4 Professional Practice Reports

Chris Wood

Volume 2 of a thesis submitted to
The University of Birmingham
towards the degree of
Applied Educational and Child Psychology Doctorate

The School of Education
The University of Birmingham
June 2014

UNIVERSITY OF
BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

Introduction

The following thesis details 4 discrete pieces of research completed during my year 2 and 3 supervised professional practice placements.

The first comprises a detailed analysis of the evolving frameworks for Autism diagnosis, alongside emergent 'novel' diagnoses which may require further evidence to affirm their legitimacy. This research was borne out of a practical piece of 'casework' completed while on placement; the young person had received a diagnosis from a private organisation which did not correlate with any diagnostic frameworks from existing handbooks. Given the potential controversy relating to this case (and, more broadly, other cases of a similar nature across the local authority), 'PPR1' contributes to the knowledge base of Autism diagnosis and may therefore be valuable to service delivery in the host LA.

The second report details a therapeutic intervention delivered with a young person described as 'selectively mute'. There are a number of uncertainties and inconsistencies with this diagnosis which mean that psychological formulation is of paramount importance. Consequently, the report details the intervention 'journey', from initial formulation, to appraisal of appropriate evidence, the eventual delivery of a cognitive behavioural therapy (CBT) intervention and subsequent follow-up. Outcomes are positive. There is limited research detailing CBT for use in selective mute populations, and thus this report contributes to this emerging domain.

The penultimate report relates to the development of a framework for supporting young people who demonstrate, or have been subject to, Harmful Sexual Behaviour (HSB). The report details a small scale project completed within local primary schools; determining their current practice with relation to HSB, and also any training needs which they feel are required. The results indicate that there is currently significant inconsistency across practice, and recommendations provided at the end of the report are done so to support the development of practice frameworks in future.

The final report details a qualitative research paper relating to the use of 'Alternative Provisions' in the host local authority. The host local authority has access to a high number of alternative education providers, however there is little consistency across them; from the requirements of attendance to the education provided. This brings up discussions relating to inclusion, and more philosophically the entitlement of young people to education. The small study asked professionals involved in working with these alternative providers about their view on the efficacy, value and purpose of each alternative setting.

Overall, each piece of research, while arguably disparate, contributes to many domains of service delivery in this host LA; each research study is original in nature, and all have been well received by host stakeholders. In addition, much of the research appraised in each study has been contemporary in nature, and thus the papers held within this document might arguably contribute to developing domain knowledge of wider psychological theory.

Contents:

Professional Practice Report (PPR)	Pages
Professional Practice Report 1: Autism Spectrum Conditions: A Changing Landscape	4 - 31
Professional Practice Report 2: 'Can't Talk? Won't Talk?' - Selective Mutism, Cognitive Behavioural Therapy and the role of the Educational Psychologist.	32 - 76
Professional Practice Report 3: Supporting the Development of *"Harmful Sexual Behaviour"* (HSB) Policy and Practice in a West Midlands Local Authority (LA): Primary School Perspectives	77 - 118
Professional Practice Report 4: Professional Perspectives on the Purpose, Efficacy and 'Value' of *"Pupil Referral Units"* in a West Midlands Local Authority.	119 - 170

Professional Practice Report 1: Autism Spectrum Conditions: A Changing Landscape

Abstract

Defining distinct subtypes within the autism spectrum has been notoriously difficult. As such, some contemporary research suggests that splitting autism diagnoses into separate phenotype presentations is no longer appropriate, and as a consequence, the previous 'categories' (as in the *Diagnostic and Statistical Manual of Mental Disorders – IV - TR*) within the autism spectrum are to be restructured, with 'autism' remaining as the sole available diagnosis in the DSM-V.

The principal aim of this development is to acknowledge the diverse range of presentations in autism through being more inclusive of the variation, but less specific as to any subtype 'classification'. This change of discourse has been prompted by improved awareness of the substantial parallels with diagnoses both within the spectrum (e.g. 'Asperger's Disorder') and between other conditions seen currently as distinct (e.g. 'Attachment Disorder').

Some researchers argue, however, that there remains significant value in defining homogenous groups within the spectrum – and that this can be beneficial for a young person. '*Pathological Demand Avoidance*' (PDA) is an example of one recently proposed 'new' homogenous group.

This label has gained prominence in both the research and practical arenas; however, given the developing autism discourse challenging the value of differential diagnoses, how useful and valid is this distinction within the spectrum, and to what extent does available evidence support this position?

This question also pertains to a wider consideration: to what extent are diagnostic frameworks 'fit for purpose' in differentiating between the Autism Spectrum and other conditions – then supporting professionals to make accurate and reliable diagnoses and use these to inform selection of evidence-based interventions?

This paper reflects critically on both the widely available diagnostic systems and also the taxonomy of autism. Particular emphasis is given to 'PDA' and the professional practice of educational psychologists involved in needs assessment of autism and subsequent intervention.

Section 1: Rationale and Introduction – Setting the Scene

'[Educational psychology] is not about putting people into pigeonholes or labelling people, even though it has often been employed for this purpose'

(Cameron, 2006, p. 301)

Introduction: Professional Relevance and a Changing Landscape

"*[The EP role is] a necessarily fluid one, positioned between interconnected systems."*

(Fallon et al, 2010, p. 2).

Contemporary educational psychologists (EPs) occupy a unique position within the wider assessment and diagnostic landscape; a position that requires integration with a variety of perspectives and modes of practice - though this is not always without conflict (Hymans, 2008).

Although historically the EP profession was more aligned with child-deficit perspectives (Gillham, 1978), over time there has been a progressive move away from '*a positivist, reductionist paradigm towards a more constructionist, holistic and systemic approach'* (Wicks, 2013, p. 153). Rather than situating presenting difficulties as an occurrence purely 'within' an individual, EPs consider additional factors to provide *'fundamentally a richer and more effective perspective'* (Wicks, 2013, p.153).

It follows that the practical role of the EP has also transformed to reflect this paradigm shift: '*The traditional role of the EP [has] changed from being diagnostic, which placed the EP as an expert, to one that promote[s] the EP as a collaborative problem-solver'* (Wicks, 2013, p. 154). This is the leading discourse present within the profession (Fallon et al., 2010).

Nevertheless, while the EP may no longer play the dominant role of diagnostician, involvement with the diagnostic process remains a professional reality – whether that be through working with children that already have an 'official' diagnosis, or providing assessment information that may inform a later diagnostic procedure (Wicks, 2013). A professional practice consideration is therefore: what continuing role does (and should) the EP play in diagnosis? This question provides one strand of inquiry for the following paper.

A further substantial consideration for the practitioner psychologist is that many diagnostic practices found commonly within the educational landscape continue to subscribe tacitly to a 'medical model' paradigm, underpinned by frameworks (e.g. Diagnostic and Statistical Manual of Mental Disorders – DSM; International

Classification of Diseases - ICD) that use a realist ontological interpretation of diagnostic categories (Gillman, 2004).

Diagnosing along the *DSM-IV/ICD-10* axes continues to be standard practice in clinical work and many disorders remain viewed as dispositional and *within* the makeup of an individual (Wright and Lopez, 2002).This appears opposing to the modern EP perspective, and there looks to be no firm reconciliation to this disparity in professional practice (Fallon et al., 2010). With the newest edition of the 'DSM' (DSM-V, 2013) published recently, this dialogue has again been brought to the fore (e.g. Division of Educational and Child Psychology Conference, 2013). It therefore seems an appropriate time to provide a reflection on these professional challenges.

In addition, diagnoses, when considered from this perspective, are fixed, stable and *'are underpinned by the assumption that [they] reflect "facts" about people struggling in the world.'* (Lopez et al., 2006, p. 259). However, many cases are available which highlight this fallacy (Barone et al., 1997); some 'disorders' are not fixed entities and diagnostic descriptions change – whether that be via enhanced understanding through research, or due to changes in people's beliefs, societal norms and values (Brown, 1995). How much confidence can therefore be placed in *any* diagnostic descriptor, and what utility do they have in practice?

A prominent exemplar of the difficulties mentioned thus far can be found within the domain of autism spectrum conditions – and it is this particular area of study that provides the context for the current paper. Autism, since first outlined, has been the subject of significant change, and serves to highlight many of the wider concerns relating to accurate assessment, reliability of diagnoses, condition classification and boundaries (Selfe, 2002). Autism also remains a condition where certainties are few, and controversy is abundant (Wing et al., 2011) - though often these uncertainties are not reflected fully in practice (Volkmar, 2009).

Even though it has been twenty years since the introduction of the DSM-IV criteria, questions still remain regarding the validity of the autism *DSM-IV* subtypes (Asperger's disorder, childhood disintegrative disorder, and PDD-NOS) as separate and distinct from autistic disorder. Further, many longitudinal studies (e.g. Daniels et al., 2011) have found inconsistencies with subtype distinctions over time (e.g., a young person may meet the criteria for autism at age 3, and PDD-NOS at age 5). In addition, reliability of the application of diagnostic criteria demonstrates poor consistency across settings (e.g. a young person might get diagnosed with Asperger's disorder at one site and autism at another; Lord et al., 2012) though often little qualitative difference is noted across these groups (Macintosh and Dissanayake, 2004).

As such, using the assessment and diagnosis of autism as a model, the following paper aims to engage with long-standing professional practice concerns by focussing on:

- What are the critical issues for educational psychologists working with assessment and diagnostic practices – and with autism specifically? And;

- To what extent are available frameworks 'fit for purpose' in supporting the educational psychologist in their practice?

Before considering these questions, it is important to provide an outline of contemporary autism research and practice.

The Need for Defensible Practice: A Caveat

When, albeit tentatively at first, I elected to approach the noted professional considerations through the domain of autism (and related conditions on the 'spectrum') as an exemplar, I did so with some trepidation. This was for a number of reasons: primarily, as part of my developing role and identity as a trainee educational psychologist I had become aware throughout my professional practice that the identification and diagnosis of autism and other '*Pervasive Developmental Disorders'* ('PDD') was often an inexact science - with educationalist and parental anxiety widespread: 'clear-cut' assessments outcomes or diagnoses are rare (Volkmar et al., 2009).

One consequence of this anxiety is that considerable emotion and controversy are present in both the practical and research spheres and this is a long-standing position. Indeed Russell and Norwich (2012) report that:

"*Educational professionals recognise tensions experienced by parents as they struggle with the identification of their children's [autism]…*"

(Russell and Norwich, 2012, p. 230).

Significant debate continues predominantly in the research domain – noted rarely in mainstream discourse - in relation to questions surrounding: the epidemiology of conditions within the spectrum (Fombonne, 2008), the epigenetic bases and hereditability of autism conditions (Dunham, 2007), the genotypic and neurological variation in autism (e.g. the 'mirror neuron' thesis of Oberman and Ramachandran, 2009) and the theoretical mechanisms that may be associated with the condition (e.g. 'theory of mind' Baron-Cohen and Frith, 1985 onwards and 'central coherence' Happe, 1994).

Conversely however, some disagreements within autism research have been played out on a public stage, exemplified in recent years by the relationship posited between the Measles, Mumps and Rubella (MMR) vaccine and the development of autism (the now retracted paper of Wakefield et al, 1998).

Although there was (and is) no evidence available which empirically verified this link - and a thorough *debunking* has since occurred (e.g. Deer, 2011) -, the consequences of this scientifically questionable and methodologically flawed research have been pervasive:

'The damage [of the Wakefield research] *to public health continues, fuelled by unbalanced media reporting and an ineffective response from government, researchers, journals, and the medical profession.*

(Deer*,* 2011, p.342).

While only connected tenuously to the broader aims of the current paper, the motivation for outlining this controversy is to provide a picture of the contextual landscape of contemporary autism research and practice. It appears that significant confidence is placed in researchers, and that speculative hypotheses generated by poor research can be adopted quickly by the general population as fact - with or without convincing empirical data and robust scientific foundations. Given that, as mentioned previously, certainties within the domain of autism are scarce, this is a concerning reality.

Therefore, as a guiding philosophy, it is crucial that all research and developments in this domain are considered carefully and sensitively - and appraised critically. Casting an analytical and somewhat sceptical eye on all developments in the field is important both to mitigate the potential emotive impact of research that challenges existing parameters and to ensure that any findings are well supported - and limitations of their validity and reliability acknowledged explicitly. It is this position of mindful caution that provides the philosophical foundation for the current paper:

'As the awareness of Autism Spectrum Conditions has grown, so has the media's attention and the speed with which news, accurate or not, spreads through the autism community.'

(Lord and Jones, 2012, p. 504).

With this in mind, the current paper now turns to the first 'professional practice' consideration: what are the current critical issues surrounding autism?

Section 2: Critical Issues in Autism Spectrum Conditions – Assessment and Diagnosis

'There is no medical test for autism — no objective, definitive test'

(Selfe, 2002, p.337)

There are a number of significant critical issues that relate to the general practice of assessment and diagnosis of autism spectrum conditions: e.g. the reliability of 'early' assessment and diagnosis (Moore & Goodson, 2003), predictive validity of assessment tools (Bailey & Parr, 2003) and variability of intervention success (Hwang & Hughes, 2000; Strain & Hoyson, 2000).

