JOURNAL OF EARLY YEARS RESEARCH

Volume 3, Issue 2 (2023)

ISSN: 2810 9015

THE JOURNAL OF EARLY YEARS RESEARCH

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(2021-2023)

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A Word from the EYRAS President

This issue welcomes an interesting article on *Wellness Science* submitted by Dr Chia Kok Hwee. Wellness science encompasses a multidimensional approach to achieving optimal health, focusing on integrating physical, mental, emotional and social well-being. Among the myriad factors contributing to wellness, exercise emerges as a cornerstone, exerting profound effects on the body and the mind. There is an intricate relationship between physical exercise and wellness science, especially the release of endorphins and *brain-derived neurotrophic factor (BDNF)*, and their synergistic roles in supporting overall well-being.

Exercise, whether in the form of vigorous cardiovascular activities or mindful practices like yoga, sets in motion a complex cascade of physiological and neurochemical responses within the body. Central to this symphony are endorphins, often referred to as the body's natural painkillers and mood elevators. These neurotransmitters, produced in response to physical exertion, create a sense of euphoria and well-being. Simultaneously, exercise influences the production of BDNF, a protein crucial for the growth, survival, and function of neurons.

Endorphins, short for "*endogenous morphine*" are neurotransmitters produced by the central nervous system and the pituitary gland. The release of endorphins is a natural response to stress and pain, with exercise acting as a powerful trigger for their secretion. Engaging in physical activity, whether it be jogging, cycling, or dancing, stimulates the release of endorphins, leading to a state of euphoria commonly known as the "runner's high."

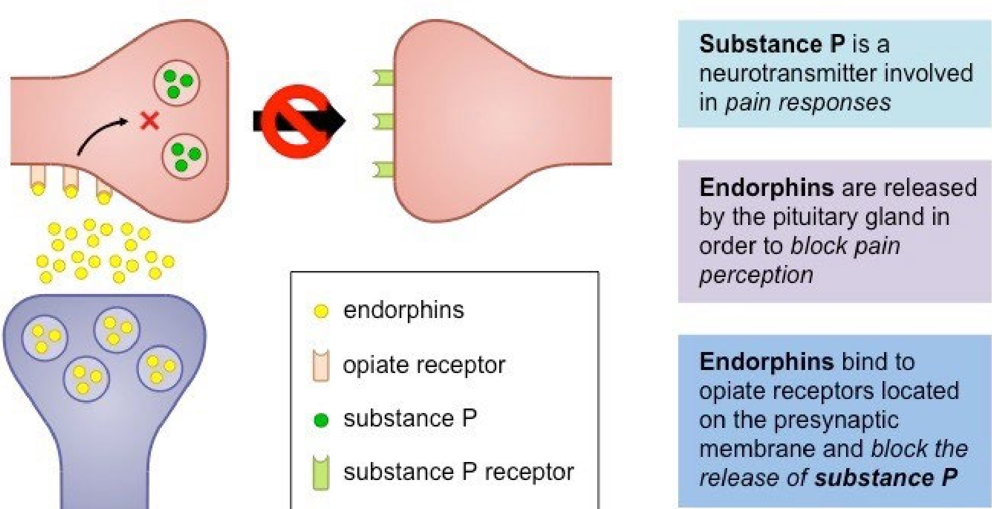

Figure 1: Suppression of Pain Perception by Endorphins (Extracted from ib.bioninja.com.au)

The impact of endorphins on mental well-being is multifaceted. These neurotransmitters bind to the opioid receptors of the presynaptic neurons in the brain, inhibiting the presynaptic neurons from releasing *Substance P*, a neuropeptide which is a short chain of amino acids, dampening the perception of pain and inducing feelings of pleasure and happiness (See Figure 1). Substance P plays a role in transmitting pain signals and is involved in various physiological processes, including the regulation of mood and stress. Consequently, individuals often report reduced stress, anxiety, and improved mood following exercise. The ability of endorphins to act as natural stress relievers contributes significantly to the overall mental well-being promoted by the wellness sciences.

In parallel to the endorphin response, exercise influences the production of BDNF, a protein that plays a pivotal role in maintaining the health of neurons. BDNF supports synaptic plasticity—the ability of neural connections to adapt and grow. BDNF binds to a receptor called TrkB (Tyrosine receptor kinase B) on the postsynaptic neurons. When BDNF binds to the TrkB receptor, it triggers a signalling cascade inside the neuron, influencing processes such as synaptic transmission, dendritic growth, and cell survival.

This interaction is essential for the maintenance and plasticity of neural circuits in the brain. This process is fundamental for learning, memory, and overall cognitive function. Dysregulation of BDNF has been implicated in various neurological and psychiatric disorders, emphasizing its importance in the broader context of brain function and well-being.

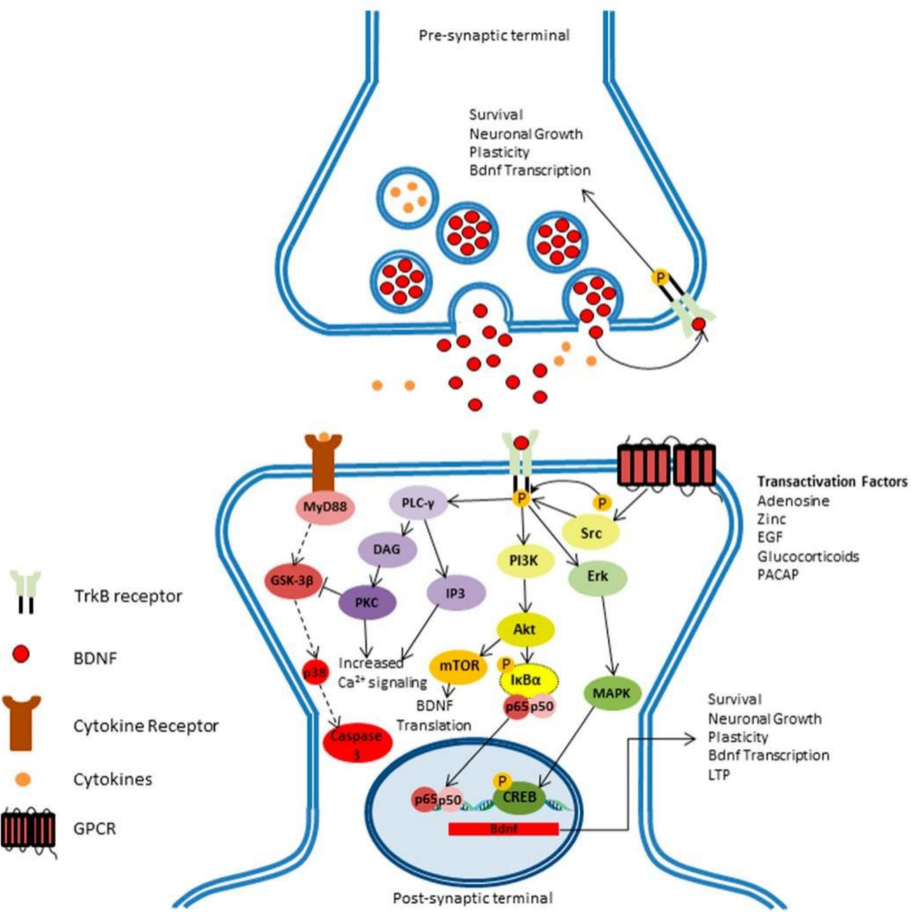

Figure 2: BDNF binding with postsynaptic receptor TrkB (extracted from https://doi.org/10.1007/s12035-018-1283-6)

Regular physical activity has been associated with increased levels of BDNF, creating an environment conducive to the growth and survival of neurons. This neurotrophic factor also participates in

neurogenesis, the formation of new neurons, particularly in the hippocampus, a region of the brain crucial for memory and emotional regulation. The positive impact of BDNF on neural plasticity and neurogenesis underlines its significance in the broader context of wellness science.

The relationship between exercise, endorphins, and BDNF is not isolated; rather, it is a dynamic interplay that contributes synergistically to the promotion of wellness. Physical activity not only triggers the immediate release of endorphins, inducing a sense of happiness and stress relief but also sets in motion long-term processes that elevate BDNF levels, fostering the growth and maintenance of a healthy brain.

The combined effects of endorphins and BDNF extend beyond mood enhancement. Studies have suggested that the neurotrophic support provided by BDNF may have protective effects against neurodegenerative conditions and cognitive decline associated with aging. Furthermore, the mood-stabilizing effects of endorphins can serve as a natural remedy for conditions such as anxiety and depression, aligning with the holistic approach of wellness science.

Understanding the neurobiological underpinnings of exercise, endorphins, and BDNF has practical implications for designing wellness programs and interventions. Incorporating regular physical activity into one's routine can be considered a proactive strategy for mental well-being. The diverse forms of exercise, from aerobic activities to mindfulness practices, offer flexibility in catering to individual preferences and needs.

Moreover, the benefits of exercise extend beyond the immediate post-workout euphoria. The enduring impact of increased BDNF levels supports cognitive function and emotional resilience over the long term. As a result, wellness science embraces exercise as a potent tool for preventive mental health care, aligning with the philosophy of promoting overall well-being rather than simply addressing illness.

In the intricate relationship of the factors of wellness science, exercise emerges as a key choreographer, orchestrating the release of endorphins and the production of BDNF to promote mental and physical well-being. The interplay between these neurochemical processes creates a harmonious symphony that extends beyond the immediate feelings of happiness associated with a workout. Instead, exercise, endorphins, and BDNF collaborate to nourish the brain, support cognitive function, and enhance emotional resilience.

As we navigate the complexities of modern life, the integration of regular physical activity into our routines becomes a cornerstone of a holistic approach to wellness. By embracing the interconnected roles of endorphins and BDNF, we not only harness the immediate benefits of improved mood and stress relief but also invest in the long-term health of our brains. In this way, exercise becomes a powerful ally in the pursuit of wellness, contributing to a fulfilling and resilient life.

Last but not least, I would like to express my sincerest appreciation to the authors who have contributed their insightful articles to this journal. I would also like to express my gratitude to Dr Chia Kok Hwee for his continuous guidance and effort in compiling the articles.

Meng Kiat TAN
Honorary President
Early Years Research Association of Singapore
26 December 2023

Autism Spectrum Disorder: A Review of Therapy Techniques

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APA Citation: Guo, G. Q. (2023). Autism spectrum disorder: A review of therapy technique. *Journal of Early Years Research*, *3*(2), 6-14.

Abstract
Autism spectrum disorder (or autism for short) is a neurodevelopmental disorder that is challenging for clinicians and therapists. To effectively grapple with autism, therapists have to provide interventions for autism core symptoms with co-existing psychological issues. In recent years, there have been a number of emerging techniques, and some are popular and widely requested by parents and promoted by therapists. However, research has shown mixed and sometimes conflicting results. In this short paper, the author aims to evaluate these techniques and outline treatment component that confers clinical benefits. Concurrently, it would examine the strengths and limitations of respective techniques. Drawing on empirical research and proven best practices, this research paper aims to highlight salient clinical intervention elements for effective treatment plans.
Key words: Autism, Symptoms, Techniques, Therapy

Introduction

Autism, also known as autism spectrum disorder (ASD), is a neurodevelopmental disorder characterized by difficulties in social interaction, communication, and repetitive patterns of behavior with a range of severity (Lord et al., 2018). This diagnosis of ASD can be made as early as 18–24 months of age (i.e., before the age of 3), which is typically when a distinction could be made between typical development and other developmental delays or conditions. Recent research showed that autism spectrum disorder (ASD) is prevalent across all racial, ethnic, and socio-economic groups and estimated to be close to 4 times more common among males than females (Alpert, 2021). Global research suggested that the prevalence is around 1% among the population (Zeidan et al., 2022). In addition, autistic individuals tend to experience high rates of comorbid psychological conditions, specifically, depression, anxiety disorders, and obsessive-compulsive disorder (OCD) (Russell et al. 2016; Simonoff et al. 2008; Wigham et al. 2017). These also present with transdiagnostic characteristics (i.e., features occurring across psychological disorders) such as emotional dysregulation (Mazefsky et al., 2013). Such co-morbidity impairs autistic individuals' functional skills (White et al., 2014) and is associated with greater difficulties with school adjustment, social skills, loneliness, self-injurious behavior, and family conflict (Jones & Frederickson, 2010; Kaat, Gadow, & Lecavalier, 2013). The prevalence and complexity of disorders pose a challenge to clinicians and therapists in formulating effective treatment. Previous research mainly focused on efficacy and treatment outcomes through meta-analysis and systematic review. However, none has comprehensively reviewed various intervention approaches' strengths and weaknesses or outlined treatment components that contribute to treatment efficacy. This research aims to address this and would enable researchers, therapists, and educators to draw from this research to develop effective autism treatment plans. Further, it serves as vital input for program evaluation and to optimize future interventions.

It is meaningful to review DSM-5's definition of autism (APA, 2013), and it has been classified under the "Pervasive Developmental Disorders" (PDD) category. The criteria in the DSM-5 for diagnosis of autism include three listed impairments or deficits in social communication and interaction. The criteria in the DSM-5 for diagnosing ASD include three listed deficits in social communication and social interactions. To be diagnosed with ASD, an individual must meet all three of the following criteria:
(1) impairment in social-emotional reciprocity such as unable to demonstrate social empathy, poor conversation skill, and reading and expressing emotions;

(2) impairments in non-verbal communication used for social interaction like poor eye contact, awkward body language; and
(3) poor social skills and inability to develop and maintain relationships such as difficulties in sharing interests with others, rarely engaging in imaginative plays and lack of ability to read or use body language and facial expressions in communication.

Another criterion is demonstrating at least two of the following 4 restricted repetitive and sensory behavior or interests, and activities:
(1) stereotyped speech, repetitive motor movements, echolalia (repetitive use of words or phrases);
(2) fixation and rigid adherence to routines, ritualized of verbal or nonverbal behaviors, and resistance to changes; and
(3) increased or decreased sensitivity to sensory input or unusual interest in sensory aspects of the environment, such as pain sensation, touch or smell.

In addition, ratings of severity have been included to assess levels of ASD diagnosis. The three levels include the following levels of support needed for individuals diagnosed with the disorder:
Level #1 (i.e., Requiring Support): It refers to the high-functioning form of autism which individuals may have difficulties in understanding social cues and may not be able to forge personal relationships. Individuals would need help in planning and organization, adapting to changes in the environment and less reliance on routines.
Level #2 (i.e., Requiring substantial support): It refers autism who need more support than Level 1. Individuals demonstrate difficulties in verbal and non-verbal communication. They have poor social skills, and cannot initiate social interactions, leading to interpersonal difficulties. Their restricted interest and repetitive behaviors could interfere with their daily functioning. So, they feel distressed and frustrated when their interest or behaviors are interrupted.
Level #3 (i.e., Requiring very substantial support): It refers to individuals who require the most support and have difficulties in communicating or understanding verbal and nonverbal communication. They exhibit limited interest to interact with others, an inability to engage in imaginative play with peers, and difficulty in forming relationships with others.

For this paper, the author has chosen to focus on the following common psychosocial interventions:
(1) Cognitive-behavior training;
(2) Applied behavior analysis,
(3) Relationship development intervention and social skill training;
(4) Orton-Gillingham approach and speech therapy;
(5) Sensory integration therapy; and
(6) Art and/or arts therapy.

This overview would consider their mechanism and clinical outcomes, specifically the treatment component which contributes to therapeutic efficacy. By understanding the strengths and weaknesses of respective therapeutic approaches, therapists could be educated and implement appropriate treatment to address autism issues optimally. Effective and targeted interventions are necessary as autism treatment tends to be protracted and requires much resource and man hours. The lack of progress could also lead to "autistic burnt out" as autistic individuals experience navigating neurotypical environment (e.g. Endow, 2017; Rose, 2018) and ongoing efforts to conceal their autistic traits within social interaction (Hull et al., 2017; Lawson, 2020).

