A Developmental Approach to Supporting Behaviour

An MSW Field Practicum Report

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Abstract

This paper summarizes my MSW Field Practicum experiences which took place with the Ministry of Social Services, Child and Family Programs. In this paper an overview of trauma and developmental trauma is offered, with a discussion about supporting behaviour related to trauma exposure in children. The clinical work that was undertaken is outlined, alongside a discussion of theories and approaches that assisted in informing the work. General recommendations that assist in supporting challenging behaviour are offered. The professional development opportunities, as well as the challenges that arose throughout the practicum, will be reflected upon in this paper. A discussion of values and ethics is also incorporated within these pages. The central intention of this report is to examine how I was able to meet learning objectives throughout the field practicum process by integrating theory into practice.
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I would like to dedicate this work to my hometown of Humboldt, and especially to those that have shown incredible strength and compassion amidst a challenging and tragic time in our community.

To my family, thank you for your support and encouragement in everything I pursue. To my husband, Corey, you deserve an extended thank-you for your unconditional support, patience, and love while I pursued this endeavor. It means the world to me.
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Introduction

Social work, as a career, has always been an absolute fit for me. I have found a profession which aligns strongly with my values and ethics which is a true blessing; each day I am grateful for finding this field early in my academic endeavours. The connectedness that I feel with this human work and those on this journey alongside me is something that invigorates me each day. The opportunity to make change, to help others, to keep learning about and become involved in the interconnectedness of the human experience, and to learn about myself as a person is unbelievably gratifying. The quality of my life would be lessened without this work. For me, social work feels like home.

The many fields of social work in which I am interested became an obstacle throughout the practicum selection process. I found it very difficult to decide which area I would focus on for my field practicum. Indigenous issues, persons living with disabilities, mental health, and rural social work are just a few of the practice areas in which I have found myself deeply interested. However, working with children, has always been an interest in my life. As a young person just out of high school I had an incredible job opportunity to work with children and youth with disabilities. Initially this work was foreign to me, but I found it to be a very natural fit. This job was an opportunity to learn about all children, their strengths and challenges, but most importantly, about their resiliency. It was also my first insight into the disability realm – specifically learning about diverse abilities and barriers within a small grouping of children. Over the years, as I gained more leadership in this position, it became clear to me that not every strategy or approach worked for each child. This conclusion prompted ten years of developing skills towards supporting children with unique needs.
Throughout my journey as a social work student, I was presented with opportunities that helped me gain momentum into the disability field. I completed a certificate with the Institute of Applied Behaviour Analysis and sought to learn more about positive approaches to supporting challenging behaviour. Fetal Alcohol Spectrum Disorder (FASD) in particular became an area in which I did a lot of studying and presenting. Learning more about the roots of complex behaviours, I became very interested in the brain and child development.

In the process of obtaining my Master of Social Work (MSW) degree, and with new research emerging about trauma, I began to read more about attachment, developmental theory, and early trauma, which fueled the basis for this field practicum. Because I had not worked in the child welfare field, I wanted to enhance my understanding of this large arena of social work. After a recommendation from a fellow student, I had discussions with who would eventually become my Professional Associate about the available opportunities, and I felt a practicum with the Ministry of Social Services (MSS) would be a fit. This practicum setting was unique, as the program in which I worked is different than much of general child welfare work.

The practicum opportunity I would pursue with Child and Family Programs was set within child protection work, but focused on supporting children with challenging behaviours. There was a rich variety of opportunity within the new programs that I would be connected to. It seemed that my goal of gaining graduate-level social work knowledge and experience in providing clinical interventions and support to children and youth with challenging behaviours would be met. The following objectives were sought throughout the practicum experience:

1. Develop clinical skills in conducting assessments and interventions for children and youth with challenging behaviours.
2. Gain in-depth theoretical understanding of various counseling modalities, strategies, and interventions and apply them effectively in this clinical setting.

3. Develop competency in working with parents or caregivers of children and youth accessing services.

4. Enhance knowledge of approaches to working with children who may have complex trauma and attachment concerns.

5. Enhance understanding of effective management skills.

In the proceeding pages, this paper will recount my MSW field practicum experience at the Ministry of Social Services, Child and Family Programs, which was completed on a part-time basis from January to July, 2018. I will provide an overview of Outreach and Prevention Services (OPS) and the Community Response Services (CRS) Unit, and explore the learning experiences that occurred therein. A brief overview of trauma and trauma-informed approaches is provided. I will explore the clinical work that occurred throughout the practicum, incorporating information on developmental trauma. Common interventions for best supporting children are recommended. The process of behaviour support and intervention are outlined. The paper reflects on professional development opportunities and challenges that occurred throughout the practicum and provides a discussion of values and ethics. The central intention of this report is to examine how I was able to meet learning objectives throughout the field practicum process by integrating theory into practice.

**Agency Overview**

The Ministry of Social Services, Child and Family Programs is located at the Sturdy Stone Building, 122 - 3rd Avenue North, Saskatoon, Saskatchewan. The MSW Field Practicum occurred within the Community Response Services Unit, primarily under the Outreach and
Prevention Services (OPS) program umbrella. Until recently, OPS was known as Multi-Disciplinary Outreach (MDO) services. Outreach and Prevention Services is a unique service based on a partnership between the Ministry of Social Services, Child and Family Programs and Community Living Service Delivery (CLSD) (Ministry of Social Services, 2017a). Children and youth who are under 21 years of age and have current involvement with Child and Family Programs, or who are eligible for Community Living Service Delivery can access Outreach and Prevention Services (Ministry of Social Services, 2017b). The OPS program focuses on children and youth who exhibit challenging behaviours and consequently are at risk of losing their residential placement or their residence in their homes (Ministry of Social Services, 2017a). Children may be living in their family home, with an alternate caregiver, in a foster home, or in a residential group placement.

Referrals to Outreach and Prevention Services are reviewed, and once accepted are vetted based on an assessment of need and immediacy. Crisis referrals are also possible, where the individual is at immediate risk of losing their residential placement, and their behaviours are challenging and posing a threat to others (Ministry of Social Services, 2017a). Outreach and Prevention Services provides strategies for crisis reduction to preserve placements, as well as planning for emergencies and safety (Ministry of Social Services, 2017a). The goal of the intervention is to implement strategies for long-term learning and to change the impact of the children’s challenging behaviour (Ministry of Social Services, 2017a). OPS service providers will assist in training staff or caregivers to implement new interventions that best support the child (Ministry of Social Services, 2017a). OPS will not duplicate existing services and therefore does not replace front-line workers, provide case management, or provide residential services (Ministry of Social Services, 2017a). The role of OPS is to provide consultative
services and interventions to assist in managing and changing challenging behaviours in children.

Caregivers are a critical component to success with Outreach and Prevention Services. The program recognizes that caregivers are ready to engage with services when they are aware of the referral, the reasons for the referral, and are willing to participate in services and follow recommendations (Ministry of Social Services, 2017a). The caregiver must also be willing to have OPS staff in their home and in the child’s school to observe the child’s behaviours and to develop strategies with all of the child’s support people (Ministry of Social Services, 2017a). A caregiver must understand that OPS provides support on a short-term basis, and that participation in the program is voluntary (Ministry of Social Services, 2017a). Caregivers must remain engaged with OPS staff throughout the process or services will discontinue if there is a lack of engagement (Ministry of Social Services, 2017a).

The roles which I participated in and observed were those of Program Specialist Consultant (PSC) and Crisis Support Therapist (CST), although there are several other important roles within the CRS unit such as Child Care Workers, Managers and Supervisors. As a MSW practicum student, I was able to observe and act in other capacities, working with children’s more immediate and challenging needs and also with those whose need was not as urgent.

**Development of a New Unit**

It was a fortunate time to be involved with Child and Family Programs. My Professional Associate and his team had been working on the development of the Community Response Services Unit for several years, which was finally falling into place. The time span of the practicum allowed me to observe the final components of the planning stages, as well as the fruits of their labor with the official implementation of the new unit. It was a unique experience
to be able to observe and engage in organizational planning and witness developmental components in action. One of the overarching goals for the new unit's development was to improve outcomes for children with high needs who are involved in the child welfare system.

Research and guidelines based out of the United States of America were utilized to assist with the developmental process. The philosophical underpinnings of change and efficacy were based primarily on research from the Annie E. Casey Foundation (ACF), which acknowledges that children involved with the child welfare system are amongst the most vulnerable (ACF, 2015). One of the core foundations for the unit’s development was to focus on effective planning for children in residential placements. Research shows that children do best in family units, and group living is often unable to provide the individualized nurturing that is most beneficial and important for children (ACF, 2015). It was therefore stated that the end goal of group residences for children should be part of a process to prepare children for living within a family unit (ACF, 2015). Based on the end-goal of having children connected to a family unit, the Foundation provides recommendations for policy and practice (ACF, 2015).

