of the teachers were 45 years of age or older. All 10 participants had graduated from high school. Four of the teachers had attended some college, and two of them were working on their Child Development Associate (CDA) credentials when they were interviewed. Four of the participants had earned college degrees, two held associate degrees, one had obtained a bachelor's degree in elementary education, and one had acquired a master's degree in psychology.

Study respondents had been employed in their current teaching role for 6 months to 11 years. One participant who had recently changed jobs, was previously employed in a child development center for 3 years. Four participants worked for 1 to 4 years in the program where they were currently employed. Four teachers had been at the present site for 5 to 6 years. One participant had worked in the same center for 11 years.

Eight participants were working in centers with a licensed capacity for 100 to 159 children. One participant was employed in a program with 60 to 99 children. One participant was teaching in a center with more than 160 children.

At the time the interviews were conducted, three teachers worked with infants and seven teachers worked in preschool classrooms as defined by KDHE. While employed in the ECCE field, eight participants had experience working with children in multiple age groups from infancy through school age. Participant 8 worked with infants and toddlers only. Participant 1 worked only with preschoolers, including children with special needs.

The respondents reported between 3 to 5 years of teaching experience in early care and education. The average length of time of service was 15.5 years. Collectively, the interview participants have nurtured and educated young children for a total of 154.5 years.

Participants were asked 12 interview questions organized around four research questions. Four major themes were identified from the analysis of the data: teachers' perceptions about trauma in early care and education; teachers' professional development needs working with young children who may have experienced trauma; resources and professional development opportunities available to ECCE teachers; and challenges working with young children who may have experienced trauma. The following sections provide a summary of the data and an explanation of the findings with regard to the four themes. The themes generated from responses to interview questions are identified. Direct quotations are included to highlight and demonstrate interview participants' perceptions about their experiences working in ECCE classrooms with young children who may have experienced trauma and the adequacy and accessibility of training to work with young children who have experienced trauma.

Teachers' Perceptions About Trauma in Early Care and Education

Study participants were asked to describe their classroom experiences in the ECCE center with young children who may have experienced trauma. Within this theme, four subthemes emerged in participants' responses: a definition of trauma, the behaviors of children who have experienced trauma, the responses of other children to a child who has experienced trauma, and teachers' responses in the classroom to the behaviors of a

child who has experienced trauma. The following four sections report the participants' comments related to each of these four subthemes.

Teachers' definition of trauma. Study participants were asked to provide their definition of or understanding of trauma. All respondents agreed that trauma is an event that impacts a child's future experiences. Two respondents mentioned the uniqueness of trauma. Participant 1 stated, "It has to be defined by the child, how they respond to whatever is happening then in their world." Participant 4 stated, "Trauma differs. What an individual perceives is completely different and unique."

Three respondents described trauma as a disruption in a young child's life. Participant 4 noted, "[Trauma is] something that has happened that's big enough to disrupt their feelings in the way that they see the world." Participant 5 said, "[Trauma is] something that has caused them in their past to change their behaviors and change their actions." Participant 8 stated, "I see trauma as something that emotionally impacts a child for a longer period of time. If it continues to affect them, then they were traumatized."

Three participants identified trauma as a negative experience. Participant 2 said, "[Trauma is] an experience that has impacted a child, usually in a negative way, and has some effects on their learning or their abilities, or just their overall academic experience." Participant 10 remarked, "Trauma is "something that affects a child in a negative way, a hurtful way." Participant 6 commented, "Trauma is something that sets a core memory. So, I would define it as a negative core experience."

Teachers offered numerous examples of traumatic events that children may experience. Participant 1 stated, "Trauma can be different for different people." When

offering examples of trauma, Participant I said, “[It’s] kids that have been abused and neglected." Participant 1 noted that children of divorce “may just not have had their basic needs met. They may be bounced back and forth between mom and dad in fights." Participant 3 shared a personal experience,

> Trauma is a family dynamic, divorce, or even military life where a spouse has to leave for a long period of time. My kids don't understand that. So, that's traumatizing for them. Even moving suddenly and not being prepared could be traumatizing.

Participant 7 stated, “Traumatic events may range from mom and dad not being together or a death in the family.”

Two teachers identified the current time we are living in as trauma. Participant 1 declared, “We're all living in trauma now with a pandemic.” Participant 9 pointed out,

> With COVID the children have to start wearing masks and that disrupted their routine for the past four years of never having to wear a mask, and now all of a sudden, having to wear a mask. So that's trauma for them.

Behaviors of children who have experienced trauma. All participants offered examples of behaviors exhibited by children when asked what characteristics they had observed in a child in their classroom who has experienced trauma. Respondents described a range of behaviors observed in children who may have experienced trauma. For example, Participant 2 said, "Sometimes it can be those fight or flight responses, depending on the type of trauma." She went on to say, "There's a continuum. They could be either shy and not really verbal, and not really wanting to express anything, or they could be super aggressive to peers or themselves or their teacher." Participant 4

remarked, “They just shy away from the room, they don't want to do anything, and they're mostly in their safe space half the time that they're in the classroom.” Participant 3 shared her thoughts, “I think the biggest thing that I have observed is their social-emotional skills are just not there. They struggle with simple things.” She continued, “I’ve also had a kiddo that had severe attachment issues and actually formed an attachment to me to the point where he always had to be next to me, or he didn't feel safe.”

Participant 8 reported,

> It's different for each kid. When certain kids are having meltdowns, they need you to leave them alone for a minute, but some of them may need you to hold them and hug them. When they're already upset, it's really hard to find out from them what they need.

Participant 10 said, “[There] may be some anxiety separation issues.” Participant 7 offered a personal experience,

> I had a little girl who was in foster care. Her mom was on a drug bender. And the little girl was with her at the time in the hotel. She was very attached to certain people in the classroom. So, if somebody new walked in, she was very skittish. She didn't know exactly what to do. If I would walk out of the room, she would scream, she would throw things. She was not happy.

Participant 6 recalled, “I had a little girl who was extremely anxious. Anytime that she felt anxious, she would pull out her hair. She would get so nervous, like when she had to leave her mom, she would pull her hair.” Participant 5 shared a personal experience, “I had a student last year that was sold by her mother into prostitution at age four. When

she came back, she had scars and was very quiet and withdrawn, her behavior changed because of her trauma." Participant 4 reported,

> It seems to either go one of two ways. They [traumatized children] withdraw and do not-engage with anybody, students or teachers, or become aggressive. They seem to lash out a lot at everyone around them and are very, very quick to anger.

Participant 9 stated, "I would have to say the children act out. They don't listen. They decide to be defiant, throw things at the teachers, and hit other students. Things like that." Participant 8 described a child's behavior, "He would just go off the handle. Actually, we ended up having to ask him to leave the center because he trashed one of our classrooms breaking shelves during one of his tantrums." Participant 10 recalled, "When I was in Head Start there were a lot of anger issues. Kids hurting other kids and throwing computers and tipping over furniture. Just the anger issues because they're so angry inside." Participant 1 commented, "They may hit another child. They may just not know how to ask for attention appropriately."

Three participants reported they had seen regression in children's development. Regression was seen most often in toileting skills. Participant 4 stated, "A big one that I've seen is regression in a lot of things, so if we're potty training, the child regresses back to having multiple accidents." Participant 3 noted, "Kids also sometimes tend to have more accidents, potty accidents, when they experience trauma depending on what type of trauma it is." Participant 8 identified behaviors of two children who had experienced trauma. "Both of them were four at the time and were still in pull-ups due to their situations. One of them wouldn't go in the bathroom alone without screaming."

Six teachers described food and eating issues demonstrated by children who may have experienced trauma. Participant 9 mentioned, “It might affect their eating habits.” Participant 5 explained, “If they've been denied food and they start to take food in their pockets or stash it away in their cubby, they've obviously had some kind of a traumatic event to cause them to feel they need to store food.” Participant 4 reported, “They also have eating problems. Sometimes they won't eat, or sometimes they eat really fast.” Participant 2 commented, “Someone who was neglected with food or something like that might be overly hungry or think they're overly hungry and [they] gravitate [to] and pull things out of the trash or steal people's food." Participant 1 reported she had "seen kids that have double-fisted food, telling me that they may not be getting their needs met for meals at home." Participant 7 described a child’s response, “When it was time to eat, she would hurry up and scarf everything down as if it was going to be her last meal."

One teacher shared a child's behavior that the other respondents had not noted. Participant 6 recalled an experience of a child in her care,

> His parents were divorced. They went through the divorce when he was younger. He would dress up, like princess gowns and everything, but that was him acting out his family. I saw that as him just projecting how he wanted his mother or his father to be around when he was at the other home. So, if he was at his dad's house, he would want to wear wigs that week. But if he was at his mom's house, he wanted to bring his tractors to school.

She continued, “It was strange to see how he would flip from week to week. It was strange to see how the dynamics flipped when he was switching homes.”

Two participants reported children were expelled from the early care and education program due to behaviors that may have been impacted by trauma. For example, Participant 2 commented, "Sometimes those kids might get kicked out of one program because the teachers or staff there don't know how to or can't work with them. It was too challenging for them." Participant 8 shared the example of the little boy trashing a classroom multiple times and then being asked to leave. She explained, “We were unable to help him in our facility due to not having the proper tools and training to deal with someone of that nature.”

Responses of other children to a child who has experienced trauma. All respondents shared multiple ways the behaviors of a child who may have experienced trauma impacted the other children in the ECCE program. Teachers described occasions when classmates avoided the child or were frightened by the behaviors displayed, or engaged in similar behaviors. Participant 2 pointed out, “It can be a safety concern for other children.” Participant 4 stated, “When those behaviors arise it complicates the mood, the tone, [the] activities and such in the classroom.”

Five respondents recognized that other children avoided the child with the challenging behaviors in the classroom. Participant 3 reported, "Some children don't seem to be bothered by it. But I think that they just kind of shy away from it." Participant 1 recalled,

> I feel like in our little center, I've noticed other kids will sort of avoid them, especially if they're lashing out with behavior, or shyness might be another one where they kind of just go inward and keep to themselves. The other kids tend to not go toward them socially. I feel like they're already at a deficit.

Participant 9 stated, “The other children would be more hesitant to want to play with those kids or to want to go into that classroom knowing that that student will be in there.” Participant 5 shared,

> The aggressive students they will avoid. Those older kiddos really remember, 'Oh, you hit me with the block yesterday, and I don't want to play with you today.' And two-year-olds obviously would let it go, water under the bridge, new day. Not my kiddos. They figure out who they want to play with and who they don't really quickly.

Two teachers stated that children were frightened by the challenging behaviors displayed by a child that may have experienced trauma. Participant 8 recalled, "I did have children telling me that they were scared when the child was screaming." Participant 3 reported, "Sometimes when kiddos are crying a lot, the other kids in the classroom sometimes get scared and cover their ears and ask “Why is this happening? Why is so and so, so upset?'"

Three respondents described the feelings of the other children in the classroom. Participant 8 stated,

> You're focusing on that child that needs you in that moment. And then these other kids, they feel like they feel ignored because they're trying to come up to you and have conversations with you during all of this. You literally have to say, ‘I can't do this right now.’

Participant 4 remarked, “I'd say that they just require a lot more of the teachers who are present. I would say the other kids don't get the needed focus.” The teacher continued, “It could also harbor bad feelings among the students about this child, if it's like

aggressive stuff, or if they see the teacher is favoring this kid a little more or something similar to that." Participant 8 noted,

> They just seem to not understand that other children don't deal with things the same way they do. It makes it really hard to communicate with them. 'I'm sorry, I know you need me right now. But they need me more right now.'

Two participants reported that other children might engage in similar behaviors exhibited by the children who may have experienced trauma. Participant 3 offered her opinion, "Other kids, I think, seek attention from the teacher more because they feel like that child is getting more attention obviously because that child is struggling." Participant 3 commented, "Honestly, one of the biggest things I think I've experienced is there's a lot of aggression in that child, then you have some behaviors that seem to start to be difficult with other kids because they're learning that behavior."

