ASHA American Speech-Language-Hearing Association

LSHSS

Tutorial

Applying Principles of Trauma-Informed Caregiver Coaching in Early Language Intervention

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ABSTRACT

Purpose: Childhood trauma is pervasive and can have widespread negative influences on language development. Children with disabilities, especially with communication disorders, are at elevated risk for, and have barriers to reporting, neglect and abuse. Protective factors, such as responsive caregivers and trauma-informed services, can buffer against the influence of trauma for individual children. Caregiver coaching is a common delivery method of early language intervention. Although principles of trauma-informed practice exist broadly in the field of mental health, there has been limited direct application to early language intervention. In this clinical tutorial, we aim to (a) describe how childhood trauma can impact language interaction, development, and caregiver coaching and (b) apply trauma-informed practice to caregiver coaching in early language intervention.
Method: We adapt the Substance Abuse and Mental Health Services Administration principles of trauma-informed care—realize, recognize, respond, and resist—to the context of early language development and intervention. In the first section, we use the ecobehavioral model of early language development as a framework for realizing the mechanisms by which trauma might impact children's development and their caregivers. We also describe how to apply an International Classification of Functioning, Disability and Health model of assessment to systematically and comprehensively recognize individual child and caregiver strengths and needs. In the second section, we present applied strategies for responding to trauma and resisting retraumatization.
Conclusions: The pervasiveness of childhood trauma and the uniqueness of individual experiences necessitate trauma-informed practices within early language intervention. This tutorial provides background knowledge and applied strategies for clinicians to implement trauma-informed strategies.

Childhood trauma is associated with lower academic, social, and health outcomes (Legano et al., 2021; Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). More than 67% of children report having experienced at least one traumatic event by the age of 16 years per the Substance Abuse and Mental Health Service Administration (SAMHSA, 2019). SAMHSA defines "individual trauma as an event or circumstance resulting in physical harm, emotional harm, and/or life-threatening harm. The event or circumstance has lasting adverse effects on the individual's mental health, physical health, emotional health, social well-being, and/or spiritual well-being" (SAMHSA, 2024). Importantly, whether an event is traumatic depends on the individual. Two people can encounter the same potentially traumatic event or circumstances and have very different experiences and life impacts. Additionally, the definition above highlights that experiences can be traumatic through direct or indirect exposure.

SAMHSA describes the following categories of potentially traumatic experiences: "psychological, physical, or sexual abuse"; "witnessing or experiencing domestic violence";

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"community or school violence"; "natural disasters or terrorism"; "commercial sexual exploitation"; "refugee or war experiences"; "sudden or violent loss of a loved one"; "military family-related stressors"; "physical or sexual assault"; and "serious accidents or life-threatening illnesses" (SAMHSA, 2019). Childhood trauma spans racial, ethnic, socioeconomic, linguistic, and cultural groups. However, systemic inequities (e.g., lack of safe public transit in a neighborhood) can increase the likelihood of experiencing trauma and reduce access to protective factors (e.g., trauma-informed therapeutic services; SAMHSA, 2019).

Children with disabilities—including communication disorders—experience traumatic events such as abuse or neglect at more than three times the rate of their typically developing peers (Brownlie et al., 2017; Legano et al., 2021). Additionally, young children who have experienced trauma are at higher risk for language delay or disorder (McDonald et al., 2013; Sylvestre et al., 2016). The repercussions of trauma can impact a child's learning opportunities and environment directly (e.g., limited exposure through neglect or limited responsivity from caregivers experiencing their own trauma). Trauma can also change brain function to affect learning processes (e.g., through an overtaxed stress-response system; Legano et al., 2021). Thus, child language disorders and trauma can be reciprocally influential.

Understanding the connections between language skills and trauma is supported by a systems-level perspective. Specifically, language development is a complex, dynamic, layered process (Ford et al., 2020), and the impacts of trauma can occur across levels. Within a systems-level approach to supporting early language development, trauma-informed care is a critical component of evidence-based practice for speech-language pathologists (SLPs). The American Speech-Language-Hearing Association (ASHA) highlights that a "trauma-informed model of care … emphasizes the need for behavioral health practitioners and their professional organizations to recognize the prevalence and pervasive impact of trauma on their lives and on the lives of the people they serve—and to develop trauma-sensitive or trauma-responsive services" (ASHA, 2024). ASHA recognizes the need for trauma-informed care to foster patient safety and provider well-being. An SLP's trauma-informed scope of practice includes direct action (e.g., applying principles of trauma-informed practices to our existing clinical frameworks to support individual family needs) and indirect supports (e.g., referring children and families for mental health or other services). This tutorial focuses primarily on the direct actions within the SLP's scope of practice, but we offer suggestions for referral opportunities and resources.

Given the pervasiveness of childhood trauma, especially for children with disabilities, early language intervention during the 0–5 period is a critical context for trauma-informed practice. SAMHSA describes that "a program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; **responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively **resist** retraumatization" (see Figure 1; SAMHSA, 2014). Although trauma-informed services have traction in the medical and behavioral-health fields, there is little or no specific guidance for caregiver coaching in early language intervention. Importantly, we **do not need to know an individual's trauma history** to provide trauma-informed care. Trauma-informed care involves implementing a specific set of tools to create safe, collaborative, empowered environments and is relevant for all families (SAMHSA, 2014).