Change within an agency involves altering not only beliefs but practices as well (Lewis, 2011). Implementing change can be an arduous task, especially in a large governmental organization. The work that my Professional Associate and his team have been doing is complex and multi-layered. Responsibilities such as communication, assessing change outcomes, implementation, and addressing failures and successes, are all pieces inherent to organizational change (Lewis, 2011). Throughout the course of my practicum, I was able to observe my Professional Associate in several roles and in a variety of challenging and complex situations, which allowed me to achieve the objective of learning more about high-level leadership and management skills.
Given the goal of the Community Response Services (CRS) unit, it was especially appropriate to merge with the OPS team, given their clinical skill and expertise in supporting children’s challenging behaviour, which frequently disrupts placements. The newly developed CRS unit and its practices are rooted in the overarching goal of achieving better outcomes for children. I am very impressed by the work that this team has done and know it will have a meaningful impact on the system. The efforts that are put forth by the CRS team are in an attempt to mitigate the effects of trauma, a significant concern that impacts many children involved with the child welfare system.

**Trauma**

Trauma occurs as a result of intense experiences that pose significant danger to ones’ safety, often through events such as abuse, neglect, natural disasters, violence, and sudden loss, and the effects of trauma subsequently interfere with an individual’s ability to cope (APA, 2013; Arthur et al., 2013; Bolton et al., 2013; Herman, 1992; Trauma-Informed Approaches, 2015). Malchiodi (2015) defines trauma as “an autonomic, physiological, and neurological response to overwhelming events or experiences that creates a secondary psychological response” (p. 4). Traumatic reactions occur when resistance and escape is not possible and where self-defense systems become overwhelmed (Herman, 1992).

When one experiences trauma, the responses to danger persist even in the absence of danger, occurring in a disorganized way that tends to be altered and exaggerated (Herman, 1992, p. 33). As a result of traumatic experiences, profound changes in physiological arousal, emotion, memory, and cognition are produced, severing functions which may have normally been integrated with one another (Herman, 1992, p. 33). Herman (1992) notes that people who are traumatized frequently feel distanced from their nervous systems, operating in a disconnected...
way from the present moment. After a traumatic occurrence, one’s body goes on permanent alert, known as a state of hyperarousal (Herman, 1992). The body acts as though the danger could return at any moment and continues to function in this high arousal state, where one is startled easily, is more irritable, and has trouble relaxing or resting (Herman, 1992). This is commonly known as the fight or flight response.

Traumatized people frequently relive the traumatic experience which can inhibit the course of daily life (Herman, 1992). Flashbacks during waking states, nightmares, and insignificant things that occur can serve as constant reminders of the trauma whereby an individual has the sensations and images as if they were in the traumatic situation (Herman, 1992). Due to its intrusive nature, trauma can interfere with the course of normal development (Herman, 1992). In trauma response mode, the higher-level, rational part of the brain is not in control (Harvey, 2012).

After a traumatic incident, one’s body can also enter a powerless state of surrender, known as a freeze response (Herman, 1992). In this case, a person’s self-defense system completely shuts down, and the person enters a paralysis-like state (Herman, 1992). When a freeze response occurs, the individual may feel a disconnected state as though the event is not happening to them and rather, they are observing it as an outside event (Herman, 1992). This altered state which typically occurs in combination with emotional detachment may serve as protection from the intense pain (Herman, 1992).

Trauma effects can be experienced in daily life through anxiety, depression, and poor physical and mental health (Bolton et al., 2013; Herman, 1992). The impact of trauma can differ from individual to individual, but younger children tend to be more susceptible to becoming overwhelmed (Levine & Kline, 2007; Malchiodi, 2015). Traumatic events happen all around the
world and even the safest countries are not exempt from traumatic occurrences (Gunaratnam & Alisic, 2017). Most people who encounter a traumatic event will not go on to experience post-traumatic stress disorder (PTSD) (Bolton et al., 2013; Layne, Rimmasch, Southwick, Moreno, & Hobfoll, 2008; Malchiodi, 2015). Seventy-six percent of all Canadians have reported exposure to some form of trauma throughout their lifetime (Arthur et al., 2013).

**Child Welfare and Trauma**

There is a high probability that children will be exposed to some form of trauma throughout their childhood (Gunaratnam & Alisic, 2017). According to McLaughlin et al. (2013), two-thirds of all children will experience a traumatic event before becoming adults. Many children involved in the child welfare system have histories of complex trauma and it is their histories of traumatic events which most likely leads to involvement by the child welfare system in the first place (Ko et al., 2008; Valdez, Bailey, Santuzzi, & Lilly, 2014). Child welfare workers are often tasked with assisting children and their families through challenging and complex situations, frequently dealing with the after-effects of maltreatment as well as the historical trauma of the parents (Conners-Burrow et al., 2013).

Unfortunately, practices that occur routinely within the child welfare system such as removal of children from the family home, multiple out-of-home placements for children, and separation from support people, might cause a child to re-experience trauma over and over again (Greeson et al., 2010; Ko et al., 2008). Children who are directly exposed to trauma and do not have adequate social supports are more susceptible to the effects of trauma (Malchiodi, 2015). Many children in child welfare fall into this category (Malchiodi, 2015). Despite good intentions to keep children safe, the instability of some child care placements can lead to further disruptions of secure attachments (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Children
who have trauma symptoms as a result of maltreatment may also have more negative experiences within the child welfare system. Poor social skills and interpersonal conflict may also lead to challenges for children in residential placements (D’Andrea, 2012). Systemic helping procedures can either improve or exacerbate the effects of trauma.

It is prudent that those people who are supporting children practice from a trauma-informed background. A trauma-informed approach to child welfare can help child care workers “understand the impact of trauma on children and families, potential trauma triggers, and ways that traditional service delivery approaches may exacerbate the effects of trauma” (Conners-Burrow et al., 2013, p. 1830). Those working with children in child-welfare can have a big impact on recovery for children (Arthur et al., 2013; Ko et al., 2008).

**Trauma-Informed Approaches to Behaviour Support**

Trauma-informed approaches focus on safety and engagement for those accessing services (Arthur et al., 2013). Recognition of the importance of giving trauma survivors choice, providing a safe environment, an opportunity to develop trust, and building on the clients’ strengths and skills are important principles of the trauma-informed approach (Arthur et al., 2013; Herman, 1992). These principles are woven into service delivery models and do not necessarily require the child to disclose their trauma for trauma informed services to be put into place (Arthur et al., 2013). Rather, trauma-informed practice is "more about the overall essence of the approach, or way of being in the relationship, than a specific treatment strategy or method" (Arthur et al., 2013, p.12). Developing trust and safety, as well as provision of choice and collaboration with the survivor are key characteristics of this model (Arthur et al., 2013). It is important that clients feel in control of the process and do not re-experience additional trauma as a result of the services provided to them (Arthur et al., 2013).
Trauma-informed approaches are interwoven with the behavioural support provided by the Outreach and Prevention Services program. The recognition that trauma may exist is a crucial component to in working with a trauma-informed approach and is utilized within OPS (Hodas, 2006). In order to provide competent trauma-informed services, service providers must have an understanding of trauma and its implications (Hodas, 2006). The possibility of trauma playing a role in the challenging behaviour is acknowledged immediately, which is where the trauma-informed approach begins. It is not only the child that is supported in the behaviour consultation process, it also includes their caregivers. Outreach and Prevention Service Providers also recognize that in some cases, the caregivers themselves are also dealing with trauma effects. By taking the potential for trauma of both caregiver and child into perspective, it is essential to begin OPS involvement gently. When new services are initiated, a thorough discussion of what would be expected of parents and caregivers is held, as commitment to the recommendations by OPS staff can be intensive and time-consuming. By providing all of the information up front, it ensures that the caregivers can become an active and willing participant in the service.

It is also critical to remind caregivers that although the program is associated with Child and Family Programs, participation is voluntary. The first meeting typically occurs with only the parent or parents, and not the child who will be receiving intervention. The caseworker who made the referral, or other service providers such as a mental health support worker, frequently attend with the caregiver, which allows for safety and trust to be slowly built with the OPS staff. Staff emphasizes the choice that one has in the participation in the service. OPS service providers build on the caregivers’ strengths and skills to help them in supporting their child through a positive approach. The education that is provided helps to build the caregiver’s capacity to
continue to provide care for the children with disruptive behaviours and improves their confidence and skills in dealing with difficult behaviours.

Although a lot of support and interventions are provided to the caregiver, the focus of trauma-informed care is placed on the child receiving Outreach and Prevention Services. Cues about the child’s capacity, coping skills, and progress are taken from the child throughout the behaviour support process, which determines the pace in which services and interventions occur. Services are provided in a way intended to emphasize safety and trustworthiness, as well as reduce feelings of being overwhelmed, including the setting and activities that are part of the interventions (Arthur et al., 2013). The development and sustainment of the therapeutic relationship is essential with trauma-informed care (Cohen, Mannarinas, Kliethermes, & Murray, 2012). It is essential that the client feels safe, both physically and emotionally (Hodas, 2006). The environment in which services are provided is typically a space where the child feels comfortable; this may include their own home, a park or other recreational space in their community, and often involves an activity of their choice or interest such as playing basketball or getting a treat from the store. Non-traditional activities allow an opportunity for choice, collaboration and connection (Arthur et al., 2013; Hodas, 2006). Outreach and Prevention Services staff allow adequate time for relationship building, and gain a sense of rapport with the child prior to delving into more challenging work together, such as working on a crisis cycle and talking about difficult feelings.