Cognitive Behavior Approach
Cognitive behavior therapy (CBT) adopts both cognitive and behavioral strategies such as psychoeducation, cognitive restructuring, problem-solving and social skill training in treating internalizing and externalizing disorders. Systematic reviews have supported the efficacy of CBT in the treatment of young children struggling with anxiety who have ASD (Kester & Lucyshyn, 2018; Vasa et al., 2020). Adapted cognitive behavior therapy for ASD (the Behavioral Interventions for Anxiety in

Children with Autism [BIACA] program) has been found to have added clinical advantages compared to standard cognitive behavior therapy (Wood et al., 2020).

Several treatment components have been found to contribute to this efficacy of CBT:
(1) the inclusion of contextual factors pertaining to ASD-associated stressors as well as social and communication challenges;
(2) greater parental involvement than typical CBT programs;
(3) modality approach in administering treatment to target multi-faceted clinical presentation of ASD;
(4) comprehensive reward system to reinforce target behavior and to promote motivation and treatment engagement;
(5) special interest is treated as an asset and included in treatment to promote engagement;
(6) emphasis on social skill to facilitate autistic individuals' social engagement; and
(7) disruptive behaviors are targeted and addressed to minimize non-compliance and aggression on treatment engagement.
Indeed, these treatment components were found to promote social-communication functioning, anxiety reduction, and adaptive outcomes.

Applied Behavior Analysis
Applied Behavior Analysis (ABA) is a widely applied intervention approach for autism. It is based on behavioral science and learning principles which systematically analyze and modify behaviors, and has been found to be effective in improving various adaptive outcomes and managing dysfunction behaviors among autistic individuals (Yu et al., 2022). Principles of ABA have been adopted and tailored to develop programs such as discrete trial training (DTT), natural environment training (NET), and Early intensive behavioral intervention (EIBI) (Granpeesheh, Tarbox, & Dixon, 2009). Research has showed that it has been effective in promoting academic skills among individuals with ASD such as reading comprehension, math and geography (LeBlanc,et al., 2003; Flores & Ganz, 2007; Tiger, Bouxsein, & Fisher, 2007). Further, it has been found to be effective in promoting independent living skills, vocational skills, and social skills (Charlop-Christy & Daneshvar, 2003; Goodson et al., 2007; Tiger, Hanley, & Bruzek, 2008). Based on clinical reviews, ABA program should be intensive, long term and comprehensive. For instance, 30 to 40 hours per week for 2 years and target all areas of deficit and include discrete trial training (DTT) and natural environment training (NET) in Early intensive behavioral intervention (EIBI). It also requires collaboration between psychiatry and applied behavior analysis practitioners.

Sensory Integration Therapy
Recently, sensory integration therapy (SIT) has been a novel intervention approach for autism. However, the findings seem to show inconsistent efficacy and widely varied therapy practices. This therapy is formulated on the basis that sensory integration and sensory processing as neurological and physiological functions that influence behavior. Though many practitioners advocate sensory processing approach to promote self-regulation, many did not include sensory processing measures or neurophysiological measures in their assessment and research (e.g. Bonggat and Hall, 2010; Kane et al., 2004).

Interestingly, SIT appears to be a popular and highly requested form of therapy. Over 60% of children with ASD receive this form of therapy, making it a popular form of therapy (Green at al., 2006). Sensory interventions adopt a range of sensory modalities (e.g., vestibular, somatosensory, and auditory) and target behaviors which could be associated with sensory processing disorder (Case-Smith, Weaver, & Fristad, 2015). Common approaches are the Ayresian sensory integration therapy (Ayres, 1972), the sensory-based intervention (Case-Smith & Arbesman, 2008) and the auditory integration training (Bettison, 1996). The Ayresian SIT integrates play activities and sensory-enhanced interactions to develop adaptive responses. Through this, it improves the ability to integrate sensory information, therefore developing more organized and adaptive behaviors, including enhanced joint attention, social skill, motor planning, and perceptual skill (Baranek, 2002). These SIT activities often involve stretching the child's developmental skills and customized equipment such as therapy balls and swings that would

provide vestibular and proprioceptive stimulations, and hence, promoting adaptive responses (Mailloux & Roley, 2010). Another is the sensory-based intervention that draws on similar principles and integrates sensory activities common in autistic individuals' daily activities such as brushing and massaging. Such activation of somatosensory and vestibular systems is hypothesized to foster behavioral regulation (Lang et al., 2012). A systematic review established the positive effect of sensory processing intervention on individualized therapy goals and recognized its benefit in fostering lasting behavior changes as therapies are carried out in natural settings through play or structured activities. In a way, such an arrangement facilitates individuals' motivation and self-esteem over time (Parham& Mailloux, 2010). However, this form of therapy seems to be effective in developing functional behaviors and may not generalize across academic or other types of activities. It is also difficult to structure activities to ensure optimal level of arousal and behavior regulation (Miller et al., 2007).

Relationship Development Intervention

Relationship Development Intervention (RDI) is a parent-based, cognitive-developmental approach that trains primary caregivers to provide opportunities for their child to develop adaptive functional skills in their daily life. This therapy aims to develop a repertoire for their child to cope with dynamic social environments (Gutstein, Burgess, & Montfort, 2007). Few research (e.g., Gutstein, 2004; Gutstein, Burgess, & Montfort, 2007; Zane, 2013/14) had been done on RDI and most were inconclusive. A program evaluation showed that participants become more socially adaptive and communicative, and could function more effectively in school with lesser adult's participation and supervision (Gutstein, 2004; Gutstein, Burgess, & Montfort, 2007). While it has been commonly advocated by therapists as a novel approach to promote socio-emotional well-being and social skill, research failed to demonstrate the superior clinical efficacy of this technique (Wang, Wang, & Han, 2019).

Social Skill Training

Social skills training (SST) is another popular form of intervention that addresses deficits in social skills among autistic individuals (McLeod, Malatino, & Lucci, 2016). By improving social skills, individuals with autism are less prone to underachievement in academics and work, loneliness, and poor psychological well-being (Howlin, 2000). These trainings are tailored according to the age and level of functioning of individuals, and arrangements include peer mentoring, social skills groups, and video modeling (Bohlander, Orlich, & Varley, 2012). Through face-to-face training, SST facilitators train children with autism in conversation skills, friendship, and problem-solving skills (Gordon-Lipkin et al., 2016). A recent version of SST is Behavioral Intervention Technologies (BITs). This technology-based intervention promotes positive behavioral and psychological changes (Mohr et al., 2013). Other evidence-based social skill training programs which are less prominent include peer mentoring, social stories and video modelling (Bohlander, Orlich, & Varley, 2012). It is important to outline the components of SST which confer beneficial outcomes. For instance, peer-mediated SST and social skills groups go beyond one-to-one interaction with facilitators and provides opportunities for children with autism to interact with typically developing children in a natural, inclusive classroom setting. Hence, it has been effective in acquiring early communication skills and can generalize developmental gains across time and settings (Strains, 1984; Bass & Mulick, 2007). Video training provides social skill demonstration as a role model for children to emulate socially appropriate behaviors (Bellini, & Akullian, 2007).

Orton-Gillingham Approach, Language and Reading Therapies

Language development and impairments are probably another area of challenge for individuals with autism. Children with autism tend to exhibit impairments in language understanding (i.e., receptive language), which inevitably adversely impact their daily functioning, and their social, academic, and vocational achievements (Ellis-Weismer, Lord, & Esler, 2010; Maljaars et al., 2012). Extensive research indicates that students with autism may have relative strength in word recognition but have poor comprehension abilities (Chiang & Lin, 2007; Nation et al., 2006). Relatedly, individuals with ASD have difficulties in verbal and nonverbal social communication. Indeed, research showed that three out of four children with ASD have mild or severe language impairments when they enter kindergarten, while the rest demonstrate typical or exceptional language development (Ellis-Weismer,

2014). For speech-language intervention, individuals with autism learn through imitation, specifically pragmatic language skills or functional communication behavior (i.e., alternative or augmentative communication).

The Orthon-Gillingham approach to reading instruction has these characteristics:
(1) direct and explicit entails lessons format encompasses learning content, learning motivation and lesson outlines;
(2) structured and sequential refers to structuring lessons so students can learn progressively to master content;
(3) diagnostics refers to progress monitoring of students' difficulties and development by closely analyzing their verbal, non-verbal and written responses;
(4) prescriptive in that intervention is focused on addressing students' deficits and building on their strength; and finally,
(5) multi-sensory in which the therapy will engage all modalities: seeing, hearing, feeling, and touch (Sayeski et al., 2018).

A recent meta-analysis commentary revealed that there are no significant improvements in foundational skills, vocabulary, or comprehension outcomes among students who did not receive OG interventions (Solari, Petscher, & Hall, 2021). While the meta-analysis did not reveal significant improvements, researchers and practitioners find that it is still a "promising" approach due to the multi-sensory approach (see Steven et al., 2021, for detail).

Art or Arts Therapy

Art or arts therapy[1] (AT) has been a sought-after form of therapy approach to manage some core symptoms of autism spectrum disorder (ASD). While art or arts therapy is widely believed to be an exercise to express their emotions or de-stress, it goes beyond promoting psycho-emotional well-being, sensory regulation, psychomotor development and facilitates communication. The multi-sensory nature of artwork and relational nature of art are deemed to be therapeutic and soothing for highly strung autistic individuals (Durrani, 2019). Research (e.g., Emery, 2004; Martin, 2009; Schweizer, Spreen, & Knorth, 2017) have demonstrated the effectiveness of managing emotional and social stress associated with ASD. It is also associated with better communication, improved social skills, confidence, reduced anxiety and flexibility (Alter-Muri, 2017; Schweizer, Spreen, & Knorth, 2017). It also showed that ASD children have a preference to use art as a form of communication and expression, particularly for those who find social communication aversive (Durrani, 2019). Art or arts therapy is implemented in group setting. This is especially effective when art or arts therapy is a form of bonding and communication among group members. Participants are encouraged to discuss art projects and become more emotionally attuned and empathetic (Kuo et al., 2016).

Conclusion

Having reviewed various intervention approaches for ASD, it is important to note that there are caveats or limitations. One issue is the misdiagnosis of clinicians and potential mismatch in the administration of therapeutic approaches. This is usually common when therapists and clinicians are unfamiliar with nosology and nosography, especially due to the heterogeneity of autism and co-existing psychological or neurodevelopmental conditions.

Interventions could be protracted and there is a variability in individual responses at times. Such would require an individualized therapy program that has to be intensive and long-term, which would entail high financial commitment and family involvement. Hence, this high financial commitment would limit the access of family from middle or lower socio-economic status. Often, such therapy would require long-term continual support and involve a combination of interventions for optimal outcomes. This is because each intervention has its own limitations as outlined earlier. For instance, applied behaviour

[1] There is a slight difference between art therapy and arts therapy. Art therapy involves fine art such as painting, drawing and sculpture, whille arts therapy include the whole field of artistic endeavors including threature, poetry, dance, etc.

analysis would be effective in fostering functional skills but less effective in training autistic children in reading and speech.

Language and Orton-Gillingham approach might not be effective in developing social skills and emotional regulation competencies. Art or arts therapy and cognitive behavior therapy might be effective in facilitating emotional adjustment but do not promote academic learning. Other therapies such as art or arts therapy and sensory integration therapy still lack standardized protocols and specific guidelines for the administration, which pose a challenge in implementing consistent outcomes. Further, intervention approaches tend to overlook the significance of motivational and engagement as well as adapting therapy to increase cultural relevance. This could be addressed in future research.

Unlike past research that is mainly concerned with efficacy and procedures, in this paper, the author has reviewed and identified respective therapy approaches' efficacy and the respective treatment component or recommendations and best practices that contributed to this clinical utility and advantages. Such findings are important as therapists and clinicians could focus on and accentuate the respective treatment component for optimal results since it has been found to confer incremental therapeutic benefits. Future research could draw on these recommendations and best practices to develop more comprehensive and efficient therapy programs for treating ASD.

References

Alter-Muri, S. B. (2017). Art education and art therapy strategies for autism spectrum disorder students. *Art Education*, 70(5), 20–25.

American Psychiatric Association, DSM-5 Task Force (2013). *Diagnostic and statistical manual of mental disorders-5th edition: DSM-5*™. Washington, DC: The Author.

Alpert, J. S. (2021). Autism: a spectrum disorder. *The American Journal of Medicine*, *134*(6), 701-702.

Ayres, A. J. (1972). *Sensory integration and learning disorders*. Los Angeles, CA: Western Psychological Services.

Baranek, G. T. (2002). Efficacy of sensory and motor interventions for children with autism. *Journal of Autism and Developmental Disorders, 32(5)*, 397-422.

Bass, J. D., & Mulick, J. A. (2007). Social play skill enhancement of children with autism using peers and siblings as therapists. *Psychology in the Schools, 44*, 727-735.

Bellini, S., & Akullian, J. (2007). A meta-analysis of video modeling and video self-modeling interventions for children and adolescents with autism spectrum disorders. *Exceptional Children, 73*, 264-287.

Bettison, S. (1996). The long-term effects of auditory training on children with autism. *Journal of Autism and Developmental Disorders, 26*, 361-374.

Bohlander, A. J., Orlich, F., & Varley, C. K. (2012). Social skills training for children with autism. *Pediatric clinics of North America*, *59*(1), 165-177.

Bonggat, P. W., & Hall, L. J. (2010). Evaluation of the effects of sensory integration-based intervention by a preschool special education teacher. *Education and Training in Autism and Developmental Disabilities, 45*(2), 294-302.

Case-Smith, J., Weaver, L. L., & Fristad, M. A. (2015). A systematic review of sensory processing interventions for children with autism spectrum disorders. *Autism: The International Journal of Research and Practice*, *19*(2), 133-148.

Chiang, H. M., & Lin, Y. H. (2007). Reading comprehension instruction for students with autism spectrum disorders. *Focus on Autism and Other Developmental Disabilities*, 22(4), 259-267.

Charlop-Christy, M. H., & Daneshvar, S. (2003). Using video modeling to teach perspective taking to children with autism. *Journal of Positive Behavior Interventions*, *5*(1), 12-21.

Durrani, H. (2019). A case for art therapy as a treatment for autism spectrum disorder. *Art Therapy, 36*(2), 103–106.

Ellis-Weismer, S. (2014). Developmental language disorders: Challenges and implications of cross-group comparisons. *Folia Phoniatrica et Logopaedica*, *65*(2), 68-77.

Ellis-Weismer, S., Lord, C., & Esler, A. (2010). Early language patterns of toddlers on the autism spectrum compared to toddlers with developmental delay. *Journal of Autism and Developmental Disorders*, *40*(10), 1259-1273.

Emery, M. J. (2004). Art therapy as an intervention for autism. *Art Therapy*, *21*(3), 143-147.

Endow, J. (2017, March 9). Autistic burnout and aging. *Aspects of Autism* [Translated]. Retrieved from: http://www.judyendow.com/autism-and-aging/autistic-burnout-and-aging/.

Flores, M. M., & Ganz, J .B. (2007). Effectiveness of Direct Instruction for Teaching Statement Inference, Use of Facts, and Analogies to Students With Developmental Disabilities and Reading Delays. *Focus on Autism and Other Developmental Disabilities*, *22*, 244 - 251.

Granpeesheh, D., Tarbox, J., & Dixon, D. R. (2009). Applied behavior analytic interventions for children with autism: a description and review of treatment research. *Annals of Clinical Psychiatry: Official Journal of the American Academy of Clinical Psychiatrists*, *21*(3), 162–173.