Tutorial Purpose and Learner Outcomes

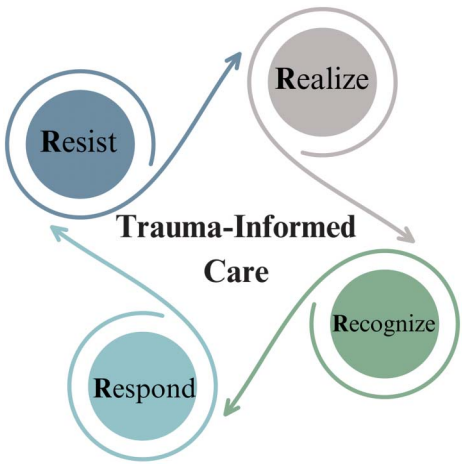
In this tutorial, we aim to connect the theoretical underpinnings of trauma-informed care specifically in early intervention to clinica-practice guidelines across assessment and intervention. The tutorial is divided into sections based on the four components of the SAMHSA (2014) model above (see Figure 1). Specifically, we address the following learner outcomes:

1) Realize and recognize: Describe how childhood trauma can impact language interaction, development, and caregiver coaching.

2) Respond and resist: Apply trauma-informed practice to caregiver coaching in early language intervention.

Within the SAMHSA (2014) model, we use an eco-behavioral framework (Ford et al., 2020) to explore the

Figure 1. Substance Abuse and Mental Health Services Administration principles of trauma-informed care.



potential impacts of trauma on early language development and intervention (Ford et al., 2020). Furthermore, we aim to support clinicians in applying the World Health Organization's (WHO's) International Classification of Functioning, Disability and Health (ICF; Centers for Disease Control and Prevention [CDC], 2024) to guide clinical decision making in caregiver coaching as part of early language intervention. We discuss how trauma can impact ICF's contextual factors (i.e., features of the developmental environment) and health conditions (i.e., identified medical, developmental, or mental health conditions or disorders), and ultimately the child's functioning and disability (i.e., strengths and support needs; Ford et al., 2020; Kostanjsek, 2011). We provide strategies for trauma-informed assessment and intervention to support caregiver-coaching in early language intervention (see Table 1) and a reflection and application activity to practice applying these principles and strategies (see the Appendix).

Importantly, many existing early intervention practices (e.g., interdisciplinary collaboration) are in alignment with trauma-informed care. Thus, clinicians might already be using some of the specific strategies presented in this tutorial. However, this tutorial offers novel opportunities for clinicians to deepen their understanding of the link between language development theory and trauma-informed care as well as expanding their tools for clinical application.

Connecting Theory to Trauma-Informed Practice

Trauma-informed practice is grounded in theoretical models and clinical guidelines spanning multiple disciplines (e.g., public health, psychology). In this tutorial, we integrate theory and practice to address the unique application of trauma-informed care in caregiver coaching as part of intervention. Within the SAMHSA (2014) realize, recognize, respond, and resist sections, we describe the eco-behavioral model of early language development (EMELD; Ford et al., 2020) theoretical framework to support clinicians' understanding of the complex, multilayered nature of development. EMELD (Ford et al., 2020) is helpful for identifying potential strengths and barriers in children's language development. However, we recognize the need for

Table 1. Applying Substance Abuse and Mental Health Services Administration's (SAMHSA's) 4Rs to early language intervention.

SAMHSA (2014) Principle	Application strategies for early intervention
Realize the widespread impact of trauma	• Describe the types, prevalence, and intersectionality of childhood trauma. • Examine how strengths and needs within children, caregivers, and learning environments can interact to shape development. • Identify potential mechanisms for trauma's impacts on child language development and early intervention.
Recognize the signs and symptoms of trauma	• Appraise a child's unique strengths and needs, considering how trauma and its effects might impact early language development or intervention. • Inspect your own early intervention assessment and intervention practices to identify opportunities for individualized, trauma-informed intervention. • Evaluate potential individual-level impacts of trauma relevant to direct services or referral, considering that each person's experiences and responses vary.
Respond by integrating knowledge about trauma	• Apply the ICF framework to assess individual caregiver, child, and family strengths and needs. • Listen and apply what you know about the child, family, and their lived experience to their individual assessment and intervention plan. • Recognize and respond your own feelings, biases, experiences, and triggers. • Plan how you will respond to sensitive information, including categorizing trauma-informed services that are directly within your scope of practice versus those which might require reporting or referral.
Resist retraumatization	• Design assessment and intervention materials that are culturally responsive, inclusive, and limit assumptions. • Practice responding to sensitive information disclosures outside of actual clinical interactions. • Support caregiver and child self-efficacy through information, planning, practice, and choices. • Assemble comprehensive referral resources with an emphasis on reducing barriers to access to additional support services.

specific recommendations to inform assessment and intervention. Thus, we demonstrate application of the ICF (CDC, 2024) clinical guidelines for trauma-informed clinical decision making in early intervention. Importantly, these frameworks provide complementary information for understanding the theory underpinning (EMELD) and practical application of (ICF) trauma-informed care specifically related to caregiver coaching in early language intervention (see Figure 2). We refer to lowercase "early intervention" throughout the tutorial to refer broadly to language-support strategies for children birth to 5 years of age. We use uppercase "Early Intervention" to indicate state and federal language-support programs specifically implemented as part of the Individuals with Disabilities Education Act (IDEA).

Realize and Recognize

Realize: Potential impacts of trauma on early language interaction and development. Children's language skills before school entry are good predictors of their later academic, social, and health outcomes (Pace et al., 2019). Strong early language skills develop through repeated, supportive interactions with caregivers. We use supportive interactions here to capture elements of early language interaction quality (e.g., mutual engagement, linguistic breadth and depth, naturalistic contexts, ecological validity, cultural responsivity; Adamson et al., 2020; Short et al., 2019) that tend to be robustly positively associated with language growth and academic outcomes. Furthermore, we recognize that supportive language interaction occurs across languages, dialects, cultural groups, and interaction contexts.