An understanding of the whole child is a trauma-informed process incorporated into Outreach and Prevention Services; the child is observed in all applicable contexts with the intent to understand the challenges from the child’s perspective (Hodas, 2006). The child is therefore observed across all waking hours, at home, in school, and community. OPS staff also seek to
minimize any potential for power imbalances in order to emphasize empowerment on the part of the child, an important factor in a trauma-informed approach (Hodas, 2006). Approaches which incorporate recognition and understanding of trauma are important in order to best support both the child and caregiver and are built into the clinical services that are provided by Outreach and Prevention Services.

**Clinical Work**

The clinical work provided by the Outreach and Prevention Services team includes providing behavioural assessments, completed by staff working in the roles of Program Specialist Consultants and Crisis Support Therapists (Ministry of Social Services, 2017a). A consultative approach to behaviour is taken in clinical work which results in a written assessment that is provided to the child’s support team. The assessment includes an outline of the recommended interventions, supports, strategies, and trauma-informed practices that can be implemented in the child’s environment to reduce challenging behaviours and create meaningful change (Ministry of Social Services, 2017a). A definition of ‘behaviour’ will be provided in order to position it in the context of these support practices.

**Behaviour**

The Merriam-Webster dictionary defines the term behaviour as the actions and conduct of a person (behaviour, n.d.). Behaviour can be positive or negative, but often in clinical work refers to behaviours that others find challenging such as aggression, defiance, stealing, and so forth. Behavioural analysts concur that behaviour is a language, intended to assist an individual in meeting basic needs (Harvey, 2012). Behaviour serves a variety of purposes which are typically referred to as the underlying function of the behaviour (LaVigna & Donnellan, 2007).
The process of analyzing and supporting behaviour often occurs through applied behaviour analysis, a science that seeks to understand an individual’s behaviour and study the underlying factors that influence behaviour (LaVigna & Donnellan, 2007). Those working in behaviour support seek to address the causes of the behaviour rather than deal with the behaviour itself directly (Harvey, 2012). This practice looks to meet the underlying needs expressed by behaviour in order to reduce challenging behaviours. Many children who receive clinical services have experienced complex trauma, which will be explored.

**Developmental Trauma**

Developmental trauma is the result of exposure to traumatic experiences that occur early in life (Arthur et al., 2013). Childhood is a sensitive and critical period; brain development occurs rapidly from infancy to three years of age (Heller & LaPierre, 2012; Perry, 2004; Treisman, 2017). A baby’s brain is constantly being shaped by its experiences and its environment (Treisman, 2017). Children are more susceptible to the effects of trauma during childhood due to their rapidly growing brains (Treisman, 2017). Physical, sexual or emotional abuse, neglect, violence, or death that occurs during early childhood interferes with the child’s ability to develop healthy attachment relationships and the child’s overall development (Arthur et al., 2013).

Exposure to trauma frequently occurs at home with the child's caregivers as perpetrators and can involve maltreatment and neglect from an early age (van der Kolk, n.d.). The Adverse Childhood Experiences (ACE) Study, which focused on negative experiences in childhood such as abuse, neglect, and dysfunction in the family unit, showed that these events are far more common than acknowledged (van der Kolk, n.d.). The ACE study results concluded significant connections between early adverse experiences and negative outcomes later in life such as
depression and suicide, addictions, domestic violence, as well as negative implications for physical health (van der Kolk, n.d.). Health complications can result as a direct physical consequence of the trauma, but also as a result of long-term habits and coping which amplify risk of poor health outcomes (Hodas, 2006). Physical conditions such as obesity and type 2 diabetes may also be more prevalent in adults who have experienced childhood trauma (Rich-Edwards et al., 2010). The term complex trauma has been adopted “to describe the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (eg. sexual or physical abuse, war, community violence) and early-life onset” (van der Kolk, n.d., p. 2).

The adverse impact of trauma on development can be significant, with implications that can continue to occur over the long-term (Pynoos, Steinberg, Schreiber, & Brymer, 2006). Children who have experienced developmental trauma tend to “have lived through a matrix of multiple, overlapping, and co-occurring traumas, losses, and stressors” (Treisman, 2017, p.1). Treisman (2017) points out that when traumatic events occur in childhood, but especially before the age of three years “during this critical sensitive window, it is likely to have an impact on the child’s neurological, social, emotional, sensorial, physiological, moral, and cognitive developmental trajectory” (p. 9). Traumatic childhood experiences “cause abnormal organization and function of important neural systems in the brain” which inhibits the capacity of these systems to function (Perry, 2006, p. 29). Based on these brain differences, children are more likely to experience challenges with cognitive and executive functioning, emotional regulation, and sensory integration (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Treisman, 2017).
There are seven domains of impairment related to the effects of complex trauma in children including attachment, biology, affect regulation, dissociation, behavioural regulation, cognition, and self-concept (Cohen et al., 2012; Cook et al., 2005). Each domain has significant implications in how a child may adjust to, and function in, the world. These domains will be explored further to ascertain a sense of how individuals may be impacted by the secondary, psychological trauma responses. Attachment is one area that can have a significant impact on a child’s development.

 Attachment. John Bowlby was one of the first to recognize the important impact that an infant-mother relationship had on healthy psychological and social development (Levy & Orlans, 2014). Bowlby found that “infants are evolutionarily primed to form a close, enduring, dependent bond on a primary caregiver beginning in the first moments of life” (Hardy, 2007, p. 27). This drive to bond and form attachments is basic survival (Perry, 2013). The process, however, is only activated when infants receive certain cues initiated by their caregivers (Levy & Orlans, 2014). Bowlby studied the consequences of emotional deprivation on children that occurred through events such as early mother-child separation and homelessness (Levy & Orlans, 2014). Problems such as lack of empathy, attentional deficits, conduct disorders, and inability to give and receive affection were found in children who had been deprived early in life (Levy & Orlans, 2014). Bowlby's discovery about the importance of the infant-caregiver connection, and the consequences of deprivation negated many approaches to child rearing that existed before the 1950's, which were based on a behaviourist perspective believing that children were blank slates to be shaped by their environment (Levy & Orlans, 2014). The perspective that children were blank slates encouraged limited contact and minimal affection, so as not to create a
needy child (Levy & Orlans, 2014). Bowlby’s findings had significant implications for the overturning of the belief that a mother-child bond created dependence (Levy & Orlans, 2014).

Conditions such as stressful life situations, lack of impulse control, unresolved trust issues, mental health challenges such as depression, drug, and alcohol abuse, and difficulty understanding the child's needs may influence a parent to become neglectful, and neglect interferes with healthy attachment (Levy & Orlans, 2014). Children with disabilities, an irritable or difficult temperament, or prior history of loss and attachment may be more susceptible to maltreatment (Levy & Orlans, 2014). Increased and complex needs of a child in addition to other parental stressors can also be a risk factor (Levy & Orlans, 2014).

In addition, environmental variables also influence maltreatment. Environmental variables include poverty, stress, domestic violence, addictions, parental mental health issues, unemployment, and lack of support networks (Levy & Orlans, 2014). It is important to note that not all parents who experienced childhood maltreatment themselves will go on to neglect their own children (Levy & Orlans, 2014). Resiliency, or overcoming stress and adversity despite risk related experiences, is an important consideration that occurs on an individual basis (Rutter, 2012). Access to a supportive and loving relationship with an adult can be a protective factor for a child (Levy & Orlans, 2014; Rutter, 1999). Therapeutic interventions that seek to resolve issues stemming from adverse early experiences are helpful in reducing the impact of maltreatment throughout the lifespan (Levy & Orlans, 2014). As an adult, having a supportive partner or other social supports throughout parenthood can mitigate the risk of maltreating one’s own child (Levy & Orlans, 2014).

Attachment problems can also occur due to parental ignorance of child development and knowing what a child requires developmentally (Perry, 2013). The attachment bond requires
three key elements which include an enduring emotional relationship with a specific person; the relationship with this person is safe, soothing and comforting; and the loss or threat of loss of this person evokes extreme distress in infants (Perry, 2013). Therefore, when children have multiple placements or are removed from situations where there is a strong attachment to a caregiver, considerable damage can be done to the child’s attachment style and subsequently their development.

The early, vulnerable period of life is critical in acquiring the ability to form emotionally healthy and intimate relationships (Gibbs, Barrow, & Parker, 2015; Perry, 2013). Bowlby recognized that children who were significantly deprived of attachment in early life tended to develop conduct disorders, lacked empathy, had more attention problems and lacked the ability to give and receive empathy (Levy & Orlans, 2014). When infants’ needs are unmet, “their brains have not received consistent enough feedback to assure them that relationships are trustworthy” (Konrad, 2013, p. 22). Without this reassurance, a myriad of problems may develop such as being unable to communicate their needs or self-soothe, which can have far-reaching effects on development and adult life (Konrad, 2013). The severity of problems will be related to the nature, length, and severity of the emotional neglect (Perry, 2013).