Green, V. A., Pituch, K. A., Itchon, J., Choi, A., O'Reilly, M., & Sigafoos, J. (2006). Internet survey of treatments used by parents of children with autism. *Research in Developmental Disabilities*, *27*(1), 70-84.

Goodson, J., Sigafoos, J., O'Reilly, M., Cannella, H., & Lancioni, G. E. (2007). Evaluation of a video-based error correction procedure for teaching a domestic skill to individuals with developmental disabilities. *Research in Developmental Disabilities*, *28*(5), 458-467.

Gordon-Lipkin, E., Foster, J., & Peacock, G. (2016). Whittling down the wait time: Exploring models to minimize the delay from initial concern to diagnosis and treatment of autism spectrum disorder. *Pediatric Clinics*, *63*(5), 851-859.

Gutstein, S. (2004). The effectiveness of relationship development intervention in remediating core deficits of autism-spectrum children. *Journal of Developmental & Behavioral Pediatrics*, *25*(5), 372-375.

Gutstein, S., Burgess, A., & Montfort, K. (2007). Evaluation of the relationship development intervention program. *Autism*, *11*(5), 397-411.

Howlin, P. (2000). Outcome in adult life for more able individuals with autism or Asperger syndrome. *Autism*, *4*(1), 63–83.

Hull, L., Petrides, K. V., Allison, C., Smith, P., Baron-Cohen, S., Lai, M.-C., & Mandy, W. (2017). "Putting on My Best Normal": Social camouflaging in adults with autism spectrum conditions. *Journal of Autism and Developmental Disorders*, *47*(8), 2519-2534.

Jones, A. P., & Frederickson, N. (2010). Multi-informant predictors of social inclusion for students with autism spectrum disorders attending mainstream school. *Journal of Autism and Developmental Disorders*, *40*, 1094-1103.

Kaat, A. J., Gadow, K. D., & Lecavalier, L. (2013). Psychiatric symptom impairment in children with autism spectrum disorders. *Journal of Abnormal Child Psychology*, *41*(6), 959-969.

Kane, A., Luiselli, J. K., Dearborn, S., & Young, N. (2004) Wearing a weighted vest as intervention for children with autism/pervasive developmental disorder: Behavioral assessment of stereotype and attention to task. *The Scientific Review of Mental Health Practice, 3*(2), 19-24.

Kester, K. R., & Lucyshyn, J. M. (2018). Cognitive behaviour therapy to treat anxiety among children with autism spectrum disorders: A systematic review. *Research in Autism Spectrum Disorders*, *52*, 37-50.

Kuo, C.-C., Lin, C. I. T., Kuo, B.-J., Kuang, C. C., & Dai, L. T. (2016). Learning experiences of young artists with ASD in a university enrichment program. *Universal Journal of Educational Research*, *4*(9), 2144-2162.

Lang, R., O'Reilly, M., Healy, O., Rispoli, M., Lydon, H., Streusand, W., ... & Giesbers, S. (2012). Sensory integration therapy for autism spectrum disorders: A systematic review. *Research in Autism Spectrum Disorders*, *6*(3), 1004-1018.

Lawson, W. B. (2020). Adaptive morphing and coping with social threat in autism: An autistic perspective. *Journal of Intellectual Disability - Diagnosis and Treatment*, *8*(3), 519–526.

LeBlanc, L. A., Miguel, C. F., Cummings, A. R., Goldsmith, T. R., & Carr, J. E. (2003). The effects of three stimulus-equivalence testing conditions on emergent US geography relations of children diagnosed with autism. *Behavioral Interventions*, 18(4), 279-289.

Maljaars, J., Noens, I., Scholte, E., & van Berckelaer-Onnes, I. (2012). Language in low-functioning children with autistic disorder: differences between receptive and expressive skills and concurrent predictors of language. *Journal of Autism and Developmental Disorders*, *42*(10), 2181-2191.

Mazefsky, C. A., Herrington, J., Siegel, M., Scarpa, A., Maddox, B. B., Scahill, L., et al. (2013). The role of emotion regulation in autism spectrum disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*, 679–688.

Martin, N. (2009). Art therapy and autism: Overview and recommendations. *Art Therapy*, *26*(4), 187-190.

McLeod, D. S., Malatino, K. W., & Lucci, D. (2016). Social skills training for autism spectrum disorder. In C. J. McDougle (Ed.), *Autism spectrum disorder* (pp. 369–384). Oxford, UK: Oxford University Press.

Meinzen-Derr, J., Sheldon, R. M., Henry, S., Grether, S. M., Smith, L. E., Mays, L., Riddle, I., Altaye, M., & Wiley, S. (2019). Enhancing language in children who are deaf/hard-of-hearing using augmentative and alternative communication technology strategies. *International Journal of Pediatric Otorhinolaryngology*, 125, 23-31.

Miller, L. J., Anzalone, M. E., Lane, S. J., Cermak, S. A., & Osten, E. T. (2007). Concept evolution in sensory integration: a proposed nosology for diagnosis. *The American Journal of Occupational Therapy*, *61*(2), 135-140.

Miller-Kuhaneck, H. & Watling, R., eds. (2010). *Autism: A Comprehensive Occupational Therapy Approach*. 3rd ed. Bethesda, MD: AOTA Press.

Mohr, D. C., Burns, M. N., Schueller, S. M., Clarke, G., & Klinkman, M. (2013). Behavioral intervention technologies: evidence review and recommendations for future research in mental health. *General Hospital Psychiatry*, *35*(4), 332–338.

Nation, K., Clarke, P., Wright, B., & Williams, C. (2006). Patterns of reading ability in children with autism spectrum disorder. *Journal of Autism and Developmental Disorders*, *36*(7), 911-919.

Parham, L.D. and Mailloux, Z. (2010) Sensory Integration. In J. C. Smith, & J. C. O'Brain (Eds.), *Occupational therapy for children (6th Edition)* (pp, 349-355). Berkeley, CA: Elsevier Inc.

Rose, K. (2018, May 21). An autistic burnout. *The Autistic Advocate*. Retrieved from: http://www.theautisticadvocate.com/2018/05/an-autistic-burnout.html.

Russell, A. J., Murphy, C. M., Wilson, E., Gillan, N., Brown, C., Robertson, D. M., ... & Murphy, D. G. (2016). The mental health of individuals referred for assessment of autism spectrum disorder in adulthood: a clinic report. *Autism*, *20*(5), 623-627.

Sayeski, K. L., Earle, G. A., Davis, R., & Calamari, J. (2019). Orton-Gillingham: Who, what, and how. *Teaching Exceptional Children*, *51*(3), 240–249.

Schweizer, C., Spreen, M., & Knorth, E. J. (2017). Exploring what works in art therapy with children with autism: Tacit knowledge of art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 34(4), 183–191.

Simonoff, E., Pickles, A., Charman, T., Chandler, S., Loucas, T., & Baird, G. (2008). Psychiatric disorders in children with autism spectrum disorders: Prevalence, comorbidity, and associated factors in a population-derived sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*, 921-929.

Stevens, E. A., Austin, C., Moore, C., Scammacca, N., Boucher, A. N., & Vaughn, S. (2021). Current State of the evidence: Examining the effects of Orton-Gillingham reading interventions for students with or at risk for word-level reading disabilities. *Exceptional Children*, *87*(4), 397-417.

Strain, P. S. (1984). Social behavior patterns of nonhandicapped and developmentally disabled friend pairs in mainstream preschools. *Analysis and Intervention in Developmental Disabilities*, *4*(1), 15-28.

Solari, E., Petscher, Y., & Hall, C. (2021, March 29). What does science say about Orton-Gillingham interventions? An explanation and commentary on the Stevens et al. (2021) meta-analysis. *PsyArXiv Preprints*. The Society for the Improvement of Psychological Science. Retrieved from: https://osf.io/preprints/psyarxiv/mcw82.

Tiger, J. H., Hanley, G. P., & Bruzek, J. (2008). Functional communication training: a review and practical guide. *Behavior Analysis in Practice*, *1*(1), 16–23.

Wang, N., Wang, Y., & Han, H. (2019, January). Efficiency of Relational Development Intervention Program for Children with Autism. In *2018 International Workshop on Education Reform and Social Sciences (ERSS 2018)* (pp. 827-832). Paris, France: Atlantis Press.

White, S. W., Mazefsky, C. A., Dichter, G. S., Chiu, P. H., Richey, J. A., & Ollendick, T. H. (2014). Social-cognitive, physiological, and neural mechanisms underlying emotion regulation impairments: Understanding anxiety in autism spectrum disorder. International *Journal of Developmental Neuroscience*, 39(1), 22-36.

Wigham, S., Rodgers, J., South, M., McConachie, H., & Freeston, M. (2015). The interplay between sensory processing abnormalities, intolerance of uncertainty, anxiety and restricted and repetitive behaviors in autism spectrum disorder. *Journal of Autism and Developmental Disorders*,45, 943–952.

Wood, J. J., Kendall, P. C., Wood, K. S., Kerns, C. M., Seltzer, M., Small, B. J., Lewin, A. B., & Storch, E. A. (2020). Cognitive Behavioral Treatments for Anxiety in Children With Autism Spectrum Disorder: A Randomized Clinical Trial. *Journal of American Medical Association (JAMA) Psychiatry*, 77(5), 474–483.

Vasa, R. A., Keefer, A., McDonald, R. G., Hunsche, M. C., & Kerns, C. M. (2020). A scoping review of anxiety in young children with autism spectrum disorder. *Autism Research*, *13*(12), 2038-2057.

Yu, Q., Li, E., Li, L., & Liang, W. (2020). Efficacy of Interventions Based on Applied Behavior Analysis for Autism Spectrum Disorder: A Meta-Analysis. *Psychiatry Investigation*, 17(5), 432-443.

Zane, T. (2013/14, Winter). Relationship development intervention: A review of its effectiveness. *The Current Repertoire: Newsletter of the Cambridge Center for Behavioral Studies*, 1-3. Retrieved from: https://behavior.org/resources/704.pdf.

Zeidan, J., Fombonne, E., Scorah, J., Ibrahim, A., Durkin, M. S., Saxena, S., ... & Elsabbagh, M. (2022). Global prevalence of autism: A systematic review update. *Autism Research*, *15*(5), 778-790.

Inner Child Self-Reflection & Why It Is Important

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APA Citation: Wong, M. F. Y. (2023). Inner child self-reflection & why it is important. *Journal of Early Years Research*, *3*(2), 15-22.

Abstract
This paper explores the importance of inner child therapy and self-reflection in understanding and healing the wounded inner child. The inner child represents the child-like part of ourselves that holds our childhood memories, emotions, and experiences. Neglecting and ignoring this inner child can lead to negative behavior patterns and emotional distress in adulthood. Additionally, the causes of a wounded inner child, including childhood trauma, attachment disruptions, emotional suppression, family dysfunction, and societal influences are also explored. It also highlights the signs of a wounded inner child and emphasizes the importance of self-reflection in inner child therapy, as it helps individuals understand the root causes of their struggles, heal emotional wounds, break unhealthy patterns, enhance self-compassion, and empower personal growth. This paper proposes that by engaging in self-reflection and inner child work, individuals can foster emotional well-being, and personal growth, and lead a more fulfilling life.
Keywords: Assessment, Culture, Collectivistic, Depression, Psychometric, Suicide, Self-reflection

Introduction
The inner child refers to the child-like part of ourselves that lives within us (see Capacchione, 1991, for detail). It is the part of us that holds our childhood memories, emotions, and experiences (Bendelow & Williams, 2002). The inner child is often neglected and ignored in our daily lives. However, it is essential to understand that it plays a significant role in our lives. Self-reflection is a way to understand our inner child, and it is important to reflect on our experiences to understand how our inner child affects our behavior, thoughts, and emotions. This paper using the case study of Walsh Sheila, a Scottish-born American contemporary Christian singer, and author, explores the conceptual understanding of the inner child, the importance of self-reflection, and how understanding the inner child can positively impact one's life.

What is the Inner Child?
The inner child is a term that is often used in psychology and therapy to describe the child-like part of ourselves. It is the part of us that holds our childhood experiences, memories, and emotions (Bendelow & Williams, 2002; Capacchione, 1991). Our inner child can be positive or negative, and it can affect how we see ourselves, our relationships with others, and our behavior. If our inner child was hurt or neglected during childhood, it can lead to negative behavior patterns and emotional distress in adulthood.

We have to listen to the child we once were, the child who still exists inside us. That child understands magic moments. We can stifle its cries, but we cannot silence its voice. "The child we once were is still there" as cited from Paulo Coelho, a Portuguese author of the highly acclaimed *The Alchemist* (HarperCollins, 1988).

Trauma and What Causes A Wounded Inner Child?
According to Ardelt and Grunwald (2018), trauma is an inherent and inevitable aspect of human life. However, the way individuals and communities respond to distressing and overpowering experiences, which can have lasting and detrimental effects, can greatly differ.

Reflecting on our younger years, we encounter a range of experiences that have the potential to leave lasting imprints. These wounds can manifest in different ways, impacting our lives today. When we

look back, we may recall seemingly minor hurts, such as not getting a toy that we wanted or not getting our mother's attention because she was always tired out from work when she came home. While these may not seem to cause major psychological damage, they can still contribute to the woundedness of our inner child.

On the other hand, more significant wounds can arise from experiences of physical abuse or emotional neglect, which can have profound effects on our emotional well-being. It is important to recognize that the specific circumstances and situations that wounded our inner child are unique to everyone. It would be impossible to create an exhaustive list encompassing all the potential sources of childhood trauma. However, if we have experienced childhood trauma, its effects are likely to manifest in our lives today.

Understanding the impact of these past wounds is crucial for healing and self-discovery. By acknowledging the presence of a wounded inner child, we can embark on a journey of compassion, self-reflection, and growth, unraveling the layers of our experiences to reclaim our authentic selves.

Some factors that can contribute to the wounded inner child are as follows:
(a) **Childhood Trauma and Adversity**: Experiences of abuse, neglect, or significant adversity during childhood can profoundly impact the development of the inner child. Traumatic events, such as physical or emotional abuse, loss, or chronic stress, can leave lasting imprints on the psyche, resulting in a wounded inner child.
(b) **Attachment Disruptions**: Early attachment disruptions, such as inconsistent or neglectful caregiving, can hinder the healthy emotional development of the inner child. When the child's needs for safety, validation, and attunement are not consistently met, it can lead to emotional wounds and/or issues of unresolved emotions related to trauma. Stanley (2016) made a distinction between two types of trauma: (i) event-based trauma, which has personal and debilitating effects, and (ii) developmental trauma. It is the latter which is caused by emotional neglect in significant relationships during childhood, resulting from a lack of attunement, feeling understood, and mutual resonance. These effects can be devastating for individuals and often have long-lasting impacts that extend through multiple generations.
(c) **Emotional Suppression and Invalidation**: Growing up in an environment where emotions are suppressed, invalidated, or ignored can leave the inner child feeling unheard and unseen. When a child's authentic emotional experiences are not acknowledged or validated, it can lead to emotional wounds that persist into adulthood.
(d) **Family Dysfunction and Patterns**: Dysfunctional family dynamics, including conflict, substance abuse, mental health issues, or unhealthy coping mechanisms, can negatively impact the inner child. These patterns may create an environment where the child's needs are not prioritized, leading to woundedness and emotional distress.
(e) **Societal and Cultural Influences**: Societal and cultural factors can also contribute to a wounded inner child. Messages that emphasize achievement, perfectionism, or unrealistic expectations can lead to feelings of inadequacy, self-criticism, and a disconnection from one's authentic self.
(f) **Generational Trauma**: Trauma can be passed down through generations, impacting the inner child. Unresolved traumas experienced by ancestors can manifest as wounds in subsequent generations, perpetuating patterns of pain and disconnection.