Two respondents reported that other children in the classroom made an effort to engage the child who may have experienced trauma. Participant 5 said, "Depending on which behavior they're exhibiting, children will try to bring the quieter students into play and encourage them to join them." Participant 6 described a situation in her classroom where a child moved between his divorced parents' households, and he would dress in clothing of the parent he was not living with that week. She revealed, "It was actually just kind of positive because the other little boys were like, "Oh, well, we can dress up and be whatever we want to be too." She went on to say,

> They were like, 'We could just all play together. It doesn't matter if I dress up in a princess dress, because I like it. Or if we play with blocks doesn't matter.' So

> that was kind of fun, just to see the gender roles kind of melt away. And everybody just embraced that fun learning experience.

Participant 6 offered an additional positive experience among the children in her classroom,

> With the little girl, her friends realize, 'Oh, she's having a hard time, we need to give her space.' In that class, there were a lot of little girls. So, it was very nurturing, very calming, 'We just need to give her space. All she needs is some time away.'

Teachers' responses in the classroom to the behaviors of a child who has experienced trauma. All participants described how the behaviors of a child who has experienced trauma impacted their ability to manage classroom experiences and learning activities. Four study participants disclosed teachable moments. Participant 1 reflected,

> It can certainly be challenging. I guess for me it's kind of a trial and error. When you get kids at the beginning of the year, you don't always know their background or their history. And I may try to set those boundaries right away and realize, well, that's making it worse. So, then I have to rethink and adjust, maybe giving them a little bit more positive feedback, a little gentle touch here and there. Whatever it takes to find what works for that child.

Three teachers talked about offering children reassurance and feelings of being safe. Participant 10 stated,

> I would say, me personally learning to help them to feel safe and let the whole class know. Include the whole class in not singling the child out. But to talk to everybody about the issue. Like it was a class issue, not just the child's issue.

Participant 5 fondly recalled,

> I tell them every day that they are safe and it's my job to keep them safe. And I need them to help me do that, and they tell their parents that when they go home and their parents come back and say, 'so, it's your job to keep them safe.' Yup, it's my job. I teach them too, I promise. Gotta keep them safe first and foremost.

Participant 7 shared,

> A lot of children don't fully understand some of the emotions. So that's why we do emotion cards and talk about emotions with the children. When a child is having one of those moments, we sit with them and talk to them. And also, let the other children in the classroom know that we don't do certain things like this. And if we need to have a moment, we need to breathe, and that's going to be okay.

Six teachers described the adjustments that may be made in the classroom routine and activities when working with a child who may have experienced trauma. Respondents described a balancing act between the child needing one-on-one attention and engaging the rest of the class. Participant 1 said,

> It would depend on whatever the needs of that child are, and then trying to be creative. A lot of times, it's a child that maybe can't focus in the group. So maybe name it with a fidget toy or something like that. I give the directions to the whole group, and then I go and give them their own direction, just to make sure you know, eye contact, closeness, just to make sure that they've understood what I've expected of them.

Participant 2 stated,

> Yeah, that can be hard because depending on what it is, you may need to give more attention to that child or really stop whatever you're doing, leading the classroom or teaching in the classroom, to work through this with this child because you don't want to just leave them when they are having a meltdown or whatever the case may be.

Teachers described modifications in the schedule or planned activities. Participant 4 explained,

> I just don't have time following our schedule that we normally follow because B is having trouble. And they need more attention from the teacher who wants to help them through their situation, and they don't want to make it worse. So instead of having to focus on this one small group that may or may not be working at the time, I usually just fall back to having them all do their centers, and that way, I can work through each child individually as the other ones are more occupied doing what they would like to do at that time.

Participant 8 recalled,

> But there's also days where I had to cancel circle time because it was too intense of a moment. I couldn't focus on teaching all the kids and helping one student who is acting out at the same time. It disrupts everything so much that you can't always get back to it. You have to move forward and move on with your day.

Participant 9 reiterated,

> It makes it a little bit harder to work with the other children when you have to focus one-on-one on that child who's acting out. The other children get left to do

> whatever they want instead of actually teaching them their letters or how to write their names and stuff because you now have to focus on one child who is throwing things at the teachers. You have to be one on one with that child.

Participant 8 summed up classroom activities, “I mean, there are good days and bad days. There have been days where I was able to have my normal class.”

Two participants expressed their frustrations with being the only teacher in the classroom when challenging behaviors occurred. Participant 3 disclosed,

> Honestly, it makes it very difficult. You need an extra set of hands. You cannot teach all of your children and get your routine done and everybody gets the attention and education that you want to give them when you are constantly having to help this child that has experienced trauma that cannot function more than 10 - 15 minutes at a time some days.

Participant 3 further stated,

> And we also need to be listened to when we say that we need help, meaning that when two teachers cannot do a room of 12 kids when you have two children who have trauma. With the ratios, you think you should be able to handle that. But it's not feasible because both of you are still dealing with the children that have trauma. And neither one of you can teach.

Participant 4 replied, “I feel like we have too many kids in the classroom and too few teachers to have to deal with the behaviors that arise. So, I definitely feel like maybe I need extra help managing the classroom." Participant 2 stated, “They [teachers] really require some additional hands in the classroom. So that way, we can keep the rest of the group going while we're working through this issue.”

Two participants identified the possibility of children leaving the classroom or the ECCE program. Participant 2 reported, “They [the child] may be pulled out of the classroom for some special services to help work through that trauma.” She continued describing the alternative,

> Sometimes those kids might get kicked out of one program because the teachers there, the staff there, don't know how to or can't work with them. You know, it was too challenging for them. So, then they get bounced to another place, and it is just kind of a cycle that goes down. So, trying to break that cycle in early childhood is a challenge. And obviously, not one person can be the person that solves it by themselves.

Two respondents recalled there was little change in the classroom experiences. Participant 6 commented, “It was never really crazy things to manage.” Participant 7 explained,

> I wouldn't say it impacted me or didn't impact me. It was kind of the opposite. They were willing to do activities in the classroom with the other kids. They didn't stray away from the class of what we were doing. They were very adamant if the other kids in the class are having fun, they want to have fun as well and learn and use their fine motors and working on pincer grasp and everything like that in between.

Professional Development Needs of ECCE Teachers

During the interviews participants were asked what information and skills they perceived they needed to work with young children who may have experienced trauma. All 10 respondents identified multiple needs. Within this theme, three subthemes were

identified in participants' responses: information needed by ECCE teachers, skills needed by ECCE teachers, and attributes desired for ECCE teachers. Each of the subthemes is described in the next sections.

Information needed by ECCE teachers. Five participants described a need for general information about trauma. Participant 10 offered, “I just think it's [trauma] something that every teacher should maybe be trained on. At least get an insight or a little taste of some training for it and how to recognize it.” Participant 7 advocated,

> I believe that all teachers in any child care should have a trauma class that they attend so they know how to deal with children who have had any sort of trauma in their life, from mom and dad not being together or a death in the family.

Participant 3 commented, “I think the biggest thing about children that do have trauma is understanding what their trauma is. Once we understand what they have gone through, then we can have the empathy that we need to have as human beings.” Participant 1 remarked,

> That's a broad question. [We need] constant education as far as defining trauma. Some people don't recognize trauma as trauma. I think that we have a lot of that. I feel like we need a lot more knowledge of the ever-changing, and I know the pandemic is also still basically new.

Seven teachers wanted a child’s background information regarding trauma and the triggers that may impact the child’s behavior. Participant 5 reported, “The first thing that came to my mind is more information. If there's background information that we know, it'd be really nice to be able to have it from the get-go.” Participant 5 continued,

> And a lot of times, we don't have that information. Sometimes we get students, and we have no idea what they've been through. [It would] help us [if] they all came with the book, and you just read it, "Oh, look, their grandma died six months ago, [or] their uncle's really sick in the hospital right now.

Participant 9 acknowledged,

> I would need to know a little bit about [the child's] family background. Did the parents lose their jobs? Are the parents working from home? Are the parents out? Are the parents traveling? So, information about their family and stuff to see what kind of care that I could [provide to] help them. Because if a child doesn't have their mom around all the time, then I would be able to give that child a little extra love and stuff. Cuz not everybody has a normal mom and dad all the time at home. Some children only have a mom. We got one child whose father was not in the picture and then all of a sudden came back in the picture, and now that child started acting up. We'd like to know these kinds of things so we could be able to prepare ourselves for the way the child may behave.

Participant 2 commented,

> I always like to have as much information as I'm able to have. It really helps you to understand more clearly what's going on and what might be triggers or how to help. So, the more information, the better. Obviously, sometimes you don't get all of that [information]. And then you just have to work with what you can get.

Participant 10 remarked,

> Learning how to help them cope with what they've been through. Recognizing the signs of what they might need, whether it be something to hold on to, help them feel safe, or just some hugs. Learning, just learning through these classes.

Participant 8 said, "[I need] communication between parents or foster parents or grandparent, whatever the situation may be. Just information and communication with them would definitely help." Participant 7 stated, "There are certain children that have struggled with more traumatic experiences than other children. I think that we, as individuals, as teachers, we need to know what and how to resolve an issue." Participant 3 indicated,

> If the kiddo is on an IEP having that information as teachers in a childcare setting is the number one thing if their trauma is related through that. Because if we don't know what's going on at school and why they are on that individual education plan, then we can't help them when they're not at school. So being in those meetings, being in contact with those teachers is a huge part of the communication that needs to happen. And it really fails to happen a lot of the time.

Skills needed by ECCE teachers. Respondents were asked to reflect on the skills needed to provide quality ECCE while working with young children who have expressed challenging or problem behaviors that may be associated with trauma. Among the skills participants identified were communication techniques and strategies to aid in calming and self-regulation for the child and themselves. Participant 1 stated, "You can have the information, but you have to be able to apply it." The interviewee went on to say, "If you

have an educator in there that can kind of give us guidance on how to respond when a kid does different behaviors. So, you can actually see it, match it." Participant 9 responded, "Just trial and error. Just trying to figure out what works best. And if that doesn't work, then try something else." Respondent 9 noted, “We're starting to learn different ways to help kids that are in trauma. So that would be a really good skill too, so I can know other ways to help people.”

Five teachers specifically mentioned skills included in the practices of Conscious Discipline®. Participant 8 admitted,

> I need to learn, personally, myself, how to help children get out of their brainstem when they're in that fight or flight instinct when their defenses are up and you just can't get through to them. I need to learn how to refocus them. And I need to find ways to get them out of that moment.

Participant 3 emphasized,

> Definitely that's where my Conscious Discipline® comes in to affect being able to keep myself calm and to help that child calm themselves and get back and in their brainstem and not be in that fight or flight mode. I think it is a really big tool, a skill, but I think everyone needs it. Because if we can't stay calm and not be frustrated with the situation, then we can't help that child.

Participant 4 commented,

> I'm not sure how to explain it. But I would like the things that they teach in Conscious Discipline. I'm not 100% sure what they're called, but the steps that they take to kind of get inside the child's head in how they're reacting and how

> they're behaving. I don't think it's empathy but more something along the lines of that.

Participant 5 described the skills needed in her classroom,

> Oh my gosh! Conscious Discipline® is valuable here with the I Love You rituals to build those connections. And the breathing. I cannot tell you how many times people will hear me down the hall saying smell the flower, blow out the candle. If there's a blow-up, smell the flower and blow out the candle. And then they're doing that as they hear me say it. I know it works really great to calm yourself and the entire room, including myself. The Conscious Discipline® training has absolutely changed everything that I have done in my classroom in the last decade at least.

Participant 6 advocated,

> I think you definitely need to learn some sort of Conscious Discipline® practice. I know I keep saying that a lot. Over quite a few years that I've been at [redacted], we've had a lot of talk about Conscious Discipline®. And I think it's the best method of communication because it makes a child, I feel, makes them feel heard. So, I really think that those kind of practices are good. And making sure that you learn how to talk to a child, getting down on their level, using phrases that they understand, and making sure they understand what they're saying.