Poor attachment is associated with a multitude of behavioural and emotional problems later in life that ranges from mild interpersonal discomfort to profound problems in social and emotional functioning (Herman, 1992; Perry, 2013). Children with attachment problems will often have developmental delays, unusual patterns of eating or hoarding food and will act in cruel and aggressive ways (Perry, 2013). Aggression and cruelty tend to be related to poor impulse control, and lack of empathy (Perry, 2013). Challenges in emotional functioning are common, with symptoms such as anxiety and depression (Perry, 2013). Children with attachment
problems may also have confusion about intimacy and exhibit indiscriminate attachment, by being clingy and loving to strangers (Perry, 2013). This behaviour is in an effort to seek safety, rather than a close emotional bond (Perry, 2013). Bizarre behaviours such as biting, head banging, and rocking are examples of primitive self-soothing methods often utilized by children with disrupted attachment (Perry, 2013).

Children model the behaviour around them, even if it is unhealthy (Perry, 2013). Children with attachment problems may learn that abusive behaviour is acceptable by witnessing it in their world and this often has negative implications for their social functioning (Perry, 2013). Children with attachment issues who have been sexually abused may be at risk of repeating sexually abusive behaviours and may be at risk for further abuse (Perry, 2013) by putting themselves in high risk situations (Herman, 1992). There are other areas of development that are also at risk due to complex trauma, such as biology.

**Biology.** The biological disruption associated with complex trauma is correlated to specific symptoms which fall over a spectrum (D’Andrea et al., 2012). The biological disruption can have behavioural, affective, cognitive and relational implications for the child (D’Andrea et al., 2012). For example, actual biological alterations have been found in some children and adults with histories of trauma such as differences in brain volume (De Bellis et al., 2002). Evidence also exists that suggests that pregnant women who are under chronic stress can biologically impact the development of stress reactivity and self-regulation in their unborn child (Levy & Orlans, 2014). Children with poor self-regulation tend to be impulsive, have trouble following rules, overreact to frustration or disappointment, and have social challenges.

When children exposed to trauma are under stress, their “analytical capacities tend to disintegrate, leaving them disorganized cognitively, emotionally, and behaviourally and prone to
react with extreme helplessness, confusion, withdrawal, or rage” (Cook et al., 2005, p. 393).

Biological predispositions can have a significant impact on the way that the child carries themselves in the world. With supporting behaviour from a biological standpoint, it is essential to recognize that brain differences may exist. Affect regulation is a component that may be impacted by brain differences.

**Affect regulation.** The term affect regulation describes the ability to manage and respond to emotional experiences (Ford & Greene, 2017; Rolston & Lloyd-Richardson, n.d.). The concept of emotional regulation is having control over the intensity, as well as how and when emotions are felt, experienced and expressed (Dvir, Ford, Hill, & Frazier, 2014, p. 149). The ability to regulate emotional affect is threatened when trauma occurs in early life (Cook et al., 2005; D’Andrea et al., 2012).

Poor or inconsistent affect self-regulation is rooted in early caregiving experiences. Children who are securely attached to their caregiver can utilize their caregiver to assist with emotional regulation (Bowlby, 1969; Kim-Spoon, Cicchetti, & Rogosch, 2013). In a given situation, the caregiver’s behaviour has an immediate effect on the child’s emotional response and self-regulatory strategies (Kim-Spoon, Cicchetti, & Rogosch, 2013). When secure attachment is compromised, it inhibits the infant from learning how to regulate their body when in distress (Moutsiana et al., 2014). Optimal development of children’s abilities to self-regulate may also be threatened due to a lack of sensitive caregiver interaction (Kim-Spoon, Cicchetti, & Rogosch, 2013).

The capacity to identify and regulate emotion is impaired due to the inability to self-regulate and self-soothe (Kim-Spoon, Cicchetti, & Rogosch, 2013). To safely regulate emotions, and express what is happening internally during an emotional experience, a child must first be
able to identify their emotional state and then know how to deal with these emotions in a manner that helps them cope (Cook et al., 2005). Accurate identification of the emotion is necessary to recognize differences in arousal states (Cook et al., 2005). Those who have experienced trauma may not have strategies for emotional regulation that are necessary to adapt to environmental demands (Rolston & Lloyd-Richardson, n.d.). Emotional reactivity and inappropriate emotional responses are common (Lewis, Todd, & Honsburger, 2007). Dysregulation of affect can take many forms, including having a flat or numbed affect, being explosive and angry, or having inappropriate and incongruent affect for the situational context (D’Andrea et al., 2012). When dysregulation is expressed behaviourally, it is common to see self-injurious behaviour, withdrawal, aggression or opposition, as well as compulsivity (D’Andrea et al., 2012). Children who are better able to regulate negative emotions achieve higher levels of social competence (Kim-Spoon, Cicchetti, & Rogosch, 2013). When attachment is impaired, and there are neurobiological differences, the potential for challenges with affect regulation are significant (Cook et al., 2005; Kim-Spoon, Cicchetti, & Rogosch, 2013). The concept of dissociation is another domain of development which can be impacted by complex trauma exposure.

**Dissociation.** Children who have experienced repeated trauma are at risk of developing dissociation (D’Andrea et al., 2012). Dissociation is a typical reaction to trauma where an individual may forget pieces of their experiences or the emotions attached to them, as a way to cope (Treisman, 2017; Young, 2010). In an effort to psychologically protect themselves; dissociation is a means of cutting off their mind from their body especially when there is physical trauma (Treisman, 2017).

Although dissociation can be a tool that helps children cope with reoccurring trauma, it “interferes with the ability to be in one’s body, as well as interferes with the ability to learn and
to form close friendships with others” (Levine & Kline, 2007, p. 33). The severity of dissociation can fall on a continuum (Hodas, 2006; Mental Health America, n.d.). Dissociation can be illustrated through deficits in planning and judgment, compartmentalizing painful memories and feelings, and detachment of emotions from self (Cook et al., 2005). Executive functioning of the brain is the set of mental skills that help to connect past experiences to present action which can be disrupted as a result of exposure to trauma (D’Andrea et al., 2012; NCLD, 2013). Executive functioning of the brain is crucial for paying attention to and remembering details, managing time and space, organizational and planning skills, and learning in school (NCLD, 2013). Executive functioning plays a key role in behaviour regulation as well.

**Behavioural regulation.** Early caregiving experiences can have important implications for behavioural regulation (D’Andrea et al., 2012). The development of self-regulation processes are impacted by early caregiving (Kim-Spoon, Cicchetti, & Rogosch, 2013). Exposure to traumatic events may increase behavioural symptoms in children (Gunaratnam & Alisic, 2017). Behaviour patterns in children serve a continuum of functions that range from automatic responses, to attempts to gain control, to approval or attention, to avoidance or attempts to recover from emotional arousal (Cook et al., 2005; D’Andrea et al., 2012). The behavioural regulation patterns associated with a childhood of complex trauma involve both over and under controlled behaviour patterns (Cook et al., 2005). Over-controlled behaviour tends to be rigid; examples include over-compliance with adult expectations, inflexible bathroom routines, and resistance to any changes in routine (Cook et al., 2005). Children who have experienced victimization may display aggressive and controlling behaviours (Cook et al., 2005). In some cases, these behaviour patterns occur due to a reenactment of the traumatic experience (Cook et
al., 2005). Several components of the brain can be impacted by trauma, including a child’s cognition.

Cognition. Decreased cognitive functioning is another consequence for children who have experienced repeated abuse and neglect (Cook et al., 2005; D’Andrea et al., 2012; Mansueto et al., 2018). Trauma can have an adverse effect on cognitive functioning for example; lower intelligence quotients (IQ) have been associated with childhood trauma (Bücker et al., 2012; Perez & Widom, 1994). Children who have a traumatic background may perform worse in areas such as concentration and attention, mental speed, working memory, and verbal intelligence due to disruptions during developmental periods (Aas et al., 2012; Bücker et al., 2012; Lysaker, Meyer, Evans, & Marks, 2001; Schenkel, Spaulding, DiLillo, & Silverstein, 2005; Shannon et al., 2011). The areas of the brain that serve cognition can be impacted in both structure and function due to severe stress (Lupien, Maheu, Tu, Fiocco, & Schramek, 2007; McCrory, DeBrito, & Viding, 2011). In one study by Bücker et al. (2012) children with histories of trauma also reported less time at school which was hypothesized to occur due to high rates of neglectful caregiving, another important implication for cognition. Less time at school may also result in lower academic performance (Bücker et al., 2012). The resulting poor performance in areas such as school can have implications for a child’s self-concept and future endeavors.