It is important to note that these factors can vary in intensity and combination for each individual. Understanding the root causes of a wounded inner child allows us to approach healing and self-compassion with empathy and insight. By addressing these underlying wounds, we can begin the transformative journey of nurturing and integrating our inner child, fostering emotional well-being and personal growth.

Signs of a Wounded Inner Child
The following inexhaustive list of telltale signs indicates a wounded inner child. By recognizing these patterns within ourselves, we can begin to understand the underlying impact of childhood wounds and take steps toward healing and growth.

Some of these signs include:
(1) **Frustration or Irritation:** A persistent sense of frustration or irritability can indicate unresolved issues from childhood that are affecting your present experiences and interactions.
(2) **Strong Reactions to Unmet Needs:** If you find yourself having intense reactions to unmet needs, such as feeling disproportionately upset or angry, it may be a sign that your inner child is still seeking validation and support.
(3) **Childish Outbursts and Impulsive Behavior:** Engaging in childish outbursts, such as throwing tantrums or saying hurtful things without truly meaning them, can be a manifestation of unresolved childhood wounds.
(4) **Feeling Misunderstood or Unheard:** Constantly complaining that no one understands you or that you do not feel heard may stem from unaddressed emotional needs from your past.
(5) **Difficulty Explaining Feelings** (Alexithymia): Struggling to articulate your emotions or explain why you are upset can be a sign of alexithymia, which often indicates unhealed wounds from childhood.
(6) **Low Self-Esteem**: A pervasive sense of low self-worth or a constant inner critic can be rooted in childhood experiences that have left lasting emotional scars.
(7) **Immaturity**: Displaying behaviors or thought patterns that are characteristic of a less mature emotional state may indicate unresolved issues from childhood.
(8) **Self-Sabotage Patterns**: Engaging in self-sabotaging behaviors, such as undermining your success or sabotaging relationships, can be indicative of underlying wounds that need attention.
(9) **Fear of Abandonment or Commitment Issues**: Experiencing a deep fear of abandonment or struggling with commitment in relationships can stem from unresolved childhood attachment wounds.
(10) **Challenges with Boundaries and Expressing Needs**: Difficulties in setting and maintaining healthy boundaries or expressing your needs may be rooted in unmet childhood needs for safety and validation.

If we resonate with any of these patterns, childhood wounds may be contributing to our current experiences. Acknowledging and understanding how our inner child requires support can serve as a catalyst for resolving these patterns and fostering healing and growth as an adult.

Healing can only start once we have done the work of self-reflection to recognize these patterns within ourselves. It is only by identifying these patterns, can we begin to understand the underlying impact of our childhood wounds and take steps towards healing and growth.

Self-reflection is, therefore, the gateway to self-awareness, enabling us to observe our thoughts, emotions, feelings, and actions from an impartial standpoint. By engaging in this practice, we unlock the ability to examine ourselves with a fresh sense of curiosity and intrigue. As we delve further into the depths of our inner world, we inevitably find ourselves questioning the essence of our existence, pondering, “What is the underlying reason behind these emotions I experience?”

The practice of inner child work centers around acknowledging and tending to our unfulfilled needs through re-parenting ourselves. This process of self-exploration enables us to gain insight into our behaviors, triggers, desires, and requirements. When we embark on the journey of inner child healing, we tap into a part of ourselves that is vulnerable and pliable.

Benefits of Inner Child Work

There are profound benefits that emerge from engaging in inner child work, emphasizing its transformative power in healing and personal growth. By delving into the realm of our inner child, we open doors to various advantages that include the followings:
(1) **Emotional Awareness and Understanding:** Inner child work allows us to develop a deeper awareness and understanding of our emotions, uncovering the root causes behind our patterns and reactions.

(2) **Healing Childhood Wounds**: Through the process of inner child work, we can address and heal unresolved wounds from our past. This healing journey liberates us from the burdens and limitations imposed by these wounds, fostering emotional well-being and freedom.
(3) **Self-Compassion and Self-Acceptance:** Inner child work nurtures the cultivation of self-compassion and self-acceptance by acknowledging and validating the experiences and emotions of our inner child. This self-compassion extends to embracing our authentic selves and fostering a sense of worthiness.
(4) **Improved Relationships:** By addressing our inner child's unmet needs and healing emotional wounds, we enhance our capacity for healthier and more fulfilling relationships. Inner child work fosters empathy, compassion, and understanding toward others, allowing for deeper connections.
(5) **Authenticity and Self-Expression:** Engaging with our inner child supports the discovery and expression of our authentic selves. By honoring our true desires, passions, and talents, we cultivate a life aligned with our genuine essence.
(6) **Emotional Regulation and Resilience:** Inner child work equips us with tools and practices for regulating our emotions effectively. This heightened emotional regulation enables us to navigate life's challenges with greater resilience and adaptability.
(7) **Personal Empowerment and Boundaries:** Through inner child work, we reclaim our power and learn to set healthy boundaries. This empowers us to make choices aligned with our needs, desires, and values, fostering a sense of autonomy and empowerment.
(8) **Break Free from Destructive Patterns:** By recognizing and healing the wounds of our inner child, we break free from destructive patterns and self-sabotaging behaviors that may have held us back. Inner child work empowers us to create new, healthier patterns that support our overall well-being.

In essence, engaging in inner child work offers a transformative journey toward self-understanding, healing, and personal growth. By tending to the needs of our inner child, we cultivate self-compassion, authenticity, resilience, and healthier relationships, ultimately leading to a more fulfilling and empowered life.

Why is Self-Reflection Important?

Self-reflection is the process of looking inward to understand our thoughts, feelings, and behavior. It is an important tool for personal growth and development. By reflecting on our experiences, we can identify patterns in our behavior and thought processes. Self-reflection can help us become more self-aware and make positive changes in our lives.

Self-reflection can be challenging, but it is an essential part of personal growth. When we take the time to reflect on our experiences, we gain a better understanding of ourselves, our inner child, and how we relate to others. Self-reflection allows us to identify our strengths and weaknesses, and it can help us make positive changes in our lives.

Through inner child therapy, by self-reflection, I have become more attuned to my physical, mental, and emotional imbalances. And through the mindfulness-based practices of moving, breathing, and being, I have been able to cultivate more kindness, compassion, respect, and equanimity towards others - and slowly towards myself: "Compassion for myself is the most powerful healer of them all" as cited from Theodore Isaac Rubin (b.1923-d.2019), an American psychiatrist and author as well as a past president of the American Institute for Psychoanalysis and the Karen Horney Institute for Psychoanalysis.

Reflective practice involves purposefully engaging in a thoughtful process of examining experiences to glean valuable lessons from mistakes, recognize personal skills and strengths, and generate strategies for change and future accomplishments. It surpasses mere documentation of training for professional growth, instead intertwining reflection and action to foster critical thinking, acquire fresh knowledge, gain insights, and facilitate ongoing learning and personal advancement.

The cultivation of self-reflection and mindfulness seems to play a significant role in the process of recovering from trauma and discovering constructive resolutions during times of crisis. Gaining a deeper understanding of oneself, others, and the surrounding environment is crucial for accessing the vast spectrum of human wisdom and implementing actions that are essential for restoring a world grappling with crises.

Self-Reflection in Inner Child Therapy

Self-reflection is a fundamental aspect of inner child therapy, which aims to heal and nurture the wounded inner child within individuals. The inner child represents the unresolved emotions, unmet needs, and past experiences from childhood that continue to affect one's present behavior and emotional well-being. By engaging in self-reflection, individuals can develop greater self-awareness, explore their inner dynamics, and gain insights into their emotional wounds and patterns of behavior. This process can lead to emotional healing, personal growth, and the development of healthier coping mechanisms.

Self-reflection in inner child therapy serves several important purposes as shown here:
(1) **Understanding the origins:** Reflecting on personal history provides insights into how past experiences shape emotional development. By delving into childhood experiences and associated emotions, individuals gain clarity on current struggles and behavioral patterns.
(2) **Healing emotional scars:** Self-reflection enables the acknowledgment of emotional wounds and unmet childhood needs, fostering care and support for one's inner self. This process facilitates healing and integration.
(3) **Breaking detrimental cycles:** Reflecting helps recognize and challenge unhealthy behavioral and relational patterns stemming from the past. Awareness empowers individuals to consciously choose healthier ways of interacting with themselves and others.
(4) **Cultivating self-kindness and acceptance:** Engaging in self-reflection fosters self-compassion and acceptance by exploring inner experiences with curiosity and non-judgment. This attitude nurtures self-love and care.
(5) **Empowering personal development:** Self-reflection aids in assessing strengths, values, and aspirations, leading to a clearer self-understanding. Armed with this awareness, individuals can set meaningful goals and progress towards personal growth and fulfillment.

All theories of adult human development revolve around the process of overcoming challenges and obstacles. These difficulties can manifest as developmental crises in stage-based models, social injustices in sociogenic models, external and internal conditioning in liberating models, or the transcendence of self-centeredness in transpersonal and spiritual models of development. Ultimately, the common aim across all these models is to cultivate self-reflection and awareness, leading to personal fulfillment and well-being, not only for oneself but also for others and society as a whole. This pursuit also encompasses achieving genuine mental health, which includes cognitive, emotional, and social well-being, as highlighted by Marie Jahoda (b.1907-d.2001), an Austrian-British social psychologist.

In summary, self-reflection plays a vital role in inner child therapy by enabling individuals to gain insight into their emotional wounds, understand their patterns of behavior, heal their inner child, and foster personal growth and well-being.

A Case Study of Walsh Sheila

The example discussed here is sourced from Sheila Walsh's podcast (refer to Walsh, 2017). Sheila, a Scottish-American contemporary Christian figure, renowned as an inspirational speaker, Bible educator, and bestselling author, has sold over 5 million books. Her impactful global ministry, characterized by authenticity, transparency, humor, and the transformative essence of God's teachings, has deeply impacted countless women. Sheila has openly shared moments of both joy and sorrow from her early family life, highlighting her struggle to validate her worthiness of God's love. Readers can delve into the exploration of how introspective inner child therapy contributes to the process of healing.

According to Walsh (2017), at the age of 6, her father experienced a significant change in personality due to a severe brain aneurysm, which resulted in paralysis on his left side and the loss of speech. Sheila's mother assumed the primary caregiving role until her father's violent behavior rendered it unsafe for him to remain at home. Consequently, he was admitted to a nearby psychiatric hospital, where he tragically took his own life at 34. Following his death, the Walsh family faced the loss of their home and car, transitioning from a relatively normal family to experiencing poverty within their community. Sheila received free school meals and uniforms during this time.

During her childhood, Sheila embodied a tomboy spirit and held a deep attachment to her father. However, the final memory she has of him is marred by an inexplicable hatred in his eyes, leaving her bewildered as a child. She struggled to comprehend why her father harbored such animosity towards her, leading her to grow up carrying a heavy burden of shame. It was not that she felt inherently wrong, but rather an ingrained belief that something about her was fundamentally flawed.

For much of her life, Sheila coped by burying her pain deep within. She likened the cellar of her soul to a crowded space, where any emotions she could not process were simply pushed down, buried, or repressed. This coping mechanism eventually spiraled into depression, and at around 34 years old – coincidentally, the same age at which her father ended his life – she even attempted suicide.

Sheila's antidote to that overwhelming sense of guilt and shame that she had caused her father's death was to just work harder. She felt that if she just did more and try harder that somehow she was proving to God (who became her second chance father figure after her biological father's death) that she would do whatever to gain God's approval.

How Self-Reflection In Inner Child Therapy Could Help

The practice of self-reflection in Inner Child Therapy can help someone like Sheila through some of these deep-seated issues. A common self-reflective inner child therapy method is to engage with the client's inner child - the younger, vulnerable, and impressionable self that carries wounds and unmet needs.

In Sheila's case, witnessing her father's personality change from a loving to a hateful and violent father due to an aneurysm, likely had a profound impact on her inner child. Through self-reflective inner child therapy, she can embark on a journey of healing and self-discovery.

As a result, Sheila could experience the following issues:
(1) **Acknowledging the Wounded Inner Child:** Identifying and acknowledging Sheila's wounded inner child comes as the initial step. This includes recognizing the pain, confusion, and emotions stemming from her transition as her father's cherished daughter to the one he despised. This emotional turmoil inflicted deep wounds due to the abrupt loss of validation, a crucial aspect in any child's life. Not only did she endure emotional hurt, but the physical pain from her father's outbursts compounded the distress caused by his rejection. Acknowledging the profound effect of these experiences on her younger self stands as a crucial component in her journey towards healing.
(2) **Creating a Safe Inner Space**: In therapy, Sheila has the chance to create a secure inner sanctuary to reconnect with her inner child. This safe space offers her an opportunity to explore the memories and emotions linked to her father's abrupt rejection and eventual suicide. This process allows her to acknowledge and express her feelings within a caring and supportive environment. Sheila used to suppress these emotions whenever they arose, immersing herself in work to avoid confronting the negative emotions she had locked away inside herself. Through self-reflection, she realizes that she had inaccurately believed for a long time that her actions had caused her father to harbor hatred towards her.
(3) **Nurturing and Re-parenting the Inner Child**: Sheila has the opportunity to nurture her inner child, offering the love, understanding, and support that might have been absent when her father struggled with hatred and violence. By tending to her inner child's needs, she can provide the care and validation that were missing during that difficult period, promoting healing and cultivating self-compassion.

With the medical knowledge that present-day research has revealed, she can also tell her inner child that a tumor present in the same part of the brain as the one in her father's could cause changes in someone's personality and cause them to turn violent and angry against the family member whom they love the most. Individuals diagnosed with primary intrinsic brain tumors often experience a range of neurological, cognitive, and psychiatric symptoms that significantly impact their daily functioning. The American Brain Tumor Association (2019) has identified several common psychiatric symptoms that can be observed in these patients. These include the following:

a) Verbal, emotional, or physical abuse;
b) Hostile or violent attitude and behavior;
c) Intense feelings of displeasure and hostility (anger);
d) Profound changes in personality, either magnifying existing traits or developing new ones;
e) Episodes of uncontrollable, violent anger (rage);
f) Engagement in suicidal behavior, which can involve expressing thoughts of wanting to die or engaging in self-harm gestures; and
g) Engaging in physically, sexually, or emotionally violent behavior

With this in mind, Sheila can go about talking to that child on the inside of her, to affirm her worth and to coax her into changing the belief that had shaped her growing up years: That she had not just done something wrong, but at some core level that she was something wrong. Below are suggested ways that Sheila can engage her inner child:

(1) Sheila can engage in compassionate dialogue with her inner child, addressing unmet needs and emotions resulting from her father's aneurysm. This dialogue fosters understanding, forgiveness, and integration, aiding her wounded inner child's healing alongside her adult self.

(2) Through inner child therapy, Sheila reclaims her power and sets healthy boundaries, understanding how her father's change impacted her. Reflecting on this, she releases limiting beliefs, regaining agency in her life.

(3) Inner child therapy helps Sheila cultivate self-compassion and acceptance, embracing her wounded inner child with love. This fosters self-understanding, resilience, and a sense of wholeness, leading her on a transformative healing journey.

(4) Sheila's doctors noted her struggle to acknowledge her inner anger or advocate for herself.

(5) Her doctors asked Sheila what defines her, to which she replied, "I fear losing what gives me my identity. Would I be left with nothing but an empty vessel if stripped of superficial layers?"

(6) Sheila grappled with false beliefs, thinking her father's death was her fault. She worked tirelessly to compensate her mother and brother for their loss.

(7) Sheila realized her journey towards faith was about seeking God's approval and avoiding disappointment. However, she came to understand that the Lord is a companion rather than a judge, allowing her to live securely in her faith.