Two participants did not specifically mention Conscious Discipline® strategies but described similar skills and additional practices. Participant 10 commented,

> Learning to remain calm is a big thing through any rough patches that one of these children might have. And learning how to help them cope with what they've

> been through. Recognizing the signs of what they might need, whether it be something to hold to help them feel safe or just some hugs. Learning, just learning through these classes.

Participant 7 remarked,

> You need to set yourself up to a standard of learning more from other teachers. So, I did classes through KCCTO [Kansas Child Care Training Opportunities], and I learned a lot of information from them and doing my own research to have better skills of writing things down and taking notes if this happened again. I would know the time of day, and when it occurred, and what happened if there was another child involved. I'm just being extra cautious to certain things that might trigger a child. We never know if the child may have certain triggers or smells that might cause them to go back if they did have trauma. Just making sure that we have a sheet in our classroom that would remind us, this is what you need to do. This is how you need to calm down. And this is what we can work on with the other children in the classroom.

Attributes desired for ECCE teachers. All 10 study participants identified one or more attributes desired for teachers of young children who may have experienced trauma. Attributes included patience, self-confidence, listening skills, and the desire to be a leader in the ECCE field. Six out of 10 respondents acknowledged patience was an attribute required by ECCE teachers. Participant 9 recognized, “I'm definitely going to need to be patient for a child.” She went on to say,

> The teachers just need to be more patient and ask for help instead of trying to think that they can do it all on their own. Teachers definitely need to just ask for

> help and say, Hey, I'm not sure what I need to do to make this work. Can you help me?

Participant 4 commented, “I would say patience, for one. I feel like we have too many kids in the classroom and too many teachers to have to deal with the behaviors that arise.” Participant 2 noted,

> Patience and understanding even if you don't completely understand what they're going through. I guess it kind of wraps back into patience and sympathy or empathy - to try to relate to that kid and just let them know that you're there and caring. You have to care that they've went through something and that you need to work through it.

Participant 5 agreed with Participant 2, “Patience and empathy, you don't know what they've gone through. You don't know where they've been. You just have to be patient and give them a chance to trust you.” Participant 7 replied, “I think you need to have patience.” Participant 6 recalled,

> Prior to being an early childhood education teacher, I was a retail manager for a very long time, which has made me acquire a lot of patience. So, I feel like as long as you have the education and patience, it’s not easier by any means, but I feel more equipped, just having the education along with patience.

Two participants described self-confidence as an attribute needed by ECCE teachers. Participant 1 shared, “I think there's something to say about doing the same thing for 30 years. You feel a little more confident, and I know how to handle this. This is the problem; we can take care of it.” Participant 4 stated,

> I guess self-confidence while they are dealing with the trauma. Sometimes they [teachers] might lack the confidence in doing and think that they're not doing the right thing or doubt themselves and how they're supposed to handle the situation and how they've handled other children in their care. So, I feel like that's just the greatest challenge of all, at least in my experience.

Two respondents noted that listening skills were attributes needed by teachers working with young children who may have experienced trauma. Participant 6 explained,

> I think just listening to the kids, and if you think that something is happening, just listening and letting them know that you're there, and they're in a safe place. You're a person that they trust. In my household, we use the term 'trusted adults.' As a mother, I like to use the word 'trusted adult' so that they know that I'm somebody they can talk to.

Participant 10 identified several skills teachers might need, “Nurturing and listening skills. Just to be there for them, just to recognize the signs that they might need extra care. Empathy.”

Two participants voiced a desire to be leader in the ECCE field. Participant 2 stated,

> I have kind of, in the last few years, really learned how to be an advocate for them. And you know, not be afraid to push some buttons to ask them questions to try to get them the help that they need and that they deserve.

Participant 2 later added, "Being proactive. There's been some times that I've taken some online courses about things that I need to know more about." Finally, Participant 4

stated," I have also done my fair share of research in trauma care just because I enjoy doing research on how to better myself as a teacher."

Resources and Professional Development Available to ECCE Teachers

Participants were asked to describe how they gained information and skills about social-emotional development and instructional strategies for effectively working with young children who may have experienced trauma. Answers to questions resulted in identifying three subthemes: resources needed by ECCE teachers, professional development available to ECCE teachers, and networks and organizations accessed by ECCE teachers. The following three sections provide additional detail for each of the three subthemes.

Resources needed by ECCE teachers. Respondents acknowledged the need for additional help inside the classroom, communication with the family, and external resources. Participant 10 stated,

> I would say maybe resources like another person to help me to help them [students]. Resources to help me to back the child or give me insight about how to help them. Any extra information or resources to help me help them.

Participant 3 offered,

> Getting the right resources to be able to help that child not just at school but when they're not at school. To help the behavior of that child in the whole child aspect. Taking that approach, I feel like it not only helps that kiddo but also helps me balance my classroom. So, we know what to do when Joey's crying for this or that. We have tools in place to help that child.

Professional development available to ECCE teachers. When ECCE teachers were asked how they gained information and strategies for effectively teaching young children who may have experienced trauma they described a variety of venues. Examples included post-secondary courses, face to face classes, online sources, and personal research. All participants had obtained professional development through in-person classes. Participant 4 commented,

> [I need] lots of training in what to do. I'm more of a hands-on kind of person. I appreciate someone coming in and showing me how to go through the motions of how to deal with a situation instead of just watching it on online training or having a PowerPoint shown to us.

Participant 1 stated, “It's all been in person.” Nine respondents had also obtained training online. Participant 8 responded, “Most of our yearly trainings like our modules and stuff we did online.” Participant 6 mentioned, “Courses through school are online.” Participant 9 identified specific online classes, “I've done a few of the courses in the KCCTO program.” In addition to classes, Participant 3 said, “I've done a lot of just sitting back and observing what's going on and taking notes.” Participant 2 noted, “There's been some in-person trainings, and there’s been some online trainings, especially about the COVID and those sorts of things. Some of its just word of mouth, you know, like meeting with other teachers.”

Regarding information on social-emotional development, Participant 5 noted, “I've not had any formal training that I can tell you exactly. I've gotten the information that I have from coworkers and management and trainings over the years. I took Child Development in college too.” Participant 6 explained,

> Learning about social-emotional education is fascinating for me. I think children who have experienced trauma might have bigger emotions you can see more quickly. So, I think me having at least some sort of education, a teacher's in-service or my child development classes, has helped me always learn as an educator.

Participant 5 stated,

> Once you've gotten your child abuse and neglect, your first aid, and safety, then what? That's it? We're done. Twenty-nine years ago, I did that? I don't remember much from it. I did it so long ago, decades ago, but there's nothing after that. And in-service may or may not touch on it [trauma] during professional development days. There's just not a lot of training out there that, at least from my point of view, that we're exposed to or know of.

Participant 3 shared, “I’ve had very little training on it [trauma] through a few websites. But besides that, that's really all the information and tools that I've been given or have been able to find on dealing with kids with trauma in the classroom.” Participant 6 acknowledged, “We do have our in-service days where we learn about the trauma.” Participant 9 mentioned, “Just taking classes and stuff.” Participant 6 recalled,

> One of my [CDA] classes is actually pretty much geared toward classroom management and dealing with children who have experienced trauma. It's based on understanding how to deal with them and making sure they have a safe space, making sure that they can talk to you. And they just have a space to deal with those emotions.

Participant 7 explained, “I would definitely say training classes, only because there are certain children that have struggled with more traumatic experiences than other children. I think we, as individuals, as teachers, we need to know what and how to resolve an issue.” Participant 9 reported, “My center is doing a trauma care training that we're starting the school year with presented by someone. We're starting to learn different ways to help kids that are in trauma.”

Four teachers reported that Conscious Discipline®is a resource for professional development. Participant 2 commented, “We built in a lot of training with Conscious Discipline®. So that was kind of an underlying curriculum or strategy that we used there." Participant 4 stated,

> We've also had a couple of Conscious Discipline® trainings with people who have been certified in Conscious Discipline® throughout the years. We also have a couple of resources. One of our directors is trained in Conscious Discipline® so we could always ask her questions and talk to her about different things. And I think that might be all.

Participant 8 reported, “We've done Conscious Discipline® training. And we've done several yearly trainings, but nothing specifically for the kids that need you more than others.” Participant 3 said, “I've really researched on my Conscious Discipline® website for tools and things through Becky [redacted], and what information she has on trauma, and how to help children with it.”

Participant 4 described another professional development resource, "We have had a lot of meetings. She [the director] definitely wants us to have basic information before we walk into the classroom. So, we do modules from KCCTO. We do a bunch of things

through there." Participant 2 recalled, “At one center I worked in we did use some social-emotional curriculums, and things like that to try to help. We used the Second Steps, social and emotional curriculum.”

Five respondents revealed they gain information through reading. Participant 5 remarked, "I know that I read everything that comes across my newsfeed or my news apps. They all know I'm interested in childcare-related things. So, all those things pop up." Participant 2 shared, "I've also read a couple books. Mostly like parenting books, but sometimes those can relate into the classroom as well." Participant 9 mentioned, "Just learning kind of from a book." Participant 7 reported, “I'm always reading stuff on the internet of new things that are coming out in child care and new things about children having emotions and people not understanding them.” Participant 1 said, “I also read a lot online. And I will seek out information if I have a specific behavior or something that I feel is a little out there.”

Networks and organizations accessed by ECCE teachers. All 10 respondents reported they had contact with organizations and agencies that provide support for children that may have experienced trauma or an informal network of colleagues and peers. Four of 10 participants reported personal connections to professional agencies and organizations that support children who may have experienced trauma. Participant 10 shared she received support through the foster care system, “I'm fostering my niece right now who has gone through trauma, and I've taken [foster parent] classes that have helped me.” Participant 5 disclosed,

> I've been sending people to the school district for decades to get screened for that 3 - 5-year-old Early Childhood Developmental Screening the Shawnee Mission

> School District has there once a month. One of my students and her caseworker came by today from Johnson County Mental Health. This child doesn't have any obvious behavioral challenges. She fits right in. And so, I asked the lady what I can do to get help for the kids that I really could use assistance with. [She said] you just have to refer them to Johnson County Mental Health. She said that they are teaming up with the school district. Evidently, the mental health clinic is now working with the school districts for those intake sessions. That was exciting news that they were teaming up.

Participant 1 recounted,

> I was feeling a little burned out. I took one year off. During that time, I was volunteering. I learned so much about the systems that are in place. I completed my CASA volunteer training. And then, I went on to the LeAnn Britton Center, which is now the BC center. I worked as a para there. I learned so much from watching those teachers that have been doing that for years. I was trauma-informed trained through that.

Participant 9 recalled, “I have experience with children that have behaviors and are on the spectrum. In my 10 years of early childhood, I was a para-educator in the school district for three years.” Participant 2 reported,

> The only center that I've worked in that really had a partnership with someone was the Family Conservancy. The Family Conservancy aided in all of those trainings. Had we not had that partnership, I don't know that we would have gotten those trainings. I don't know that we would have known about the trainings about trauma-informed care.

Four participants noted that they rely on an informal network of peers and colleagues to gain information and support when working with children who may have experienced trauma. Participant 9 commented,

> Just asking veteran teachers, 'Hey, you know, I'm not quite sure about this child, you know, behavior and the way they're acting, is that normal?' Somebody who may have a little bit more experience than me maybe will say, 'Yeah, pretty normal for the age.'

Participant 1 stated, “I can also reach out to the people that I worked with prior to my current setting and get some tips. I also troubleshoot with my other teachers.” Participant 2 explained,

> I depend on my peers and coworkers a lot. 'Hey, I have a kid doing XYZ. What has worked for you?’ Kind of bounce those ideas off or calling upon more professionals in the field like the school social worker, psychologist, or whoever might have some resources that could help in those ways.