Self-concept. The concept of self refers to self-identity, which becomes stable and integrated throughout childhood (Cook et al., 2005). Campbell et al. (1996) note that the self-concept is classified into knowledge and evaluative components. The knowledge component includes questions such as ‘who’ or ‘what’ am I and encompasses beliefs about specific traits or physical characteristics (Campbell et al., 1996). The evaluative center of self-concept includes beliefs about the self, and self-esteem (Campbell et al., 1996).
Traumatic events that occur during childhood can disrupt the development and integration of a child’s self-concept which can damage positive identity (Evans, Reid, Preston, Palmier-Claus, & Sellwood, 2015; Hemenover, 2003). The disruption in self-concept development can have long-term implications for the child. One study by Tanaka, Wekerle, Schmuck, Paglia-Boak, and MAP Research Team (2011) found that childhood emotional abuse has linkages to lower self-compassion in adolescence. On the contrary, a stable self-concept has positive implications towards psychological well-being (Campbell, Assanand, & Di Paula, 2003). When an individual has a clear self-concept, their image of self is “clearly and confidently defined, internally consistent, and temporally stable” (Campbell et al., 2003, p.122). Clear self-concept is positively correlated with self-esteem (Campbell et al., 2003).

While all children may not exhibit or be impacted in each of these seven domains, it is essential to keep in mind the complex potential for interplay between domains. Resilience and vulnerability are two key factors that can impact the development of trauma symptoms (Malchiodi, 2015). In order to understand how the preceding domains of development can be supported, it is crucial to get a sense of the behaviour interventions that are employed by the Community Response Services unit.

**Behaviour Interventions and Recommendations**

While it is not possible to look at all of the behaviour interventions that help to support complex trauma, it may be helpful to explain a few of the conventional approaches that were used throughout this practicum such as strengthening the child-parent relationship and increasing self-regulation skills. Because complex trauma is multi-layered, recommended interventions depend on many different factors. Each child is unique and will be impacted in their own way, and respond differently to approaches and interventions. As OPS provide a consultative service,
most recommendations are intended to be carried out by caregivers or other service providers involved with the child. These services are intended to have a therapeutic effect on the client.

**Therapeutic Interventions**

There is a significant benefit for children who have complex trauma to engage in therapeutic interventions to address the underlying trauma. Ordinarily, trauma effects do not get better without help (Terr, 1990). In many cases, a recommendation is made for the child to access therapeutic mental health services or play therapy to assist in the facilitation of this process. Therapists who work with children that have backgrounds of trauma must be able to form a trusting and positive relationship with the child and incorporate developmentally appropriate methods into treatment (Malchiodi, 2015). There is an abundance of therapeutic approaches that utilize a wide array of creative interventions to connect with children and address unresolved trauma (Malchiodi, 2015). Some therapists also utilize relaxation techniques that involve creative or expressive approaches (Malchiodi, 2015).

In some cases, when therapeutic support is available, disclosure of trauma is useful and can enhance self-regulation, self-empathy, and feelings of control (Hemenover, 2003). A therapeutic process which allows the individual to gain insight and understanding of their situation may help to facilitate increased feelings of control over one’s life, which can also provide benefit by increasing positive emotions (Hemenover, 2003). In addition, trauma disclosure also increases positive self-concept and resiliency (Hemenover, 2003). While acknowledgement of trauma can be effective for the child, it is also imperative that the parent or caregiver play a supporting role in working with behaviour that is trauma related.
Approaches to Parenting

**Importance of the parent-child relationship.** When supporting children who have developmental trauma, strengthening of the parent-child relationship is a major focus (Treisman, 2018). It is likely that children with complex trauma have lived through several negative patterns of interactions in the parent-child relationship (Treisman, 2018). Healthy home environments that provide children with stability and safe relationships serve a reparative function that can support the development of secure attachments (Treisman, 2018). Modeling healthy relationships can have a considerable impact in repairing trauma effects. The best place for healthy modeling to occur is in the environment where significant time is spent such as in the home (Treisman, 2018). Children thrive when they have a stable parental relationship, where they can learn to trust and feel safe, emotionally, cognitively, and physically (Treisman, 2018). A healthy parental relationship also supports healthy brain development (Treisman, 2018). Finding ways to help a child facilitate a sense of belonging and connectedness with their family or a substitute family is an example of a nurturing way to build relationships (Treisman, 2018). Including the child in family activities like holidays, family meals, creating a family mural, family door sign, or labeling items with their family name could help facilitate a sense of belonging (Treisman, 2018). The importance of the parent-child relationship is frequently emphasized when supporting children with complex trauma. The creation of a stable environment can be an important component of this relationship.

**Creating stability.** Creating stability in a home is a process that takes time and patience. One step is to develop consistent parental responses. It is helpful for children to have a general sense of how their parent or parents will respond to a spectrum of situations (Treisman, 2018). It is especially important for children who have experienced inconsistency and unpredictability in
their parent’s responses to have consistency and stability from adults in their world (Treisman, 2018). These children are likely to have also experienced broken promises and chaos in their home environment. Parents must, therefore, follow-through with promises and do what they say they will do (Treisman, 2018). Consistency and predictability provides a sense of safety and allows children to build trust.

Choosing your battles. The parent-child relationship is important, and when trust has been broken, or a relationship does not exist, it is important to build this relationship (Treisman, 2018). Some trauma-related behaviours can be extremely challenging, and there may be constant battles in the home (Treisman, 2018). However, parents must decide which battles they choose and which can be reduced or avoided or ignored (Treisman, 2018). Being constantly in conflict can be exhausting and it does not improve relationships in the home (Treisman, 2018). Picking your battles is a common practice which Outreach and Prevention Services workers encourage in the home. It is important for caregivers to understand that the child’s behaviour is communicating a message and parents can use clues and what they know about their child to try to understand what need is currently unmet. The parent must be able to take these clues and incorporate developmental theory to understand what may be a realistic expectation of behaviour for their child, given their history of trauma exposure.

Reasonable and clear expectations. It is important that when looking at behavioural expectations for a child, that these expectations are aligned with the child’s developmental capabilities. Parents who understand what is reasonable for their child, and who offer developmentally appropriate instructions will build confidence in their child (Back to Basics, 2018). Outreach and Prevention Services assists parents to learn what are developmentally appropriate expectations. It is important to be clear about the limits for expectations, which
should be related to safety and protection, and limitations should be few and straightforward in explanation (Back to Basics, 2018). It is also essential to consistently reinforce the limits of behavioural expectations and to state the limitations in a positive manner (Back to Basics, 2018). By providing an explanation of the limits in a positive way and telling the child what to do instead of the negative behaviour, it helps the child to learn what behaviour we expect them to do, rather than telling them what not to do (Back to Basics, 2018). This approach ensures that children know the expectations without having to guess and it provides a positive approach that reduces the likelihood of children responding with defensiveness (Back to Basics, 2018). When giving instruction, caregivers are encouraged to provide warnings and cues, as well as time for the child to process the instructions (Back to Basics, 2018). Instruction can be provided in a way that encourages the parent-child relationship.

**Connection.** When children feel connected to their caregivers, they feel loved (Schwarz, 2015). For caregivers and parents, having a good relationship with children and connecting with them is a key piece necessary for discipline which is often overlooked (Schwarz, 2015). This step is often skipped because parents feel that they are giving in, or being soft if children misbehave and they do not apply consequences (Schwarz, 2015). Rather, children who feel connected to their parents and caregivers have a stronger desire to respond to parental requests, which provides a positive impact on power struggles, arguments, and other challenging situations (Schwarz, 2015). When children feel connected to their parents and loved by them, they do not need to try to gain attention in negative ways (Schwarz, 2015). In order to facilitate a positive connection with children, OPS encourages caregivers to listen and use empathy (Schwarz, 2015). Parents may not know how to connect with their child or find it awkward at first. Listening with empathy involves truly being present and allowing yourself to see a situation from a child’s point
of view (Schwarz, 2015). Building a positive relationship and connection is a common intervention that is used as well as helping caregivers understand the importance of and benefits for this relationship. Assisting parents and caregivers to find ways to connect with their child is an important part of the intervention. Building connection often requires the parent to remain calm in times of stress or upset (Schwarz, 2015). Helping caregivers come up with a self-regulation plan for themselves and provide calm responses when they are upset, can help to promote connection between children and their caregivers (Schwarz, 2015). A critical component to this process is to help caregivers understand their own triggers and become aware of responses or approaches that may not be helpful (Schwarz, 2015). Self-awareness is a valuable tool that can also assist in improving one’s self-regulation abilities.