However, these wider topics are can be handled effectively only once difficulties fundamental to the conceptualisation of autism are understood comprehensively. However, when reviewed closely, a number of inconsistencies emerge.

'Autism' and other conditions on the spectrum *should not* be considered as homogenous groups (Wing et al, 2011), though they are often conceptualised as such (Volkmar et al, 2009); children with autism spectrum conditions seldom fit neatly within discrete boxes or 'frameworks' and *'in reality, no one autistic child is very much like another'* (Selfe, 2002, p.336).

Nevertheless, children that receive a diagnosis of an autism spectrum condition, under the current structure, are collected together currently into discrete groups based upon comparable characteristics with each-other; 'autistic traits', 'behaviours consistent with Asperger's disorder', and so forth (Wing et al, 2011).

The very fact that classification occurs in this manner is a predictable conclusion given that the assessment tools used widely (e.g. Diagnostic Interview Schedule and Childhood Operation -DISCO (Wing & Gould, 1991)) – are structured to relate closely to diagnostic frameworks that have finite available outcomes (autism *or* Asperger's disorder *or* Pervasive Development Disorder-Not Otherwise Specified (PDD-NOS)).

Yet, while there have been developments in the tools available to aid in the assessment of autism (diagnostic schedules and interviews now also used widely e.g. Lord, Rutter, & Le Couteur, 1994), the diagnostic process is still largely underpinned by the '*consensual definitions as operationalized in the DSM-iV / ICD-10)*' (Klin et al, 2000).

It is therefore unsurprising that children who receive a diagnosis will be categorised in to discrete 'conditions' by virtue of key characteristics that are outlined in these texts (Volkmar et al, 2009).

However, one of these long-standing difficulties with this process relates to the accuracy of the eventual diagnosis (particularly with subtype specificity) and the

considerable range of behavioural presentations noted within the spectrum (Lord and Jones, 2012): do the diagnostic frameworks 'capture' the nuances of autism spectrum conditions fully? It is to this critical issue that the paper now turns.

The Difficulty with Differentiation

Although there *is* now largely a consensus about the essential nature of autism spectrum conditions more widely (Lord and Jones, 2012), a pervasive difficulty remains with *specificity.*

There has, historically, been considerable uncertainty relating to condition 'boundaries' and this endures currently (detailed in Skellern et al, 2005): for example, how can a clinician differentiate reliably between Asperger's Syndrome and 'high-functioning autism', or between a 'pervasive developmental disorder' and other diagnostic concepts, e.g. semantic–pragmatic language impairment (Bishop & Norbury, 2002), attention deficit disorder plus PDD (Hellgren *et al.*,1994), right hemisphere learning problems (Weintraub & Mesulam, 1983), and schizoid disorder (Wolff, 2000) – each of which has 'overlap' with the more traditional conceptualisation of autism. This process remains a considerable challenge.

Operational diagnostic criteria for any *specific* condition on the spectrum have been notoriously difficult to identify (Volkmar et al, 2009) and the process of determining the appropriate diagnosis continues to be based on a fusion of a young person's developmental history and observations made by a clinician – this formulation then matched retrospectively to diagnostic criteria (Lord and Jones, 2012).

However, this process has yielded underwhelming results – particularly with the 'matching' of observed behaviours to those outlined in diagnostic handbooks. Williams et al (2007) found that there was 'a *general lack of agreement between the diagnostic labelling used by clinicians and diagnosis - based on DSM-IV criteria – indicat[ing] a lack of consistency'* (p. 108) and a literature review (Witwer and Lecavalier, 2008) found that, often, the reliability of any eventual diagnosis is poor - there is considerable inequity and confusion present with the process. It also emerges that there is little confidence that eventual diagnoses are precise, and diagnostic outcomes vary:

"The ability of clinicians and researchers to differentiate reliably between autism, Asperger's Disorder, and PDD-NOS based on the current DSM criteria [continues to be] far from optimal"

(p. 1623)

Some commentators suggest further that the current descriptors in the diagnostic manuals simply do not account fully for the *significant* variation that is apparent within the population – and that the descriptions provided are unclear (Klin, 2000): guidance offered to clinicians by the available frameworks requires considerable

interpretation by the practitioner; a challenge *'particularly among less experienced clinicians'* (Klin at al 2000).

This is perhaps unsurprising given the extensive range of 'symptom' expression within conditions on the autism spectrum – both intellectual and communicative functioning – and that these are not stable over the life course changing with both chronological and developmental 'age' (Lord, Pickles, McLennan, 1997: Rutter et al., 1997).

The outcome of assessment therefore seems dependant on *when* a young person is assessed, and *the interpretation of the specific practitioner*. This inconsistency is concerning:

"Although the psychometric properties of the current DSM-IV criteria for autism and Asperger's Disorder appear *quite acceptable, there is likely to be a high rate of misclassification of children given a diagnosis"*

(Mahoney et al.1998; p.284)

Why does such inequity exist, and why has this difficulty been pervasive throughout the chronology of autism? There are a number of possible reasons for this. Firstly, throughout the history of autism various interpretations of the condition have developed. These have been mirrored by changes *within* diagnostic frameworks - e.g. the well documented transition from *'Childhood Schizophrenia'* (DSM I) to '*Infantile Autism'* (DSM-III), to the 'Multi-Axial' *Autism Spectrum (*DSM-IV-TR).

However, each time these classification systems are revised, the new definitions change subtly the nature of how the condition is construed – which inevitably alters the formulation of the characteristic difficulties. Diagnostic frameworks attempt to frame a 'condition' using the best available evidence at the time (Volkmar, 2009) but, if the conceptualisation of autism -and any proposed subtypes - is variable over time, then confidence in the reliability of the final diagnosis is predictably poor. A diagnosis may be accurate *at that point in time*, but may quickly become outdated (Wright and Lopez, 2002).

Further to this, the aetiology of autism and other proposed conditions within the spectrum remains unknown and complex. Not only are various underlying causes proposed but there is – as yet – no consensus as to early psychological, biological or behavioural markers (Volkmar, 2009). Simply, studies from a causal perspective do not outline clearly the demarcation of what is, for example, 'autism' or 'Asperger's Disorder'. Up-to-date research (e.g. Walsh & Bracken, 2011) shows that there are *no* as yet known independent causal mechanisms which account wholly for each proposed subtype:

‘The evidence now indicates that we are dealing with several different ‘‘autism spectra’’, and the most appropriate term for the whole group of disorders discussed here might be ‘‘the autisms’’

(Coleman & Gillberg, 2012).

While Geschwind (2011) offered the possibility that specific and shared genetic markers are present for autism in general and that on a genetic level the autistic brain may differ to a typical brain, genomic differences *between* distinct conditions on the spectrum are also not – as yet - identified:

“Not only are many different genetic patterns associated, at some level, with autism, but also many of these same patterns are associated with numerous other psychological and psychiatric disorders.”

(Guilmatre et al., 2009, in Lord and Jones, 2011, p.491).

Given these difficulties, inconsistencies with the accuracy of any eventual diagnosis are therefore expected, and it seems reasonable to suggest that the available diagnostic utilities have demonstrated poor efficacy at capturing fully the range of ‘symptoms’ within autism spectrum conditions and, when attempting to be *specific* about any subtypes, confidence is diminished further.

However, significant changes in the diagnostic frameworks aim to reflect the current position with the understanding of autism: this is likely to affect significantly the work of those involved in the assessment or diagnostic process. An outline of these changes is now provided.

DSM-V and Autism Diagnoses: A Novel Approach

‘The specific diagnostic criteria provided in [diagnostic handbooks] are meant to serve as guidelines to be informed by clinical judgement and were not meant to be used in a “cookbook” fashion’

(Wing et al, 2011, p. 771)

Proposed adjustments to diagnostic criteria for autism spectrum conditions in the DSM-V attempt to meet these pervasive challenges of diagnoses head on through the merging of some currently discrete conditions under a single category - for example considering Asperger’s Syndrome *as part of* the parent disorder of autism (rather than a phenomenologically independent condition) - and the complete removal of others due to their aetiology e.g. Rett’s Syndrome due to the suggestion of a distinct underlying cause – a mutation in the methyl CpG binding protein 2 – a biological abnormality wholly independent from autism (Lintas et al, 2012)

Rather than a fixed set of criteria, the new framework represents an effort to diagnose all persons showing the signs of an autism spectrum condition by being more inclusive and flexible with the diagnostic process. Through utilising a robust dimensional approach, less emphasis is to be put on trying to differentiate between conditions on the basis of clinical characteristics in favour of formulating a balanced and comprehensive *description* of the individual's symptomatology and associated strengths and/or impairments.

This is anticipated to have a functional benefit of ensuring that an individualistic approach is adopted for diagnoses: those involved in the diagnostic process may be able to 'describe' a young person as, for example, demonstrating 'atypical social/communication difficulties' that require significant support, and 'restricted or repetitive behaviour' that evokes less concern. Less focus is to be put upon classification – more on creating a holistic and exhaustive picture of a young person's needs:

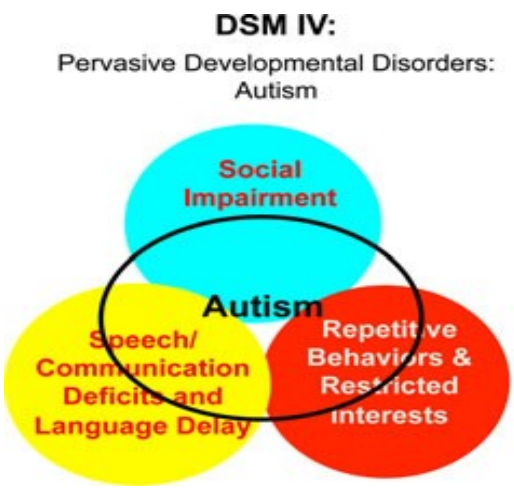
"For clinical purposes a unitary label of ASD may be beneficial in planning the support systems for all *individuals "on the spectrum" who require help from education and health- and social-care systems"*

(Lai et al, 2013, p. 3)

These changes appear to reflect more accurately the historic difficulties with diagnosis specificity as mentioned previously.

Further to this, changes proposed by the DSM-V '*working group'* also argue that it is now appropriate to collapse the traditional 'triad of impairments' (Wing and Gould, 1979), often used currently as criteria for diagnosing autism, into two categories: *'social communication and interaction'*; and *'repetitive and restrictive behaviour'* (DSM working group, 2012):

(A)



(B)

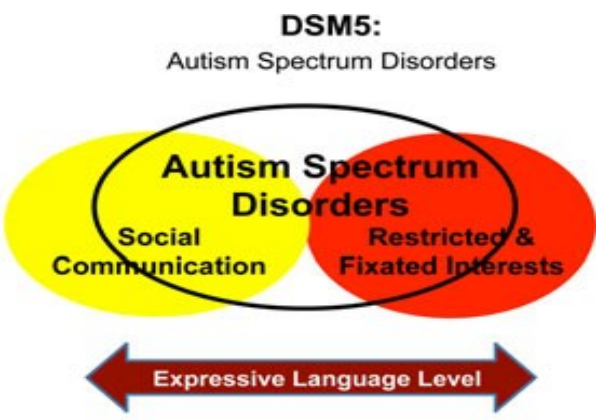


***Figure 1**: (A) Existing diagnostic classification according to the DSM-IV for Pervasive Developmental Disorders/Autism. (B) Proposed DSM-5 classification dimensions for autism spectrum disorders (from Lord and Jones, 2012, p. 493).*

This is a direct response to the aforementioned range of 'symptoms' that are noted under the umbrella of 'autism' and the historic difficulty with separating social impairments and speech/communication deficits (Wing et al, 2011). Unsurprisingly, these developments have ignited considerable discussion.

Nevertheless, studies are emerging (e.g. MacPartland, et al. 2012; Mandy et al. 2012) which assess the impact that these new criteria would have for those individuals with a current diagnosis. Preliminary findings suggest that when applying the proposed DSM-5 diagnostic criteria for autism, 60.6% (95% confidence interval: 57%-64%) of cases with a current clinical diagnosis of an autism spectrum condition met revised DSM-5 diagnostic criteria (MacPartland, et al. 2012).

Although these two studies have been criticised for poor methodological rigour (particularly in the datasets used for the participants: Swedo et al. 2012), further investigation using a dataset more reflective of the autism population (i.e. including individuals with other diagnoses *across* the spectrum - Heurta et al, 2012) have found that there would be some individuals (9%) with a *PDD* who would not meet the new 'autism' criteria. As these changes are relatively new, how this works 'in practice' remains to be seen.

Nonetheless, changes to the diagnostic methodology appear to be promising on two levels: firstly, reflecting the general discourse that attempting to define distinct subtypes on the spectrum is not an efficacious process – and shifting the focus to being more descriptive - while secondarily ensuring that those with a current diagnosis are 'included' within the new conceptualisation.