Participant 7 emotionally described,

> I also have a friend. Her and her kids have gone through a lot of trauma in their life. She lost a son at three months old from SIDs. Her older kids witnessed the ambulance and everything. So, I've dealt with a lot of that with her and her children. So, I learned a lot from her. Only because she has so much going on, I take a lot of her advice and a lot of her information. I always have it in the back of my head.

Participant 7 continued, “There's also some Facebook groups with parents that talk about their children and their emotions and types of therapy or stuff that they've read or learned about. I get a lot of information from them as well.”

Challenges Working With Young Children Who Have Experienced Trauma

Participants identified numerous challenges facing ECCE teachers working with young children who have experienced trauma. Within this theme, six subthemes emerged from the participant's responses: lack of awareness of trauma, needs of children who may have experienced trauma, the lack of preparedness of ECCE teachers, lack of relevant training opportunities for ECCE teachers, lack of research regarding young children who may have experienced trauma, and attitudes toward ECCE and trauma. Each of the six subthemes is described in additional detail in the next sections.

Lack of awareness of trauma. Six participants commented about the lack of awareness about trauma, noting that people have never heard of trauma in young children and do not understand or recognize it. Participant 2 acknowledged, “[I] never heard of trauma-informed care 10 years ago.” Participant 1 stated, “People don't recognize what it [trauma] is.” The teacher continued,

> [I] feel like it's still fairly new. I remember being trained back with CASA, and they were saying that they are getting ready to do all of the trauma-informed training to schools. And I don't know if that, in fact, happened.

Participant 3 commented, “There's a lot of trauma that is out there that is related to children that people don't understand. That's trauma as well.” Respondent 4 revealed, “They don't really read or observe the signs of trauma or challenging behaviors in children.”

Participant 7 expressed her concern, “I think teachers need to be more aware of what they need to look for - signs and symptoms. Kids who may just not be there and just be super upset.” Participant 5 shared the confusion among her coworkers,

> One of my coworkers had a baby with a blue bottom. It was actually a greenish bluish tint. And they immediately jumped to ‘Oh, my gosh! He’s been spanked so hard that there's a bruise.’ They didn't think about the fact that the baby just had a birthday and that it ate a bunch of icing that had discolored its poop. They immediately wanted to redline it and call it [abuse].

Participant 7 stated,

> As a teacher, I think we have other members of our staff that do not recognize it [trauma] or seek it [training] out. So sometimes, if you have to have an assistant in your classroom, they may handle something totally different than you would have handled it. That is my frustration.

Needs of children who may have experienced trauma. Four participants described young children's needs: the need for special attention, the skills to release anger and get into a calm state, and someone present to support them. Participant 10 recognized,

> They [children] need resources to help release that anger and help to get them in a calm state, and to know how to bring their emotions down. Kids have such big feelings and so many feelings that they don't understand. And so we have to help teach them about the feelings and the emotions that they feel because they don't know how to recognize them.

Participant 7 commented,

> Basically, just making sure that each child in the classroom knows where they stand. And I think that some teachers in the classrooms don't know how to deal with children that are having a blowout of being very upset and not knowing how to calm down. And I think that's a key importance for not just the children, but I think it's more key for the teachers to know how to make that child feel a little bit better, supporting them through whatever they need for their schooling or their friends.

Participant 10 remarked, “We have to keep reminding ourselves that this child has been through way too much. And they need special attention. They need special things in their life.” She also offered,

> We've got so many children coming through our class that we forget sometimes, 'Oh, this child needs me. I need to make special arrangements in my class for the needs of this child so that the other children don't really notice who takes away from them’.

Participant 7 said, “Any child that has had any trauma in their life, definitely [needs] having somebody there for them, to show them emotions and show them how to calm down.”

Three participants noted the developmental needs of children. Participant 1 stated,

> We look at our little three-year-olds who have not really remembered anything outside of living in a pandemic. So, we were talking about, for example, a lot of teaching and learning goes on through facial expressions with the masks. You

> know, for one year, you can probably get it. We are now starting basically our third year affected by this. So, like one thing that I'm doing, I'm wearing a mask lanyard. So, I can pull my mask down and stand far away because a "B" and a "V' sound the same inside there. I want them to see my face more. We're just trying to be creative with how to maybe get some of the little ones with what they just missed out on. But it will be interesting to see how that's going to impact them in the long run.

Participant 3 expressed her concern,

> It's important to me, with this whole mask thing, different people feel different about it. Kids are traumatized by that unfortunately. And my kiddos that are special needs in my room go to school every day and have to wear a mask. I know it's for their safety, and it's for the safety of others, but it's not helping develop their developmental needs. These kiddos have speech issues. One has speech, hearing, physical, I mean, he's got a long list of things. The past two years, it's been nothing but a damper on his education and physical development and mental development, too, because he can't hear you, and then he can't see your face. So, it's just, it's been really hard this year with that, and I've struggled a lot with that. I really hope that it gets changed soon, but I know it's not going to.

Participant 7 commented, “I just think we need to educate, constantly question, what can we do to get them [children] up to speed?”

Four participants were mindful of the support needed by children and teachers. Participant 8 stated, "I don't want to feel like they are getting forgotten or not getting the

things they need. But I honestly don't think that we are able to give them the things they need, at least not on a large scale." Participant 2 expressed her concern,

> They get bounced to another place, and then it's just kind of a cycle that goes down. So, trying to break that cycle in early childhood is a challenge. Obviously, not one person can be the person that solves it by themselves.

Participant 3 remarked,

> Just knowing what to do and how to do it and having a good support system is the biggest thing that we need as early educators so we can help these kiddos. Otherwise, I don't know how they can stay in a program that doesn't work for the teachers and the kid.

Participant 7 shared her thoughts,

> Children, you know, their brain is a sponge, and they remember. They don't remember everything, but it absorbs so much. Teachers do need to understand that as well. So, when the child is at home, and they're seeing these things, it's absorbing into their brain. They might have that experience. They might take it to school.

Lack of preparedness of ECCE teachers. Six respondents reflected on the lack of preparedness of ECCE teachers which included unrealistic expectations, inexperience or no experience, and insufficient skills and tools. Participant 8 stated," Honestly, I just don't think we're trained for it [trauma]. I don't think we're equipped for it [trauma]. And I don't think we're given the right tools to help those children." Participant 3 noted,

> I think more than anything; we are not educated enough on how to deal with trauma. So not having the resources provided for us, we get burned out.

> Unfortunately, places start losing teachers because we don't know what to do. We're not trained in this area of expertise. On top of the fact that we're already shorthanded in the early education field as it is. So, it just really makes it a challenge and a struggle to go to work every day and do your job.

Participant 4 reflected,

> In my personal experience, I think it's just the kind of people that enter the early child care community. Most of them don't really know what they're getting into. I mean, as a high schooler, I never imagined that I'd be a preschool teacher, you know, and that I'd be dealing with all of this.

Participant 7 voiced concern regarding inexperienced teacher hires,

> I do think that if a teacher has not had any childcare experience at all, or experience with children, definitely classes for them to take or read about something. Not all teachers are around children or have ever worked in childcare. So, they may not experience what we experience as teachers and what we know. I definitely think that they should have like a little film, or [information] in our pamphlet or booklet that we have for employment of how to deal with these things [trauma]. And if they haven't dealt with trauma, then we can all share stories of what we have gone through in our classrooms. Or if we had our own personal experience with children, then we can let them know of signs to look for. I would hate for a teacher to go into a classroom and not know anything about trauma.

Participant 1 shared an observation,

> As a teacher, I think we have other members of our staff that do not recognize trauma or seek it [training] out. So sometimes, if you have to have an assistant in your classroom, they may handle something totally different than you would have handled it.

Participant 4 said,

> Sometimes they might lack confidence and think that they're not doing the right thing or doubt themselves, and how they're supposed to handle the situation and how they're handling other children in their care as well. So, I feel like that's just the greatest challenge of all.

Participant 8 added a reflection, “The whole situation just opened my eyes up to how unprepared we are to help kids like that if we don't know the situation. And a lot of times we can't ask the situation.”

Lack of relevant training opportunities for ECCE teachers. All participants described challenges and limitations experienced in obtaining training related to the needs and challenging behaviors of children who may have experienced trauma. Participant 2 shared**,**

> Depending on where you work, it kind of depends on how much training you get. If you work at somewhere that I've worked at, you know, places that don't give you a whole lot of training. Thankfully, I have my bachelor's degree and have quite a bit of experience under my belt. But not everybody has that. And so, they don't know how to handle it. They may just think that somebody is acting out for

> attention or something like that and not really know how to figure out what the root of it is.

Participant 3 commented, “I think the biggest thing is there needs to be more training out there.” Participant 4 remarked,

> I think the biggest one is, in fact, training. Teachers don't really have the sufficient training to deal with this [trauma] appropriately, and sometimes they think that they're not doing the right thing or doubt themselves and how they're supposed to handle the situation and how they're handling other children in their care as well. So, I feel like that's just the greatest challenge of all.

Participant 5 shared an observation,

> I don't know that they [ECCE teachers] have enough training other than the first aid and safety and child abuse and neglect that we do when we first start in this field. I see a lot of teachers struggling with a student or a child and not understanding why that child is struggling. They get angry and frustrated about their child not being compliant. And then it's aggravating because you don't know what they've gone through or where they're coming from.

Two participants stated they did not have challenges in obtaining ECCE professional development. Participant 6 revealed,

> Our director, I feel like she really wants us to learn, and she wants to have a good staff. So anytime we've experienced interest in classes or asked her for help, she's really great about putting us in those courses or making sure she gives us the tools so that we can have a better education to teach the children. So, I personally haven't had any challenges with that.

Participant 1 disclosed, “I just feel like that's a matter of educating them [ECCE teachers], you know, getting the in-services in and hoping that they all seek it out to learn.”

Among the challenges in accessing professional development for ECCE teachers, five participants identified the cost of the training. Participant 9 stated, "Sometimes the cost. Sometimes if the cost of a class is $20, and I may not have that extra $20 right then and there to take that class." Participant 2 reported, "I think cost is one of the challenges. Especially when you're in a private center it can be very expensive to have somebody who is an expert in those fields provide quality training." She continued, "I think that it's hard for centers to find good quality resources and training. And then if they [teachers] do ask for the training, maybe it's too costly." Participant 5 noted, "Sometimes, the school will help pay for training. Often, the school won't or can't cover the cost involved in additional training. And they just give you the amount that you need for an annual compliance check."

Three participants acknowledged that the center pays for their professional development. Participant 4 admitted,

> I think that if [the director] wasn't providing it [training] for us, that it would be more of a money problem. I know that this training definitely cost a lot to take. She just paid for all of it. She does the same with other trainings that we've had throughout the years. And then we do our own research to try to find some free trainings throughout the year.

Participant 8 recalled, "At first, I didn't know that work would pay for it. And it was a money situation." On the other hand, Participant 6 stated, "Our center pays for it all."

Three participants talked about the availability of ECCE training. Participant 3 provided insight into the current availability of professional development,

> Right now, because of COVID, I think we're very limited to anything that is face-to-face as far as training for any topic, but trauma as well. We had a really hard time finding anything out there that was trauma-related, and I can't remember what the site was. So, we finally did find one [training session], but we really have a difficult time finding any training.

Participant 5 reported, “An absence of the knowledge obviously, is frustrating. Sometimes we don't know when there's trainings available that could help that would benefit us.” Participant 2 reported, “I think that it's hard for centers to find good quality resources and training. And then if they [teachers] do ask for the training, maybe it doesn't work with the center schedule.” She added,

> The Family Conservancy aided in all of those trainings. Had we not had that partnership, I don't know that we would have gotten those trainings from there. I don't know that we would have known about the trainings about trauma-informed care.

Three participants described the role the ECCE program took in providing professional development. Participant 7 disclosed, “I've never really thought it was hard to get training because [the director] did provide a lot of us with some trainings.” She continued, “Sometimes it just might not be on the day that is best for you. But it always seems to work out.” Participant 5 stated, “Another factor would be where they have the trainings. It is usually at the center”.