**Increasing Self-Regulation**

Self-regulation is a significant challenge for many children who have suffered complex trauma. Learning self-regulation skills is a discovery process where the child must become aware of their arousal states and learn skills on how to self-manage them (Moore, 2008). It is important for each person to become aware of the sensory input that they may find helpful for calming, and or for improving concentration, as each person will respond differently (Moore, 2008). The sensory profile is tool which measures a child’s response to sensory events. Sensory profiling can be a helpful tool to understand preferences or interferences in functioning (Moore, 2008). Sensory activities involve the senses such as smell, taste, vision, touch, and taste; however, this list is not conclusive (Moore, 2008). Incorporating sensory activities into the child's day can help to calm or improve alertness (Moore, 2008). Activities that may be calming include a massage, chewing gum, doing yoga, rocking in a chair, listening to relaxing music, and guided breathing (Moore, 2008).
Exercises that help children to be able to identify their own arousal states and understanding what can be done to alter or balance their state can be a helpful tool (Moore, 2008). Helping children to understand what helps them regulate their emotions can improve their overall ability to self-regulate and often includes a stress-management plan (Moore, 2008). A stress-management plan serves as a practical guide to assist in self-discovery and improve self-regulation in stressful situations. A component of a stress-management plan may include learning about sensory experiences that the child finds bothersome and creating a plan to manage it, including who can help (Moore, 2008). For example, some children may find certain smells or foods highly irritating, particularly if they are connected to the traumatic incidents (Moore, 2008). Caregivers can provide prompts and reminders for children to engage in behaviours that assist with self-regulation when the child starts to feel triggered.

The aforementioned strategies are examples of interventions and approaches that are taken by the Outreach and Prevention Services team. The recommended strategies and interventions that are given to each child are developed on an individual basis, which occurs through an assessment process. The following section will provide an overview of the stages of service provision that occur for clients who are receiving behaviour support through Outreach and Prevention Services.

**Stages in Service Provision and Discussion**

When interventions are comprehensive, with the intent to address the spectrum of trauma symptoms, the likelihood for positive treatment outcomes are increased (D’Andrea et al., 2012). When supporting behaviour, it is important to recognize that a one-size fits all approach will not work when we consider the vast differences and spectrums of trauma effects.
Throughout the field practicum, my clinical work with Outreach and Prevention Services included providing support to seven different children who were assigned directly to me. The caseload of seven clients provided a well-rounded experience of variety in clinical practice and behaviour intervention. There was a range of residential settings for the children, including children who lived in the family home, children who were in group care permanently, children in alternate caregiving arrangements, and children in temporary group placements. The children also came from a range of backgrounds including newcomers to Canada, Indigenous peoples, and those of Caucasian, settler societies. My caseload of seven included two girls and five boys. Two of the children who were on my caseload were referrals from Community Living Service Delivery, indicating that these children would have an intellectual disability to qualify for CLSD services. The other five children were directly involved with Child and Family Programs, for a spectrum of reasons.

A common presenting problem and reason for referral was the child’s aggression, and concern for safety of the child and for their caregivers and siblings or others living in the home. For most of my clients, I had the opportunity to connect with other external supports including mental health support workers and other community supports, but most commonly I had involvement with school teams. I had a positive experience working with each of the schools, who believed that Outreach and Prevention Services played a valuable role in supporting the student.

In my caseload I also had an opportunity to explore the four different stages of service provision as outlined by Outreach and Prevention Services. In some circumstances, I took over the client’s file from a previous worker who had moved into a new position. I also became involved with one child who had been part of an ongoing caseload for several years, where
workers had had limited availability to assist. Four times I had the opportunity to begin working with the client from the beginning stages of service provision, where the client was a new referral to the program. In some cases, the children to whom I was assigned were quite stable and doing well, and others were considered high priority and nearing crisis stages. The different backgrounds and complexities of each child with whom I worked provided a rich experience of clinical work.

There are four stages of service provision within the Outreach and Prevention Services program. In this section I will describe each stage and will outline basic steps taken to support children referred to the program. The core function of the service is to promote change within the child, their supports, and their environment. Promoting change in the individual child includes facilitating personal growth through skill development and positive programming. Building the capacity of support providers through education and skill development occurs to promote changes in a child’s support systems. In order to effect change, environmental mismatches that do not work well for the child are adapted or managed. Outreach and Prevention Services follows the principles and process of applied behaviour analysis, and also incorporates relevant trauma theory and interventions. The first stage of service begins with collecting information about the client.

**Stage One – Engagement and Information Gathering**

Communication and involvement with the child’s team of support people is an essential component to success when providing behaviour support. The team may include members from the referring Ministry of Social Service program (example a Community Living Service Delivery Community Service Worker, or a Child Care Worker from Child and Family Programs), as well as school staff, mental health professionals, parents, alternative caregivers or group home staff,
and other invested professionals. One of the first steps in the behaviour support process is to make contact with the team of professionals who are already supporting the child and introduce oneself, ensuring that everyone is aware of the support that will be provided through the OPS program.

Stage one focuses on engaging those who are involved in the child's life and gathering information. An initial meeting occurs with the OPS service provider, referring caseworker, and caregivers. This meeting includes a discussion of the behaviour support role, and how involvement occurs. At this meeting, information is gathered around what a good day, and what a bad day look like for the child. Parents and caregivers are asked to note any triggers to challenging behaviour that they are aware of, as well as how they have responded to the behaviour and to describe any strategies that they are currently using. Information that can be provided by service providers, schools, and so forth can be helpful. If a child lives in a residential placement, incident reports and other behaviour tracking documents may be requested. It may also be beneficial to access child protection records that give insight into the child's history and the nature of involvement with the child welfare system.

Once access to documentation has been obtained (if applicable), the next step is to develop specific interview questions to find out more about the behaviour. In many cases, a functional assessment interview is conducted. The functional analysis has become a hallmark of behaviour assessment and seeks to look at cause and effect relationships. The term function refers to the purpose that behaviour serves (Hanley, Iwata, & McCord, 2003). Included in a functional analysis may be an assessment of the ecology or the environments that surround the child with challenging behaviour (LaVigna & Donnellan, 2007). Looking at the presenting
problem and its context provides insight into the behaviour (LaVigna & Donnellan, 2007). Many variables are assessed as part of functional analysis (LaVigna & Donnellan, 2007).

An antecedent-behaviour-consequence (ABC) analysis is completed during the first stage of intervention as well. The ABC analysis offers insight into understanding the behaviour, and intent or communication behind it (LaVigna & Donnellan, 2007). An ‘antecedent’ looks at what led to the behaviour, and what happened immediately before the behaviour occurred (LaVigna & Donnellan, 2007). The ABC analysis also provides insight into the people, objects, and events that occur in the environment at the time of the behaviour (LaVigna & Donnellan, 2007). The second, or ‘behaviour’ component, of the ABC analysis is a thorough description of the behaviour that needs to be observable and measurable (LaVigna & Donnellan, 2007). The ‘consequence’ section of the analysis describes what happened immediately following the behaviour and how support providers responded (LaVigna & Donnellan, 2007). The ABC analyses can be completed by caregivers, once they are educated on what is specifically required for each. Analysis of the communicative functions of the behaviour are also completed which hypothesizes what the behaviour is trying to accomplish (LaVigna & Donnellan, 2007).

Data collection occurs through the interviews. Gathering data can also occur indirectly by using assessment tools, and directly by observation (Hadaway & Brue, 2016). Observation of the behaviour occurs in the first stage and is important. Observation is more than just watching the child, but being able to collect data about the child’s behaviour during this time (Hadaway & Brue, 2016). It is important to observe the child in each of the settings that they are regularly in, such as home, school, and recreational activities. Observation should occur across all waking hours as well to get a sense of the child’s entire day.
Harvey (2012) asserts that in supporting children with behavioural challenges, functional assessments that utilize an applied behaviour analysis (ABA) do not always meet the mark, especially with those who have backgrounds of trauma. Rather than behaviour being seen as manipulation or to achieve a specific purpose, behaviour for those who have experienced trauma may be an expression of emotion based on traumatic experiences (Harvey, 2012). A traumatized child can become inundated with memories that feel as though they are occurring in the present moment, and trigger emotional, irrational behaviours (Harvey, 2012). At times when people appear to be easily triggered without reason, it can be a possible response to trauma and it may provide insight as to the severity of trauma (Harvey, 2012). Clinicians supporting those with challenging behaviours must, therefore, remain flexible and dynamic in their work, with the ability to move between both the world of ABA, and developmentally appropriate behavioural interventions.

As OPS consultants obtain the necessary information that they need about the child they are supporting they will come to the end of the first stage of service provision. Stage two of service provision begins to look at assessment and the development of strategy, given what knowledge they have gathered during stage one, as well as incorporating what they know about developmentally appropriate behaviour supports.

**Stage Two – Assessment and Strategy Development**

The second stage of service provision involves determining the appropriate responses and interventions based on the information that has been acquired. During this time, specific strategies are developed, and additional assessments are completed as deemed necessary. An assessment that I used regularly was the Sensory Checklist, a checklist which includes questions that indicate signs and symptoms of sensory dysfunction (Biel & Peske, 2005). The sensory
checklist assists in determining if there are patterns of sensory seeking such as avoiding, mixed, or neutral behaviours (Biel & Peske, 2005). I am not an expert in sensory processing, but the tool was helpful in determining if there were any obvious patterns in response to sensory stimuli. Utilization of this tool can assist in determining if further professional services in the area should be consulted, such as involving an occupational therapist.

A problem behaviour inventory (PBI) was also a tool that I utilized in practice, often within the first few sessions. The PBI is a behaviour rating instrument that assists in gathering information about behaviours that the caregiver finds challenging, as well as determining the severity and frequency of each behaviour (Rojahn et al., 2012). In some cases, the PBI was helpful to determine if behaviours were occurring as frequently as it seemed at the time of referral.