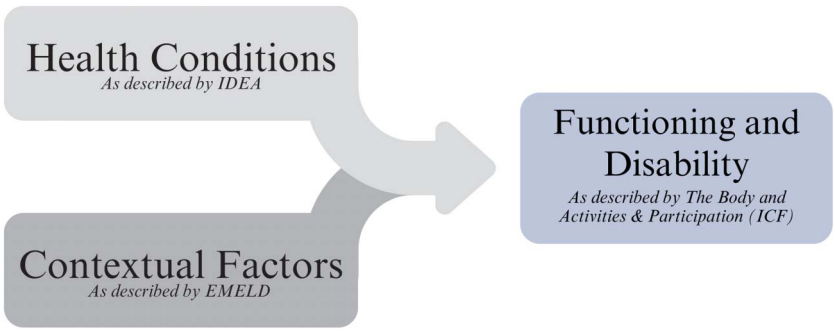
Our current understanding of supportive caregiver–child interaction, language development, and early intervention is grounded in broader models of child development (e.g., social-interactionist, bioecological, and ecobehavioral; Bronfenbrenner & Morris, 2007; Dickinson & McCabe, 1991; Ford et al., 2020; Vygotsky, 1980). These models emphasize development as a social, reciprocal process. Importantly, these models also capture how developmental processes within the child interact with their environment (e.g., caregivers, family, educational, community). Barriers and strengths at any level, including trauma and its impacts, can effect change in a child's developmental trajectory.

An ecobehavioral model of language development describes how differences at the level of the child, the caregiver, and the community environment can influence individual developmental outcomes from a contextual perspective. A recent paper by Ford et al. (2020) applied broader ecobehavioral theory to propose an "ecobehavioral model of early language development." The Ford et al. (2020) model, which we will refer to with the acronym EMELD, retains the layered nature of broader ecobehavioral models. However, EMELD focuses on potential sources of variability specific to the quantity and quality of early language interaction (Ford et al., 2020).

The layers of EMELD (see Figure 1 in Ford et al., 2020) are depicted as nested boxes, with the innermost beginning with the child and moving outward. The first box contains "caregiver–child interactions," which captures the individual contributions of the caregiver, the child, and their dyadic dynamic to language development. Moving outward, the next layer is "caregiver knowledge, beliefs, and behaviors," which includes caregiver/family culture, developmental knowledge and behavior, as well as education level. The third layer, "environmental components and resource availability," captures materials, resources, and experiences. Finally, the outermost layer, "policies and practices," captures societal needs and supports such as high-quality early childcare, early screening and identification, and educational standards (Ford et al., 2020).

Critically, EMELD (Ford et al., 2020) offers a systematic framework for considering the many dynamic factors influencing child language development proximal to and distal from the child. Given its pervasiveness and complexity, trauma can have intersectional impacts across

Figure 2. The International Classification of Functioning, Disability and Health (ICF) framework: Functioning and disability is the product of the health conditions and contextual factors. IDEA = Individuals with Disabilities Education Act; EMELD = ecobehavioral model of early language development.



the EMELD (Ford et al., 2020) model. For example, a child who has experienced relational trauma might need additional support to engage in supportive early language interaction with an unfamiliar adult. EMELD is helpful for systematically understanding the multifactorial and dynamic nature of child language development, including the potential impacts of trauma. However, it was not designed to assess functioning or directly inform treatment. Therefore, EMELD (Ford et al., 2020) can be supplemented by other frameworks for applied clinical decision making in early language development and intervention. We present the ICF framework as an applied tool to supplement EMELD in clinical decision making.

Applying Trauma-Informed Theory to Caregiver Coaching in Early Language Intervention

Protective factors such as supportive caregivers and trauma-informed support systems can buffer against the long-term negative impacts of trauma in children (SAMHSA, 2019; Short et al., 2019). Thus, assessing a child's strengths and needs systematically across levels of the eco-behavioral model is consistent with trauma-informed early language intervention (Ford et al., 2020). Individualized, trauma-informed care includes identifying the risks and protective factors that impact lifelong developmental outcomes and is supported by the ICF framework (Kimberg & Wheeler, 2019; WHO, 2002). Readers can practice identifying these factors using the reflection and application activity provided in the Appendix.

Early intervention is highly individualized, including the application of trauma-informed practices. To best characterize the child and their environment, the WHO recommends a comprehensive taxonomy, the ICF framework (WHO, 2002). The ICF is a systematic approach to observing and collecting information pertinent to the individual's functioning and support needs, or the functioning and disability of the individual. The CDC and WHO endorse the ICF as an applied framework systematically describing the functioning and disability of the individual by indexing the health conditions and contextual factors involved (see Figure 2; CDC, 2024; Kostanjsek, 2011, WHO, 2002).

The ICF is designed for "framing, describing, recording and measuring functioning" from a multidimensional perspective (Leonardi et al., 2022). ASHA endorses this system for collaborative, person-centered care and offers clinician resources for the ICF's application to speech-language and hearing disorders across child, adult, and geriatric populations (e.g., language disorder, social communication disorder, aphasia). Application of the ICF framework to capture individual strengths and needs is consistent with trauma-informed, evidence-based, clinical practice (ASHA, 2024, 2025b).

Universality, parity, neutrality, and environmental factors underlie the ICF framework. Thus, the ICF is applicable to all people, covers a breadth of health conditions (e.g., "mental" vs. "physical"), employs neutral language for the purpose of classification, and considers the context of the individual (WHO, 2002). This comprehensive, systematic taxonomy for characterizing functioning that is sensitive enough to capture the strengths and needs of children birth to 5 years. Importantly, the ICF is agnostic to etiology, meaning that functioning is assessed regardless of the possible sources of strengths and needs. Practically, clinicians are responsible for integrating knowledge about trauma into clinical practice.