Critical Issues in Autism Spectrum Condition Diagnoses: A Summary

This opening section has endeavoured to outline the context and key challenges for contemporary autism research and diagnostic practice. To bring this introductory section to a close, it appears to be a reasonable suggestion that there are – at present - no resolutions to the pervasive issues within autism:

- There is no collective agreement on the divide between autism and other conditions proposed on the spectrum – and questions relating to the reliability of diagnostic methods have been prevalent;

- There appears to be little evidence which suggests each condition upon the spectrum currently is 'different' on a genetic / biological level, and;

- The available diagnostic frameworks do not appear to 'capture' the diversity within the autism population.

Changes on a national level, however, are attempting to reflect these uncertainties – yet whether this works in practice can only be determined once the new framework is operationalized.

However, if this national picture does signify a change in how autism and other related conditions are conceptualised – particularly a move away from separating distinct autism phenotypes - what does this suggest for other proposed conditions that have emerged recently in the research domain, e.g. Pathological Demand Avoidance (PDA); and what will these changes mean for educational psychology *practice*? Significant and rigorous evidence will be required to justify any new condition existing as a distinct phenotype – a position seemingly opposed to the broader discourse within autism.

For the remainder of the paper I aim to build the argument that proposed changes to the way in which autism is diagnosed are encouraging – particularly for the *professional practice* of educational psychologists who may be involved in the diagnosis process, and that although increased interest and support for the phenomenon of PDA has developed (particularly in the context of my personal local authority role), the available evidence suggests that - parallel with national changes – the boundary between PDA and autism is indistinct and that continued endeavours to divide the spectrum may be fruitless.

The paper now outlines the recent history of PDA before considering the evidence available and then the wider position of educational psychologists.

Section 3: Pathological Demand Avoidance

Pathological Demand Avoidance: a History.

The first use of Pathological Demand Avoidance (PDA) as a distinct term can be found in research from the 1980s by Professor Elizabeth Newson (e.g. Newson, 1988), borne out of clinical investigation of young people referred to the Child Development Research Unit at Nottingham University. This centre provided an opportunity for educational and clinical psychologists in professional training to engage with young people presenting complex and distinctive difficulties.

Often these young people would present similar characteristics to typical autism; however, many also exhibited traits that were inconsistent with typical autism as outlined through diagnostic frameworks. This often led to a diagnosis of 'atypical autism'.

Over time, however, professionals involved in work at the centre became increasingly dissatisfied with the imprecision of the 'atypical autism' outcome, and began to identify that there were distinctive characteristics *within* the 'atypical autism' group. As such, Newson (1990) proposed that there exists a distinct homogeneous population that presented *some* traits analogous to autism -*did not* meet the full criteria for a diagnosis of autism - yet frequently displayed similar characteristics to each other:

'*Discriminate functions analysis shows PDA to be significantly different, on many counts, from classic autism and Asperger's syndrome, both separately and together including an equal sex ratio (150 cases)'*

(Newson et al, 2003, p.595).

The central characteristic of this emergent group was proposed as '*an obsessional avoidance of the ordinary demands of everyday life* (Newson, 1990, p.2), combined with adequate '*social understanding and sociability'* to be 'manipulative' in their avoidance. This was termed 'Pathological Demand Avoidance (Syndrome)'.

Through further investigation in clinic, a set of distinct characteristics was determined and published. Individuals diagnosed with PDA often:

- obsessively resist ordinary demands;
- appear sociable on the surface but lack depth in their understanding (often recognised by parents early on);
- [display] excessive and sudden 'mood swings';
- appear comfortable (sometimes to an extreme extent) in role play and pretending;
- [exhibit a] language delay, seemingly as a result of passivity, but often with a good degree of 'catch-up', and;

- [display] obsessive behaviour, often focused on people rather than things.

(Newson, 2003, p. 13)

Following the definition of this condition, the Nottingham clinic began to utilise PDA as a distinct diagnosis. A number of further cases were identified to which the criteria of PDA seemed appropriate, supplementing and reinforcing the original claims, and leading Newson to assert that:

'This clinical description of "pathological demand avoidance syndrome" (PDA), conceptualised as a separate entity within the pervasive developmental disorders(autism spectrum), has already been found clinically useful by many paediatricians, psychiatrists, and psychologists in diagnosing a group of children otherwise seen as puzzling and atypical in relation to the autistic spectrum.'

(Newson, 2003, p.598)

Since the emergence of these criteria, debate has been present in the academic sphere particularly regarding the strength of evidence used to support PDA as a distinct diagnostic category. Indeed in my professional practice as a trainee educational psychologist, the emergent discourse surrounding PDA has been significant – particularly responding to parental requests for clarity of whether their child 'has' PDA, and what PDA *'actually is'*.

Before considering whether this term does have value in supporting the *professional practice* of educational psychologists, it is important to examine critically the credibility and strength of the evidence used to support the claims of PDA representing a distinct condition on the autism spectrum – within the context of the wider difficulties with autism diagnoses.

'PDA' – The Research Context

Since beginning my training in educational psychology, the number of enquiries received relating to 'PDA' has increased substantially. I therefore completed a literature review to identify, select, synthesize and appraise all high quality research evidence relevant to the topic - both to support my general professional development and also to improve my competence in this domain.

The investigation strategy involved accessing search engines and databases including Psychinfo, Psychnet, ERIC, Google Scholar, MEDLINE, ScienceDirect and Swetswise; and specific journals such as Educational Psychology in Practice and the European Journal of Special Educational Needs. The University of Birmingham Library catalogue and 'e-library' were also used to search for relevant articles and reference lists were followed up from articles used, along with searching 'EPNET' - a forum for the exchange of ideas and information among University research/teaching staff working in the field of Educational Psychology and Educational Psychologists

throughout the UK and elsewhere. Prominent search terms were utilised which were relevant to the topic being searched for:

- PDA,
- Pathological Demand Avoidance,
- Pathological Demand Avoidance (syndrome),
- Atypical autism,
- PDD-NOS,
- Pervasive Developmental Disorder,
- DSM-IV(5) + autism
- Aetiology (etiology) + autism, and;
- Autism, PDA, Pathological Demand Avoidance + educational/practitioner psychologist.

(N.B The term 'Autism' was extended, where appropriate, to include the terms ASD(C) and Asperger Syndrome.)

Using the investigation strategy it soon became clear that the number of available papers was small, and authors were recurrent (Newson, 1988/1990/2003: Christie, 2006 / 2011) within the domain of PDA: there appeared to be no research available that was not conducted at the 'NORSACA' centre in Nottingham – the centre from where PDA was first suggested as a distinct concept. Although all of the papers found were presented as distinct and original, it appeared that there was significant amount overlap between them. This presented a concerning picture – particularly in light of the lack of diversity and poor quantity of evidence available to reinforce claims made about this phenomenon.

The 1988 version of Newson's paper is the first introduction to the concept of pathological demand avoidance, and it is here that Newson outlines the findings from the research unit at Nottingham University. Accordingly, a number of papers have stemmed from this initial volume: the more recent updates attempt to refine the characteristics for PDA, although the significant features of the condition have remained stable throughout subsequent revisions: *'The summary of defining criteria…originated in 1988, was hardly revised at all in 1995 except to include a brief note on language'*. (Newson, 1998, p.1.3).

Newson outlines originally the case for PDA representing a distinct phenomenon using qualitative examples of twenty-one young people who presented characteristics similar to each other, but not consistent with an autism phenotype. Although this is arguably a limited cohort derived from a convenience sampling

method, Newson considered the evidence available was strong enough to assert that:

'Resistance to demands is the most obviously salient feature of the group and in fact is the major reason for their dramatic failure at school which is true for all the children unless equally dramatic educational intervention takes place'

(p.5)

A list of behaviours for each child is given, with particular attention focussed on the extent to which a young person resists demands (Figure 2).

Figure 2: A selection of* 'demand resistant' *characteristics within the PDA group**:

Child	*Demand Resistant Characteristics?*
Marilyn	'Yes ++. Won't give known answer. 'Swans off; panics. Only sings alone.'
Jenny	'Yes ++. Pull away, switches off, gets weepy, imitates in private.'
Ruth	'Yes ++. Totally overpowered by school; goes quiet, answers randomly'
Billy	'Yes++. Escapes to 'act', frantic pace. Disengages. Looks away from task'

(1988, p. 31)

(A more detailed outline of behaviours found in the proposed PDA subtype can be found in Appendix 1).

To present a critical appraisal – particularly considering the affective nature of the domain as indicated in the introduction - while the behaviours displayed by the young people presented in the Newson (1988) study are suggested as distinct and 'demand resistant' (thus supporting the hypothesis of this emergent homogenous group of PDA) they may also be representations of difficulties with other behaviours and attributes: anxiety, low social competence, low self-esteem and confidence – difficulties that are also commonly observed with *typical* autism (Gillott et al, 2001; White et al, 2009; Bellini et al, 2004).

Additionally, the breadth and range of behaviour advocated as evidence for PDA existing as a homogenous group is substantial (Appendix 1). It is challenging to determine which of the behaviours is PDA-*specific* or those which could be attributed

to the wide range of presentations in autism more widely as discussed earlier in this paper.

Although 'social manipulation' is indicated as the primary difference between the demand resistance behaviour of a young person with PDA and a young person with autism, as has been found consistently in research, social skills in children with autism are significantly varied (Bishop, 1989; Klin et al 2002). Where, then, is the 'cut off' for an autistic child with social competence developed sufficiently to allow the child to be socially manipulative and a young person with PDA; how are they qualitatively *different*? Disappointingly answers to this question remain elusive.

As mentioned previously, this may be a further example of the considerable challenge with determining accurately the boundaries for, and specificity of, autism spectrum conditions – simply, the range of behaviours and complexity of the autism phenotype may be too broad to demarcate neatly, and behaviours proposed as PDA specific may be better considered as behavioural traits of autism more widely.

With this criticism in mind, further studies completed by Newson attempted to refine and conceptualise the condition of PDA with greater rigour.

For example, Newson et al (2003) argue further for the validity of PDA, and necessity of its distinction from other pervasive developmental disorders, on the basis of additional cases referred to the Nottingham clinic (n=150).

Using the data obtained from these 150 cases, the salient criteria for PDA – as outlined in previous publications by Newson (e.g. 1988) - are reinforced and suggestions that the term '*gives "specific" status to a large proportion of those children (and adults) who would earlier have been diagnosed as having "pervasive developmental disorder not otherwise specified (a-typical autism)"* (p. 598) are presented.

Regrettably, while this paper again argues for the distinctness of PDA, similar concerns to those raised previously are present –it remains challenging to determine accurately whether PDA is a distinct condition *in itself*: the range of behaviours outlined as 'indicators' of PDA could be considered too wide to justify the demarcation of a specific subtype. Indeed there are also no studies available that replicate or support the claims made by Newson (2003). If – as is suggested by Newson (1990) – PDA represents a *distinct* condition on the autism spectrum, further evidence is required to suggest how PDA is qualitatively unique when compared to the range of behaviours found within autism more widely (Klin, 2002). It is also concerning that there are no research papers available that are not attached to the Nottingham centre – and thus little evidence to independently substantiate the claims presented.

To improve confidence in this area consideration could be given to devising a system for PDA / autism similar to that of Moran (2010) designed to distinguishing between

‘Attachment Disorder’ and autism. A grid displaying the differences between PDA and other autism spectrum conditions would be beneficial for practitioners – particularly given the difficulties from this literature review:

“Although at the point of referral children may look similar, there appear to be important differences in the way their problems are expressed in daily functioning”

(Moran, 2010, p. 48)

For my professional practice, I have been unable to find - in the research base relating to PDA - answers to the questions posed frequently by anxious parents. It appears to be a reasonable argument that the evidential picture for PDA, at this juncture, is limited. Further research may be required to challenge/ evidence the distinctness and specificity of this condition.

However, as has been the thread running throughout this current paper, attempting to determine discrete conditions on the spectrum has been notoriously difficult, and if the discourse of autism more widely is moving away from differential diagnoses, what then is the *value* - in terms of professional practice – for continued endeavours to determine these phenotypes in the autism spectrum? It is to this question, in relation to professional practice, that this current paper now turns.

Section 4: Autism, PDA and Professional Practice of Educational Psychologists

This paper opened by outlining the historic and current challenges faces with autism diagnosis – particularly the poor efficacy of diagnostic manuals at establishing reliably the boundaries of conditions on the autism spectrum and reflecting fully the breadth of 'symptoms' noted: this is a professional challenge for those involved in the diagnostic process. The paper then outlined that – in practical terms – autism discourse is moving away from attempting to determine subtypes and that new diagnostic frameworks reflect this trend.

From this, an overview of 'PDA' was given to illustrate that some researchers suggest that distinct subtypes *are* valid and justified – however when a closer examination was undertaken, similar issues to those faced historically with autism were found in relation to the lack of specificity of the defining behaviours and condition boundaries. There seems to be little evidence to suggest that PDA should be considered a distinct condition within the autism spectrum.

Arguably, however, the key issues for educational psychologists is not necessarily the nuances of the diagnostic criteria or the discreteness of conditions, but more how understanding these conditions more thoroughly can be used better to support, and improve outcomes for, young people; '*the issue of support, building upon an individual's profile of strengths or weaknesses, is more important than distinctions between autism, PDD-NOS or Asperger's syndrome*' (Volkmar, Lord, Bailey, Schultz, & Klin, 2004, p.109).