Throughout the behaviour support process, a reinforcement inventory is frequently completed with the caregiver and the child (if appropriate, based on age and cognitive ability), to determine what the child enjoys most (Hadaway & Brue, 2016). This inventory can be utilized to assist in determining ‘reinforcers,’ or preferred items that motivate the child (Hadaway & Brue, 2016). These can be incorporated into positive programming.

Once adequate information has been acquired, and data has been collected, a hypothesis for the behaviours can be formed. It is important to recognize that based on the population that is typically served, a functional analysis may not provide the full picture in that $a + b$ does not always equal $c$, especially when working with children who have experienced trauma. The parameters can be blurred due to the seven domains of functioning that were impacted by trauma. Though a functional assessment is frequently utilized when supporting challenging behaviour, Harvey (2012) cautions that “the functional assessment may oversimplify and
actually mask the genetic and biological roots of a behaviour” (pp. 25-26). Subsequently, a lack of trauma training can lead to misunderstanding of the child’s symptoms or behaviour problems (Conners-Burrow et al., 2013). These symptoms are the adaptive reactions made by the body in response to distressing events (Malchiodi, 2015).

A key component to behavioural support is distinguishing the function of a behavioural response. Distinguishing the reason for the behaviour can be challenging when a trauma-based response can look similar to a behaviour response (Harvey, 2012). A key difference for a trauma-based response is that it occurs in reaction to a fight or flight response of the sympathetic nervous system based on a reminder in the environment that triggers this response, rather than a calculated response to achieve a desired outcome (Harvey, 2012). Environmental triggers and emotional responses can essentially occur from unconscious memories (Harvey, 2012). It would be a mistake and unhelpful to determine that behaviour is occurring to manipulate, rather than due to a fight, flight or freeze response from within the nervous system. Developmental theory and knowledge must be incorporated in assessing behaviours.

In stage two, the caregiver’s parenting practices are assessed. The caregiver plays a significant role in the management of challenging behaviour and how the caregiver can best be supported is considered. Attempts to offer support may include an education and training framework, to teach the caregiver about the child’s needs, communication styles, understanding trauma and trauma reactions, and so forth. If crisis occurrence has been a concern, strategies for crisis prevention and safety planning will be incorporated.

A crisis cycle is a form of a data collection that is also utilized. To develop an individualized crisis cycle, caregivers talk step by step through crises phases and identify actions or events that decrease or escalate the behaviour. This is a helpful tool to understand how
caregivers respond to given situations. From this information, a crisis cycle is developed. Helpful communication strategies that can be used at each stage of crisis are provided, seeking to provide a framework for best practices in crisis management (Sellnow & Seeger, 2013). If appropriate, this tool is adapted for the child to use, to learn more about their patterns of crisis response and to assist with regulation. As services move into stage three, these tools become integrated into the client’s daily living.

**Stage Three – Delivery and Implementation**

Stage Three of services is the delivery and implementation phase. Based on the assessment and strategy development in the second stage, services begin focusing on the education and training framework that was developed for the caregiver. In stage three, those who are part of the child’s daily life are instructed as needed. Education is frequently provided to foster insight into the child’s identity, their strengths and needs, and recommended strategies. Supporting caregivers through the process of implementation occurs in the third stage and can often be a challenge. This is an opportunity for parents to put new strategies and interventions into daily practice with their child. This will look very different depending on the child’s behaviours, supports, and living situation. Throughout the implementation of the plan, the effectiveness of strategies will be gauged. It is critical to determine if goals are achievable and if the outcomes developed from team meetings are being met. As success is seen in the child’s behaviour, OPS begins to move on to stage four of service provision.

**Stage Four – Phase out and Closure**

In the fourth stage, OPS begins to look at phasing out from the team and ending the involvement. At this point, the interventions and responses have likely been successful; there has been a decrease in negative behaviours and therefore, a reduced need for support. At this time,
caregivers should feel confident and competent in addressing aspects of challenging behaviour and employing developmentally appropriate responses to trauma related behaviour. There are likely combinations of both proactive and reactive strategies that are incorporated into daily life. As the interventions progress, the behaviour support looks at fading out of the team. It is ensured that all team members are aware of the roles they need to play in continued support of the child. A Summary of Services document is provided, which identifies current supports, results of information gathering, observation, and assessment, and recommendations and strategies that can be utilized by parents and service providers. A final team meeting concludes the process.

Developing an understanding of the four stages of service provision, observing my colleagues in the process, and eventually carrying out the process myself was an effective way to fully immerse myself in the behaviour consultation process with OPS. Learning and incorporating the four stages used by OPS provided insight and ensured that the work was being done in an effective manner that was on course. There were several opportunities for professional development throughout the field practicum, which also enriched the learning experience.

**Professional Development**

Ongoing professional development is vital for any social worker who seeks to improve their practice. Throughout my practicum, I was able to engage in some professional development opportunities which helped to contribute to my overall learning, as well as to assist in achieving the learning objectives set out in my field practicum proposal.

One of the most beneficial opportunities was the Back to Basics Training, which was facilitated by my counterparts from the Outreach and Prevention Services Team. This two-day training included information about development theory, interrupted development, and the
implications. The purpose of the Back to Basics training is to assist front-line workers in increasing their fluency with understanding behaviour as a function of communication. Several best practice approaches and strategies were offered to professionals to assist in effective support for children. The Back to Basics training incorporated activities and discussions that helped to solidify much of the knowledge which I already incorporated into my practice. This training fit well into the objectives for clinical skills with children and youth with behaviours, as well as theoretical understanding of various modalities, strategies, and interventions. The training also assisted with objective four which was to enhance knowledge of approaches to working with children who may have complex trauma and attachment concerns.

I was able to take advantage of a few online training opportunities which worked well during the times when I did not have client appointments scheduled, or when there were cancellations. Trauma and the Body: An Introduction to Sensorimotor Psychotherapy was a webinar offered by the Canadian Association of Social Workers. This webinar provided insight into the physiological responses associated with trauma and how trauma becomes remembered in the body. Mindfulness and somatic approaches were key concepts in this webinar, which I felt were important to my objective to learn more about complex trauma.

A social worker who focuses on vicarious trauma, held an online class entitled Compassion Fatigue: Vicarious Trauma and Burnout. Not only was this interesting as it contained much information around trauma, but it also helped me to start thinking about my emotional safety as a social worker, and how to acknowledge when my health and safety are at risk.

Individualized Service Plan (ISP) Training took place for CLSD staff members during my practicum, which I attended. The ISP is a tool utilized within CLSD, as well as the OPS team
to assist with complex case planning. The ISP tool is commonly used in cases where there are several service providers, and the clients’ needs may be multi-layered. The tool outlines objectives, action items, and dates, and clarifies roles. The document outlines who the service providers are and the core team, as well as external service providers. The ISP keeps track of the start and end dates of these professionals’ involvements. Throughout team meetings, goals are developed, and the individual and their support providers identify service priorities. For each goal, tasks are identified, as well as the name of the person responsible for that task, and date the task is to be completed. An important component of this tool is that review dates are set at the first meeting to ensure accountability and follow-up. Indicators that outcomes have been met are identified, which helps the team to discern when the outcome has been met. There is also a column for updates that occur along the way to keep track of progress. Overall the Individualized Service Plan tool is very helpful to track goals and progress and ensure accountability of all service providers.

The professional development opportunities in which I partook provided extra depth and richness to the practicum experience and helped to achieve my learning objectives. There were also some challenges which I experienced throughout my time in the placement. A description of these challenges, as well as a critical reflection of each, will be provided.

Challenges

It is anticipated that within any practicum or new learning experience, there will be challenges to encounter and unfamiliar territory to navigate. Although there were a few challenges which I encountered throughout the practicum process, there were also solutions that followed. Upon further reflection, it was within the context of these challenging practicum experiences that significant learning occurred for me.
Beginning a practicum in an unfamiliar work environment and structure initially presented itself with several challenges, and areas that I needed to become accustomed to. At the start of my practicum, the previous work experience I held had primarily been working in non-profit, community-based organizations. These environments were typically smaller grass-roots style offices which included only a handful of people. To go from a small office atmosphere to a large government bureaucracy was a significant change for me, environmentally speaking. It was a new and exciting experience to go from being the only social worker, or one of a few social workers, to many of the social workers on one floor. Suddenly everyone including human resources and management were social workers.

Beyond the educational background of my coworkers, it was apparent very quickly that there were different managerial and organizational processes than I had been used to in the past. Formal processes and specific protocols exist for each task such as booking a vehicle, access to filing systems or getting access to technology. These steps were not challenging once the process was clear, however knowing who the appropriate people or channels were to gain access was not always apparent. At times this caused delays in accessing necessary programs, items or tools to complete the work. By doing my practicum on a part-time basis, it seemed to take several weeks and at times months to clarify procedures.