The ICF functions as a clinical taxonomy and nomenclature for describing Part 1, functioning and disability, and Part 2, contextual factors. In fact, Part 1, functioning and disability, operates as the outcome of the dual influences of health conditions and Part 2, contextual factors (see Figure 2). As such, the ICF framework may be universally employed regardless of condition, disability, or function as an equation relating these three key features (Kostanjsek, 2011; WHO, 2002).

Health Conditions

Exploring the ICF equation: functioning and disability as the product of health conditions and contextual factors (see Figure 2), we first turn to health conditions. Children with or at risk for communication disorders may need intervention to maximize their language learning. IDEA Parts C (ages 0–3 years) and B (ages 3–5 years) mandate that children whose early language skills are significantly below those of their chronologically same-age peers are entitled to evidence-based Early Intervention (IDEA, 2004). Specifically, the U.S. Department of Education notes that intervention is intended to address infants and toddlers with disabilities and their families. Federal, state, and local governments are responsible for carrying out this free and appropriate education and require that Early Intervention providers complete an individualized family service plan (IDEA, 2004). Thus, eligibility for Early Intervention programming, proscribed by IDEA, is influenced by the health conditions (WHO, 2002) underlying the need for assessment and intervention. The layers and categories of the ICF clinical framework interact with one another; child disability and functioning are the products of the health conditions and the contextual factors.

Contextual Factors

Contextual factors include environmental and personal factors and are organized from proximal to distal

(e.g., support and relationships, attitudes, services, and systems and policies). Ecobehavioral models, such as EMELD, provide a theoretical framework for understanding the role of contextual factors in language development and intervention. Strengths and challenges at contextual levels interact over time to shape an individual child's developmental language environment and, ultimately, language development (CDC, 2024; Kostanjsek, 2011; WHO, 2002). The aim of trauma-informed care within the ICF is to holistically assess and support the presence of all contextual factors, including risk and protective factors.

To best scaffold clients' needs and strengths, clinicians can benefit from self-reflection practices. Specifically, reflection regarding our own biases can help prevent pathologizing or misidentifying disorders in cases of cultural difference. ASHA provides resources on cultural responsiveness and humility with the goal of reducing the negative impacts of clinician biases (e.g., see ASHA, 2025a). Systematic and thorough assessment of the child's disability and functioning using the ICF as a guide serves to limit undue clinician bias. For example, access to clinical intervention could serve as a protective contextual factor. So too could access to community and family supports such as living in a multigenerational household with multiple caregivers. Thus, when assessing and intervening, providers must consider all contextual factors experienced by the child, not only those familiar to the provider and their experiences. Providers can better recognize the signs of trauma in the child and their family with cultural responsiveness by using the ICF framework to identify protective and risk contextual factors.

Functioning and Disability

Functioning and disability is further characterized by the body and activities and participation. The body includes body functions (e.g., mental functions, voice and speech functions) and body structures (e.g., the nervous system, structures involved in voice and speech), measured or interpreted via anatomical structures or other physiological measure. Activities and participation include activities and functions of daily life (e.g., learning and applying knowledge, communication, self-care), measured by capacity and performance (CDC, 2024; Kostanjsek, 2011; WHO, 2002).

Applying the ICF Framework

Caregiver coaching is an evidence-based approach for early language intervention in the 0–5 period employed across developmental disciplines and targets a variety of outcomes. Family-centered early language intervention relies upon identifying the unique strengths and needs of each client to provide individualized intervention services. Additionally, this approach furthers the goal of providing trauma-informed care. Caregiver-coaching approaches have often focused heavily on the child's needs and specific language-support strategies, although there is a need for a more systematic approach to assessment and intervention specific to caregiver coaching in early language intervention. Early intervention begins with characterizing the child's strengths and needs (functioning and disability) based on their health conditions in their environment (contextual factors; see Figure 2; CDC, 2024). For practice applying this ICF clinical framework, see the reflection and application activity in the Appendix.

Language intervention focuses on the child's participation in the context of the family and early education. Thus, most target outcomes will relate to the child's functioning and disability (CDC, 2024), although planned goals may directly address levels, or contextual factors, described by EMELD (Ford et al., 2020). For example, intervention may address aiding the family's access to community resources (e.g., connecting families to social workers), scaffolding existing caregiver knowledge and behaviors, and facilitating caregiver–child interactions. Additionally, goals may directly target activities and participation (e.g., following two-step directions to get dressed) or body functions (e.g., approximating a new target word).

Assessment and intervention are reciprocally influential processes scaffolded by the clinician to aid the caregiver in self-monitoring and self-assessment—key coaching components. Caregiver coaching involves the clinician individually scaffolding the caregiver in shaping their child's early learning environment to support language development. There is strong empirical support for caregiver coaching as a mechanism for fostering supportive early language interaction (Akemoglu et al., 2020; Heidlage et al., 2019; Roberts et al., 2019).

Although the specific strategies vary, there are some commonly shared characteristics of early intervention programs including: family and caregiver involvement across stages, clinician modeling, opportunities for practice with feedback, an emphasis on quality over quantity, caregiver self-reflection, and ongoing support (e.g., Alper et al., 2023; Carter et al., 2011; Heidlage et al., 2019; McGillion et al., 2017; Roberts et al., 2019; Roberts & Kaiser, 2012; Rogers et al., 2012). Enhanced milieu teaching, often delivered through caregiver coaching, is an example of a robust early intervention paradigm implemented using principles of adult learning (i.e., teach-model-coach-review [TMCR] framework; Kaiser & Roberts, 2013; Kasari et al., 2014; Roberts & Kaiser, 2012; Wright & Kaiser, 2017).