Indeed Christie (2006) – from the perspective of PDA -echoes this sentiment and suggests that continued effort to determine whether PDA is 'distinct' is '*distracting*' (p. 6) and that '*we should be constantly focussed on the true purpose of diagnosis: to better understand and make sense of individuals and to use that understanding to help us formulate more effective forms of intervention and provision*' (p.6). Where does this leave the educational psychologist?

The Educational Psychologist's Role with the Autism Spectrum: Discussion

At the start of this paper, the question was posed: to what extent are available frameworks 'fit for purpose' in supporting the educational psychologist in their practice? As this paper has outlined, the answer is not encouraging:

"Diagnosis should be the starting point for assessment, intervention and treatment, but all too often it appears to be the endpoint"

(Selfe, 2002, p. 336)

As EPs focus typically on a young person's strengths and difficulties – often in relation to the learning environment in which they are educated – and then how any

presenting problems may be supported or resolved (Cameron, 2006) - autism, in various forms, is (and is likely to remain) a common focus of EP practice.

The critical issues raised previously in this paper should be given full consideration by an educational psychologist involved in practice relating to autism. It is important for the practitioner psychologist to be cognisant of the noted difficulties with the reliability and efficacy of assessment tools, and the diagnostic frameworks which underpin them, alongside the more elusive difficulties with defining subtypes within the autism spectrum. Given the highly emotive nature of autism research and practice, it is appropriate to approach novel developments within the domain with a level of scepticism – PDA is an example of where such scepticism may be warranted.

Nevertheless, there is an *'increasing pressure on schools to employ successful interventions and in turn for EPs to guide schools in achieving this'* (Ali & Frederickson, 2007, p. 355).

Optimistically, the national picture shifting focus to now presenting a detailed picture of a young person's needs, strengths and difficulties rather than focussing on whether they have Asperger's Disorder, autism, PDD-NOS, PDA (etc.), may – as described by Selfe (2002), reposition diagnosis as the starting point.

The call for this descriptive, rather than prescriptive practice has been present in educational psychology literature for some time (e.g. Glaser, 1981). Indeed in a 2006 editorial of *'Educational and Child Psychology'* this concern was reiterated:

'A medical model of diagnosis and categorisation often offers little to those who seek to develop meaningful intervention programmes, [and there is difficulty] translating diagnostic information into their everyday practice and lack good assessment tools.'

(Resing and Figg, 2006, p.4)

This statement continues to be apt. However, it appears that the wider autism discourse is becoming more aligned with the perspective of educational psychology. Specifically it is anticipated that a more robust and detailed account of a young person's needs may allow for an improvement in targeted, needs-led intervention rather than a one-size-fits-all approach dictated by diagnosis rather than assessed need. Psychologists will be able to select interventions based on a holistic picture of a young person's needs utilizing a wider range of psychological theory. A unitary label of "ASD(C)" accompanied by individualized assessment of needs for support will likely be useful in clinical and educational settings, especially to guarantee the required levels of support for all individuals "on the spectrum" who will benefit from educational, occupational, social, mental health, and medical interventions (even if they are etiologically, developmentally, and clinically heterogeneous).

This may have further, significant 'real world' benefit for the practitioner psychologist particularly in the selection of intervention. There has amassed a wealth of research

which focuses on various aspects of autism: educational approaches in autism (Tutt et al, 2006; Jordan et al, 1999), the validity and efficacy of interventions in autism (e.g. social stories (Ali & Frederickson, 2007); social-emotional instruction (Bauminger, 2002); behavioural interventions (Maurice, et al. 2001) the value and usefulness of 'early intervention' (Oono et al, 2013) and so forth.

These papers rarely focus on whether interventions are suited for individuals with 'Aspergers' or 'autism' – as, seemingly in line with the evidence presented in this paper, the qualitative differences between these conditions are indistinct. This allows the practitioner psychologist to utilise research relating to autism *as a whole* and then apply it (with context specific modifications) in their practice. Suggestions that a specific intervention may be more suited to 'Asperger's Disorder' or 'autism' (for example) it not a supportable position;

"In terms of treatment, in the 20 years that have passed since the introduction of the DSM-IV criteria, there is no evidence that the type of intervention advocated should be based on an ASD "subtype."

(Vivanti., et al 2013, p.259-260)

This is an important consideration for the practitioner psychologist: that while diagnosis remains a professional reality – and the theoretical concerns underpinning this process remain substantial as outlined in this paper – it is important to realise the limitations of any eventual diagnosis and to ensure that any interventions that are suggested are done so founded on assessed need, are professionally defensible and are based upon sound evidence. The official 'diagnosis' is a small part of a much wider picture.

Appendix 1: Example behaviours which discriminate PDA from Autism / Asperger's Syndrome

PDA CHILDREN	AUTISTIC/ASPERGER CHILDREN
1. Passive early history in first year: often doesn't reach, drops toys, 'just watches'; often delayed milestones. As more is expected of him/her, child becomes 'actively passive', ie strongly objects to normal demands, resists. A few actively resist from the start, everything is on own terms. Parents tend to adapt so completely that they are unprepared for the extent of failure once child is subjected to ordinary group demands of nursery or school; they realise child needs 'velvet gloves' but don't perceive as abnormal. Professionals too see child as puzzling but normal at first.	Seems much more abnormal much earlier; lack of social response and lack of empathy alert parents, together with poor body language and stereotypic behaviour.
2. Continues to resist and avoid ordinary demands of life Seems to feel under intolerable pressure from normal expectations of young children; devotes self to actively avoiding these. Demand avoidance may seem the greatest social and cognitive skill, and most obsessional preoccupation. As language develops, **strategies of avoidance are essentially socially manipulative**, often adapted to adult involved; they may include: *Distracting adult: 'Look out of the window!', 'I've got you a flower!', 'I love your necklace!', 'I'm going to be sick', 'Bollocks! - I said bollocks!' *Acknowledging demand but excusing self: 'I'm sorry, but I can't', 'I'm afraid I've got to do this first', 'I'd rather do this', 'I don't have to, you can't make me', 'you do it, and I'll .....', 'Mummy wouldn't like me to'. *Physically incapacitating self: hides under table, curls up in corner, goes limp, dissolves in tears, drops everything, seems unable to look in direction of task (though retains eye contact), removes clothes or glasses, 'I'm too hot', 'I'm too tired', 'It's too late now', 'I'm handicapped', 'I'm going blind/deaf/spastic', 'my hands have gone flat'. *Withdrawing into fantasy, doll play, animal play: talks only to doll or to inanimate objects; appeals to doll, 'My girls won't let me do that', 'My teddy doesn't like this game'; 'But I'm a tractor, tractors don't have hands'; growls, bites. *Reducing meaningful conversation: bombards adult with speech (or other noises, eg humming) to drown out demands; mimics purposefully; refuses to speak. *(As last resort) Outbursts, screaming, hitting, kicking, trashes room; best construed as panic attack.	Can be reluctant, but ignores or shuts out pressure in a non-social way, without acknowledging others' needs. Has very few conscious strategies for avoidance. Doesn't adapt particular strategy for particular person. Doesn't have enough empathy to make excuses, and usually not enough empathic language either. Direct, not devious.

References

Ali, S., & Frederickson, N. (2006). Investigating the evidence base of social stories. **Educational Psychology in Practice***,* 22, (4), 355-377.

American Psychiatric Association. (2000). **Diagnostic and statistical manual of mental disorders: DSM-IV-TR**, Washington, American Psychiatric Association.

Bailey, A., & Parr, J. (2003). Implications of the broader phenotype for concepts of autism. **Novartis Foundation Symposium**, 251, 26–35.

Barone, D., Maddux, J., & Snyder, C. R. (1997). The social cognitive construction of difference and disorder. In D. Barone, J. Maddux, & C. R. Snyder (Eds.), **Social cognitive psychology: History and current domains** (pp. 397–428). New York: Plenum.

Baron-Cohen, S., Leslie, A.M., & Frith, U. (1985). Does the autistic child have a 'theory of mind'? **Cognition**, 21, 37-46.

Bellini, S. (2004). Social skill deficits and anxiety in high functioning adolescents with autism spectrum disorders. **Focus on Autism and Other Developmental Disabilities**, 19 (2), 78-86.

Bishop, D.V. (1989). Autism, Asperger's syndrome and semantic-pragmatic disorder: Where are the boundaries? **British Journal of Disorders of Communication**. 24, 107-121.

Bishop, D.V., Norbury, C.F. (2002). Exploring the borderlands of autistic disorder and specific language impairment: A study using standardised diagnostic instruments. **Journal of Child Psychology and Psychiatry**. 43, 917-929.

Brown, P. (1995). Naming and framing: the social construction of diagnosis and illness. **Journal of Health and Social Behaviour**, 4, 34-52.

Bauminger, N. (2002). The facilitation of social-emotional understanding and social interaction in high-functioning children with Autism: Intervention outcomes. ***Journal of Autism and Developmental Disorders***, *32*(4), 283-298.

Cameron, R. J. (2006). Educational Psychology: the distinctive contribution. **Educational Psychology in Practice**, 22 (4), 289-304

Christie, P. (2006). **Teaching and learning strategies for children with Pathological Demand Avoidance syndrome**, Information Service, Elizabeth Newson Centre, Ravenshead, Nottingham

Christie et al, (2012).**Understanding Pathological Demand Avoidance Syndrome in Children: A Guide for Parents**, Teachers and Other Professionals Jessica Kingsley Publications, London

Coleman, M., & Gillberg, C. (2012) ***The Autisms*** (4th edn).Oxford University Press.

Daniels, A. M., Rosenberg, R. E., Law, J. K., Lord, C., Kaufmann, W. E., & Law, P. A. (2011). Stability of initial autism spectrum disorder diagnoses in community settings. **Journal of Autism and Developmental Disorders**, 41(1), 110–121.

Deer, B. (2011) How the case against the MMR vaccine was fixed. **BMJ**. 342 53-57.

Dunham, Will (2007). "International study finds new autism genetic links". [online source] **Reuters**. Retrieved 2013-01-29.

Fallon, K., Woods, K., & Rooney, S. (2010). A discussion of the developing role of educational psychologists within Children's Services. **Educational Psychology in Practice**, 26(1): 1–23

Fombonne, E. (2008). Is autism getting commoner? – In 100 words. **British Journal of Psychiatry** 193(1), p. 59.

Geschwind, D.H. (2011). Genetics of autism spectrum disorders. **Trends in Cognitive Science**, 15(9), 409–416

Gillham, B. (1978) **Restructuring Educational Psychology**. Harlow

Gillott, A., Furniss, F., & Walter, A.(2001) Anxiety in high functioning children with autism. **Autism**, 5 (3).277-286

Gillman, M. (2004) 'Diagnosis and Assessment in the Lives of Disabled People: Creating Potentials / Limiting Possibilities?' in J. Swain, S. French, C. Barnes and C. Thomas (Eds.) **Disabling Barriers - Enabling Environments,** London: Sage Publications

Glaser, R. (1981). The future of testing: A research agenda for cognitive psychology and psychometrics. **American Psychologist**, 36, 923-936.

Happe, F.G.E. (1994) An advanced test of theory of mind: Understanding of story characters' thoughts and feelings by able autistic, mentally handicapped and normal children and adults. **Journal of Autism and Developmental Disorders**, 24, 129-154.

Hellgren, L., Gillberg, I.C., Bågenholm, A., & Gillberg, C. (1994). Children with deficits in attention, motor control and perception (DAMP) almost grown up: psychiatric and personality disorders at age 16 years. **Journal of Child Psychology and Psychiatry** 35, 1255–1271

Huerta M., Bishop S.L., Duncan, A., Hus V., & Lord, C. (2012). Application of DSM-5 Criteria for Autism Spectrum Disorder to Three Samples of Children With DSM-IV Diagnoses of Pervasive Developmental Disorders. **The American journal of psychiatry**, 169 (10), 1056-64

Hwang, B., & Hughe, C. (2000). The Effects of Social Interactive Training on Early Social Communicative Skills of Children with Autism. **Journal of Autism and Developmental Disorders***,* Vol.30*.* 331-342.

Hymans, M. (2008). How personal constructs about "professional identity" might act as a barrier to multi-agency working. **Educational Psychology in Practice**, 24(4): 279-288

Jordan, R. R., & Powell, S. D. (1995). **Understanding and teaching children with autism**, Chichester: Wiley

Klin, A. (2000) Attributing social meaning to ambiguous visual stimuli in higher-functioning autism and Asperger syndrome: the Social Attribution Task. **Journal of Child Psychology and Psychiatry**, 41, 831–46

Klin, A., Jones, W., Schultz, R., Volkmar,. F & Cohen, D. (2002).Defining and quantifying the social phenotype in autism. **American Journal of Psychiatry** 159, 895–908

Lai, M.C., Lombardo, M.V., Chakrabarti, B., Baron-Cohen, S. (2013). Subgrouping the Autism "Spectrum": Reflections on DSM-5. **Biology** 11(4)

Lintas, C., Sacco, R., & Persico, A. M. (2012). Genome-wide expression studies in autism spectrum disorder, Rett syndrome, and Down syndrome. *Neurobiology of disease*, *45*(1), 57-68.