Conclusion

In conclusion, the inner child is an important part of oneself that can affect a person's behavior, thoughts, and emotions. In addition, the perspective of embodied self-awareness offers a comprehensive framework that highlights the interconnectedness of lived experiences, the social aspect of the body and mind, and their relationship with the environment. Through the practice of self-reflection and mindfulness, individuals can cultivate a heightened awareness of their present-moment experiences. This increased awareness not only enhances problem-solving abilities but also strengthens resilience in difficult situations and facilitates the process of recovering from trauma, as discussed by Ayduk and Kross (2010).

As demonstrated through Sheila's case example, self-reflection can be a most valuable tool for understanding our inner child and identifying negative behavior patterns that may be holding us back from personal growth and development. Understanding our inner child can have a positive impact on our lives by helping us heal emotional wounds, improve relationships, develop empathy, increase self-awareness, and make positive changes. It is essential to take the time to reflect on our experiences and understand our inner child to become the best version of ourselves.

In addition, humanity and the global community are currently confronting an unparalleled state of heightened uncertainty, encompassing a multitude of interconnected crises, post-pandemic. These crises encompass various challenges such as global climate change, social inequality, economic instability, terrorism, social unrest, and the fragmented nature of digital knowledge.

The cultivation of self-reflection and awareness seems to play a crucial role in the healing process following trauma and in the discovery of effective solutions to crises (Ayduk & Kross, 2010). To address the challenges of a world plagued by crises, it is essential to possess an awareness of oneself, others, and the environment. This awareness serves as a foundation for acquiring the breadth of human knowledge and taking the necessary actions to restore balance (Kelly, 2017).

References

American Brain Tumor Association (2019) .Neuropsychiatric symptoms of brain tumors. Retrieved online: https://www.abta.org/wp-content/uploads/2019/07/Neuropsychiatric-Symptoms-of-Brain-Tumors_7-19.pdf.

Ardelt, M., & Grunwald, S. (2018). The importance of self-reflection and awareness for human development in hard times. *Research in Human Development*, *15*(3-4), 187-199.

Ayduk, O., & Kross, E. (2010). From a distance: Implications of spontaneous self-distancing for adaptive self-reflection. *Journal of Personality and Social Psychology*, *98*, 809–829.

Bendelow, G., & Williams, S. J. (2002). In search of the inner child. In G. Bendelow & S. J. Williams (Eds), *Emotions in Social Life* (pp. 125-148). London, UK: Routledge.

Boele, F. W., Rooney, A. G., Grant, R., & Klein, M. (2015). Psychiatric symptoms in glioma patients: from diagnosis to management. *Neuropsychiatric Disease and Treatment*, *11*, 1413-1420.

Capacchione, L. (1991). *Recovery of your inner child: The highly acclaimed method for liberating your inner self*. New York, NY: Simon and Schuster.

Coelho, P. (1988). *The alchemist*. New York, NY: HarperCollins.

Jahoda, M. (1958). *Current concepts of positive mental health*. New York, NY: Basic Books.

Kelly, S. (2017). Five principles of integral ecology. In S. Mickey, S. Kelly, & A. Robbert (Eds.). *The variety of integral ecologies: Nature, culture, and knowledge in the planetary era* (pp. 189-227). New York, NY: SUNY Press.

Mickey, S., Kelly, S., & Robbert, A. (2017). Introduction: The history and future of integral ecologies. In S. Mickey, S.Kelly, & A. Robbert (Eds.), *The variety of integral ecologies: Nature, culture, and knowledge in the planetary era* (pp. 1-30). Albany, N.Y.: State University of New York Press.

Reis, H. T., Collins, W. A., & Berscheid, E. (2000). The relationship context of human behavior and development. *Psychological Bulletin*, *126*(6), 844-872.

Sharma, A., Das, A. K., Jain, A., Purohit, D. K., Solanki, R. K., & Gupta, A. (2022). Study of Association of Various Psychiatric Disorders in Brain Tumors. *Asian Journal of Neurosurgery*, *17*(04), 621-630.

Stanley, S. (2016). *Relational and body-centered practices for healing trauma: Lifting the burdens of the past*. New York, NY: Routledge.

Walsh, S. (2017) *A prison to set you free: Sheila Walsh's journey through depression*. Retrieved online: https://www.jesuscalling.com/podcast/sheila-walsh/.

Implementation of the Triple-D Model at BH Lim Special Needs Consultancy

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APA Citation: Tan, V. L. (2023). Implementation of the triple-D model at BH Lim Special Needs Consultancy. *Journal of Early Years Research*, *3*(2), 23-29.

Abstract
This short paper touches on the author's learning journey in her modest attempt to provide her understanding of the Triple-D Model (Wong, Chia, & Lim, 2015) and its application with her four-year-old client at her workplace, an educational therapy center that provides intervention for young children, school-age children and adolescents. It explores the four phases involved in the application of the Triple-D Model of case management process in educational therapy: Phase 1-Diagnostics, Phase 2-Dialogics, Phase 3-Transition from Dilogics to Didactics, and Phase 4-Didactics. The final phase brings the readers back to the first phase of Diagnostics where it involves the evaluation of the intervention program and also provides feedback to the stakeholders (i.e., the client, the client's caregiver or parents, and the therapists) in the second phase of Dialogics. In this way, the treatment program designed to meet the client's needs could be further improved and adapted if it is to continue.
Keywords: Case management, Diagnostics, Dialogics, Didactics, Triple-D model

Introduction

In this paper, I will attempt to describe how the Triple-D Model is being implemented at BH Lim Special Needs Consultancy (BHLSNC). I will also attempt to explain the Triple-D Model with reference to a client (anonymously designated TYF), a four-year old boy currently attending the intervention program at BHLSNC.

In the educational therapy, a well-planned case management system (CMS) is an important aspect to consider in meeting the needs of the clients and leading them to a better outcome (see Liu, Xie, & Deng, 2023, for detail). First of all, what is CMS? According to NYS Promise (2018, p. 1:1), CMS is a fundamental intervention service that helps individuals gain access to essential services needed to achieve beneficial community living and learning outcomes. Therefore, a case manager who uses a structured CMS might help in establishing an intervention plan, tracking the client's progress, as well as promoting collaboration between therapists and parents that meets the needs of the client.

In CMS, a case manager will be involved in providing support services to the clients and families such as assisting them in determining individualized service plans, providing emotional support, and facilitating collaboration with community organizations and systems (NYS Promise, 2018, p. 1:9). Hence, the roles of a case manager would include monitoring the whole process of the service, being a support service coordinator, being a family/peer mentor, and a resource coordinator for specialized services (Wong, Chia, & Lim, 2015). Due to BHLSNC's limited human resources, the therapist will also serve as the case manager in providing feedback and adequate support to clients and families, as well as providing information and referrals for specialized services such as speech and language therapy (SLT) and occupational therapy (OT).

At BHLSNC, the Triple-D CMS has been used as a guideline to manage a case to ensure effective support for the client. The Triple-D model includes Diagnostics, Dialogics, and Didactics (Chia & Kee, 2012). The client undergoes the Triple-D processes which are explained in the next section as follows.

The Triple-D Model
The Triple-D model, introduced by Wong, Chia, and Lim (2015), is a framework used in special education case management. It comprises three key components: Diagnostics, Dialogics and Didactics.

❖ **Diagnostics**
According to Wong, Chia, & Lim (2015), educational diagnostics (a term coined and used by Li, Xie, & Deng, 2023) is a process that includes screening (evidence-based psychoeducational assessments), evaluation, and profiling of a client who may be facing learning and/or behavioral challenges. In other words, this first phase involves assessing the needs, abilities, and challenges of the student. It focuses on understanding the specific learning profile, strengths, weaknesses, and any disabilities or exceptionalities. The steps involved in the Diagnostic phase (case measurement) include the following:

Step 1:
A screening assessment is conducted on a client who is suspected to have learning and/or behavioral challenges to identify the client's strengths, challenges, learning styles, and preferences. In TYF's case, an evidence-based assessment, Ages & Stages Questionnaires®-Third Edition (ASQ-3™; Squires & Bricker, 2009) was used. This is a screening process for young children aged between 1 to 66 months for developmental delays in five areas: communication, gross motor, fine motor, problem solving, and personal social (see Squires & Bricker, 2009, for detail). Alongside the ASQ-3™ (Squires & Bricker, 2009), the companion Ages & Stages Questionnaires®-Socio-Emotional-Second Edition (ASQ®:SE-2; Squires, Bricker, & Twombly, 2015) was also used. This is to screen a child between 0 to 72 months in seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people (Squires, Bricker, & Twombly, 2002, 2015).

As TYF engaged with the therapists (clinical observation phase) in interactive and stipulated activities, TYF's mother and grandmother responded to the ASQ-3™ (Squires & Bricker, 2009) and ASQ®:SE-2 (Squires, Bricker, & Twombly, 2002, 2015) interview schedules. The outcomes of TYF's ASQ-3™ scores indicated that he was below the cut-off in communication, fine motor, problem solving, and personal-social. This suggests that TYF's development is delayed in these four areas. Whilst gross motor was above the cut-off, it was in the *monitoring* zone. According to the Educator's Diagnostic Manual of Disabilities and Disorders (EDM; Pierangelo & Guiliani, 2007), TYF is said to have Global Developmental Delay (GDD). This indicates that TYF has failed to achieve developmental milestones in a few areas of intellectual functioning (see Pierangelo & Guliani, 2007, for more detail). In the ASQ®:SE-2, TYF was found to be *at-risk* for developing social-emotional issues. The outcomes of the assessment, corroborated by feedback from family members, and a close-up observation of his behavior, provide triangulated data that TYF manifests many traits suggestive of autism spectrum condition (ASC), which should not be mistaken for autism spectrum disorder (ASD).

Step 2:
In step 2, diagnostic tests based on the hierarchy of abilities and skills (innate abilities, sensory perceptuo-motor skills and abilities, adaptive behavioral skills and abilities, socio-emotional behavioral skills and abilities, and cognitive skills and abilities) are administered (Wong, Chia, & Lim, 2015).

In TYF's case, these diagnostic tests were not administered because of parents expressed financial difficulties. Absence of such essential data from the diagnostic evaluation has important implications for the therapists attempting to construct an Individualized Education Plan (IEP) appropriate to TYF's needs. Fortunately, however, as soon as financial subsidy became available for TYF, the Sensory Profile Caregiver Questionnaire (SP-CQ; Dunn, 1999) and Gilliam Autism Rating Scale-3rd Edition (GARS-3; Gilliam, 2006) were administered.

Step 3:
In this step, outcomes from the psychoeducational assessments are analyzed to have a good understanding of the client's strengths and areas of need. In TYF's case, outcomes from the assessments

suggest that TYF has gross motor skills on par with his same-age peers, but he has significant delays in the areas of communication, fine motor, problem solving, and personal-social skills.

❖ **Dialogics**

Dialogics may be defined as the process by which communicative parties attain mutual agreement on purposeful communication by verifying each other's perceived viewpoint and contextual understanding, perceived use, and relationship of conveyed ideas and perceived meanings (Bakhtin, 1939, as cited in Todorov, 1984). In other words, this second phase emphasizes collaboration and communication among stakeholders involved in the student's education. It encourages open dialogue between educators, parents, specialists, and the student to develop a comprehensive plan that addresses the individual's needs. Steps involved in the Dialogics phase (case consultation) include the following:

Step 1:

In step 1 of the Dialogics or Educational Dialogics (Liu, Xie, & Deng, 2023) phase, the client's parents collaborate with other professionals who understand the client's condition to form a Case Management Team (CMT) to support the client throughout the intervention period. Such a consultative team aims to confirm the assessment results and identifies the key personnel who will be actively involved in assisting the client throughout the intervention period (Wong, Chia, & Lim, 2015).

Going back to TYF's case, an earlier initial consultation had been conducted with members of the family to better understand TYF's first three years of life (including prenatal and postnatal information), and specific developmental milestones achieved. Family members were also asked about their concerns about TYF's development, and what their main goals were in referring TYF to BHLSNC.

Family members reported that TYF currently attends a typical kindergarten with a weekly (hourly) one-on-one additional session. TYF was also attending weekly OT sessions which his mom eventually terminated as she felt TYF was not benefiting from these sessions. However, it was not possible to obtain a report from the OT.

Further attempts to obtain more information from the OT center have not been fruitful. On reflection, attempts to "*dialogue*" with other allied fields in special needs education have been challenging due to a number of factors. First, the scarcity of services creates competition among service providers; second, service providers are often concerned about guarding over their area of "speciality". These factors seriously hinder collaboration and dialogue among the various disciplines, with the eventual "loser" being the special needs client.

Hence in the current situation, TYF's family members constitute the key personnel providing support and feedback about his progress. Apart from the brief verbal report (the family also receives a Session Intervention Report via *WhatsApp*) with family members after each intervention session, a quarterly family conference has been arranged to provide on-going feedback and review of TYF's IEP.

Step 2:

In this step, the CMT needs to decide whether the client should continue with the CM support service or be referred to other specialized services to ensure the service provided to the client who requires the most vital service (Wong, Chia, & Lim, 2015). Some resources, such as subsidies and referral systems should be provided to the client's family to help them make the best decision on selecting the next support service provider.

In TYF's case, the family decided to continue with the CM support service. Additional financial subsidy was sought to enable TYF to continue with the intervention services. The family was also recommended to seek Speech Language Therapy (SLT) services, but this was not taken up because earlier SLT services did not seem to benefit TYF.

❖ **Transition from Dialogics to Didactics**

This transition phase involves constructing the IEP for the client. The Triple-T Model of Learning is used to identify and understand how to assist clients in learning from the pedagogical perspectives (Chia & Kee, 2013; also see Wong, Chia, & Lim, 2015, for more detail). The Triple-T Model includes *Epistēmē* (*what* of learning), *Telos* (*why* of learning), and *Technē* (*how* of learning). The transition phase is also known as case development, case planning, or case building (Wong, Chia, & Lim, 2015).

In the "*what* of learning", the Carolina Curriculum for Pre-schoolers with Special Needs, 2nd Edition. (CCPSN; Johnson-Martin, Attermeier, & Hacker, 2004), was used to guide the construction of TYF's IEP appropriate to his developmental level.

The CCPSN (Johnson-Martin, Attermeier, & Hacker, 2004) is designed for young children who have mild to severe disabilities between the age of 24 to 60 months with 22 teaching sequences covering five developmental domains such as personal-social, cognition, communication, fine motor, and gross motor (Johnson-Martin et.al, 2004). The CCPSN evaluates the client's performance based on 4 legends (able to do independently, able to do with verbal prompting, able to do with physical prompting, unable or refuse to do) (see Johnson-Martin, Attermeier, & Hacker, 2004, for detail). TYF's IEP was guided by outcomes from the ASQ-3™ assessment (Squires & Bricker, 2009). Figure 1 below illustrates the short-term objectives in CCPSN (Johnson-Martin, Attermeier, & Hacker, 2004), visual perception: blocks and puzzles.

Cognition	
6-I. Visual Perception: Blocks & Puzzles	
Age (mths)	**Curriculum Sequences**
24-30	a. Places round, square, and triangular forms in reversed form board
	b. Imitates block train
30-36	c. Puts together two-piece puzzles
	d. Imitates block building
	e. Imitates block bridge
	f. Puts together puzzle with four or five interconnected pieces
36-42	g. Imitates horizontal (flat on the table) block patterns of two and three blocks (two colors)
42-48	h. Imitates horizontal block patterns of four to six blocks (two colors)
	i. Completes 8- to 12- pieces interconnected puzzles
48-54	j. Imitates construction of a simple visual pattern using parquetry blocks
	k. Builds representationally with blocks
54-60	l. Completes 15- to 25- piece interconnected puzzles
	m. Reproduces simple block designs from memory

Figure 1. Visual Perception: Blocks & Puzzles

Each intervention session conducted, usually involving more than one therapists using multi-sensory methods. Tools used usually combine two or more senses such as see (sight), touch (tactile), hear (auditory), smell (olfactory), taste, and movement (kinesthetics). Being an active child, TYF prefers hands-on activities. Talk tools have been included in the intervention session to help TYF develop oral motor skills.