Caregiver-coaching approaches offer many potential practical benefits, such as facilitating intervention in culturally

responsive, naturalistic contexts, efficiency of service-delivery, and family centeredness. Part of the move toward caregiver coaching as a model has been in response to IDEA's prioritization of intervention in the most naturalistic environment possible. Despite its many potential advantages, there are large individual differences in individual outcomes from early language caregiver coaching (Heidlage et al., 2019; Justice et al., 2019; Roberts et al., 2019).

Trauma-informed caregiver coaching within the ICF framework involves the clinician identifying the child's health conditions, characterizing the child's contextual factors, and describing the child's functioning and disability. Clinicians can determine the strengths and support needs (functioning and disability) of the child and caregivers based on the child's individual presentation of their health conditions operate within their environment (contextual factors; see Figure 2; CDC, 2024). Strengths and barriers within the child and their environment, inclusive of the child's caregivers, can shape the developmental trajectory.

Although IDEA (2004) guides the evaluation and provision of services, the ICF (CDC, 2024) framework offers a systematic approach to assessing the strengths and needs of the child via the interaction between their health conditions and contextual factors, including lived experiences or traumas. Via caregiver coaching, caregivers are encouraged to engage in all steps of the process, from the evaluation to the assessment, the intervention, and the discharge. Target outcomes are determined collectively by the team and include skills that promote functioning (CDC, 2024) in the child's naturalistic environment.

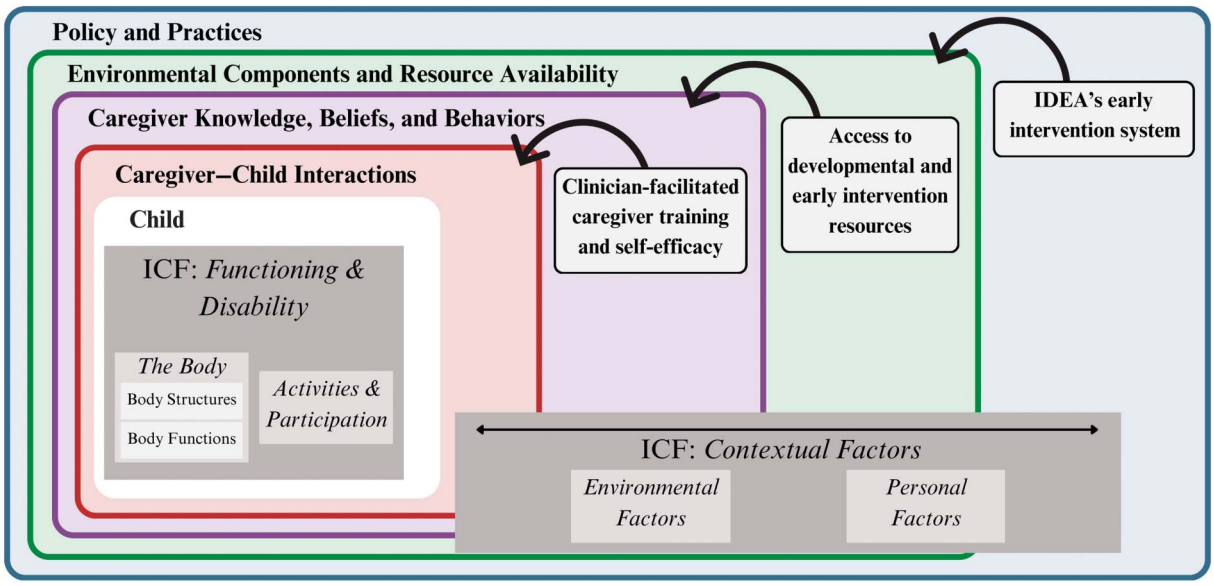
The IDEA (2004)–mandated Early Intervention system itself operates at the policy and practices and environmental components and resource availability levels of the EMELD model (Ford et al., 2020). Early intervention providers should aim to influence as many levels of the EMELD model as possible, beginning with the child but extending to caregiver–child interactions, caregiver knowledge, beliefs and behaviors, and even effecting change in families' lives by educating them on accessing resources.

Integrating ICF and EMELD

The ICF model offers a broad framework for evaluating an individual's functioning and support needs but was not developed specifically for early childhood language intervention. Thus, we suggest the combination of the theory laid out by EMELD with the practice framework described by the ICF. Employing the ICF through an EMELD lens would guide clinicians to consider caregiver, child, and family needs in the context of their environments, then support families through individualized direct and indirect services (referrals).

Together, EMELD (Ford et al., 2020) and the ICF (see Figure 3; CDC, 2024; Kostanjsek, 2011) framework can help us realize the mechanisms by which early language development and trauma may intersect broadly. Additionally, assessment using an EMELD-informed ICF approach can help to recognize the impacts of trauma on individual children and families.

Figure 3. Fitting the International Classification of Functioning, Disability and Health (ICF) and the ecobehavioral model of early language development (EMELD) together. IDEA = Individuals with Disabilities Education Act.



Moving from child factors to more distal influences, a child's or caregiver's trauma history may influence the child's language development. Indirect effects might lie in the contextual factors (ICF) and impact caregiver–child interactions, caregiver knowledge or beliefs about development (EMELD). Additionally, trauma experience might impact access to appropriate and supportive resources (EMELD). Without incorporating these practices, the systemic failures to support all families may persist via federal, state, and local policy and guidance. Thus, moving through the EMELD and ICF framework, trauma may influence the child's development through an interplay of factors (see Figure 3).