Lord, C., Rutter, M., & Le Couteur, A. (1994). Autism Diagnostic Interview-Revised: a revised version of a diagnostic interview for caregivers of individuals with possible pervasive developmental disorders. **Journal of Autism and Developmental Disorders**, 24(5), 659-685.

Lord C., Pickles, A., McLennan, J. (1997). Diagnosing autism: analyses of data from the Autism Diagnostic Interview. **Journal of Autism and Developmental Disorders** 27, 501–517.

Lord, C., & Jones, R.M. (2012). Annual Research Review: Re-thinking the classification of autism spectrum disorders. **Journal of Child Psychology and Psychiatry**, 53, 490-509.

Lopez, S. J., Edwards, L. M., Teramoto Pedrotti, J., Prosser, E. C., LaRue, S., Vehige Spalitto, S., & Ulven, J. C. (2006). Beyond the *DSM – IV*: Assumptions, alternatives, and alterations. **Journal of Counseling & Development***, 84,* 259-267.

Macintosh, K., and Dissanayake, C. (2004) The similarities and differences between autistic disorder and Asperger's disorder; a review of empirical evidence. **Journal of Child Psychology and Psychiatry** 45(3) 421-434

Mahoney, W.J., Szatmari., P, Maclean., J.E, Bryson., S.E, Bartolucci., G., Walter, S.D., Jones, M.B. Zwaigenbaum, L. (1998).'Reliability and Accuracy of Differentiating Pervasive Developmental Disorder Subtypes', **Journal of the American Academy of Child and Adolescent Psychiatry** 37: 278–85.

Mandy, W. P. L., Charman, T., &Skuse, D. (2012).Testing the construct validity of proposed DSM-5 criteria for autism spectrum disorder. **Journal of the American Academy of Child and Adolescent Psychiatry**, 51, 41–50.

Maurice, C., Green, G., & Foxx, R. M. (Eds.). (2001). **Making a difference: Behavioral intervention for autism**. Pro-Ed.

McPartland, J. C., Reichow, B., &Volkmar, F. R. (2012).Sensitivity and specificity of proposed DSM-5 diagnostic criteria for autism spectrum disorder.**Journal of the American Academy of Child and Adolescent Psychiatry**, 51, 368–383.

Moore V and Goodson S (2003) How well does early diagnosis of autism stand the test of time? Followup study of children assessed for autism at age 2 and development of an early diagnostic service. **Autism** 7: 47-63

Moran.H. (2010). Clinical observations of the differences between children on the autism spectrum and those with attachment problems: The Coventry Grid. **Good Autism Practice** 11, 44-58

Newson, E. (1990). **Pathological Demand Avoidance syndrome: mapping a new entity related to autism?** Inaugural lecture, University of Nottingham

Newson E. (1998). ***Educational and handling guidelines for children with pathological demand avoidance syndrome (PDA).***Information service, Early Years Diagnostic Centre, Nottingham

Newson E, Le Maréchal K. (1998). Pathological demand avoidance syndrome: discriminant functions analysis demonstrating its essential differences from autism and Asperger's syndrome. In: Shattock P, Linfoot G, eds. **Psychobiology of autism: current research and practice**. University of Sunderland, UK,

Newson E, Le Maréchal K, David C (2003). "Pathological demand avoidance syndrome: a necessary distinction within the pervasive developmental disorders". **Archive of Disease in Childhood.** 88 (7): 595–600

Oberman, L.; Ramachandran, V.S. (2009). "Reflections on the Mirror Neuron System: Their Evolutionary Functions Beyond Motor Representation". In Pineda, J.A. Mirror Neuron Systems: The Role of Mirroring Processes in Social Cognition. **Humana Press**. 39–62

Oono, I. P., Honey, E. J., & McConachie, H. (2013). Early intervention delivered by parents for young children with autism spectrum disorders. ***Health*.** (4)

Resing, W and Figg, J (2006) Intervention-based psychological assessment: New approaches and perspectives, **Educational and Child Psychology**, 23, 34-35

Russell, G., & Norwich B. (2012). Diagnosis, dilemmas and de-stigmatization: Parental perspectives on the diagnosis of autism spectrum disorders. **Clinical Child Psychology and Psychiatry** 17, (2), 229-246.

Rutter, M et al., (1997) Genetic influences and autism, in DJ Cohen and FRVolkmar (Eds) Handbook of autism and pervasive developmental disorders, New York: Wiley

Selfe, L. (2002) Discussion Paper--Concerns about the Identification and Diagnosis of Autistic Spectrum Disorders, **Educational Psychology in Practice,**18 (4) 335-341

Skellern C, McDowell M, Schluter P. (2005) Diagnosis of autistic spectrum disorders in Queensland: variations in practice. **Journal of Paediatric Child Health**. 41, 413-18

Strain, P., & Hoyson, M. (2000). The need for longitudinal intensive social skill intervention: LEAP follow-up outcomes for children with autism. **Topics in Early Childhood Special Education***, 20,* 116-123.

Swedo, S. E., Baird, G., Cook, E. H., Happé, F. G., Harris, J. C., Kaufmann, W. E., et al. (2012). Commentary from the DSM-5 workgroup on neurodevelopmental disorders. **Journal of the American Academy of Child and Adolescent Psychiatry***, 51*(4), 347–349.

Tutt et al (2006) Educational Approaches in Autism: What we know about what we do **Educational Psychology in Practice**, 22 (1), 69-81

Vivanti, G., Hudry, K., Trembath, D., Barbaro, J., Richdale, A., & Dissanayake, C. (2013). Towards the DSM-5 Criteria for Autism: Clinical, Cultural, and Research Implications. **Australian Psychologist**. (48) 4 258-261

Volkmar F.R. & Cohen D.J. (1988) Classification and diagnosis of childhood autism. In **Diagnosis and Assessment in Autism**, E. Schopler&G.B. Mesibov (eds), 71-89. Plerium Press, New York, NY

Volkmar F, Klin A, Paul R, Cohen D, (2004).**Handbook of Autism and Pervasive Developmental Disorders**. NewYork: Wiley.

Volkmar, F., State, M., &Klin, A. (2009). Autism and autism spectrum disorders: diagnostic issues for the coming decade. **Journal of Psychology and Psychiatry**,50, 108–115.

Wakefield AJ, Murch SH, Anthony A, et al. (1998) Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive-developmental disorder in children. **Lancet**, 351 637-641.

Walsh, K.M. & Bracken, M.B. (2011). Copy number variation in the dosage-sensitive interval accounts for only a small proportion of autism incidence: A systemic review and meta-analysis. **Genetics in Medicine** (published online February 1, 2011),

Weintraub, S., &Mesulam, M-M. (1983). Developmental learning disabilities of the right hemisphere: Emotional, interpersonal, and cognitive components. **Archives of Neurology**, 40, 463-468.

White SW, Oswald D, Ollendick T, Scahill L. (2009). Anxiety in children and adolescents with autism spectrum disorders. **Clinical Psychology Review**, 29, 216–229

Wicks, A (2013). Educational Psychology in Practice: theory, research and practice in educational psychology **Educational Psychology in Practice**, 29(2): 152-162

Williams, K (2007) Diagnostic labelling of autism spectrum disorders in NSW. **Journal of Paediatric Child Health** 44, 108-13

Wing, L and Gould, J (1979) Severe impairments of social interaction and associated abnormalities in children: epidemiology and classification, **Journal of Autism and Developmental Disorders**, 9 (1), 11–29.

Wing, L. (1991), "The Relationship Between Asperger's Syndrome and Kanner's Autism", in Frith, U. (ed.), **Autism and Asperger Syndrome**, Cambridge, Cambridge University Press.

Wing, L., Gould, J., &Gillberg, C. (2011). Autism spectrum disorders in the DSM-V: Better or worse than the DSM-IV? **Research in Developmental Disabilities**, 32(2), 768–773.

Witwer AN, Lecavalier L. (2008).Examining the validity of autism spectrum disorder subtypes. **Journal of Autism and Developmental Disorders**. 51, 347–349

Wolff, S. (2000). Schizoid personality in childhood and Asperger syndrome. In A. Klin, F. R. Volkmar, & S. S. Sparrow (Eds.), **Asperger syndrome** (pp. 278-305)

Wright, B. A., & Lopez, S. J. (2002). Widening the diagnostic focus: A case for including human strengths and environmental resources. In C. R. Snyder & S. J. Lopez (Eds.), **The handbook of positive psychology** (pp. 26–44). New York: Oxford University Press.

World Health Organisation. (1992). **ICD-10 Classifications of Mental and Behavioural Disorder: Clinical Descriptions and Diagnostic Guidelines**. Geneva. World Health Organisation

Professional Practice Report 2: 'Can't Talk? Won't Talk?' - Selective Mutism, Cognitive Behavioural Therapy and the role of the Educational Psychologist.

Abstract

'Cognitive-Behavioural Therapy' (CBT) is promoted by the National Health Service (NHS) as a recommended 'treatment'/intervention for anxiety disorders and a significant amount of evidence has amassed which supports this position. Given that 'Selective Mutism' (SM) is now agreed collectively to be a manifestation of anxiety-related difficulties, it follows that CBT would be considered an appropriate and relevant approach to intervention with this 'disorder'.

However, studies which apply the CBT methodology for cases of SM are relatively sparse. The current case study aims to contribute to this emerging area of research by describing the process of using CBT principles to support a primary-age child, presenting behaviours consistent with SM, in a mainstream education setting. The intervention outlined in the current paper comprises elements of psycho-education, exposure to stimulus, and cognitive restructuring.

The study highlights the complexities of the SM phenomenon and the practicalities of embedding therapeutic principles within educational settings.

Emphasis is also given to the wider professional practice of educational psychologists involved in therapeutic approaches: are EPs well placed to engage in work of this nature, and if so, how does this contend with other role obligations?

The process of intervention as described in the paper is underpinned by best-practice guidelines outlined by the Division of Educational and Child Psychology (DECP), and assessment, monitoring and evaluation measures provided by the CAMHS Outcomes Research Consortium (CORC).

Intervention outcomes are positive, and provide further support that CBT may be applicable to SM.

Introduction

'He who does not understand your silence will probably not understand your words'

(Elbert Hubbard, American Philosopher - 1906)

'Selective Mutism' (SM) is a complex and often misunderstood phenomenon. Complex insofar as there is little agreement in literature as to the aetiology of the 'condition' and presentations can vary considerably; misunderstood insofar as prevalence rates are ambiguous and comorbidity with a variety of other conditions is high (Cohan et al, 2006).

The importance of intervening early with this population has been demonstrated (Kolvin & Fundudis, 1981; Schwartz & Shipon-Blum, 2005), and should intervention not be provided, most children who exhibit traits of SM will remain 'symptomatic' when compared with typical peers (Bergman et al, 2002). Although discourse of '*it's just a phase*' is common (Bergman et al, 2002), this assertion is not supported by evidence and spontaneous 'remission' is rare (Cohan et al, 2006).

The following paper outlines the use of 'Cognitive Behavioural Therapy' (CBT) as an intervention method for a young person presenting behavioural traits consistent with SM as outlined in the *'Diagnostic and Statistical Manual of Mental Disorders'* ('DSM-IV-TR, 2000').

Although pure behavioural interventions have been favoured historically (e.g. Haydon, 1980), there has been a recent change in discourse with CBT emerging as a promising intervention technique (Heimberg, 2002). However, peer-reviewed papers using this therapeutic approach are relatively rare – though findings in infrequent publications are encouraging (e.g. Ooi et al, 2012; Reuther et al, 2011). The current paper aims to contribute further to this emerging knowledge base by describing the use of CBT in an *educational* setting: much of the research available currently is situated within *clinical* settings.

Selective Mutism has become an area of particular interest throughout my professional practice as an educational psychologist. Although reported prevalence rates vary considerably -some suggesting that an educational psychologist may only 'meet' such a child every five years (Imich, 1998) - my own personal contact with individuals described as 'selectively mute' would refute this statistic.

I have developed an awareness that with this particular difficulty there are no 'quick fixes' and that the difficulty is multi-faceted and complex. Reflections on this observation are also provided in the ensuing study.

The following intervention charts the process cycle - consistent with guidance from the 'Division of Educational and Child Psychology' (DECP)'s 'Framework for Psychological Assessment and Intervention' (DECP, 2002, p. 27) - of an individual

piece of casework, using an evidence-based intervention approach. Use of this framework promotes adherence to psychologically sound and defensible practice and should underpin all psychological intervention.

However, before moving on to the intervention procedure, it is important at this early stage to bring the reader's attention to the complexities of the SM phenomenon, and particularly one of the most prominent and long standing discussions that has permeated the history of (s)elective mutism; the question of terminology.

Although variations can be found in the literature, the terms 'elective' and 'selective' should now be considered separate as they relate to historical developments in the understanding of this difficulty.

Section 1: Conceptualisation of Selective Mutism

(S) Elective Mutism: What's in a Name?