As a practicum student present on a part-time basis, it was challenging at times to find a place to work due to limited office space. My office setting shifted frequently due to new staff being hired, interoffice changes, and office space demand. Finding a consistent area in which to work that met my needs for privacy, confidentiality, and access to the computers, printers, and computer programs was challenging. I felt that at times, this inconsistency decreased the amount
of work that I was able to accomplish. There were days where it seemed as though my office space changed several times over the span of eight hours.

Throughout the practicum, there were staffing changes that took place inside and outside of the agency which was a challenge to keep up with. There were a few occasions where I was not up to date when a caseworker changed caseloads or moved to a new unit, and I had been trying to get into contact with them. It seemed as there were days when I was busy doing detective work in order to track down the proper person from which to get assistance due to changes in outside agencies. In some cases I was not included in important email correspondence; my part-time presence seemed to contribute to forgetfulness, so I was not always up to date with the most recent events. There were also a few points in the practicum where I had coworkers and supervisors transitioning into different roles, which meant limited availability from them. It was challenging to jump into a fast-paced world where people have high-caseloads. However, I did feel that overall I was supported.

One of the most challenging pieces of work was merely around time constraints. Having limited availability throughout the week contributed to scheduling challenges with clients and other professionals who have full calendars. With one case, in particular, there were several missed appointments, conflicting schedules, and sometimes weeks would pass by without a meeting. The most challenging component of this was the frustration that it felt like limited progress was being made. Meeting only every few weeks reduced the effectiveness and consistency of the work, and made completing an assessment a significant challenge.

In addition to time challenges with clients, there were many learning objectives which felt daunting to complete in only 450 short hours. The days seemed to go by quickly and the scheduling process went by quite slowly. A canceled meeting or tour often meant that the
opportunity would not arise again in the time that I would be there. Doing training to access computer programs and with a wait period in between to gain access meant that I needed to relearn everything that was a part of the initial training.

This practicum was uniquely positioned, working officially with Child and Family Programs, but also being closely connected to, and sharing office space with, Community Living Service Delivery. This dual connection was both challenging and beneficial. For example, challenges existed around knowing which meetings I needed to attend that were applicable and appropriate for my position. Frequently sharing space with CLSD allowed me to understand more about their processes, an opportunity which generally would not have been available in a Child and Family Programs practicum placement. However, in some ways, this knowledge was not critical to my practicum, and it became a task to understand what knowledge was relevant and which was not. Outreach and Prevention Services is connected with both programs and at times it was confusing to navigate. For example, it sometimes became confusing which manager to contact for which particular program.

The services provided by OPS are based on a voluntary referral system. There were times when it was important to emphasize to clients that although the program is connected to Child and Family Programs, participation in this program is voluntary. Given that many people have an involuntarily connection to Child and Family Programs, I wondered about the pressure they felt from caseworkers to participate in the program. The OPS program is hugely beneficial, but it encouraged me to think about whether some caregivers were ready, willing, and able to engage in services because at times it did not appear that way. Another challenge with referrals was that I received one, who upon further inspection did not exhibit the extreme behaviours as outlined in the referral. This was not due to worker error, but instead it seemed that the family had
overemphasized their challenges. This situation was unavoidable, as the referral was appropriately accepted given the referral information; it was only upon further inspection that it became apparent that the service was not appropriate.

One of the first issues that I encountered when I began my practicum was a lack of knowledge about the inner workings of Child and Family Programs. Understanding general processes, understanding acronyms and how the program is organized created some confusion when jumping in at a graduate level. However, I was comfortable asking questions to help get me up to speed and it did not take long to understand the services in Child and Family Programs. If I would have been unable to inquire, and clarify, or question basic services, I would have missed important information that influences systemic processes. I am glad that my practicum placement occurred in an atmosphere where I was not knowledgeable as it was a great learning experience, one that was outside of my comfort zone.

The challenges that I have reflected upon here demonstrate areas where the most learning occurred. There were valuable lessons to be learned in adaptation and flexibility. Overall, the challenges that I experienced helped me to develop more tolerance for and understanding of complex systems that are aiming to serve so many people with limited resources. The challenges that I experienced also prompted critical thought and reflection on the implications of social work values and ethics throughout the field practicum.

Values and Ethics

Ethical challenges and considerations are an essential component of learning as a social work student, and are encountered frequently in professional practice. This practicum was not unlike other social work practice positions, in that there were ethical components which I came across throughout the practicum period. Social workers must follow the Canadian Association of
Social Workers Code of Ethics (CASW, 2005), and utilize the Guidelines for Ethical Practice (CASW, 2005) to help influence ethical decision making in practice.

Throughout this practicum, I was very thankful for the insight and knowledge I have acquired from the MSW courses. In particular, the Current Aboriginal Issues in Social Work Practice class which I took which was of the utmost benefit to me in this practicum. Transformational is a word that I can use to describe the reflection and learning that I undertook in this process. I believe that this knowledge positioned me to uphold Value 1 of the Canadian Association of Social Workers (CASW) Code of Ethics, Respect for Inherent Dignity and Worth of Persons, at a graduate level (CASW Code of Ethics, 2005). The CASW Guidelines outlined in section 1.2 emphasize the demonstration of cultural awareness and sensitivity (CASW Guidelines, 2005). In particular, the class was influential "to acknowledge and respect the impact that their own heritage, values, beliefs, and preferences can have on their practice and on clients whose background and values may be different from their own" (CASW Guidelines, 2005, p. 4). The self-discovery work I undertook in the previously mentioned class allowed me to think a lot about my own cultural context and how this impacts my worldview as a social worker. Working in a role that had a multi-cultural context, I was able to challenge any beliefs or hidden assumptions that I would not have been able to do before. I was able to ask more questions, as suggested by CASW Guideline 1.2.4, “social workers seek a working knowledge and understanding of clients’ racial and cultural affiliations, identities, values, beliefs and customs” (CASW Guidelines, 2005, p.4) and incorporate this knowledge into my interventions or recommendations that I made. The openness to learn and inquire is especially important to understand how cultural beliefs may impact parenting practices, perceptions of behaviour, and culturally appropriate interventions.
In considering values and ethics, it was imperative for me to be aware of my position as a practicum student and the limitations of my role. As there was a definite ending to my role, it was necessary to ensure that clients were aware of this. I also felt it very important to be able to determine when my involvement would be more harmful than beneficial. In some circumstances, my presence and availability was able to fulfill a need and increase services where there were gaps. However, in other cases, I believed that my continued involvement would be more harmful than helpful. These were considerations which I took seriously, especially as I was nearing the end of the practicum.

Most times I felt that becoming involved with a new client was still beneficial, but I placed restrictions on how that looked; for example, I would provide consultative services to parents, but not engage with the children. I believed that I could adequately explain the situation to the parents so that they could access services more quickly. Not meeting the children and engaging with them was a trauma-informed approach. It was important to consider that the children may have had several short or negative relationships with service providers, and the amount of time left in my practicum would not allow for sufficient relationship building and intervention. These actions were guided by CASW Guideline 1.8.5 which notes that “social workers at the earliest opportunity inform clients of any factor, condition or pressure that affects their ability to practice adequately and competently” (CASW Guidelines, 2005, p.10). Due to limited time, I was cognizant of not wanting to engage with children only to leave them shortly thereafter, as many had already experienced workers leaving in their life. I also made sure to include a plan to transfer each family to another colleague who would be taking over the case, following Guideline 1.8.6 (CASW Guidelines, 2005, p. 11). The MSW courses allowed me to
dive more deeply into ethical exploration that I had not previously explored. Graduate work has allowed me to explore values and ethics in deeper, more meaningful ways.

**Conclusion**

Completing a field practicum with the Community Response Services unit within the Ministry of Social Services, Child and Family Programs was a gratifying and interesting experience. My learning objectives were met through working alongside people who incorporate trauma-informed practices into their daily work and seek to improve outcomes for children and families involved in the child welfare system. My practicum setting allowed me to learn from two different programs within the Ministry of Social Services and it was an opportunity to embed my existing knowledge of behaviour and disability into the trauma realm. The value of incorporating developmentally appropriate supports and services was highlighted daily.

Throughout the practicum I was able to enhance my clinical skills in working with children. I also learned more about developmental theory, trauma-informed practice, and attachment. Professional development opportunities also assisted in achieving the learning objectives for this practicum. Through client work, I was able to move through the Outreach and Prevention Services process of behaviour support and integrate theory into practice. The practicum process has been a positive experience for me. The learning that occurred throughout both formal and informal avenues was extremely valuable to developing my social work practice. The set of skills that I was able to develop prior to this practicum, and then integrate, heighten, and solidify throughout my field practicum experience was extremely invaluable. As a result of these experiences, I have become more comfortable in new settings, grown as a social worker, and have enhanced my social work practice skills. I will be able to carry this new perspective and knowledge with me as I move forward in my social work journey.
The importance of developmentally appropriate behaviour support cannot be understated, and I hope that this field will continue to expand. Although I am not currently practicing with children, the knowledge and understanding I obtained will still hold significant relevance in working with anyone who is impacted by trauma. It is likely that my future social work practice will include working with children, who continue to amaze me with their capacity for resilience.
References