Intersectional generational and individual traumas can influence children and families in unique and compounding ways. All children exist within their contextual factors. For example, a child and caregiver experiencing persistent economic adversity might have inconsistent access to educational resources, nutritious food, or safe housing. These contextual factors could acutely influence the child at multiple levels of EMELD including caregiver knowledge and beliefs regarding development or caregiver behaviors directly shaping the child's environment including specific features of caregiver–child interactions. Although providers need not know the etiology or nature of the trauma, individualized care through understanding these nested contextual factors is a step toward trauma-informed care.

A comprehensive review of the many tiers of influence on the child's developmental environment can only be completed with the input of the caregiver. With this information, the assessment team, including caregivers, can construct a treatment plan that matches the needs of the child and family. Trauma can influence the child's contextual factors (Ford et al., 2020) and activities and participation (CDC, 2024). Providers need to remember that the caregivers and family members providing essential information about the child exist in overlapping ecobehavioral systems. Thus, it is essential to approach the therapy relationship respecting the shared as well as individual needs of the caregiver and child. Although we primarily aim to influence the child's disability and functioning, coaching approaches must consider the functioning of the caregiver. There are no health conditions absent contextual factors, and thus no functioning and disability without consideration of the child's entire ecobehavioral system (CDC, 2024; Ford et al., 2020).

In the following section, we suggest approaches to navigate early intervention, specifically caregiver coaching. A common argument in support of including caregivers as agents of intervention is the potential increase in intervention dosage the child receives. For example, the child might only spend 1 hr weekly with the therapist versus many waking hours the child interacts with their caregivers (Kemp & Turnbull, 2014). By leveraging this time and the child's natural context, language intervention can be meaningful and functional for the family. However, under the best circumstances, caregivers juggle many responsibilities including their own personal lives, the well-being of their children, and other important people in their lives. IDEA and Early Intervention (Individuals with Disabilities Education Act of 2024, 2004) mandate caregiver involvement to optimize child outcomes. However, providers must collaborate with caregivers to determine the level of involvement that constitutes a reasonable load for an individual caregiver. By considering the complete ICF (CDC, 2024) equation, early intervention providers can individualize their approach to limit the burden and maximize the impact of intervention. For practice in applying the integrated theoretical and clinical approaches of EMELD and the ICF, see the Appendix.

Respond and Resist

Trauma-informed practices and caregiver coaching in early language intervention. In the first section of this tutorial, we explored two of the SAMHSA (2014) components of trauma-informed care—realizing the pervasive nature of trauma and recognizing its signs. Specifically, we explored the potential impacts of trauma within the context of child language development and early intervention. Furthermore, we highlighted broader models of trauma-informed care that recognize the potential impacts of trauma across caregivers and children.

In this section, we will address the last two components of SAMHSA's (2014) definition of trauma-informed care—responding and resisting further trauma through purposeful practices (see Table 1). We describe trauma-informed strategies for assessment of strengths and needs, caregiver coaching, and monitoring progress within an early language intervention context. Importantly, this is a non-exhaustive list of applications for trauma-informed practice. For practice applying these clinical skills, see the reflection and application activity in the Appendix.

Assess Your Own Support Needs

The respond component of the SAMHSA (2014) framework involves putting the knowledge you have gained about trauma broadly as well as your individual client's strengths and needs into practice. A key step in implementing trauma-informed practice is recognizing and responding to what we—the clinicians—are bringing into the session. Clinicians need to put on their own metaphorical oxygen masks before they can help others. This could include recognizing if and how trauma has played a role in our lives and planning for how to care for ourselves if

triggered in a work setting. SAMHSA (2014) recognizes that physical and emotional safety for all—patients and clinicians—is part of trauma-informed care. Furthermore, clinicians may need support for secondary trauma experienced as part of clinical practice. ASHA has a Trauma-Informed Care page on their Practice Portal (https://www.asha.org/practice/trauma-informed-care/) with links to a variety of resources as a starting place for clinicians in need of support or information.

Challenge Internal Assumptions

One of the difficulties associated with applying research to practice is avoiding logical pitfalls such as making assumptions about an individual based on group-level trends. For example, while early economic adversity is associated with lower language skills at the group level, it is not an individual clinical indicator (Alper et al., 2021). Likewise, trauma is pervasive, but individuals experience and are impacted by it differently. As clinicians we may have little or no specific information about a child or family's trauma history. Luckily, this does not limit our ability to use trauma-informed practices for all families. Even if we know about potentially traumatic events a child or family has experienced, we must objectively assess—rather than assume—the strengths and needs relevant to our clinical services.

The respond component of applying SAMHSA's (2014) trauma-informed practice to early language intervention includes examining and resisting the assumptions we make about our clients before you meet them. For example, we can try to use open-ended, inclusive interview questions to minimize bias and assumption (e.g., "When are some of the times you most enjoy interacting with your child?" instead of "Do you like to read with your child?"). The same principle applies to determining the needs for referral or additional resources. For example, clinicians can normalize the need for support through discussing the assortment of referral resources available with all families (e.g., "Many families benefit from additional community resources. We have a list here that includes housing, food, childcare, child abuse prevention, early education, mental health, intimate-partner violence, immigration, dentistry, and pediatricians. Please let me know if I can be helpful in connecting you to any of these providers.").

Planning these conversations ahead of time to examine the language for implicit or explicit assumptions is critical. Asking inclusive questions and providing the opportunity for candid response is critical to identifying strengths and needs as well as fostering trust—essential components of trauma-informed practice (SAMHSA, 2014). Comprehensive assessments, such as those guided by the ICF model (WHO, 2013), can also aid in identifying objective strengths and needs at all levels of the child and caregiver's experience.