SM is now considered a *'childhood disorder,* [characterised by] *a persistent failure to speak in certain social situations'* (Cohan, 2006, p. 1085). Although acknowledged originally in 1877 – then termed 'aphasia voluntaria' for children who were able to speak but presented a voluntary 'refusal' – it was not until considerably later (in the DSM-III, 1980) that the phenomenon gained the label 'elective mutism' and became recognised as a valid, aetiologically distinct disorder.

The salient feature of this initial inclusion in the DSM-III continued to be that of a 'refusal' to speak, with shyness and anxiety being only considered associated factors;

'[A] c*ontinuous refusal to speak in almost all social situations. Some have delayed language development and articulation abnormalities'*

(Diagnostic Features for Selective Mutism from DSM-III, 1980)

With the discourse surrounding mutism at this time being related to a 'refusal' to speak, the phenomenon was considered aligned with oppositional, defiant conduct (Lowenstein, 1978). Interventions were therefore focussed on changing this 'problematic' behaviour, and approaches targeted primarily towards positive and/or negative reinforcement of the 'problem' behaviour were common: a child being placed in a 'negative' situation and being 'removed' from it when s/he spoke, for example a child being influenced strongly to say "goodbye" to the teacher before being permitted to go home from school. (Hayden, 1980).

However, these approaches constantly demonstrated limited efficacy:

"These interventions are at best "Band-Aid" therapies which eliminate the highly visible presenting symptom but do not address the reason these children engaged in this high cost behavior."

(Hayden, 1980, p. 10)

It is perhaps not surprising that due to the demonstrably limited effectiveness of the favored interventions at the time - and as research began studying the disorder from an anxiety-related perspective (e.g. Kolvin and Fundudis, 1981; Kumpulainen et al, 1998) - the conceptualisation of 'elective' mutism became unsatisfactory: a change in terminology thus occurred which positioned mutism as a 'failure' to speak in specific social situations (DSM –IV) and de-emphasized any 'oppositional' behaviour presented by the selectively mute child.

This view of selective mutism being a 'failure' to speak is the prevailing contemporary viewpoint, as demonstrated in the most recent edition of the DSM (DSM-V, 2013). (Appendix 1)

Given the current widespread acceptance of the term 'selective mutism' (SM) – and the now considerable research evidence conceptualising the phenomenon from an anxiety-based perspective (Cohan, 2006 for a review) - it is this terminology which is employed for the remainder of this paper.

However, this uncertainty relating to the terminology in selective mutism sets a precedent that continues when other aspects of the condition are considered. A detailed appraisal of the essential nature of selective mutism is now provided, with scrutiny given to contemporary literature within the domain.

The Essential Nature of Selective Mutism: Myths and Truths.

One of the most controversial aspects that can be found within literature relating to selective mutism is that of its epidemiology.

Although there is some agreement within the research relating to *gender specificity* (SM is reportedly more common in girls – Cunningham et al., 2004; Dummit et al., 1997; Kristensen., 2000), *age of onset or when initial concerns are apparent* (SM is noted typically before the age of five, though diagnoses often occur much later - Black & Uhde., 1995; Dummit et al., 1997; Steinhausen & Juzi., 1996) and that children described as selectively mute *regularly exhibit elements of the disorder prior to starting school* (e.g. Schwartz, Freedy, & Sheridan, 2006), there are a number of incongruences.

Though some of these papers may appear out-of-date, they could be considered pivotal in the history of understanding SM and thus remain relevant. Using search engines and databases (including Psychinfo, Psychnet, ERIC, Google Scholar, MEDLINE, ScienceDirect and Swetswise; and specific journals such as Educational Psychology in Practice and the European Journal of Special Educational Needs) with

the terms ‘Selective Mutism’ and ‘Elective Mutism’, with (Boolean) ‘epidemiology OR frequency OR prevalence’ returns results consistent with these seminal, albeit dated, research papers.

There has been, to date, no *conclusive* report as to how common this difficulty is, and studies which do report incidences within the population are considerably varied (Table 1):

Table 1 Showing recent studies outlining estimated prevalence rates (adapted from Viana et al, 2009)

Study	*Prevalence (percentage)*	*Country*	*N*	*Age*	*Sample*	*Diagnostic Measures*
Steinhausen and Juzi (1996)	.47	Switzerland	12,438	7.81 (mean)	Clinic	ICD-10
Kopp and Gillberg (1997)	.18	Germany	4093	9.74 (mean)	Clinic	ICD-10
Kumpulainen et al (1998)	1.90	Finland	2009	7-10 (range)	School -based	DSM-III-R
Bergman et al (2002)	.71	USA	2256	Kindergarten – Grade 2	School -based	DSM-IV
Elizur and Perednik (2003)	.76	Israel	8475	4-6 (range)	School -based	DSM-IV
Chavira, Stein, Bailey and Stein (2004)	.50	USA	190	8-17 (range)	Clinic	DSM-IV

Potential hypotheses for this variation in reported prevalence rates have been proposed, however the prevailing viewpoint is that children and young people who present with difficulties of this nature are *‘not seen as a bother’* (Standart and Le Couteur, 2003, pp. 155), are not a disruption to the school class room (Cleave, 2009) and the discourse reported commonly that they are ‘*just shy’* (Kumpulainen et al, 1998, p. 27).

Simply, it seems that due to the essential nature of the condition (i.e. *not* talking), that many young people presenting with this difficulty remain unnoticed until later in their life, with initial concerns being characterised as ‘shyness’ (Cleave, 2009). Once identified, the common belief that – without intervention – the young person will overcome their difficulties (an assumption unsupported by evidence, e.g. Haydon, 1980; Cohan, 2006) may present a further barrier to representing fully the frequency of this phenomenon. It will not be until a clearer understanding of this phenomenon emerges that epidemiological data can be derived.

However, ‘understanding’ this particular difficulty is not straight-forward. While concerns relating to the potential (mis)identification of SM – and the subsequent skewing of prevalence data - are abundant in the literature, a lack of consensus relating to the aetiology of the condition presents a further, considerable challenge: both for understanding the nature of SM, but also in ascertaining the most appropriate intervention response once a child with SM is identified correctly. An analysis of competing hypotheses is now provided.

Aetiology of Selective Mutism – Competing Theoretical Models

Several competing theories have been presented to explain the development of the condition, however ‘*little consensus exists regarding the cause or causes of the disorder’* (Cohan, 2006, p. 1086). Most researchers involved actively in this domain suggest that selective mutism is best conceptualised as arising from a complex relationship between various environmental and genetic factors (Viana et al, 2009). Nevertheless, there is a clear link between how the disorder is conceptualised, and the subsequent intervention that occurs.

Early research from a psychodynamic perspective cited exposure to trauma or unresolved internal conflicts as being the catalyst for the emergence of selective mutism (e.g. Yanof, 1996). Support for the unresolved internal conflict hypothesis has since waned following an increase in research from an anxiety perspective, however some research continues to explore the hypothesis that selective mutism develops as a response to trauma/abuse (e.g. Andersson and Thomson, 1998).

Although there *is* evidence that mutism can occur following a traumatic event (e.g. Manassis et al, 2003), the muteness which occurs typically following a stressful event is transitory and presents in *all* situations – a presentation distinct from *selective* mutism. Indeed, a significant amount of evidence is available which suggests that there is no apparent causal link between a trauma and the development of selective mutism (Black & Uhde, 1995; Dummit et al, 1997; Kopp & Gillberg, 1997; Steinhausen & Juzi, 1996).

The most prominent viewpoint noted in a review of the available literature suggests that selective mutism is best viewed as an anxiety disorder variant (Cohan et al, 2006). Evidence for this perspective can be found in two specific domains: a disproportionately high rate of psychopathological difficulties in families of individuals with selective mutism, and a significantly high level of internalising pathology of individuals with selective mutism along with high rates of co-morbidity with other anxiety-related difficulties.

Familial Influences

The evidence for selective mutism occurring more often within families with other anxiety-based conditions is convincing. Remschmidt et al (2001) reviewed the family circumstances of 45 children referred for difficulties relating to selective mutism and

found that a significant history of mutism in other family members was present: Mothers, 18%, Fathers, 9% and Siblings 18 % respectively, and that in the sample 'taciturnity' (minimal speech) was evident in Fathers (51%) and Mothers (44%).

To further support this claim, Kristensen and Torgersen (2001) investigated personality and symptom characteristics of parents of children with SM. Their findings suggest that in comparison to control families, mothers and fathers of children with SM had a much higher rate of shyness or social anxiety (Mothers: 38.9% in comparison to 3.7% in the control group; Fathers: control - .9% vs. 31.5%):

"These findings suggest that psychopathology, in general, and avoidance, anxiety, and a preference for being alone, in particular, may characterize families of children with SM."

(Viana, 2009, p. 59)

It appears that familial circumstances influence considerably the development of SM.

Internalising Pathology and Co-morbidity

The behavioural presentation of selective mutism has been argued, in a number of studies (e.g. Beidel & Turner, 2007; Black & Uhde, 1995; Dow, Sonies, Scheib, Moss, & Leonard, 1995; Garcia et al., 2004) to be consistent with that of a highly anxious state. Typical behaviours exhibited with selective mutism (e.g. avoidance, withdrawal from environment) are found commonly in other anxiety-based conditions suggesting that the core feature of the SM is *anxiety* with the 'failure to speak' criterion being the key factor that distinguishes it from other anxiety disorders: fear of speaking in unfamiliar circumstances or with unfamiliar people.

Indeed Kristensen (2000) found that individuals who meet the criteria for a diagnosis of SM also met the criteria for social phobia (67.4%) and separation anxiety disorder (31.5%). Similarly high levels of overlap between SM and other anxiety conditions were found by Black and Uhde (1992): 97% of children with SM met the DSM-IV criteria for social phobia, avoidant disorder or both.

Studies utilising different methodological approaches also appear to support the hypothesis that SM is a variant of an anxiety disorder: Achenback et al (2001) found that children with SM scored significantly higher than controls on personality rating scales in the areas of 'shyness', 'anxiety' and were 'at risk' of internalising worries, while studies which utilised teacher reports found 'elevated' levels of anxiety across young people with SM (Bergman, Piacentini, & McCracken, 2002; Vecchio & Kearney, 2005).

To further support this hypothesis, self-reports from children with SM suggest that, in comparison to controls, a significantly high level of social anxiety is present (Manassis et al, 2007).

The quantity of research, variety of methodological approaches used and subsequent confidence in findings relating to selective mutism being a variant of an anxiety disorder provides the most robust conceptualisation of the condition at this point in time: there is little research which opposes this view (Cohan et al, 2006). As such, it is with some confidence that the intervention at the heart of this paper (CBT) is justified given that *'CBT appears to be both efficacious and effective in the treatment of anxiety disorders'* (Otte, 2011, p.413).

A review of the most contemporary research relating to the use of CBT for selective mutism specifically is prudent.

Why Cognitive Behavioural Therapy?

Cognitive behavioural therapy has, in recent years, become the intervention of choice for a variety of psychological difficulties (Beck, 1993; Butler, 2006).This is evidenced further by 'National Institute of Clinical Excellence' guidelines (2011) in which CBT is the 'recommended' intervention for: depression ('mild', 'moderate' and 'severe' presentations), anxiety (panic disorder and generalised anxiety disorder), obsessive compulsive disorder, post-traumatic stress disorder and body dysmorphia (NICE, 2011, p. 13-16).

CBT interventions involve a combination of a number of elements: psycho-education relating to the nature of the presenting fear and/or anxiety, self-monitoring of thoughts, actions and response behaviours, cognitive re-structuring, and exposure to the feared stimulus (Otte, 2011): different elements are emphasised in response to the nature of the presenting difficulty.

For anxiety disorders specifically when conceptualised as excessive fear and subsequent avoidant behaviours in response to objects or situations where no danger is present - CBT is considered the 'gold standard' intervention method (Otte, 2011). A number of meta-analyses have been completed which appear to support this position both with adults (e.g. Hofman, 2008), and children (In-Albon and Schneider 2007):

'The current findings are consistent…CBT is effective for children with anxiety disorders'

(In-Albon and Schneider 2007, p. 20)

Why not Cognitive Behavioural Therapy?

Although it appears that there is a wealth of literature which suggests CBT as being an efficacious therapeutic intervention for anxiety difficulties (e.g. Butler et al 2006, meta-analyses), some consideration must be given to alternative approaches; why were these methodologies not selected for the current intervention?

Solution Focussed Brief Therapy (SFBT): SFBT is a therapeutic approach which focusses on 'solutions' to any challenges that are faced. It is a 'strength-based approach' (Woods, et al, 2010) and emphasises the resources that people possess, and how these can be used effectively in constructing ways forward, as opposed to *a 'detailed analysis of problem dimensions'* (Woods, et al, p.5).

While there is a developing body of research which suggests that SFBT may be a valuable approach to therapeutic intervention, there remain concerns about the methodological rigour used in many of the studies to date:

'several limitations are apparent within the current small evidence base on the effectiveness of SFBT, including the absence of control or comparison groups, limited use of reliable and valid outcome measures and limited information about how different elements of therapy may be utilized and combined with different problem areas, client types and complementary interventions.'