Participant 2 described the problems in finding training resources, “I think that it's hard for centers to find good quality resources and training.” Participant 2 further explained,

> I think it's more of an access standpoint. When you work for a school district, you know people. It's kind of that social network in place that you can get to a school psychologist quicker or social worker quicker to help you get in contact with places like The Family Conservancy or whatever. At a center I worked at, we just happened to have that partnership. But there's several centers that I've worked at that didn't have any partnerships like that. So, there was not really any help that they could get besides just googling, finding somebody that might be able to help, if that makes sense.

Participant 10 responded, "Challenges? Time - finding the time between just juggling life. It's been hard. But we've made it through."

Four teachers discussed the relevancy and quality of course content. Participant 8 spoke honestly, “It's also not knowing what I should be taking. I can always ask to take a class, but I don't know what classes I should take.” Participant 2 pointed out trainers may not deliver the content expected,

> Sometimes the trainings that we've had just don't address the topic. You talk to them, and you're like, we need training on this [topic], but then when they show up, they kind of go off on a different tangent. And so, it didn't really necessarily help.

In defense of the trainer, Participant 2 said, “I think in that same breath, it can also be hard for the trainer to scaffold to the teachers and the program too.” Participant 5 described her frustration regarding the relevancy of the training content,

> We have a professional development day, a half of that is dedicated towards training. But not necessarily trauma victims and how to deal with them. It's so boring because, you know, you've been through 1000 of them at this point in time, and you've heard all of it. It's just it's frustrating to listen to the other teachers.

Participant 2 reiterated, “Sometimes for the experienced teachers, it can just be a repetitive thing and not any new information for them.”

Two teachers reported little continued use of the training obtained. Participant 8 commented, "I just feel like anything that gets trained or taught to us, we use it for a little while, and then we revert back to what's natural for us, what we've always done. Participant 8 recalled,

> I was given an opportunity to take an online course. It taught me about classroom setup and how placing your shelves will stop [children] running in your classroom and having it be like a safe space that also doesn't allow them too much free space at the same time. I did learn some of that. But it didn't really stick.

Lack of research regarding young children who may have experienced trauma. Two respondents expressed the need for more research. Participant 2 noted, “There’s just been more research in the last 10 years, more studies. More knowledge base around it [trauma].” Participant 3 agreed, “I think the biggest thing is there needs to be more training out there. There needs to be more research out there.”

Attitudes toward ECCE and trauma. Three participants revealed attitudes held by adults toward children who may have experienced trauma. Participant 1 observed among her peers, "They just think that kids are behaving that way. Because they just need to be more disciplined or whatever it is, they may not understand that the child is kind of screaming out for more guidance and love." Participant 7 replied**, "**A lot of people and teachers say, "Well they are kids. It's gonna be okay. They don't remember a lot". But honestly, they do remember a lot." Participant 4 stated, "I think that most people don't take it [behavior] as seriously as they might need to." The comments offered by participants demonstrated a lack of understanding of trauma and its relationship to behavior.

Seven of 10 participants shared their expectations for continuing work in the early care and education profession and working with young children who may have experienced trauma. Three respondents described their expectations for the ECCE community. Participant 4 commented, "There should be more training involved before coming into the field or more knowledge of what the field is going to be like before hiring people." Participant 2 noted, "I wish that there was more training for those private sectors. Unfortunately, a lot of times, those are the ones that need it the most, or that have a lot of the trauma kids." Participant 10 declared, "Every teacher should be trained on it [trauma]." Three participants expressed their hopes for the future. Respondent 1 stated, "Hoping that they [ECCE teachers] all seek it [training on trauma]." Participant 5 fondly recalled, "I tell everybody I work with what I tell my students, so they will also tell all their kids how much they love them and that their class is the best class in school. Every teacher can say that to their own kiddos." Participant 7 expressed her goals, 'Being

the best teacher that I can be for all these children. I want to know everything that I can because I don't want to let these children down." Participant 6 shared her aspirations, "Hope other centers have someone who is as knowledgeable as my director." She added, "Hope everybody is passionate about it [early care and education]."

Summary

Chapter 4 provided the results of the analysis of responses to interview questions provided by 10 ECCE teachers working in KDHE licensed ECCE centers in Johnson County, Kansas. Questions focused on the ECCE teacher's experience working with children who may have experienced trauma and its impact on classroom experience. Participants reflected on the information, skills, and resources needed to provide quality ECCE for young children who may have experienced trauma. Lastly, participants shared perceptions about the challenges of accessing professional development and the networks needed to work with young children who may have experienced trauma.

Chapter 5 provides an interpretation and recommendations related to the study. This last chapter provides a study summary that includes an overview of the problem, purpose statement and research questions, methodology review, and major findings. The major findings related to the literature are reported. Finally, chapter 5 provides conclusions that include implications for action, recommendations for future research, and concluding remarks.

Chapter 5

Interpretation and Recommendations

The current study investigated ECCE teachers' perceptions about how trauma has impacted young children in early childhood center-based programs; the information and skills needed to meet the needs of young children who have experienced trauma; professional development opportunities available to them that provide preparation to meet the needs of young children who have experienced trauma; and the challenges ECCE teachers face in accessing professional development to aid them in working with young children who have experienced trauma. Chapter 5 is organized into three major sections. The first section presents an overview of the research problem, the purpose of the study and research questions, a review of the methodology, and major findings. The second section relates study findings to the current literature. Finally, the third section concludes with the researcher's implications for action, recommendations for future research, and closing remarks.

Study Summary

This section summarizes the study, including an overview of the problem. Next, the purpose statement and research questions utilized in the study are identified. Finally, this section concludes with a review of the methodology and the major findings.

Overview of the problem. The National Association for the Education of Young Children (NAEYC) (1993) reported that it is increasingly evident that teachers and child care providers who provide specialized knowledge and skills to their job are best able to offer high-quality services to young children and their families. Early care and education teachers play a significant role in young children's social and emotional development.

They are often on the front lines observing children's behaviors and interactions with peers, other adults, and the environment. ECCE staff frequently recognize or identify a challenge, a need, or a red flag in a young child's development (Sorrels, 2015). Erdman et al. (2020) reported that nearly every teacher would have contact with a child or family who has been impacted by trauma and indicated that the intervention and support a young child receives can make a critical difference in lifelong development. Slightly over one-quarter of the children ages 0-4 have experienced trauma (Bailey & Krause, 2018). Trauma in young children is a public health crisis (Erdman et al., 2020; Van der Kolk, 2014). The American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents (2008) indicated that most children and adolescents with traumatic exposure or trauma-related psychological symptoms are not identified and do not receive any help. Until recently, the efforts and funding to provide mental health training were focused on mental health professionals and clinicians, with limited training being offered to ECCE providers (Zero to Three, 2021). While there is compelling research about the development of young children and the quality of early childhood education experiences, few studies have focused on the perceptions of ECCE teachers about the impact of trauma on young children in center-based programs, the knowledge and skills needed to meet the challenges of these young students, and the availability and challenges of accessing professional development to work with young children who have experienced trauma.

Purpose statement and research questions. The purpose of this qualitative phenomenological study was to explore the perceptions of ECCE teachers about how trauma impacts young children in ECCE center-based programs and the adequacy of

professional development they receive to work with young children who have experienced trauma. Four purposes guided the current study. In addition, four research questions were formulated to address the purposes of this study.

Review of the methodology. A qualitative phenomenological research design was selected for this study. Phenomenological research focuses on the interpretation of the lived experiences of those interviewed. The phenomenon investigated in the current study was the perceptions of ECCE teachers in centered-based programs about the impact of trauma on young children, the knowledge and skills needed to work with traumatized young children, and the availability and challenges associated with accessing professional development focused on educating young children who have experienced trauma. This research method required the researcher in the current study to refrain from inserting personal experiences and focus exclusively on the participants' experiences. Constructivist-focused research allows the researcher to ask questions that lead to the inductive development of meaning from the data (Creswell, 2014).

Upon approval to conduct the study from the Baker University IRB committee (See Appendix B), 25 Facebook posts (see Appendix C) were sent to ECCE organizations, infant-toddler mental health professional groups, and ECCE programs. The social media posts were followed by individual emails inviting participation in the study (see Appendix D) to 40 ECCE centers. In addition, the invitation to participate letters were personally delivered to center directors at 20 ECCE programs in Johnson County, Kansas, for distribution to program staff. The efforts resulted in 12 ECCE teachers responding by email or text message expressing their interest in participating in the study. An email was sent to the 12 teachers confirming their interest in participating

in the study (see Appendix E). As a result, 10 individuals consented to participate in the study. The participants in this study were individuals who had two or more years of experience working directly with young children who may have experienced trauma. Participants were employed in a center-based ECCE classroom in Johnson County, Kansas, from January 2020 through July 2021. All study participants signed an informed consent form (see Appendix F) prior to engaging in the interview.

The interview protocol was reviewed by the researcher's major advisor, research analyst, and three subject matter experts (SMEs), who provided feedback on the validity, relevance, significance, and clarity of the questions of the research protocol. Two pilot interviews were conducted. Both pilot interview reviewers were teachers who had worked in ECCE centers with young children who had experienced trauma. The pilot interview reviewers examined the interview questions, provided potential responses, and offered recommendations for future interviews. An interview protocol that included eight descriptive and demographic questions and 12 open-ended interview questions aligned with the research questions were designed for the study. Interviews were scheduled from July 2021 thru October 2021 and lasted 30 to 45 minutes. The interviews were conducted using Zoom video conferencing and were recorded. The video-audio recordings were transcribed using Otter.ai, an online transcriptions service. Each transcript was assigned a number (e.g., Participant 1, Participant 2, etc.) to maintain anonymity. After each interview, the researcher reviewed each audio-video recording to confirm that the recording was intact. Each respondent participated in member checking the interview transcript by reviewing its accuracy. No modifications were received. The researcher conducted in vivo coding for each transcript and then compiled the data by each

interview question into a spreadsheet. Throughout the analysis, the researcher reexamined transcripts to refine, filter, or delete codes. The researcher utilized a streamlined code to theory model (Saldana, 2016), moving from raw data to codes, categories and sub-categories, themes, and assertions. The researcher then reviewed the categories and sub-categories to determine themes and sub-themes. One coding auditor reviewed and supported the researcher's coding procedures. The auditor agreed with the data coding and findings. One recommendation was made to merge the five themes into four themes. Further analysis was conducted. As a result, four themes were identified that reflected the respondents' perceptions.

Major findings. Participant responses to interview questions offered varied experiences in center based ECCE programs working with young children who may have experienced trauma. Data analysis identified four themes: teachers' perceptions about trauma in early care and education, professional development needs of ECCE teachers, resources and professional development available to ECCE teachers, and challenges working with young children who may have experienced trauma. In addition, multiple sub-themes were noted with each theme.

All participants reported their perceptions about trauma in the early care and education field. Four subthemes were identified: the teachers' definitions of trauma; the behaviors of children who have experienced trauma; responses of other children to a child who has experienced trauma; and teachers' responses to the behaviors of a child who has experienced trauma. All 10 study participants indicated that trauma is an event that impacts a child's future. Examples of traumatic events included abuse and neglect, divorce, absence of a parent, death, and the pandemic. All participants described a range

of behaviors observed in children who may have experienced trauma. Examples of children's behavior included aggression, regression, separation anxiety, and eating issues. Two participants commented that children were expelled from the child care facility due to the severity of a child's behavior in the early childhood setting. All participants shared multiple ways the behaviors of a child who may have experienced trauma impacted the other children in the ECCE program. Teachers described occasions when classmates avoided the child with the challenging behaviors or were frightened by the challenging behaviors displayed, or engaged in similar behaviors exhibited by the children. Participants reported how a child's challenging behaviors impacted their ability to manage classroom experiences and learning activities. Participant 8 summed up classroom activities, "There are good days and bad days. There have been days where I was able to have my class just normal." Four study participants disclosed teachable moments, the adjustments made in classroom routine and activities, and expressed their frustrations in being the only teacher in the classroom.