Practice Responding to Sensitive Information

SAMHSA recommends that we respond and resist retraumatization with intentional practices that respect the child and family and protect their safety. As clinicians, we may come upon sensitive or privileged information that could have emotional, practical, or legal ramifications for families. The response to some disclosures, such as child maltreatment, are tightly regulated by state mandatory reporting guidelines and readily reviewed as part of speech-language pathology license renewal. However, there are many other topics—such as mental health, suicidality, domestic or intimate-partner violence, economic trauma, immigration trauma—where there may be limited established guidelines for how to respond as an early intervention provider. Thinking through types of disclosures ahead of time can help us respond appropriately, limit retraumatization, and maintain safety. Advocate for systemic supports within your organization or create your own policies to guide your decisions and practices in alignment with state and federal laws in advance of such a disclosure.

Additionally, consider employing a systematic approach to monitoring your emotional regulation to manage recognizing what you bring into future sessions. Disclosures or unfamiliar or surprising experiences are dysregulating. *Assess your own support needs first* to ensure that you feel safe and prepared for your next session with the patient and other patients. The Office of the Surgeon General offers a variety of tools and resources to support workplace well-being (https://www.hhs.gov/surgeongeneral/priorities/workplace-well-being/).

Resist

Support self-efficacy through information, planning, practice, and reflection. An individual's self-efficacy perceptions reflect the degree to which they believe they can effect change in themselves or their environment. Self-efficacy can vary across domains—such as professional and interpersonal—within an individual (Bandura, 2001; Zimmerman, 2000). Bandura (2001) described the actionable components of self-efficacy as intentionality, forethought, self-reactiveness, and self-reflectiveness. Broadly, these elements exemplify how agency is developed through planning, thoughtful practice, and careful reflection. Children's self-efficacy perceptions are associated with positive academic outcomes (Kim, 2014; Weiser & Riggio, 2010). For caregivers, high self-efficacy and developmental knowledge are associated with positive parenting perceptions and practices (Alper et al., 2020, 2021). Trauma

might undermine child and caregiver self-efficacy including through a loss of control. Trauma-informed early intervention can include supporting caregiver and child self-efficacy development.

Supporting the child. Language skills and self-efficacy perceptions develop alongside and support each other. Children with language delays or disorders often have fewer functional communication skills, which can decrease their sense of self-efficacy and control over their environment (Paul et al., 2024). Difficulty with communication increases children's risk of experiencing trauma as well as decreases their ability to disclose and process it (Legano et al., 2021). Furthermore, traumatic experiences are often accompanied by a loss of control, which can compound their negative developmental impacts.

During the prelinguistic phase of language development—commensurate with the skills typically developed between birth and 18 months—children begin to map intent and meaning onto symbolic communication. These early communicative acts allow children to gain and share an adult's attention, express some basic needs (e.g., naming a food item they would like), and elicit linguistic models from the adult (Paul et al., 2024). Thus, first words are often accompanied by the child having increased agency in shaping their environment. Once children begin combining words, typically around 18 months, they quickly expand the purposes for which they can communicate. These new communication functions include—requesting, rejecting, commenting, asking/answering questions, and engaging in social routines. By the time children enter kindergarten, they are typically able to express many of their daily functional needs and share some experiences through early narratives (Paul et al., 2024). Targeting functional communication through a developmental approach to selecting targets is thus in alignment with trauma-informed care.

Supporting the caregiver. Caregiver coaching is one mechanism by which clinicians can support children's early language experiences and environment within an ecobehavioral framework. (Ford et al., 2020). The TMCR session structure for caregiver coaching has an evidence base in principles of adult learning and is often used in enhanced milieu teaching approaches (Wright & Kaiser, 2017). TMCR is a useful example of a semistructured intervention delivery method conducive to trauma-informed care. The TMCR framework incorporates informational counseling (i.e., teach), clinician-led demonstration (i.e., model), family-led practice with specific, individualized feedback (i.e., coach), as well as collaborative analysis and goal setting (i.e., review). The TMCR phases align well to support the caregiver's parenting self-efficacy development (Bandura, 2001). Supporting caregivers' knowledge and self-efficacy through practice, feedback, and reflection can help them identify their own strengths and challenges. Through agentic engagement in the treatment process, caregivers can be empowered to affect their own change, which is a critical component of trauma-informed care (SAMHSA, 2014).

Conclusions

Childhood trauma is pervasive; early interventionists are almost guaranteed to encounter children and caregivers with trauma histories in their practice. Trauma-informed care has been developed as a protective mechanism against the negative effects of trauma. In this tutorial, we adapt the SAMHSA principles of trauma-informed care—realize, recognize, respond, and resist—to the context of early language development and intervention. In the first section, we use the EMELD as a framework for realizing the mechanisms by which trauma might impact children's development and their caregivers. We also describe how to apply an ICF model of assessment to systematically and comprehensively recognize individual child and caregiver strengths and needs. In the second section, we present applied strategies for responding to trauma and its impacts, as well as resisting retraumatization in the therapy context. This clinical tutorial provides background knowledge and applied strategies for clinicians looking to implement trauma-informed strategies in their practice. Providers may also practice applying these skills using the activity provided in the Appendix.

Author Contributions

Rebecca M. Alper: Conceptualization, Investigation, Project administration, Resources, Supervision, Writing – original draft, Writing – review & editing, Visualization, Funding acquisition. **Katherine Eulau:** Conceptualization, Investigation, Writing – original draft, Writing – review & editing, Visualization.