In constructing the IEP, CMT looks at the annual objectives, short-term objectives, and behavioral objectives. The annual objectives are the long-term goals to be achieved by the client. Short-term objectives are developed and expanded from the annual objectives with a stipulated time frame, for example, 3 months. The behavioral objectives are developed and expanded from the short-term objectives. Behavioral objectives based on the CCPSN are carefully selected based on TYF's current developmental level, that is, not too difficult to avoid frustration, and yet not too easy so that TYF will be challenged to improve. Figure 2 below shows the objectives selected for TYF based on the CCPSN.

Annual Objective: Cognition
Short Term Objective: **6-I. Visual Perception: Blocks & Puzzles**
Behavioural Objective:
1. a. Places round, square, and triangular forms in reversed form board
2. b. Imitates block train
3. c. Puts together two-piece puzzles

Figure 2. Annual, Short-Term, and Behavioral Objectives in TYF's IEP

❖ Didactics

Didactics - also known as Educational Didactics (Liu, Xie, & Deng, 2023) - could be defined as having the ability to teach the content knowledge by implementing different teaching aids and methods to help the client to learn (Gundem, 1998, p. 19-24, as cited in Wong, Chia, & Lim, 2015). In other words, once the assessment is completed and dialogue established, this phase focuses on implementing tailored instructional strategies and interventions. It aims to deliver effective teaching methods and support systems that cater to the student's unique learning requirements. Steps involved in the didactics phase (case intervention or case treatment) include:

Step 1:
The IEP will be implemented over a period of time negotiated by CMT in consultation with TYF's family.

In the course of intervention, if TYF achieves independence in a behavioral objective, his IEP will be upgraded accordingly. At BHLSNC, a client is required to attend at least 2 intervention sessions per week, each session lasting one hour. Each intervention session is documented on a Session Intervention Record (SIR), and sent to TYF's family for their keeping. An example of the SIR is shown in Figure 3.

Cognition

6-I. Visual Perception: Blocks & Puzzles	**I**	**VP**	**PP**	**X**
c. TYF is able to put together two-piece puzzles.				
Suggested activity:-				
- *Playing with animal wooden puzzle. (**Remark:** TYF seemed confused with the orientation of the puzzle pieces. He appeared to have some difficulties in rotating the puzzle to match the shape.)*			/	

Figure 3. Example of an SIR

Step 2:
Here, the client's progress is monitored to make necessary referrals to other consultants, or to implement more appropriate strategies to support the client.

At BHLSNC, SIRs are carefully compiled and reviewed every three months. Behavioral objectives are expected to change over time depending on the client's progress. A parent conference is conducted on a quarterly basis. During the parent conference, a quarterly IEP review is presented, and parents are encouraged to provide their feedback. Therapists working with the client report on the progress (or lack thereof) in specific areas and suggest appropriate changes. This is done in consultation with the parents, who at this conference have the option to continue (or discontinue) with the intervention sessions. Should parents opt to continue with the intervention, the conference will attempt to decide on the appropriate objectives to construct the IEP for the following quarter. Figure 4 shows an example of the Quarterly IEP Evaluation Report.

Cognition
6-I. Visual Perception: Blocks & Puzzles
c. Puts together two-piece puzzles (30-36 mths)
- Requires PP
- TYF was confused with the orientation of the puzzle pieces; he has difficulty in rotating puzzle to match the shape

Figure 4. Example item in the Quarterly IEP Evaluation Report

Step 3:
This step is carried out before the eventual “*discharge*” of the client. Outcomes from the intervention sessions are collected for systematic analysis and compared to the results obtained from the assessment done in the Diagnostics phase. Such a *pre-* and *post-* analysis helps to evaluate the effectiveness of the intervention carried out.

Of course, TYF has yet to come to this stage. At BHLSNC, the client is re-screened using both ASQ-3™ (Squires & Bricker, 2009) and ASQ®:SE-2 (Squires, Bricker, & Twombly, 2002, 2015). Outcomes of this re-screen are compared to the initial outcomes carried out before commencement of early intervention to gauge the client’s progress.

Upon discharge, the client often transitions to another setting, such as a school. BHLSNC proactively supports this transition process, which usually involves the CM keeping in close contact with the client’s family, and other personnel in the new setting.

Conclusion
So, how useful has the Triple-D Model been at BHLSNC? After working with BHLSNC for more than a year, I venture to say that this model provides a clear and systematic guide for negotiating through the many challenging situations as I attempt to support my client with special needs. Reflecting on the Triple-D Model and its application at BHLSNC has helped me identify a number of limitations.

With regards to the first “D” (Diagnostics), I have come to realize that many clients do not have proper diagnosis. Some families do not seek formal diagnosis because of the fees involved; yet others are in denial, hoping their child will outgrow their difficulties, and so do not seek help much earlier. Some have attended months of SLT and/or OT services (as in the case of TYF) but were not given reports of progress.

As for the second “D” (Dialogics), there seems to be little opportunities for the professionals to consult each other. I wonder if the scarcity of services in the area of special needs has made service providers especially competitive, so that professionals hold back from sharing their knowledge. Sadly, it is the special needs client who loses out if professionals are reluctant to “dialogue” with each other.

In the final “D” (Didactics), I realize the need for more trained personnel in the field. There is a real need for persons who are trained to understand diagnostic reports, interpret them, and to put together a *Case Review Report* that accurately reflects the psycho-educational and diagnostic profile of the special needs client, before even attempting to put together an IEP that can help the client effectively.

In view of all the above, I am truly thankful to be enrolled on the Special Needs Educational Therapy (SNET) course under the auspices of the International Association of Counselors and Therapists (IACT). This has given me the opportunity to reflect on my role in BHLSNC, specifically in applying the Triple-D Model as I learn to manage the case of TYF.

References
Bakhtin, M. (1939). Cited in Todorov (1984). *The conquest of America: The question of the other*. UK: Manchester, UK: Manchester University Press.

Chia, N. K. H., & Kee, N. K. N. (2012). The triple-D framework (diagnostics, dialogics and didactics) for training of special education professionals in Singapore. *Unlimited Human!* Summer issue, 36-46.

Chia, N. K. H., & Kee, N. K. N. (2013). An integrated teaching-learning framework for special education in Singapore. *Academic Research International*, 4(2), 416-426.

Dunn, W. (1999). *Sensory Profile: User's manual*. San Antonio, TX: Psychological Corporation.

Gilliam, J.E. (2006). *Gilliam Autism Rating Scale- 2nd Edition (GARS-3): Examiner's manual*. Autisn, TX: Pro-Ed.

Gundem, B. B. (1998). Understanding European didactics: An overview on didactics. *Institute for Educational Research Report No.4*. Oslo, Norway: University of Oslo.

Johnson-Martin, N. M., Attermeier, S. M., & Hacker, B. J. (2004). *Carolina curriculum for infants and toddlers with special needs (Ccitsn)*. Baltimore, ML: Brookes Publishing.

Liu, W., Xie, G. H., & Deng, M. J. (2023). *Case management system in educational therapy.* London, UK: Lambert Academic Publishing.

NYS Promise. (2018). NYS PROMISE case management: A field guide for case managers and family coaches. *Cornell University Library*, *3*, 1:1-1:9. Available online at: https://files.eric.ed.gov/fulltext/ED592569.pdf

Squires, J., & Bricker, D. (2009). *Ages & Stages Questionnaires®-3rd Edition (ASQ-3™)*. Baltimore, ML: Paul H. Brookes Publishing.

Squires, J., Bricker, D., & Twombly, E. (2002). *The ASQ:SE user's guide: For the Ages & Stages Questionnaires: Social-emotional.* Baltimore, ML: Paul H. Brookes Publishing.

Squires, J., Bricker, D., & Twombly, E. (2015). *Ages & Stages Questionnaires®: Socio-Emotional- 2nd Edition*. Baltimore, ML: Paul H. Brookes Publishing.

Todorov, T. (1984). *Mikhail Bakhtin: The dialogical principle* (W. Godzich, Trans.). Minneapolis, MN: University of Minnesota.

Pierangelo, R., & Guiliani, G. A. (2007). *EDM : The educator's diagnostic manual of disabilities and disorders*. Available online at; http://ci.nii.ac.jp/ncid/BA83170861

Wong, M. E., Chia, K. H., & Lim, B. H. (2015). A Triple-D model of primary case management system for special education. *Asian Journal of Management Sciences & Education*, *4*(1), 12–22. http://www.ajmse.leena-luna.co.jp/AJMSEPDFs/Vol.4(1)/AJMSE2015(4.1-02).pdf

An Exploratory Study in Singapore's Mental Health Therapists: A Thematic Content Analysis

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APA Citation: Guo, G. Q. (2023). An exploratory study in Singapore's mental health therapists: A thematic content analysis. *Journal of Early Years Research*, *3*(2), 30-37.

Abstract
This study applied thematic content analysis to examine Singapore's private practice mental health websites. While Singapore and the Southeast region have recognized the importance of mental health in a nation's overall citizen well-being, these nations are still far behind Western nations like the USA and UK in regulating therapists' credentials and setting guidelines on therapists' core competencies and skill sets. Also, the examination of such websites provides a glimpse of the common mental health issues therapists focus on in private practice as well as their training and techniques or specialization. At the same time, it is an ecologically valid and interesting way to explore how therapists market and reach out to clients. This study would provide a broad overview of Singapore's mental health landscape in terms of the prevalence of therapists' specialization and areas of focus as well as their responses to meet the public's needs.
Keywords: Mental health, Psychology, Singapore, Therapy

Introduction

A recent study in Singapore estimated a major economic and healthcare cost due to depression and anxiety. Such mental issues result in absenteeism, reduced productivity and healthcare resources significantly impose Singapore's economy (Chodavadia et al., 2023). Another national survey showed that there is an increased report of major depressive disorder (MDD), generalized anxiety disorder (GAD), and obsessive-compulsive disorder (OCD) as compared to prior years (Subramaniam et al., 2019). Relatedly, there has been a spike in the number of psychological private practices in Singapore. Many are now advertising their services online to garner a customer base. Indeed, there has been an increased interest in utilizing social media in promoting mental health awareness, especially among youths (Naslund et al., 2016). It has also been applied to support mental health recovery. Such reflects the developmental significance of peer influence in adolescence and the rapid adoption of Internet and mobile technology across the world (United Nations Population Fund, 2014).

Social media has also become a pertinent area of research in mental health and intervention as it provides an inexpensive, relatively easy, and fairly discreet avenue for individuals to access mental health resources (Betton et al., 2015). As a result, individuals could impact larger groups by bringing their personal experiences into social media, thereby having a magnified impact on the public domain (Kaplan & Haenlein, 2010). Though current research suggests a mixed picture of social media's relationship with individuals' mental health and well-being, its role in facilitating help-seeking and access to mental health resources cannot be overlooked (Kranzler & Bleakley. 2019).

In the context of private practice, clients are seeking therapy (Pasley et al., 1996; Rickwood et al., 2007) and therapists are sourcing for clients (Colburn, 2013). Evidence suggested that clients take a number of steps before starting the first therapy session (Elliot et al., 2005), including identifying the issue and researching various treatment approaches (Doss, Atkins, & Christensen, 2003). Another important aspect is how clients reach out and initiate therapy sessions. However, health-seeking and consultation are often hampered by the social stigma associated with mental health issues (Berger et al., 2005). Such stigma could be overcome when individuals access large amounts of mental health resources and information, which would contribute to better adjustment and decision-making (Pantic, 2014). It also provides a fast way to connect with others online, hence reducing the barriers to seeking mental health

support and clients feel that they can better express their feelings (Burns et al., 2009). Therapists would attempt to overcome barriers and assist clients to build engagement and connection with clients, therefore having a more significant impact on clients' participation and therapeutic alliance (Kazdin, Marciano, & Whitley, 2005; Sexton et al., 2005). Research showed that marketing would enable therapists to secure and engage more prospective clients through the therapy initiation process (Colburn, 2013). It is therefore interesting to understand how therapists in private practice market themselves and their services (i.e., therapy approaches) to prospective clients.

Studies observed how therapists typically brand their therapy services in order to improve their marketing campaigns. For instance, therapists diversify their counselling practices to attract more and varied client profiles through long-distance, online therapy (Colburn, 2013). Others market based on a geographically-targeted approach (Cohn & Hastings, 2013). Others proposed that branding could provide therapists' services a strong identity that would portray a meaningful image in the thought and dialogue of those clients seeking therapy services, which would draw traffic to their website and increase their prospective clients

Psychotherapy is important in promoting positive benefits and therapeutic outcomes (Duberstein et al., 2018). Past research typically classifies techniques such as marital and family therapy and cognitive behavior therapy as psychotherapy. However, recent emerging trends in psychological intervention now extend to educational therapies (i.e., Orton-Gillingham phonics, reading and mathematics therapy), occupational and speech therapy, early childhood intervention as well as art therapy and cognitive training. The diversity also suggests the evolution and emergence of the public's demand and interest in more sophisticated therapies in addressing various psychological and neurodevelopmental issues. The spike in the number of practices also suggests that the public is more willing to engage in therapists' services. At the same time, it also means that mental health specialists and psychotherapists are facing intense competition among private practices. To date, no study has been conducted to examine Singapore's mental health private practice via a thematic content analysis approach.

This approach explores and identifies trends and distribution of various psychotherapy approaches. It would develop themes that best represent the content of these sites, specifically their specializations, focus, and underlying philosophy. An important feature of the research was the coding based on open-source internet website information pertaining to therapy resources. By exploring the content of psychological services and therapists' websites, the study provides a better understanding of psychological services and therapists' websites, such as the messages and emotional tones of these sites. Due to the exploratory nature of the study, it aims to examine:
(1) Psychological disorders and issues;
(2) Therapy approach and techniques;
(3) Training and background as well as their focus; and
(4) Marketing and therapy arrangements.

Procedure and sample
This analysis of publicly available websites does not meet the definition of human subjects' research. As materials were all extracted from web-pages, weblogs or other files available to the general public via the Internet, no issues of anonymity of results were applied. So, this qualitative study did not require institutional review board approval or informed consent. It began with developing a typology of therapy, classifying the results into categories and themes.

Based on the research questions, a methodical search for psychological services and therapy services based on the keywords "counselling", "psychology", "psychotherapy", "therapists", "interventions" and "mental health." This search was done in Linked, Singapore's Accounting and Corporate Regulatory Authority (ACRA) and Google Search Singapore. Based on the search, there were around 246 entities that market their services as individuals and companies. It is challenging to ascertain the exact figures and breakdown for each category as some therapists themselves individually and under a few companies as freelance. Other therapists market themselves as various form of therapists. For

instance, some market themselves as "counselors" and "early interventionists" and others work as "educational therapists" and "psychologists." Analysis was conducted until no new information emerged (i.e., data saturation).

Data analysis
Thematic analysis was adopted based on a dual inductive and deductive approach for data analysis so that frequently occurring themes and categories could be identified (Thomas, 2006). This technique is a commonly used qualitative data analytic method, particularly in under-researched areas like this study. Further, it would be a best practice to analyze the data with prior research and theoretical framework. By doing so, the analysis would be more meaningful, especially when it has reference and context (Castleberry, & Nolen, 2018). Two levels of analysis would be applied: (1) in semantic approach, the data is analyzed at explicit level in relation to previous literature (Frith & Gleeson, 2004; Patton, 1990), and (2) in the latent approach, it involves identifying underlying meaning and concepts with the theoretical framework as a basis (Boyatziz,1998). The analysis was done according to a six-stage thematic analytic method (Braun & Clarke, 2006). These entail familiarizing with data, generating initial codes, searching themes, reviewing themes, defining and labeling themes, and generating a report. These are:
(1) Extension of mental health services beyond socio-emotional issues;
(2) Educational therapy and special education specializations;
(3) Emphasis psychological testing and assessment; and
(4) Profile of therapists and revenue model.