All participants voiced multiple professional development needs when working with young children who experienced trauma. Three subthemes were identified: information needed, skills needed, and attributes desired for ECCE teachers. Five respondents noted a need for general information about trauma. Seven participants indicated it would be helpful to know a child's history regarding trauma and the triggers that may impact the child's behavior. Five teachers specifically described the skills necessary in the practices of Conscious Discipline®. All teachers identified one or more attributes desired for teachers of young children who may have experienced trauma.

Attributes included patience, self-confidence, listening skills, and the desire to be a leader in the ECCE field.

All participants identified the resources and professional development-available to them when working with young children who experienced trauma. Three subthemes were identified: the resources needed by ECCE teachers, professional development available to teachers, and the networks and organizations accessed by teachers. Respondents acknowledged the need for additional help inside the classroom, communication with the family, and external resources. All participants had accessed professional development through in-person classes. Nine out of 10 respondents had obtained training through online providers. Participant 2 summarized, "There's been some in-person trainings. There's been some online trainings, especially [during] the COVID." Sources of professional development included college courses, CDA classes, center in-service days and staff meetings, reading, Conscious Discipline® offerings, and KCCTO online classes. Four participants described personal connections to professional agencies and organizations that support children who have experienced trauma. Five individuals had direct contact with Kansas Infant/Toddler Services, Johnson County CASA, a school district, a foster care agency, or The Family Conservancy. In addition, four participants stated they relied on an informal network of peers and colleagues, including veteran teachers, current and former coworkers, a friend, and Facebook groups.

All participants revealed numerous challenges facing ECCE teachers who work with young children who experience trauma. Six subthemes were identified through analysis of the data: lack of awareness of trauma; needs of children who may have experienced trauma; lack of preparedness of ECCE teachers; lack of relevant training

opportunities for ECCE teachers; lack of research in the area of trauma and young children; and attitudes toward ECCE and trauma. Six participants commented about the lack of awareness about trauma, noting that people have never heard of trauma in young children and do not understand or recognize it. Four participants described young children's needs: the need for special attention, the skills to release anger and get into a calm state, and someone present to support them. Three participants described the needs and delays in language and social development of young children. Six respondents reflected on the lack of preparedness of ECCE teachers. For example, Participant 8 stated, “We're not trained for it [trauma]. We're not equipped for it. And I don't think we're given the right tools to help those children.”

All participants described the challenges and the limitations experienced in obtaining professional development related to the needs and challenging behaviors of children who may have experienced trauma. Teachers revealed difficulties in locating available professional development opportunities, the cost of training, the scheduling of training, and the relevance and quality of the training provided. Participant 2 commented, "Depending on where you work, it kind of depends on how much training you get." Participant 3 provided insight into the current availability of professional development, "Right now, because of COVID, I think we're very limited to anything that is face-to-face as far as training for any topic, but trauma as well." She added, "We really we have a difficult time finding any training." Five participants identified the cost of the training as a barrier to accessing professional development. Three respondents described difficulty in the scheduling of training. Four teachers discussed the relevancy and quality of course content. Participant 5 shared an observation, “Once you've gotten your child

abuse and neglect, your first aid, and safety, then what?" Participant 8 spoke honestly, "It's also not knowing what I should be taking." Two participants stated the need for more research regarding young children who may have experienced trauma.

Although faced with numerous challenges working with young child who may have experienced trauma all ten participants offered optimistic closing thoughts. Seven of 10 participants shared their expectations for continuing work in the ECCE profession and working with young children who experienced trauma. Three respondents described their expectations for the ECCE community. Three participants expressed their hopes for the future. Participant 7 stated, "[I want to be] the best teacher that I can be for all these children. I want to know everything that I can because I don't want to let these children down."

Findings Related to the Literature

Trauma is a negative experience that chemically impacts the brain, mind, and body for a lifetime (Van der Kolk, 2014). Reactions to traumatic events can vary from child to child and may be presented as a variety of behaviors (American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, 2008; Buss et al., 2015; Erdman et al., 2020; Nicholson et al., 2019; Zero to Three, 2020). A range of social-emotional, communication, and developmental needs can be observed in young children who have experienced trauma (Alexander, 2019; Nicholson et al., 2019; Sorrels, 2015). Because of the trauma experienced by young children, ECCE teachers may observe tantrums, aggressive behaviors, increased irritability and frustration, hyper-alert responses, increased separation anxiety, detachment, lack of interest or ability to concentrate, regression,

limited communication, or difficulty engaging adults and other children (American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, 2008; Buss et al., 2015; Erdman et al., 2020; Nicholson et al., 2019; Stone & Bray, 2015; Zero to Three, 2020). Stone and Bray (2015) reported that children who have experienced trauma might interact negatively or aggressively with classmates or adults or withdraw and not engage with others. Respondents in the current study articulated many of the same ramifications of trauma in the young children and early childhood educational settings noted by the researchers. There was consensus among all participants that trauma is an event that impacts a young child's life and may have far-reaching effects. Each participant reported one or more behaviors they had observed in children who may have experienced trauma. Seven of 10 respondents in the current study described the social-emotional and language developmental needs of trauma experiencing young children. Two participants commented that children were expelled from the child care facility because of the severity of their behaviors. Substance Abuse and Mental Health Services Administration (2020) and Tokarz (2017) reported that young children in early learning settings are expelled more than three times the number of children in elementary and secondary schools due to challenging behaviors.

Erdman et al. (2020) and Kaiser and Rasminisky (2021) indicated that early care and education programs lack the professional resources to manage the needs and challenging behaviors of children who may have experienced trauma. Bailey (2011) noted that teachers do not know what to do and are overwhelmed in their efforts to support young children with challenging behavior. According to Alexander (2019), there

is no 'how-to' manual to prescribe a teacher's most effective response when interacting with a child who may have experienced trauma. Participants in the current study voiced multiple needs related to working with young children who experienced trauma. Respondents identified information, skills, resources, and personal attributes needed by teachers of young children who may have experienced trauma. Five respondents indicated the need for general information about trauma. According to Alexander (2019), Erdman et al. (2020), and Sorrels (2015) teachers will better understand the impact trauma has on young children and be better able to respond to their needs when they possess a definition of trauma and the possible resulting behaviors. Seven current study participants wanted a child's background information regarding trauma and the triggers that may impact the child's behavior. Nicholson et al. (2019) identified several skills needed by teachers, recognizing children's observable reactions to stress, minimizing the traumatic triggers in their classroom environments, and strategies to aid children in calming and self-regulation. Five participants in the current study described the skills and practices of Conscious Discipline®. Conscious Discipline® is a social-emotional learning program that is trauma-based and trauma-informed. In addition, the program is scientifically and research-based (Bailey, 2011, 2017). Bailey and Krause (2018) stated that establishing relationships with children having experienced trauma is difficult. It requires patience, empathy, and persistence. All participants in the current study identified one or more attributes desired for teachers working with young children who experienced trauma. Attributes included patience, self-confidence, listening skills, and the desire to be a pathfinder in the ECCE field.

According to Erdman et al. (2020) and Stone and Bray (2015) teachers cannot singlehandedly meet the needs of young children. However, they are critical advocates for better resources and support services for young children. Participants in the current study acknowledged the need for additional help in the classroom, support from outside of the classroom, and communication with family. Stone and Bray (2015) stated that teachers must remember that they do not work in isolation in schools. Young children grow and develop with a vast array of needs met through a network of individuals and services (Zeanah & Zeanah, 2019). Within the state of Kansas, access to infant-toddler mental health services varies. In addition, the availability of services differs in regions due to the funding, the number of trained mental health professionals, and the community focus and priorities (Kansas Health Institute, 2012; The Family Conservancy, 2021; Zeanah & Zeanah, 2019). Four participants in the current study described personal connections to professional agencies and organizations that support children who have experienced trauma. Five respondents had direct contact with at least one agency: the foster care system, Johnson County Mental Health, Johnson County CASA, a school district, or The Family Conservancy. Four participants stated they rely on an informal network of peers and colleagues, including veteran teachers, current and former coworkers, friends, and Facebook groups.

According to LeeKeenan and Chin Ponate (2018), professional development refers to training and educational experiences that support professional growth, online coursework, workshops, conferences, onsite technical training and assistance, books, professional journals, and professional learning communities. All 10 current study participants had accessed professional development through in-person classes.

Participant 2 indicated, “There’s been some in-person training. There’s been some online trainings, especially during the COVID.” Nine out of the 10 respondents had obtained training through online sources. Respondents indicated training occurred through college courses, CDA classes, center in-service days and staff meetings, Conscious Discipline® offerings, KCCTO online classes, and personal reading. Four of the 10 respondents in the current study discussed the relevance and quality of professional development content.

Early childhood teachers are receptive and searching for knowledge and skills, yet current professional development fails to provide theoretical knowledge of child development or the relevant application of the information to their work with children and families (Alexander, 2019; Hamre, Partee, & Mulcahy, 2017; Rhodes & Huston, 2012; Zaslow, Tout, Halle, Vick Whittacker, & Lavelle, 2010). Bailey and Krause (2018) indicated that no matter a teacher's educational or professional background, no one enters work with children who may have experienced trauma with the skills they need. Several researchers cited that the early childhood field has limited resources about trauma-informed practice (Alexander, 2019; Nicholson et al., 2019; Van der Kolk, 2014; Zaslow et al., 2010). Nicholson et al. (2019) observed that educators of young children have significantly few professional development opportunities compared to professions such as social work, nursing, or K-12 teachers. Dickinsen and Brady (2006) stated that funding ECCE programs, inclusive of professional development and training, is a critical challenge across the country. Most ECCE centers and family care providers are inadequately financed and lack the federal and state funds supporting Head Start/Early Head Start to provide training for teachers (Hamre et al., 2017; National Academies of

Sciences of Engineering and Medicine, 2022). Sim et al. (2019) noted that limited resources are available to an ECCE teacher, including time and funding. Three participants in the current study reflected on the lack of preparedness of ECCE teachers. Participant 2 disclosed, "Depending on where you work, it kind of depends on how much training you get." Participant 3 provided insight into the current availability of professional development. "Right now, because of COVID, I think we're very limited to anything that is face-to-face as far as training for any topic, but trauma as well." She added, "We really have a difficult time finding any training." All participants in the current study described challenges and limitations experienced in obtaining professional development related to children's needs and challenging behaviors who may have experienced trauma. Participants described difficulties in locating available professional development opportunities, the cost of training, the scheduling of training, and the relevance and quality of the training provided.

Conclusions

The current study investigated ECCE teachers' perceptions about how trauma has impacted young children in early childhood center-based programs; the information and skills needed to meet the needs of young children who have experienced trauma; and the adequacy professional development opportunities available to them that provide preparation to meet the needs of young children who have experienced trauma; and the challenges ECCE teachers face in accessing professional development to aid them in working with young children who have experienced trauma. Ten ECCE teachers participated in the qualitative interviews. This section includes the researcher’s recommendations for action, recommendations for future research, and closing remarks.

Implications for action. Participant responses to interview questions in the current study provided insight into the needs of ECCE teachers and the resources ECCE teachers accessed when working with young children who may have experienced trauma. Participants reported that they and their colleagues possess limited knowledge about trauma and the skills needed to work with traumatized young children effectively. The results of this study have implications for additional support, resources, and professional development that is relevant and accessible.