Data Availability Statement

This is a clinical tutorial with no relevant data sets to access.

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Reflection and Application Activity

For this exercise, please reflect on your own clinical experience, observations, or coursework. We have provided some example responses to help frame your reflection and discussion. However, we encourage you to think creatively as trauma-informed care may look different across settings, contexts, clients, and clinicians.

Part 1

Think of a child you know or have worked with and construct a strengths and needs analysis using the ICF factors and a trauma-informed lens. Use the worksheet on the following page to answer the following questions. What is the *Functioning and Disability* of the child (i.e., *Body Structures and Functions* or *Activities and Participation*)? What are the *Contextual Factors* relevant to the child? How could simultaneous consideration of risk and protective factors across levels shape your clinical decisions?

Part 2

Describe a trauma-informed practice you have observed, heard of, or used in speech-language assessment or intervention. What makes these practices trauma informed? *For example, offering a location outside the home (e.g., school or community center) where families can meet with their early interventionist can be a part of trauma-informed coaching. This is a trauma-informed practice because it allows clients to choose, based on their comfort, whether they allow an outsider in their home. Furthermore, it creates more equitable access to service environments for families who are unhoused or experiencing housing insecurity. Asking all families where they prefer to meet reduces the likelihood of negative consequences of internalized assumptions.*

Trauma- Informed Early Intervention Practice

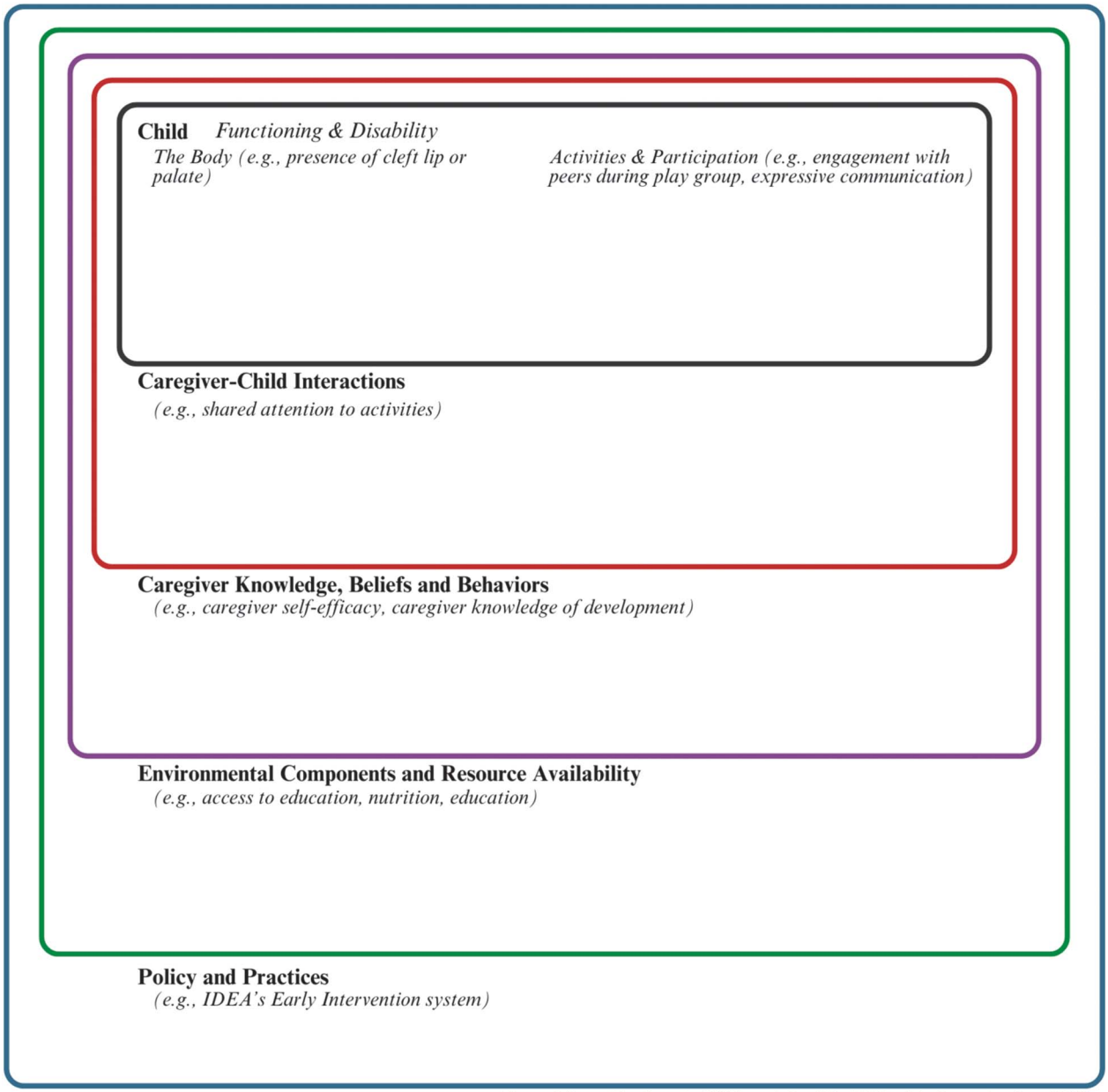
Use this worksheet to identify ICF and EMELD factors for a child. Use this information to Realize, Recognize, Respond, and Resist.

Realize & Recognize

- Notice and challenge biases relating to cultural expectations and difference/ disorder

Respond & Resist

- Ask open-ended questions
- Offer the opportunity to *ask* questions



Adapted from Ford et al., 2020 and the World Health Organization, 2013