*(*Woods et al, 2010, p. 6)

For the young person at the heart of the current paper, SFBT was not considered an appropriate approach for two dominant reasons: 1 – a less comprehensive evidence base relating to the use of SFBT for intervention in anxiety difficulties when compared to CBT, and 2 – the necessity for the an individual to utilise their own resources in overcoming their difficulty: for a young person with selective mutism, I considered it unlikely that they would engage willingly in discussion of their own skills at managing the problem due to the fundamental nature of the difficulty being supported (i.e. *not* talking).

Simply, in SFBT there is much more of an emphasis on the 'clients' own resources, and them engaging in verbal communication as part of the process. I posited that this would be a source of considerable anxiety and pressure for Ben (pseudonym – focus of this intervention), and would be damaging to the therapeutic process.

A second, perhaps less relevant alternative therapeutic approach, known as 'Personal Construct Therapy' (PCT- Kelly, 1955; Butler and Green 2007) was also considered yet not selected as the therapeutic approach of choice. The underlying assumption which provides a framework for PCT is *'the notion of constructive alternativism'* (Butler and Green, 2007, p. 3) and *'that all our current perceptions, insights and understandings are open to question and reconsideration'* (p.3).

In this therapeutic approach, one of the most essential principles can be surmised as 'If you want to know what's wrong, then ask' (Butler and Green, 2007, p.4). Again, as with the criticism of SFBT, the requirement for the individual engaging in therapy to be an active, vocal participant in the process is fundamental to the therapeutic framework. Again, I considered that this requirement would be a significant challenge for the young person at the heart of this process and may be a potential barrier for them moving forward with their difficulty.

Overall, when CBT, PCT and SFBT were considered, CBT emerged as the most appropriate therapeutic approach; not only due to the significant evidence base which underpins the approach, but also due to the underlying principles appearing more appropriate for the presenting concern.

CBT and Selective Mutism

The evidence for CBT as an intervention method for SM is sparse. This may be due to the aforementioned under-identification of young people with this particular difficulty (and thus opportunities to complete work of this nature are exceptional), or perhaps due to the significant overlap of SM with other forms of social anxiety. CBT is the most thoroughly studied non-pharmacologic approach to the treatment of social anxiety disorder, and its efficacy has been demonstrated in a large number of investigations (Heimberg et al, 2002).

Through searching the literature, there are three studies which specifically use CBT methods for intervention in SM (Ooi et al, 2012; Fung et al, 2002; Reuther et al, 2011) – however each study demonstrates methodological concerns which prevent the sceptical reviewer from concluding that CBT was efficacious.

The study by OOi and colleagues (2011), which based in Singapore, used an internet based CBT programme for 5 Singaporean children that demonstrated characteristics of selective mutism as defined by the DSM-IV. The programme consisted *'of eight training sessions, followed by six practice sessions [of] exposure using social skills training'* (p. 447). Findings presented in this paper are encouraging, with the authors suggesting that *'Post treatment, four out of five of the children improved on their verbal communication in different settings' (*p. 448). However, caution must be heeded for two dominant reasons: of the five children included in the cohort, three completed the CBT programme in *combination* with pharmacological intervention (fluoxetine – a Selective Serotonin Reuptake Inhibitor with anti-anxiolytic properties) meaning that it is not possible to judge the efficacy of the CBT intervention in *isolation*. Further to this, given the small sample size it is difficult to suggest with confidence how reflective these findings may be to the wider SM population. Nevertheless, the results are promising.

Fung (2002) also presents promising findings. Although a single case-study design is used, a number of CBT elements are included (Psycho-education, cognitive restructuring, anxiety- management, self-modelling, social skills training) and outcomes appear consistent with other studies which suggest that CBT may be an efficacious intervention in SM. The study has limitations due no follow-up being reported so long-term efficacy cannot be judged; though pre/post measures suggest global improvements in social communication.

Reuther (2011) also employed a case study design, again using pure CBT principles (psycho-education, exposure, cognitive restructuring, social skills, and maintenance

and relapse prevention), and once more the use of CBT has provided optimistic results for the young person:

‘The client's symptoms were greatly improved by the end of treatment based on fear hierarchy ratings, self-report and parent-report questionnaires, and child and parent clinical interviews. In addition, at discharge the client no longer met criteria for selective mutism. Improvements were maintained when the client was reassessed at 1-month and 6-month follow-up appointments.’

(p. 156)

Again it is difficult to determine whether these findings are generalizable to the wider SM population. Nevertheless, it appears that the evidence base for the use of CBT in selective mutism is growing, and the findings are promising.

Thus far, an outline of the current critical issues with SM has been provided, along with an appraisal of the use of CBT with this population: it is to the CBT intervention used for the current study that this paper now turns.

Section 2: Intervention Process

Descriptive Statistics and 'Problem' Clarification

Ben (pseudonym) is an 8 year old boy of Asian ethnicity. He currently attends a mainstream school in a large West-Midlands local authority on a full-time basis. He is in year four.

Ben's anxiety difficulties in relation to talking have been long-standing, occurring since he began Nursery school. Although concerns were present from this young age, due to the discourse often surrounding SM children (as mentioned in the previous section) and *'growing out of it'*, no intervention was implemented until he reached Year 2 (age 6). Spontaneous remission was anticipated, though this proved fruitless; a finding consistent with SM research.

Ben received intervention initially from the Local Authority's behaviour support team. This intervention focussed on behaviour modification by positive reinforcement, however again consistent with the findings of previous research noted earlier, this intervention was unsuccessful at resolving the observed difficulties. Due to the persistence of the concern, Ben's case was referred to the educational psychology service.

Ben is reported to be achieving at an average level in school – though assessment is challenging due to taciturnity. He demonstrates a level of anxiety related *only* to talking within the school environment; he has taken part previously in a school talent show where he performed using a Dhol drum which involved no verbal communication.

Otherwise, in class Ben presents as an anxious and shy young person, with clear difficulties relating to social interaction. He does, however, have a close group of friends who are reported to be supportive of his difficulties: he interacts through the use of gesture and expression. Ben's friends have previously encouraged him to speak, although their enthusiasm has waned following persistent refusal. As such, relationships have developed where Ben's friends will interpret his gesturing and then vocalise on Ben's behalf.

In the home environment Ben speaks fluently, loudly and clearly, although only to familiar people; if a new person is introduced in the home, the SM behaviours persist. When I completed a home visit, no verbal communication was presented. When talking, he displays a high level of language competence and his verbal communication is at a syntactically and semantically appropriate level for his age as reported by his Mother.

Ben's presenting difficulties are consistent with those outlined in the DSM-IV-TR for SM (Appendix 2)

Pre-Intervention Assessment Measures

Consistent with professional practice guidelines outlined by the DECP, once clarification has been gained relating to the essential nature of the presenting difficulties, it is imperative to complete assessment measures to ensure that subsequent 'problem' formulation is robust and applicable:

''*We believe that psychological assessments should involve a creative investigation of a broad range of hypotheses that builds on research from all areas of psychology.'*

(DECP, 2002, p. 24)

It is therefore of paramount importance that the assessment measures used are appropriate for the situation. Measures recommended by the 'Improving Access to Psychological Therapies (IAPT)' programme - approved by the National Institute of Health and Clinical Excellence (NICE) for people with anxiety difficulties - were used in the initial data gathering stage, for monitoring the progress of the intervention on a session-by-session basis, and for reviewing and evaluating the efficacy of the programme at the conclusion. Copies of the completed measures used can be found in Appendix 3.

Measure	When used	Desired outcomes
Strengths and Difficulties Questionnaire (SDQ) – Goodman, 2001	Prior to programme beginning and at the programme conclusion.	Pre / post intervention measure to evaluate efficacy of CBT intervention.
Revised Children's Anxiety and Depression Scale (RCADS) – Chorpita et al, 2005	Prior to programme beginning and at the programme conclusion.	Pre / post intervention measure to evaluate efficacy of CBT intervention.
Child Outcome Rating Scale (CORS) – Campbell & Hemsley, 2009	Session by session	To monitor progress session-by-session

In addition to these psychometric measures, I devised a non-verbal assessment tool (influenced by Johnson and Wintgens, 2001 SM resource manual) which would allow me to determine the level of anxiety Ben felt in a number of locations or situations within the school day (Appendix 4). This assessment measure also allowed me to

measure Ben's motivation to change, and to determine if there were any *physical* locations within the school where his anxiety was lower.

Evidence based Formulation and Interpretation of Assessments

"Educational psychologists should convey information about the results of tests and assessments in a way which guards against misinterpretation and also assists with interpretation"

(DECP, 2002, p. 17)

The assessment measures listed above provided a rich picture of Ben's individual difficulties.

Strengths and Difficulties questionnaire: this measure has regularly demonstrated reliability in outlining accurately any characteristics of 'psychopathology in youths' (e.g. Chorpita et al, 2001). When scoring, the process provides separate 'predictions' for three groupings of disorders, in the domains of anxiety/depression, conduct and hyperactivity/inattentiveness. Each is given a result of: unlikely, possible or probable.

Through completing this pre-intervention measure with Ben's Mother, it emerged quickly that she had some considerable concerns about the behaviours that were being presented by her son. The administration process was straight-forward, though Ben's mother did express concern that some of the questions seemed unrelated to her son's difficulties (e.g. 'Good attention span, sees work through to the end').

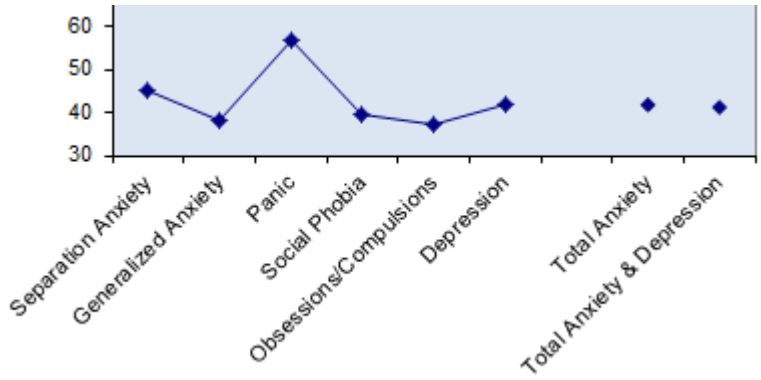
Although a number of positive traits were noted (e.g. being considerate of other peoples' feelings), *Ben was considered to have a higher than average level of 'Emotional Distress'*. This is consistent with typical behavioural presentation for SM.

Revised Children's Anxiety and Depression Scale (RCADS): this measure was used to assess Ben's levels of Anxiety and/or Depression.

As can be seen on the graph below (Graph 1), Ben's score for 'Panic' was in the high range while his other scores were average: panic behaviours being most prominent during times where speech is required. This profile is consistent with that of SM.

The administration of this measure presented a challenge due to the nature of Ben's difficulties. The young person, in a 1:1 setting, is required to select an answer (Never, Sometimes, Often, Always) to each question presented. A significant benefit of these structured measures is the opportunity to then have a discussion relating to the answer that the young person provides. With Ben this was not possible, and thus it may be argued that – while his scores can be collated to give a 'result' (Graph 1) – the qualitative data provided is limited.

Graph 1: showing Ben's RCADS t-scores.



Child Outcome Rating Scale (CORS) (Appendix 6): This measure was used on a week-by-week basis to give Ben a 'voice' in the intervention as it allowed him to provide immediate feedback on what was working and what was not. A significant amount of research has been completed using this measure: the CORS demonstrates impressive internal consistency and test-retest reliability (Miller et al., 2003; Duncan et al., 2003; Bringhurst et al., 2006; Duncan et al., 2006; Campbell & Hemsley, 2009)

This measure is appropriate for the current case due to the limited amount of verbal communication that is required in administration. The young person is asked to 'score' various questions (e.g. 'How am I doing?') on a likert scale. Although qualitative information can be elicited when using this measure, as mentioned before the nature of Ben's difficulties prevented this from being possible. However, his 'ratings' on the scales provides an immediate and visual representation of progress which is useful for both practitioner and young person.

Therapist – Client Relationship Considerations (Pre Intervention)

A positive therapeutic relationship is often considered a crucial change mechanism (Shirk and Karver, 2003) when engaging young people in therapy. Indeed this has been a long-standing position in a variety of different therapies (e.g. Axline, 1947; Freud, 1946).

However, more recently, emphasis on the importance of a therapeutic relationship for CBT specifically has developed; studies exist (e.g. Cummings et al, 2013) which suggest that positive, reciprocal rapport is the '*sine qua non'* (essential condition) for CBT with children and young people. Indeed, some authors (e.g. Gillbert and Leahy, 2007) suggest that it is important to *'recognise how the therapeutic relationship influences outcomes'* (p. 8) and that – given the emphasis on CBT as an approach underpinned by robust scientific and research-driven methods – the relationship between 'therapist' and 'client' is a variable which one must account for when considering an intervention.

With this in mind, the initial sessions with Ben were devised with the intention to build rapport, create a safe and low-anxiety environment and develop a trusting, reciprocal professional relationship. Due to the essential nature of selective mutism, it was important to not time-limit the initial rapport building sessions – and to progress at a rate at which Ben felt comfortable.