Theme 1: Extension of mental health services beyond socio-emotional issues
Notably, many psychotherapists service rid of recent mental health trends. In line with recent Ministry of Health research, schizophrenia, depression, anxiety, and bipolar disorder are the most common psychological disorders. Also, many common issues like stress and adjustment issues are highlighted on these websites. Common statements such as shown below:

"We treat a wide range of psychological conditions. The more common ones include stress, anxiety, depression and sleep difficulties."

"Everyone experiences stressors in their lives. Some major stressors could include the loss of a loved one, losing a job, or financial difficulties. However, how these stressors impact us are unique"

Besides these, family and couple relational issues are the second most areas of focus for many counselors and psychotherapists. Some examples of their marketing statement are shown below:

"When we get to know families, there are inevitable differences and issues" and *"We help couples heal from the pain experienced through rejection and disappointment in their relationships."*

More recently, there have been more demands for unconventional therapy like sex coaching or therapy and focus on "lesbian, gay, bisexual, and transgender" (LGBT). In these instances, such forms of therapy or training seem to provide an entry point for layman to enter mental health professions. Relatedly, the study also noted that some therapists focus on "lesbian, gay, bisexual, and transgender" (LGBT) for counselling and therapy sessions. By publishing this, it is believed that therapists would attract LGBT clients profile who may not be otherwise welcome by other mainstream therapists. For example, one therapist describes: *"help individuals and couples lead self-actualized and pleasurable lives. Her expertise includes working with couples who have unconsummated marriage, individuals with sexual inhibitions and discrepancies in sexual desire, men with erection and ejaculation concerns, and members of the LGBTQIA+ and kink communities."*

Others focus on children and youth with an example of such specialization that includes some of the following helpful signs a child/youth needs counseling:
(1) The child/teen has been behaving differently for the past month or so.

(2) It is becoming difficult to pacify the child/youth's emotions.
(3) The parents notice a continuous decline in the child's academic performance.
(4) The parents have observed changes in the kind of friends their child/youth has.
(5) The problem with the child/youth has been affecting the marriage of his/her parents.
(6) The child's/youth's teacher and other significant adults have been giving more alarming feedback about the child/youth.
(7) The child/youth is becoming more distant.

Similarly, gender/sex coaching appears to be an extension of the couple and family therapy, and focuses on gender/sex and intimacy which are typically not comprehensively covered in normal counselling. Other therapists may practice neurolinguistic programming (NLP) and use it as a repertoire in counselling sessions.

These real, authentic conversations with a life coach is why coaching works wonders. The relationship with the coach provides an individual a dedicated safe space to think aloud and examine what is happening or going on, and that can get really tricky to do when life demands more of one's attention

Other forms of therapy which have evolved over time from the conventional counseling of talk therapy are life coaching and career coaching. Indeed, in many institutions, these two coaching approaches form parts of the overall approach in counseling, albeit as a module or specialization track. However, these two forms of coaching are conducted by many who do not have prior psychological or therapy training. It appears that these forms of counseling tend to pivot towards motivational or power talks as well as goal setting. In a way, these two areas have a lower barrier of entry as compared to other forms of counselling or psychotherapy, which require more formal education and advanced training. This theme reflects the emergence of non-conventional therapy approaches. A few recent popular examples are Eye Movement Desensitization and Reprocessing (EMDR), hypnotherapy, neurolinguistic programming (NLP), and gender/sex coaching. A survey of websites showed that these therapists did not receive formal clinical or counseling therapy. They brand themselves to be experts in hypnotherapy who can provide alternative therapies to psychological issues such as trauma and stress management.

Theme 2: Educational therapy and special education specializations
Unlike past research that reviewed family and couple therapy as the predominant and majority approach, this paper has noted that there is an emerging trend for educational therapy and intervention for special needs populations. This showed an advancement in the field of psychology and therapy. Previously, counseling techniques and behavior modification were perceived as the holy grail of all psychological issues, including educational and special needs areas. An example is: *"helping children through learning activities designed to build on strengths while improving the weaker areas of academics and cognitive skills"; "personalized remedial teaching for children with special needs and learning problems."*

Educational therapists are trained professionals who are able to teach strategies to address challenges with reading, Math, writing, spelling, organization and study skills. Also, they *"focus on treating attention-deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), and nonverbal learning disorder (NLD or NVLD)."*

Hence, it appears that educational therapy serves a pro-motive function to enhance learning and academic performance of children as well as a rehabilitation function for children with neurodevelopmental disorders like ADHD and autism.

There are other related "education" programs known as "school preparation programs" or "early head start programs" which provide simple cognitive training or foundational concepts for pre-primary or primary schools. Some enrichment classes for speech, drama and writing are often packaged with educational psychology flavor as marketing.

Theme 3 Psychological testing and assessment

Notably, psychological testing and assessment seem to emerge as part of psychotherapy services. In the past, psychological testing and assessments are usually conducted in hospital setting or with psychiatrists. The study observed that many psychologists and therapists also provide screening and assessments. This additional service functions as an additional "value-added" service and has an edge over competing private practices. A sample of marketing statement is: *"IQ and academic testing are vital to identifying a child's cognitive strengths and weaknesses, academic needs, and preferred learning style."* Another sample is: *"A center also provides psychological testing for a wide range of needs such as organic brain injuries, IQ and career counselling, psychological profiling for employment, psychiatric legal problems, psychological screening for maids and other psychological testing such as 16PF, MMPI, IQ tests, etc."*

The increasing prevalence of psychological testing is evidence of advancement in the field and the increased skill repertoire of therapists. This is also partly due to response and demand of clients for such psychological testing and assessment (see Figure 1).

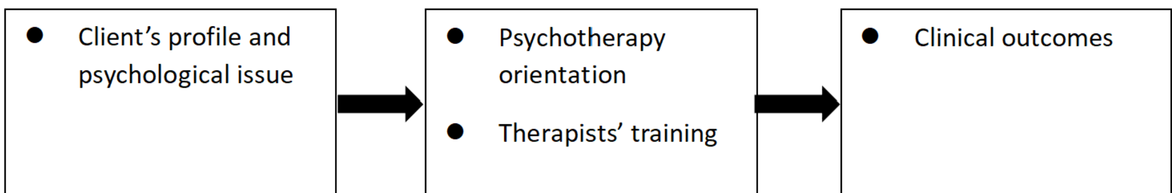

Figure 1. Factors to be considered in the Mental Health/Wellness Treatment

Theme 4: Therapist profile and private practice revenue models

Our review of private practice websites showed that therapists are from the diverse educational background: (1) polytechnic diploma in psychology, nursing, early childhood (2) bachelor degree, primarily in: (3) postgraduate training, primarily in counseling, and (4) doctoral level in psychology, counseling, and clinical psychology. A group of therapists are from speech, occupational, early childhood, and special education background. Indeed, it is an interesting phenomenon to see this influx of professions from varied training and qualification. It suggests the lucrative prospect of psychotherapy profession and flexibility.

Besides practising individual psychotherapy, many therapists are doing part-time teaching and corporate *ad hoc* training. Some centers conduct workshops for parents and schools as part of revenue-generating activities. Some therapy centers also have a training arm for counselling qualifications and clinical supervision, which generates additional revenue. Perhaps due to the competitive industry, some centers are operating day care centre and youth work assignments for charity.

Discussion

The current study provides an overview of Singapore's mental private practice. In the study, it identified the trends and focus of private practice, psychotherapists' training, and its revenue model. While the study may appear mundane, it is the first in Singapore. Beyond thematic qualitative analysis, taken together it illustrates a socio-psychological revenue model. In our analyses, the study noted that the psychological condition and clients' profiles are regularly used to market their therapy services, which is consistent with process-outcome research. These studies highlighted how the characteristics of therapists and clients affect clinical outcomes. For instance, therapists' professional experience (Goldberg et al., 2016), clients' initial symptom distress profiles (Kivlighan et al., 2019; Tschuschke et al., 2015; Uckelstam et al., 2019), or the working alliance compatibility between client and therapist (Kivlighan et al., 2014; Zilcha-Mano et al., 2018; Tschuschke et al., 2020). Such is consistent with theme 1 of the study which suggests how clients' profiles and psychological sympathology have an impact on overall clinical efficacy or outcomes. Another point of consideration is how extant research has argued that therapeutic alliance is significantly more important than therapeutic orientation (Norcross & Lambert. 2019). However, it would be erroneous to discount the necessity for rigorous

professional training or matching clients with compatible therapists and related therapeutic approaches. It would be akin to prioritizing the likeability of therapists over their experience, expertise, and therapy approach.

Another important area of consideration is the measure of clinical outcomes. Most therapists do not set the same target and psychotherapy outcomes. It is therefore challenging to make a conclusive judgment regarding the outcomes. Researchers summarized these outcomes under symptom reduction, personal targets and outcomes from the patient's perspective, improvement of quality of life, intermediate outcomes depending on the theoretical framework of the therapist, negative outcomes to be avoided, and economic outcome (Cuijpers, 2019). Other issues which these therapists tend to overlook are clients' negative outcomes and attrition rate, which are not considered. At the same, the economic cost of treatment is often not discussed. In the current psychotherapy context, it has extended to some educational or cognitive elements, which would warrant different therapeutic approaches and program evaluation criteria. Yet, many still apply a socio-emotional approach or applied behavior analysis to learning and neurodevelopmental issues, which are not appropriate or make clinical sense. Though this may seem logical or commonsensical, the author often observes junior therapists apply "free association" or some forms of counselling to all clients' issues and often overlook the context and fail to structure a proper evidence-based program.

One salient theme in therapists' profiles and revenue income revealed that the therapists' success and revenue are attributed more to marketing and business structure. It is not uncommon to observe therapists with fewer years of education and less advanced training acquire a greater customer base and revenue as compared to those with advanced doctoral practitioners with extensive experience. In some instances, it would appear that therapists who have bachelor's degrees and short certificate courses outperform medical psychiatrist doctors in their trade. So, it seems that the public. In general, does not seem to favour advanced training as what they report. Marketing and business structure enables some therapists to reach out to more client pool. Future research could adopt a quantitative approach to examine the variance attributed to each factor. Focus group discussions can also be conducted to generate more qualitative data.

References

Betton, V., Borschmann, R., Docherty, M., Coleman, S., Brown, M., & Henderson, C. (2015). The role of social media in reducing stigma and discrimination. *The British Journal of Psychiatry*, *206*(6), 443-444.

Berger, M., Wagner, T. H., & Baker, L. C. (2005). Internet use and stigmatized illness. *Social Science & Medicine*, *61*(8), 1821-1827.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychological research. *Journal of Qualitative Research in Psychology*, *3*, 77-101.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Burns, J. M., Durkin, L. A., & Nicholas, J. (2009). Mental health of young people in the United States: what role can the internet play in reducing stigma and promoting help seeking? *Journal of Adolescent Health*, *45*(1), 95-97.

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds?. *Currents in pharmacy teaching & learning*, *10*(6), 807-815.

Chodavadia, P., Teo, I., Poremski, D., Fung, D. S. S., & Finkelstein, E. A. (2023). Prevalence and economic burden of depression and anxiety symptoms among Singaporean adults: results from a 2022 web panel. *BMC Psychiatry*, *23*(1), 1-9.

Cohn, T., & Hastings, S. (2013). Building a practice in rural settings: Special considerations*. Journal of Mental Health Counseling*, 35(3), 228-244.

Colburn, A. (2013). Endless possibilities: Diversifying service options in private practice. *Journal of Mental Health Counseling*, *35*(3), 198-210.

Cuijpers P. (2019). Targets and outcomes of psychotherapies for mental disorders: an overview. *World Psychiatry*, *18*(3), 276-285.

Duberstein, P. R., Ward, E. A., Chaudron, L. H., He, H., Toth, S. L., Wang, W., ... & Talbot, N. L. (2018). Effectiveness of interpersonal psychotherapy-trauma for depressed women with childhood abuse histories. *Journal of Consulting and Clinical Psychology, 86*(10), 868-878.

Elliott, K. P., Westmacott, R., Hunsley, J., Rumstein-McKean, O., & Best, M. (2015). The process of seeking psychotherapy and its impact on therapy expectations and experiences. *Clinical Psychology & Psychotherapy*, *22*(5), 399-408.

Frith, H., & Gleeson, K. (2004). Clothing and embodiment: Men managing body image and appearance. *Psychology of Men & Masculinity*, *5*(1), 40-48.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcome in a clinical setting. *Journal of Counseling Psychology*, *63*(1), 1-11.

Kazdin, A. E., Marciano, P. L., & Whitley, M. K. (2005). The therapeutic alliance in cognitivebehavioral treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of Consulting and Clinical Psychology*, *73*(4), 726-730.

Kaplan, A.M. and Haenlein, M. (2010) Users of the World, Unite! The Challenges and Opportunities of Social Media. *Business Horizons*, *53*, 59-68.

Kivlighan, D. M., Jr., Hill, C. E., Ross, K., Kline, K., Furhmann, A., & Sauber, E. (2019). Testing a mediation model of psychotherapy process and outcome in psychodynamic psychotherapy: Previous client distress, psychodynamic techniques, dyadic working alliance, and current client distress. *Psychotherapy Research*, *29*(5-6), 581-593.

Kranzler, E. C., & Bleakley, A. (2019). Youth Social Media Use and Health Outcomes: #diggingdeeper. The Journal of adolescent health : official publication of the Society for *Adolescent Medicine*, 64(2), 141–142.

Pantic I. (2014). Online social networking and mental health. Cyberpsychology, behavior and social networking, 17(10), 652–657. https://doi.org/10.1089/cyber.2014.0070

Patton, M. Q. (1990). Qulaitative evaluation and research methods (2nd ed.).Newbury Park, CA: Sage.

Pasley, K., Rhoden, L., Visher, E. B., & Visher, J. S. (1996). Successful Step-Family Therapy: Clients' perspectives. *Journal of marital and family therapy*, 22(3), 343-357.

Power of 1.8 billion: adolescents, youth and the transformation of the future. The state of the world's population. New York: United Nations Population Fund; 2014. Available from: https:// www.unfpa.org/sites/default/files/pub-pdf/ EN-SWOP14-Report_FINAL-web.pdf [cited 2016 Mar 30].

Norcross, J. C., & Lambert, M. J. (Eds.). (2019). *Psychotherapy relationships that work: Evidence-based therapist contributions* (3rd ed.). Oxford University Press.

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems?. *Medical journal of Australia*, 187(S7), S35-S39.

Sexton, H., Littauer, H., Sexton, A., & Tømmerås, E. (2005). Building an alliance: Early therapy process and the client–therapist connection. *Psychotherapy Research*, 15(1-2), 103-116

Subramaniam, M., Abdin, E., Vaingankar, J. A., Shafie, S., Chua, B. Y., Sambasivam, R., Zhang, Y. J., Shahwan, S., Chang, S., Chua, H. C., Verma, S., James, L., Kwok, K. W., Heng, D., & Chong, S. A. (2019). Tracking the mental health of a nation: prevalence and correlates of mental disorders in the second Singapore mental health study. *Epidemiology and psychiatric sciences*, 29, e29. https://doi.org/10.1017/S2045796019000179

Thomas, D. R. (2006). A general inductive approach for analysing qualitative evaluation data. *American Journal of Evaluation*, 27, 237–246. http://dx.doi.org/10. 1177/1098214005283748

Tschuschke, V., Crameri, A., Koehler, M., Berglar, J., Muth, K., Staczan, P., von Wyl, A., Schulthess, P., & Koemeda-Lutz, M. (2015). The role of therapists' treatment adherence, professional experience, therapeutic alliance and clients' severity of psychological problems: Prediction of treatment outcome in eight different psychotherapy approaches. Preliminary results of a naturalistic study. *Psychotherapy Research*, *25*(4), 420-434.