ECCE teachers indicated they have limited resources and time to seek meaningful training opportunities from program administrators, the local resource and referral agency, and post-secondary institutions to fill in the gaps in trauma awareness and effective classroom management strategies. Early childhood administrators must consider steps to embrace and implement trauma-informed/trauma-sensitive programs to provide safe, positive relationships among children, staff, and families. To foster success for teachers and children, administrators of early care and education programs must develop a comprehensive professional development plan to support teachers' understanding of trauma awareness and the skills to employ trauma-sensitive strategies. A plan may require including a social and emotional learning (SEL) program such as Conscious Discipline®, the HighScope® Preschool Curriculum, or the Pyramid Model for Promoting Social Emotional Competence in Infants and Young Children. To bring a comprehensive professional development plan to fruition, ECCE owners, administrators, and center directors must communicate with resource and referral agencies about the need for relevant, frequent trauma-informed training for ECCE staff. In addition, they must communicate with post-secondary institutions voicing the need to provide in-depth

content on trauma in social and emotional development classes and offer accessible continuing education classes. ECCE owners, administrators, and directors must seek opportunities to collaborate and participate in cross-disciplinary partnerships in the community and region and engage in a search for infant- toddler mental health professionals and organizations to build a partnership for referrals and consultation and training for staff and families.

With the awareness that ECCE professionals seek and require relevant information and skills to work with young children who have experienced trauma, individuals and organizations must answer the call to provide accessible and affordable professional development to the private sector ECCE professionals. A review of the literature for this study revealed that research and professional development are currently available to infant-toddler mental health clinicians and service providers. Infant-toddler mental health professionals must reach out and develop partnerships beyond Head Start/Early Head Start and school districts to meet the needs of private sector ECCE programs and family care providers. Efforts must be made to expand the training opportunities usually provided to mental health professionals working with young children who have experienced trauma to ECCE teachers and family care providers. Assistance and support must be offered to ECCE owners and administrators to create and maintain trauma-responsive early care and education programs.

In order for ECCE professional and infant-toddler mental health professionals to best support young children who may have experienced trauma and their families, individuals and organizations must become collaborators and advocates. Time and effort must become a priority to alert policymakers and elected officials at the local, state, and

national levels about the mental health needs of young children and their families. In addition, policies and funding are needed to support professional development. All individuals caring for and educating young children must consider joining the advocacy efforts of NAEYC, Power to the Profession, and Zero to Three.

Parents are a child's first teacher. Families cannot be ignored or left out of partnerships with ECCE professionals and infant-toddler mental health specialists. Communication and efforts must be made to support young children who have experienced trauma. Families also have a role in advocating for their children's health and emotional well-being. Parents of young children must trust their early care and education providers and be willing to courageously share their traumatic histories, voice their concerns, and develop lasting partnerships that will benefit their children.

Recommendations for future research. The experiences described in the current study may provide insight into increasing the relevant professional development opportunities focused on information and skills to aid ECCE teachers in working with young children and their families who may have experienced trauma. The current study involved 10 ECCE teachers. The participants in this study were individuals who had two or more years of experience working directly with young children who may have experienced trauma. Participants were employed in a center-based ECCE classroom in Johnson County, Kansas, from January 2020 through July 2021.

The current study included only ECCE teachers in center-based early learning programs. Researchers have reported that over 3 million home-based ECCE providers may work with young children who have experienced trauma. The first recommendation based on the findings of the current study is to examine the perceptions of family care

providers about how trauma impacts young children in family care programs and the adequacy of the training family care teachers receive to work with young children who have experienced trauma. A future study could investigate similarities and differences between ECCE family care teachers and providers and center-based teachers and providers.

The sample was limited by geographic location where participants were employed in a center-based ECCE classroom in Johnson County, Kansas. A second recommendation for future research is to conduct a study similar to the current study to include ECCE teachers and providers across Kansas. The current study involved the use of a qualitative research design. A quantitative research design using a survey focusing on elements of the current survey could be used to investigate ramifications of trauma in early care and education, teachers' professional development needs working with young children who may have experienced trauma, resources and professional development accessed by ECCE teachers, and the challenges working with young children who may have experienced trauma. Data could provide more in-depth information about each variable. The current study included only classroom teachers in ECCE centers. Therefore, the third recommendation for future research is to study ECCE directors, administrators, and owners' perceptions of trauma-informed care and their access to professional opportunities to offer them and practices they may provide or refer their staff.

Existing research has indicated that ECCE teachers affiliated or employed with Head Start/Early Head Start programs and school districts have access to professional development to support teachers when working with young children who have

experienced trauma. Therefore, a fourth recommendation for future research is to explore the local, regional, and national infant-toddler mental health resources currently available to ECCE not affiliated with Head Start/Early Head Start or a school district. In addition, the study may examine how professional development opportunities may be accessed and collaborations formed with the private sector to support children and families who may have experienced trauma.

The current study was initiated before the COVID-19 pandemic. Therefore, the literature reviewed did not reflect the present circumstances of experiencing a collective traumatic event. The final recommendation for future research is to study the impact of the COVID-19 pandemic on information, resources, and professional development developed and accessible to the private sector ECCE teachers, programs, and family care providers in their support of young children and families who have experienced the trauma of the pandemic.

Concluding remarks. Through the experiences of the COVID 19 pandemic, it is apparent that individuals involved in the early care and education workforce are essential to the economy, the well-being of families, and the growth and development of children (Hogan, 2020; Lee & Parolin, 2021). The early care and education workforce includes nearly 2 million individuals in center-based programs and over 3 million in family care settings (Rhodes & Huston, 2012). The available literature suggests that the field of early care and education has been fragmented due to its origination, governance and affiliations, and funding sources. Over the past 30 years, efforts have been made to develop a collaboration among ECCE professionals to create a united workforce, identify professional designations, align professional preparation, advocate for compensation, and

gain government recognition and support (Hogan, 2020; LeeKeenan & Chin Ponte, 2018; Power to the Profession Task Force, 2020). Early childhood development and emotional health are critical to a child's future well-being. Access to quality early care and education and mental health services for young children who need them diminishes the risk of problems later at home, school, and in the community (Kansas Health Institute, 2012; Van der Kolk, 2014; Zeanah, & Zeanah, 2019). The information gained by mental health professionals has been slow to move into the field of ECCE (Buss et al., 2015; Sorrels, 2015). Collaborative efforts must be established and continued through local, state, and national networks comprised of early care and education and infant-toddler mental health professionals, for-profit and nonprofit organizations, and resource and referral sources, including ECCE teachers and administrators (Hogan, 2020; Zaslow & Martinez-Beck, 2006; Zero to Three, 2021). This study contributed to the literature as it is the first to examine ECCE teachers' perceptions about how trauma impacts young children and classroom experience in ECCE center-based programs and the adequacy of the training ECCE teachers receive to work with young children who have experienced trauma. Findings from the interviews and data analysis confirmed existing literature regarding the ramification of trauma on children's behavior and its impact on the ECCE classroom. Participants described the need for information about trauma, the skills, and resources to meet the needs of children in their classroom who have experienced trauma and manage classroom activities. Additionally, each participant reported challenges in accessing resources and professional development to support working with young children who may have experienced trauma. Currently, KDHE licensing requirements and post-secondary coursework do not focus on trauma or trauma-informed practice.

ECCE teachers face numerous challenges in accessing the professional development they seek or perceive that is needed to provide quality early care and education and work successfully with young children who may have experienced trauma. The current study's findings identified the need for collaboration among ECCE professionals and infant-toddler mental health practitioners and organizations to provide relevant professional development for ECCE teachers and providers and advocate for young children and their families who have experienced trauma.

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Appendices

Appendix A: K.A.R. 28-4-428a. Education and Training Requirements.

K.A.R. 28-4-428a. Education and Training Requirements.

(a) Orientation.

(1) Each person shall, before applying for a license, complete an orientation program on the requirements for operating a preschool or a child care center. If the person is not an individual, the person shall designate an individual to meet this requirement. The orientation shall be provided by the county health department or the secretary's designee that serves the county in which the preschool or child care center will be located.

(2) Each licensee shall provide orientation to each program director not later than seven calendar days after the date of employment and before the program director is given sole responsibility for implementing and supervising the program.

(3) Each licensee shall ensure that orientation is completed by each staff member who will be counted in the staff-child ratio and by each volunteer who will be counted in the staff-child ratio. Each staff member and each volunteer shall complete the orientation within seven calendar days after the date of employment or volunteering. Each staff member shall complete the orientation before being given sole responsibility for the care and supervision of children.

(4) Each licensee shall ensure that the orientation for each program director, staff member, and volunteer is related to work duties and responsibilities and includes the following:

(A) Licensing regulations;
(B) the policies and practices of the preschool or child care center, including emergency procedures, behavior management, and discipline;
(C) the schedule of daily activities;
(D) care and supervision of children in care, including any special needs and known allergies;
(E) health and safety practices; and
(F) confidentiality.

(b) Health and safety training.

(1) Each staff member who is counted in the staff-child ratio, each volunteer who is counted in the staff-child ratio, and each program director shall complete health and safety training either before employment or volunteering or not later than 30 calendar days after the date of employment or volunteering. Each staff member shall complete the training before being given sole responsibility for the care and supervision of children.

(2) The health and safety training shall be approved by the secretary and shall include the following subject areas:

(A) recognizing the signs of child abuse or neglect, including prevention of shaken baby syndrome and abusive head trauma, and the reporting of suspected child abuse or neglect;

(B) basic child development, including supervision of children;
(C) safe sleep practices and sudden infant death syndrome if the individual will be caring for children under 12 months of age;
(D) prevention and control of infectious diseases, including immunizations;
(E) prevention of and response to emergencies due to food and allergic reactions;
(F) building and premises safety, including identification of and protection from hazards that could cause bodily injury, including electrical hazards, bodies of water, and vehicular traffic;
(G) emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event, including violence at a facility;
(H) handling and storage of hazardous materials and the appropriate disposal of bio-contaminants, including blood and other bodily fluids or waste; and
(I) precautions when transporting children, if transportation is provided.

(3) Each staff member counted in the staff-child ratio, each volunteer counted in the staff-child ratio, and each program director who was employed at the facility before July 1, 2017 and who has completed the training in the subject areas specified in paragraphs (b)(2)(A), (B), and (C) shall be exempt from training in the subject areas specified in paragraphs (b)(2)(D) through (I).

(c) Pediatric first aid and cardiopulmonary resuscitation (CPR) certifications.

(1) Each staff member counted in the staff-child ratio, each volunteer counted in the staff-child ratio, and each program director shall obtain certification in pediatric first aid and in pediatric CPR as specified in this subsection either before the date of employment or volunteering or not later than 30 calendar days after the date of employment or volunteering.

(2) Each individual who is required to obtain the certifications shall maintain current certifications.

(3) Each licensee shall ensure that, for each unit in a preschool or child care center, at least one staff member or volunteer counted in the staff-child ratio who has current certification in pediatric first aid and current certification in pediatric CPR is present at all times.

(d) Medication administration training. Each program director and each staff member designated to administer medications shall complete the training in medication administration as specified in this subsection.

(1) The training shall be approved by the secretary.

(2) Each program director and each staff member designated to administer medications who was employed at the facility before July 1, 2017 shall complete the training not later than December 31, 2017. The program director or the staff member

designated to administer medications shall not administer medications after December 31, 2017 unless the individual has completed the training.
(3) Each program director and each staff member designated to administer medications who is employed at the facility on or after July 1, 2017 shall complete the training before administering medication to any child.

(e) Education requirements. Each program director shall be a high school graduate or the equivalent. For each unit in a preschool or child care center, there shall be present at all times at least one staff member who has a high school diploma or the equivalent, as required in K.A.R. 28-4-429.

(f) Annual in-service training requirements.

(1) For purposes of this subsection, "licensure year" shall mean the period beginning on the effective date and ending on the expiration date of a license.

(2) In each licensure year, each program director shall assess the training needs of each staff member and each volunteer and shall provide or arrange for annual in-service training as needed.

(3) In each licensure year, each program director shall complete in-service training as follows:

(C) for each licensure year ending during the 2019 calendar year, 12 clock-hours; and
(D) for each licensure year ending during the 2020 calendar year, and for each subsequent licensure year, 16 clock-hours.