Tschuschke, V., Koemeda-Lutz, M., von Wyl, A., Crameri, A., & Schulthess, P. (2020). The impact of patients' and therapists' views of the therapeutic alliance on treatment outcome in psychotherapy. *Journal of Nervous and Mental Disease*, *208*(1), 56-64.

Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: peer-to-peer support and social media. *Epidemiology and Psychiatric Sciences*, *25*(2), 113-122.

Uckelstam, C.-J., Philips, B., Holmqvist, R., & Falkenström, F. (2019). Prediction of treatment outcome in psychotherapy by client initial symptom distress profiles. *Journal of Counseling Psychology*, *66*(6), 736–746.

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A Prelude to Promoting Holistic Childhood Wellness: Nurturing Heath & Happiness in Young Lives

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APA Citation: Chia, K. H. (2023). A prelude to promoting holistic childhood wellness: Nurturing health & happiness in young lives. *Journal of Early Years Research*, *3*(2), 38-41.

Abstract
This short paper serves as a prelude to exploring childhood wellness, acknowledging its pivotal role in shaping a child's foundational years. The journey through young children from infancy to six years of age is often marked by unparalleled growth. It also underscores the significance of holistic development encompassing cognitive, social, emotional, and physical maturation. Central to this trajectory is childhood wellness, merging facets of health across physical, mental, emotional, and social domains. Delving into this multifaceted landscape, the author takes the readers on a brief navigation through various elements crucial to a child's holistic well-being. From nutrition, physical activity, and mental health to emotional resilience and social connections, each domain reveals its indispensable contribution to the child's flourishing future. As the discourse culminates, the significance of nurturing these domains emerges as fundamental to sculpting a resilient and thriving generation. This paper illuminates a pathway advocating for comprehensive childhood wellness, a mandate to empower our youngest generation for a fulfilled and prosperous life.
Keywords: Childhood, Emotional wellness, Mental wellness, Physical wellness, Social wellness

Introduction

Understanding a child's life for parents and early educators (Herrenkohl & Favia, 2016; Mayne et al., 2021) is characterized by unparalleled growth and foundational development. This period lays the groundwork for a child's cognitive, social, emotional, and physical maturation, profoundly influencing their future trajectory. Central to this developmental journey is childhood wellness - a holistic approach encompassing the overall state of a child's health across multiple domains. This includes the physical, mental, emotional, and social well-being of the child. Nurturing these domains is vital for fostering a robust foundation for their future growth and happiness (Faigenbaum & Bruno, 2020).

In this short paper, I shall delve into the intricate facets of young childhood wellness, exploring briefly how each domain plays an integral role in shaping a child's formative years (Faigenbaum & Bruno, 2020). From nutrition and physical activity to mental health, emotional resilience, and social connections, I shall examine the pivotal elements that contribute to a child's holistic wellness during these crucial early years.

What is it about Young Childhood and Its Wellness?

Young childhood typically refers to the early years of a child's life, usually from infancy to around the age of six. It is a period marked by rapid growth, significant developmental milestones, and foundational learning experiences that shape a child's cognitive, social, emotional, and physical development.

When we talk about childhood wellness, what I mean is that it refers to the overall state of a child's physical, mental, emotional, and social health. It encompasses aspects like proper nutrition, regular exercise, emotional well-being, healthy relationships, and access to adequate healthcare. In short, it is about nurturing a child's development to ensure they grow up healthy and happy (Faigenbaum & Bruno, 2020).

Talking about childhood wellness is crucial today because it lays the foundation for a healthy, fulfilling life. Addressing wellness early can prevent long-term physical and mental health issues, foster proper

development, and promote healthy habits that carry into adulthood (Brooks & Moore, 2016; Currie & Spatz Widom, 2010). With the rise in sedentary lifestyles, mental health challenges, and nutritional concerns, focusing on childhood wellness becomes even more imperative to ensure a brighter, healthier future for the next generation (Faigenbaum & Bruno, 2020).

Promoting Holistic Wellness I Young Children

For young children's holistic wellness, key elements include a supportive environment, proper nutrition, adequate sleep, physical activity, mental stimulation, emotional support, social interaction, and access to healthcare (Herrenkohl & Favia, 2016; Pedro-Carroll, 2001). These aspects collectively nurture their (1) physical, (2) mental, (3) emotional, and (3) social well-being. Each of these four domains will be briefly discussed as follow:

(1) What is Physical Wellness in Young Childhood?

Physical wellness in young childhood refers to the state of well-being where children have healthy bodies, engage in regular physical activity, maintain proper nutrition, get enough sleep, and are generally free from illness or injury (Hands & Parker, 2003). It encompasses developing motor skills, fostering healthy habits, and ensuring proper growth and development during these formative years (Bracken & Theodore, 2023; Faigenbaum & Bruno, 2020).

Therefore, in promoting physical wellness in young childhood, providing a balanced diet to young children should contain plenty of fruits, veggies, and whole grains (Hands & Parker, 2003). In addition, there is a need to encourage them to engage active playtime, limit their screen time, ensure regular sleep patterns for them, and schedule routine check-ups with a pediatrician (Bracken & Theodore, 2023).

Here are three examples of activities related to physical wellness:
- Physical Activity: Engaging in regular exercise, sports, or active play.
- Nutrition: Consuming a balanced diet for growth and energy.
- Sleep: Getting adequate and quality sleep for proper development.

(2) What is Mental Wellness in Young Childhood?

Mental wellness in young childhood involves a child's emotional, psychological, and social well-being (Bracken & Theodore, 2023; Kalra & Shah, 2023). It includes developing healthy coping mechanisms, emotional regulation, positive relationships, resilience, and a sense of self-confidence and self-worth. It is about nurturing the child's mental health to help them navigate their emotions, build healthy relationships, and cope with their life's challenges (Hutchins, Abercrombie, & Lipton, 2023; Pedro-Carroll, 2001).

Encouraging playtime, fostering a supportive environment, validating emotions, teaching coping skills, promoting healthy habits, and maintaining open communication can all nurture mental wellness in young children (Bracken & Theodore, 2023; Pedro-Carroll, 2001).

Here are three examples of activities related to mental wellness:
- Cognitive Development: Stimulating the mind through learning, problem-solving, and critical thinking.
- Creativity: Encouraging imagination, exploration, and artistic expression.
- Intellectual Stimulation: Exposure to new ideas, concepts, and challenges.

(3) What is Emotional Wellness in Young Childhood?

Emotional wellness in young childhood refers to a child's ability to understand and manage their emotions effectively. It involves developing skills to express feelings, handle stress, build positive relationships, and navigate various social situations with resilience and empathy. Emotional wellness lays the foundation for mental health and well-being later in life (Bagdi & Vacca, 2005) as well as educational success (Djambazova-Popordanoska, 2016).

Emotional wellness in young children is crucial. Parents (especially, the family as a whole entity; see Pedro-Carroll, 2001), teachers and the general public can nurture it by encouraging open communication, validating their feelings, teaching coping strategies like deep breathing or drawing, fostering a safe environment, providing consistent routines, and being a positive role model for managing emotions (Djambazova-Popordanoska, 2016; Pedro-Carroll, 2001).

Here are three examples of activities related to emotional wellness:
- Emotional Regulation: Developing strategies to manage emotions effectively.
- Self-awareness: Understanding one's feelings, thoughts, and behaviors.
- Empathy: Understanding and connecting with others' emotions.

(4) What is Social Wellness in Young Childhood?
Social wellness in young childhood refers to the emotional and relational aspects of a child's life (Prilleltensky, 2010). Hence, it is not surprising to note that both social and emotional aspects are often integrated as one: socio-emotional wellness, which is essential to the development of early learning, and later, school success (Bagdi & Vacca, 2005). Alone, social wellness involves developing healthy relationships, social skills, and the ability to interact positively with others, fostering a sense of belonging and connection within their community and environment. This aspect encompasses friendships, empathy, communication skills, cooperation, and understanding of boundaries (Prilleltensky, 2010).

As social wellness in young children is vital for their development, fostering social wellness in them requires patience, guidance, and positive reinforcement (Prilleltensky, 2010). Parents and teachers can play their respective roles to nurture wellness in young children (Pedro-Carroll, 2001), and in this aspect, socially, through some of the following ways as follows:

a) *Playdates and interaction:* Encourage regular playdates or group activities where children can interact, share, and learn to cooperate.
b) *Teach empathy:* Help them understand emotions by discussing feelings and perspective-taking, fostering empathy towards others.
c) *Model social behavior:* Children learn from observation, so demonstrate positive social behaviors like kindness, sharing, and listening actively.
d) *Encourage communication:* Foster open communication by listening attentively, asking open-ended questions, and engaging in meaningful conversations.
e) *Provide social opportunities:* Engage them in community events, clubs, or teams that align with their interests to build friendships and connections.
f) *Teach conflict resolution:* Guide them in resolving conflicts peacefully, teaching negotiation, compromise, and problem-solving skills.
g) *Set boundaries:* Establish clear and consistent boundaries that help them understand social expectations and develop respect for others.

Here are three examples of activities related to social wellness:
- Relationships: Forming positive connections with family, peers, and adults.
- Communication: Developing effective verbal and non-verbal communication skills.
- Teamwork: Learning to collaborate and work with others towards common goals.

Conclusion
Understanding and nurturing the multifaceted dimensions of childhood wellness stands as the cornerstone for parents and early educators to foster a resilient and flourishing future for every child (Herrenkohl & Favia, 2016; Mayne et al., 2021). The intricate interplay between physical health, mental fortitude, emotional resilience, and social connections forms the bedrock upon which a child's future trajectory is sculpted (Edlin, Golanty, & Brown, 2000; Faigenbaum & Bruno, 2020; Rath & Harter, 2010). As we navigate the profound intricacies of these developmental domains, it becomes increasingly evident that investing in the holistic well-being of our children during their formative years is not merely an aspiration but an imperative. The depth of this exploration underscores the vital

importance of a comprehensive approach to childhood wellness, one that embraces the diverse elements shaping the growth and happiness of our youngest generation. By illuminating these critical facets, we illuminate a path forward - one that champions the nurturing of all dimensions of childhood wellness to lay the groundwork for a generation empowered to thrive in all aspects of their lives.

References

Bagdi, A., & Vacca, J. (2005). Supporting early childhood social-emotional well being: The building blocks for early learning and school success. *Early Childhood Education Journal*, *33*, 145-150.

Bracken, B. A., & Theodore, L. A. (2023). Promoting Health and Wellness in Young Children: Preschool Assessment. *Perspectives on Early Childhood Psychology and Education*, *5*(1), 139-196.

Brooks, J. E., & Moore, D. D. (2016). The impact of childhood experiences on perceptions of health and wellness in African American young adults. *Journal of African American Studies*, *20*, 183-201.

Currie, J., & Spatz Widom, C. (2010). Long-term consequences of child abuse and neglect on adult economic well-being. *Child maltreatment*, *15*(2), 111-120.

Djambazova-Popordanoska, S. (2016). Implications of emotion regulation on young children's emotional well-being and educational achievement. *Educational Review*, *68*(4), 497-515.

Edlin, G., Golanty, E., & Brown, K. M. (2000). *Essentials for health and wellness*. Burlington, MA: Jones & Bartlett Learning.

Faigenbaum, A. D., & Bruno, L. E. (2020). Wellness right from the start: Birth through early childhood. *ACSM's Health & Fitness Journal*, *24*(5), 18-23.

Hands, B. P., & Parker, H. (2003). Physical Wellness: The relationship between motor skill, fitness and physical activity in young children. Strand 5: Children's Wellbeing Session 5.11. *Our Children the future Early Childhood Conference,* 1- 4 May 2003. Adelaide Convention Centre, Australia.

Herrenkohl, T. I., & Favia, L. A. (2016). Building resilience by teaching and supporting the development of social emotional skills and wellness in vulnerable children. In U. Kumar (ed.), *The Routledge International Handbook of Psychosocial Resilience* (pp. 346-354). Oxfordshire, UK: Routledge.

Hutchins, H., Abercrombie, J., & Lipton, C. (2023). Promotion of early childhood development and mental health in quality rating and improvement systems for early care and education: A review of state quality indicators. *Early Childhood Research Quarterly*, *64*, 229-241.

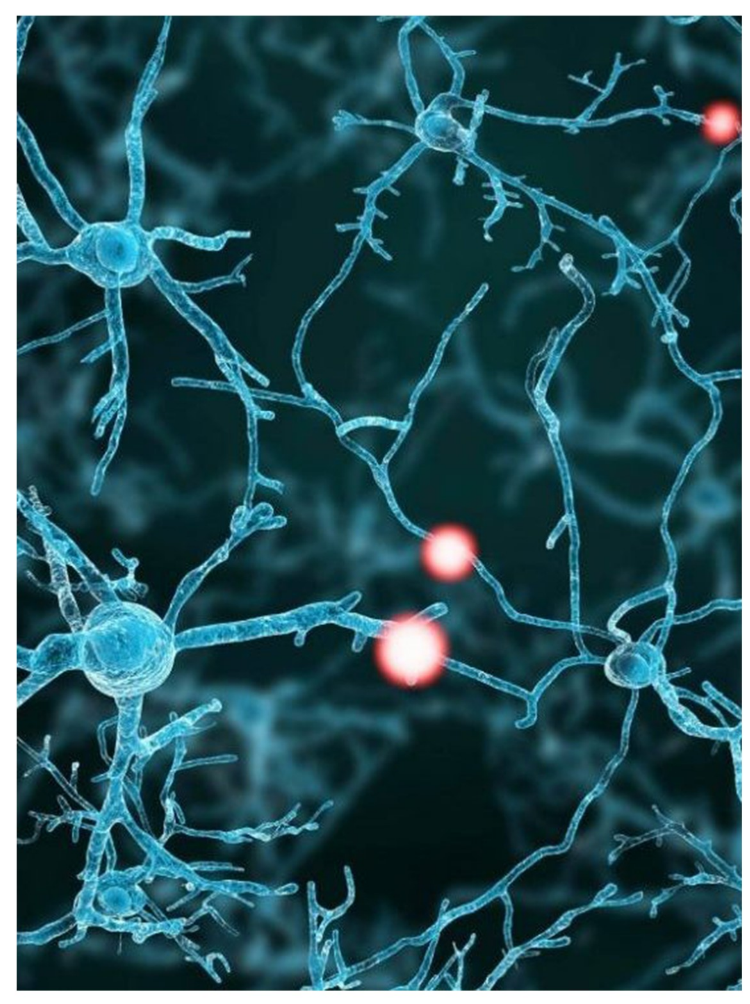
Kalra, S., & Shah, D. (2023). Care beyond newborn survival including child health and early childhood development; Mental and psychological health. *Indian Journal of Pediatrics*, 90, 37-46.

Mayne, S. L., Hannan, C., Faerber, J., Anand, R., Labrusciano-Carris, E., DiFiore, G., ... & Fiks, A. G. (2021). Parent and primary care provider priorities for wellness in early childhood: A discrete choice experiment. *Journal of Child and Family Studies*, *30*, 2238-2249.

Pedro-Carroll, J. (2001). The promotion of wellness in children and families: Challenges and opportunities. *American Psychologist, 56*(11), 993–1004.

Prilleltensky, I. (2010). Child wellness and social inclusion: Values for action. *American Journal of Community Psychology*, *46*, 238-249.

Rath, T., & Harter, J. K. (2010). *Wellbeing: The five essential elements*. New York, NY: Simon and Schuster.



ISSN: 2810 9015