(4) In each licensure year, each staff member counted in the staff-child ratio and each volunteer counted in the staff-child ratio shall complete in-service training as follows, based on the staff member's or volunteer's job responsibilities and the training needs identified by the program director:

(A) for each licensure year ending during the 2017 calendar year, 10 clock-hours;
(B) for each licensure year ending during the 2018 calendar year, 10 clock-hours;
(C) for each licensure year ending during the 2019 calendar year, 12 clock-hours; and
(D) for each licensure year ending during the 2020 calendar year, and for each subsequent licensure year, 16 clock-hours.

(5) The training shall be approved by the secretary.

(g) Documentation. Each licensee shall ensure that documentation of all orientation, training, certifications, and education requirements is kept in each individual's file in the preschool or child care center.

Appendix B: Baker University IRB Approval

Baker University Institutional Review Board

June 9th, 2021

Dear Mickie Hodapp and Tes Mehring,

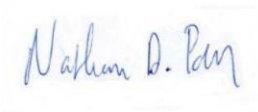
The Baker University IRB has reviewed your project application and approved this project under Expedited Status Review. As described, the project complies with all the requirements and policies established by the University for protection of human subjects in research. Unless renewed, approval lapses one year after approval date.

Please be aware of the following:

1. Any significant change in the research protocol as described should be reviewed by this Committee prior to altering the project.
2. Notify the IRB about any new investigators not named in original application.
3. When signed consent documents are required, the primary investigator must retain the signed consent documents of the research activity.
4. If this is a funded project, keep a copy of this approval letter with your proposal/grant file.
5. If the results of the research are used to prepare papers for publication or oral presentation at professional conferences, manuscripts or abstracts are requested for IRB as part of the project record.
6. If this project is not completed within a year, you must renew IRB approval.

If you have any questions, please contact me at npoell@bakeru.edu or 785.594.4582.

Sincerely,



Nathan Poell, MLS
Chair, Baker University IRB

Baker University IRB Committee
Sara Crump, PhD
Nick Harris, MS
Christa Manton, PhD
Susan Rogers, PhD

Appendix C: Facebook and Professional Messaging Board Posting

Participate in a research study on
Early Childhood Teachers Perceptions of Training to ECCE staff who Work with Young Children Who Have Experienced Trauma

Traumatic events may include a serious illness that requires significant medical intervention; the loss or life-threatening illness of a close family member; witnessing domestic or community violence or threats of terrorism; homelessness; and neglect or physical or sexual abuse.

Seeking Volunteers for Individual Interviews
to provide feedback about your early childhood experience and preparation to work with young children who have experienced trauma

Who should consider participating? Eligible early childhood education staff who are currently working with young children who have experienced trauma in a center-based program in Johnson County Kansas who have two or more years of experience working directly with young children

Date & Time will be scheduled based upon your availability and convenience.

Contact Mickie Hodapp by phone (816-898-0338) or email (michelelhodapp@stu.bakeru.edu) to sign-up or get more information.

Your thoughts and experiences are important in determining the training and support early care and education staff need when working with young children having experienced trauma.

Appendix D: Invitation to Participate

Invitation to Participate

Ladies and Gentlemen:

I am seeking preschool and child care teachers in Johnson County Kansas to voluntarily participate in a doctoral research study. The study explores the perceptions of early childhood teachers about how trauma impacts young children in the classroom and the adequacy of their preparation to teach young children who have experienced trauma.

I have worked in the early childhood field for over 20 years as an infant, toddler, preschool teacher and center director in a variety of program settings. I am currently undertaking qualitative research to complete the doctoral requirements in Educational Leadership at Baker University.

Your participation in this study is completely voluntary. There are no known or anticipated risks or discomfort associated with your participation in the study. You will not receive any compensation for participation. You may withdraw from the study at any time, or refuse to answer any individual question, or end participation at any time during the interview. Your written consent to participate is required before the interview begins. The consent form is attached to this letter.

Interviews will be conducted August 25 – September 3. One-on-one interviews will be conducted using Zoom video conferencing. It will require approximately 45 to 60 minutes of your time, scheduled at your convenience. The interview includes the 19 questions. Interviews will be audio-recorded. Confidentiality and anonymity will be maintained. Your audio-video recording and transcript will be assigned an anonymous code (e.g. Participant 1, Participant 2, etc.) known only to me. Once your interview has been transcribed, I will send you the transcript of the interview for you to review its accuracy.

The qualifications of the participant include:

- Two or more years of experience working with young children,
- Employed an child care or preschool program in Johnson County Kansas
- Employed in a center-based ECCE classroom sometime during January 2020 through July 2021.
- May have had contact with one or more young children in the center-based ECCE classroom who had experienced trauma.

Any questions don't hesitate to call or text me, 816-898-0338 or email: michelelhodapp@stu.bakeru.edu or mhodapp.hgk@gmail.com. Thank you for your consideration.

Wishing you well,

Mickie Hodapp

Michele "Mickie" Hodapp
Doctoral Candidate, Baker University

Phone: 816- 898-0338
Email: michlelelhodapp@stu.bakeru.edu
mhodapp.hkg@gmail.com

Appendix E: Confirmation to Participate

Confirmation to Participate

[Date]

Dear [Early Education Teacher's Name]:

I am delighted you have agreed to participate in my dissertation research study. This confirmation letter contains information I shared with you during our phone conversation. I am a doctoral student in the Graduate School of Education at Baker University in Kansas. I am seeking early childhood care and education (ECCE) teachers for a qualitative study regarding the perceptions of ECCE teachers about how childhood trauma impacts young children, information and skills ECCE teachers need to effectively work with young children who have experienced trauma, the training ECCE teachers have received to work with young children who have experienced trauma, and challenges ECCE teachers face regarding the availability and accessibility of professional development to aid them in working with young children who have experienced trauma.

Your participation in this study will involve approximately 45 to 60 minutes of your time, scheduled at your convenience. One-on-one interviews will be conducted using Zoom video conferencing. The interview includes 20 questions (provided below). Interviews will be audio-video-recorded.

Participation in this study is completely voluntary. There are no known or anticipated risks or discomfort associated with your participation in the study. You will not receive any compensation for participation. You may withdraw from the study at any time, or refuse to answer any individual question, or end participation at any time during the interview. All of your responses will remain confidential. Your audio-video recording and transcript will be assigned an anonymous code (e.g. Participant 1, Participant 2, etc.) known only to me. Once your interview has been transcribed, I will send you the transcript of the interview for you to review its accuracy.

The Consent Form and interview questions are included with this email. The consent form includes an agreement to participate, permission to audio-video record the interview and

allows the researcher to take notes during the interview. If you are willing to participate, please return the signed Consent Form to me at michelelhodapp@stu.bakeru.edu as soon as possible.

We have tentatively scheduled the zoom interview for _____*(date and time)*_____. Upon receipt of the Consent Form I will send an email confirming the time of our interview and the zoom link for the interview.

Although this study will not benefit you personally, I hope that the results will generate recommendations and resources for ECCE teachers to gain access to professional development opportunities that will aid and support them in working with young children who have experienced trauma.

Please feel free to contact me at 816-898-0338 or michelelhodapp@stu.bakeru.edu or my major advisor, Dr. Tes Mehring at tmehring@bakeru.edu if you have any questions about the study or interview process.

Many thanks for your time and willingness to participate in this study.

Wishing you well,

Michele "Mickie Hodapp
Ed.D. Candidate
Baker University
4016 W. 100 Place
Overland Park, KS 66207-3737
816-898-0338
michelelhodapp@stu.bakeru.edu

Dr. Tes Mehring
Major Advisor
Baker University
7301 College Boulevard, Suite 120
Overland Park, KS 66210
913-344-1236
tmehring@bakeru.edu

Appendix F: Consent Form

Consent Form

Please carefully consider the following information before deciding whether to participate in this study.

Purpose of This Study: The purpose of this qualitative study is to examine the perceptions of early childhood teachers about how trauma impacts young children in early childhood centered-based programs and the training early childhood teachers receive to work with young children who have experienced trauma.

Interview Questions: The interview will include the questions provided at the end of the Consent Form.

Interview Process: The interview will take approximately 45-60 minutes**.** The researcher will ask each participant the 20 interview questions provided at the end of the Consent Form. Additional questions may be asked to clarify responses. Each interview will be audio-video recorded and transcribed. Once the interview transcription is completed, the researcher will send the transcript to the interviewee for review of accuracy and additional comments, additions, deletions, or corrections.

Confidentiality: All responses to interview questions for this study will be confidential. A neutral code (e.g. Participant 1, Participant 2, etc.) will be assigned to the interview recording and transcript to maintain anonymity. Each interview will be audio-video recorded, transcribed, and saved to a secure database accessible only to the researcher. Your name will not be associated in any way with the research findings. Recordings and transcripts will be kept on a secure jump drive accessible only to the researcher and will be destroyed after five years.

Permission to Audio-Video Record: The interview will be audio-video recorded to facilitate accuracy in creating a transcription of the interview. Notes will be taken during the interview. Your consent to participate in the interview also indicates consent to audio-video record the interview and the interviewer to take notes.

Voluntary Participation: Your participation in this study is completely voluntary. You may choose to not answer any question in this study at any time. If you feel uncomfortable answering any of the questions, we will skip them. You may withdraw from the study at any time without penalty. You may withdraw by informing the experimenter that you no longer wish to participate (no questions will be asked). Your audio-video recording will be destroyed if you decide to withdraw from the study. If you would like to withdraw prior to the interview or after your consent form has been submitted, please contact the researcher at michelelhodapp@stu.bakeru.edu..

Risks and Benefits: No risks or discomfort is associated with participation in the study. There is no penalty for withdrawing from the study. There is no compensation or benefits for participating in this study.

For Questions Regarding This Study, Contact:

Principle Investigator:
Michele L Hodapp
4016 W. 100 Place
Overland Park, KS 66207-3737
816-898-0338
michelelhodapp@stu.bakeru.edu

Academic Advisor:
Tes Mehring, Ph.D.
Graduate School of Education
Baker University
7301 College Boulevard, Suite 120
Overland Park, KS 66210
913-344-1236
tmehring@bakeru.ed

Agreement:

The nature and purpose of this research have been sufficiently explained and I agree to participate in this study. I understand that I am free to withdraw at any time without

incurring any penalty. I understand the interview will be audio-video recorded and the researcher may be taking notes.

Signature:_____Date:

_____

Name (Printed):_____

Please return the signed consent form via email to Mickie Hodapp at:

Michelelhodapp@stu.bakeru.edu

Interview Questions

1. If you are willing please identify your age.

2. What is your highest level of education?

3. How long have you worked in the early childhood care and education field?

4. During that time in ECCE what positions have you held?

5. How long have you been employed in your current employment role?

6. What is the licensed capacity of early childhood care and education program you are currently working in?

a) 60 or fewer children

b) 61-99 children

c) 100 – 159 children

7. What is the age range of the children in your classroom?

8. Please describe other classrooms where you have worked and the age range of the children in those classrooms.

9. This research study looks at behaviors of young children who may have experienced trauma and the teachers' perceptions of being adequately prepared to work with those children who may have experienced trauma. How do you define trauma?

10. What characteristics of a child who has experienced trauma in your classroom have you observed?

11. How have the behaviors of the traumatized child impacted other children in your classroom or the early education program?

12. How has the behaviors of the traumatized child impacted your ability to manage classroom experiences and learning activities?

13. What are the greatest challenges that face early childhood teachers in the coming year in working with young children who have experienced trauma?

14. As you reflect on your experiences working with young children who express challenging or problem behaviors that may be associated with trauma what information do you perceive you need to provide quality early care and education?

15. As you reflect on your experiences working with young children who express challenging or problem behaviors that may be associated with trauma what skills do you perceive you need to provide quality early care and education?

16. Describe how you have gained information about social-emotional development of young children and characteristics of young children who have experienced trauma.

17. Describe how you have gained information about instructional strategies for effectively teaching young children who have experienced trauma.

18. How has the professional development you have participated in been delivered in-person, online, or some other format?

19. What challenges do you face in accessing professional development that would assist you in effectively teaching young children who have experienced trauma?

20. Do you have any additional thoughts or concerns regarding early childhood teachers working with young children who have experienced trauma?