In reality, rapport building was relatively straight-forward. Ben had expressed previously to both his parents and his class teacher that he would *'like to speak in school'* (Appendix 5) and he demonstrated an awareness of his circumstances. This is suggestive of Ben's state of readiness to change – and it is a reasonable hypothesis to suggest that rapport building was uncomplicated due to this: communication was developed via hand gestures ('give me 5', 'thumbs up/down') which then moved to single words responses (yes/no). Further to this, it seems likely that as I was not a 'new' person to Ben, having been in and around school for various reasons over the preceding two years, and in Ben's classroom for a number of sessions, that I would have been a familiar face. This may have contributed to the relative ease of building rapport and may have contributed positively to the therapeutic relationship.

After the first two sessions Ben presented as relaxed and enthusiastic about the CBT process (although it should be noted that during these two sessions the 'demands' placed upon him were minimal, and he was not required to speak).

Cognitive Behavioural Therapy Process

Ten sessions of cognitive behavioural therapy were conducted over a 13 week period, each session lasting for an average of 30 minutes. The process was as follows:

Psycho-education

'Psycho-educational intervention appears to be a helpful intervention. Results…suggest that patients can achieve a clinical and significant improvement in symptoms of psychological distress.'

(Houghton and Saxon, 2007, p.107)

Through using materials from Stallard (2002) (Appendix 7) work began - following rapport building sessions - on developing Ben's *understanding* of SM. It emerged that Ben's *core belief* was that if he began to speak in class, then his peers would laugh at him and he would feel embarrassed. It also became clear that Ben's physical reaction to an anxiety-raising stimulus was substantial: he would shake physically, demonstrate body rigidity, squirm and look generally uncomfortable. This is consistent with many other reports of SM presentation (e.g. Kearney and Vecchio, 2006).

As such, the psycho-educative process lasted for 3 sessions with focus on:

- Explaining the process of CBT,
- Understanding that anxiety is a 'natural' process and that – at times – can affect every person, and;
- Sympathetic nervous system / physiological response to anxiety.

(Appendix 7)

Exposure to stimulus

Ben's class teacher was fully understanding of the intervention procedure and, via a meeting where the therapeutic process was negotiated, supported potential strategies to introduce Ben to the anxiety-provoking stimulus. Through the literature review, conducted to provide an accurate problem formulation for Ben's presenting difficulty, a common theme recurred of the 'Mystery Motivator' (e.g. Rhode, Jenson, & Reavis, 2010) being used as a stimulus exposure method. 'Mystery Motivators' have demonstrated efficacy at encouraging a child exhibiting SM to respond positively to an anxiety-provoking stimulus. (Kehle and Bray, 2010)

The 'Mystery Motivator' consists of a plain envelope, displayed publically within the classroom, with only a large 'question mark' and the target young person's name upon it. Within the envelope is a reward that is desired by the target young person. The *whole class* are informed that the 'mystery' will be given to the target young person when it is asked for in an appropriate way. The requirement for receiving the reward can be intensified as required (i.e. beginning with a whisper that only the class teacher can hear, then increasing to a tone that is audible to the whole class). As the exposure to the anxiety-provoking stimulus increased week by week, there is little opportunity for stalling on progression. Although there may be concerns relating to the ethical stance of this intervention, these concerns can be mitigated by the class teacher using the intervention measure in a sensitive and appropriate way (e.g. not 'pushing' the young person too far out of their comfort zone).

In the current intervention, this procedure – along with the more didactic, cognitive elements of CBT – demonstrated considerable efficacy. Although for the first two weeks of therapy (rapport building) the 'Mystery Motivator' remained unopened, once the elements of cognitive restructuring and psycho-education had begun, Ben began to ask for the mystery in a pre-determined tone. Simply, in the 1:1 session with Ben I would suggest that *"'for this week, you can have the mystery motivator if you…'ask for it at a whisper that the class teacher can hear', 'ask for it with one of your friends near-by', etc."*

This was one element of Ben's 'homework' for the following week. After this, I would inform the class teacher of the success criteria for opening the mystery envelope, and then the class-teacher would make the judgement as to whether Ben had

achieved this. Although towards the end of the intervention this strategy became less successful (possibly due to the rewards becoming less aspirational, or diminishing motivation towards the process), for the purposes of the intervention the strategy displayed significant efficacy.

Cognitive restructuring

As elicited during the psycho-educative process, Ben's 'core belief' was that if he began to speak in class, then his peers would laugh at him and he would feel embarrassed. It was this belief that became the focus of the didactic, cognitive element of the intervention.

Using materials from Stallard (2002) (Appendix 7), a process began whereby Ben's 'core beliefs' were challenged in a safe and rational way. Anxious children tend to overestimate the likelihood of negative outcomes in anxiety-provoking situations (Rapee & Heimberg, 1997) – and this appeared to be the presenting circumstances for Ben.

The relationship between thoughts, feelings and actions were introduced with the core belief ('Everybody will laugh at me'), being challenged by evidence which does not support this ('People are my friend', 'People support me', 'People don't laugh when I whisper', ''People don't laugh at others when they are speaking').

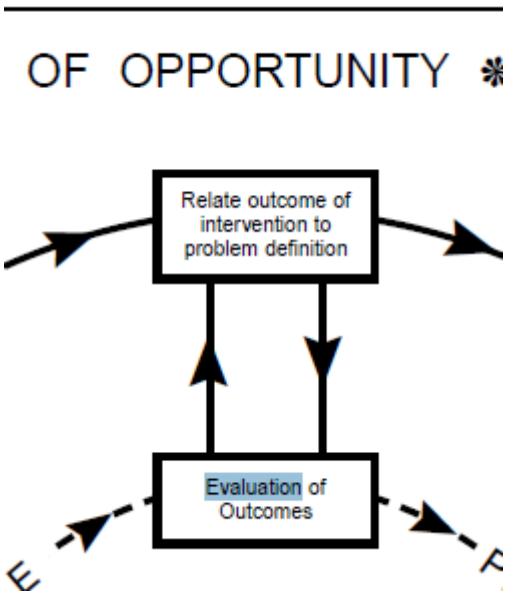
This process lasted for 4 sessions with focus on:

- Core belief and evidence which does not support this,
- Identification of negative automatic thoughts (NATs) x 2 and;
- Development of a rational response to NATs.

Evaluation of Intervention

Repeating the initial assessment measures provides a framework for evaluating the efficacy of the intervention. Although anecdotal reports were positive *('Ben is much more confident to speak – although we're not 100% there yet, we're moving in the right direction'*), it is crucial to provide observable, quantifiable evaluation where possible. This is also consistent with DECP guidelines (Picture 1). Copies of the post-intervention measures can be found in Appendix 8

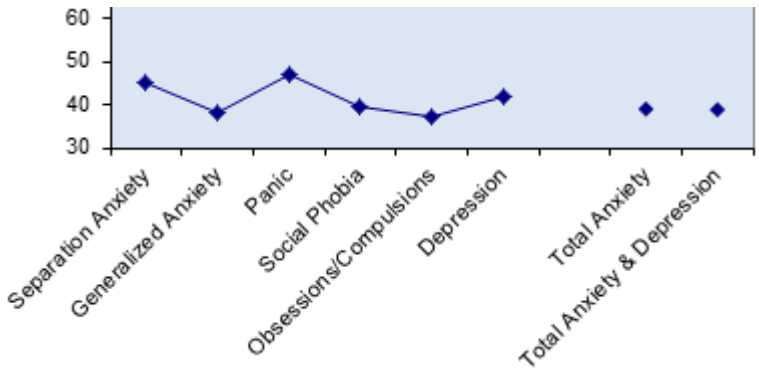
Picture 1: DECP Best Practice Guidelines for Evaluation of Intervention



Strengths and Difficulties Questionnaire (SDQ): I completed the SDQ again with Ben's Mother. She reported anecdotally that Ben seemed more confident at school, and the reports about his developing verbal confidence were encouraging. Although she still had significant concerns relating to how the Mutism may be affecting his development, she was pleased with the progression. This is reflected in the post-intervention SDQ which indicated that Ben's level of '*overall stress*' would now be – on this particular measure – within the '*average'* range.

Revised Child Anxiety and Depression Scale: Ben's scores for 'Panic' decreased overall, while his scores in other areas remained stable. For items *'when I have a problem I feel shaky'* and *'I suddenly start to tremble or shake when there is no reason for this'* a reduction was noted (Graph 2).

Graph 2 showing the reduction in 'Panic' behaviours t-scores from the initial assessment.



Intervention Summary and Follow-up Arrangements.

Although there are some persisting concerns, the current intervention did have specific positive outcomes, particularly in the reduction of panic. Ben can now talk in front of peers – and has done so in an audible and clear tone – however he does still get nervous. He is much more confident at asking for the 'Mystery Motivator', and the next steps will involve increasing the exposure to the anxiety provoking stimulus. Ben will now answer his name during registration in a tone that the whole class can hear – although full sentences remain sporadic. Overall however, given the relatively short duration of the intervention, the outcomes have been satisfactory. This provides further support that CBT may be an efficacious intervention in Selective Mutism.

Intervention has now ceased and a review of any progress will be completed within an 8 week time-frame. This is so that the longer-term efficacy can be judged, but also to determine whether any further intervention (perhaps using a different modality, e.g. the 'sliding in' behavioural approach – Johnson and Wintgens, 2001) is required.

School and parents are to continue to support Ben sensitively, with an increased awareness that behaviours typical of SM are not exhibited due to 'defiant' conduct, but more due to anxiety relating to social or environmental triggers. As Ben is about to join a new year group, it was considered appropriate that *all* intervention terminated so that he could have a 'fresh start', equipped with strategies learned throughout the CBT process.

Section 3: Reflections for the Educational Psychologist and Discussion

'The time for recognition of the place of therapy in educational psychology practice has come'

(MacKay and Greig, 2007, p. 6)

The role of educational psychologists and their relationship with therapeutic practice has been inconsistent. Although MacKay (2007) charts the 'rise and fall' of therapy in educational psychology practice – suggesting that therapy has been a key role from the very foundations of the profession – it is his assertion that *'Educational psychologists are a key therapeutic resource for young people, especially in educational contexts such as schools*' (p. 16) and that '*the educational and child psychologist brings to the therapeutic process a unique and crucial body of knowledge, skills and expertise'* (p. 6). However, a significant concern for EPs is the demarcation of the role:

"What are educational psychologists doing with 'clinical' cases? Is therapy for mental health issues an 'educational' concern?"

(Mackay, 2007, p. 11)

Given that the difficulty at the heart of this current study is aligned closely with a clinical 'disorder', in this current section I will outline arguments 'for' and 'against' EPs working therapeutically.

Educational Psychologist as 'Therapist': 'For'

If, as is proposed in Cameron (2006) *'applied psychologists approach human problems with specific and well-established psychological perspectives in mind'* (p. 293), then the 'human problem' of Selective Mutism falls squarely within this remit: not only are there clear etiological links with psychological occurrences (e.g. anxiety), the evidence suggests that there are contextual and environmental influences which contribute considerably to the emergence of the disorder, and family/school participation in intervention has been mentioned as being a critical factor in success (Anstendig, 1998; Cohan et al., 2006; Standart & Le Couteur, 2003).

The educational psychologist is positioned uniquely to operate at these multiple levels due to their access to young people directly, their parents/guardians and also the wider systems of a school. Additionally, '*EPs are the professionals most thoroughly embedded in educational systems; they have the widest training in child and adolescent psychology and are therefore best poised to be generic child psychologists'* (MacKay, 200,7 pp.5). Acting as the 'bridge' between these systems provided an opportunity for a robust problem formulation to be devised, and subsequently, an appropriately tailored intervention.

One key factor that distinguishes educational psychology from clinical psychology is the EPs knowledge of the school context: often the educational psychologist will have considerable familiarity with the school and resilient professional relationships with staff (Atkinson et al, 2013). This relationship enables the EP to propose intervention strategies that are applicable to the context specifically, and can then support with the implementation. It also seems likely that due to the EP being 'embedded' within the school, that any suggestions may be received more readily than those offered from 'external' agencies. As an EP works both *within* and *external to* the context, they are afforded a distinctive position in providing therapeutic support and building capacity for staff to support children with complex difficulties.

In addition, the opportunity to perpetually 'review' any progress or changes in circumstances allows for any intervention to be amended or re-formulated as (or when) required – this continual checking and testing of hypotheses is consistent with the guidance provided by the DECP: '*Educational psychologists should rigorously evaluate their involvement with young people, schools and families in order to review and modify intervention strategies.* (p. 17-18). Given that EPs will have considerable personal interaction with all key parties involved in the intervention, any required modifications can be implemented swiftly and without disruption to the therapeutic practice.

Plainly, a strong argument for EPs being involved in therapeutic practice is this unique position *between* systems: *'EPs are 'well placed' to play a key therapeutic role'* (Grieg, 2007, p. 20) along with the underpinning knowledge of psychology. This unique position was demonstrated clearly within the current intervention and contributed significantly to the positive outcomes noted. Indeed more widely, Atkinson et al, (2013) established that 92% of 455 UK-based EPs stated that they used therapeutic interventions in their practice and that most (82.9%) reported using them in direct, individual work with children and young people: it is clear that therapeutic practice remains a common feature of EP practice, and justification for this is patent.

Educational Psychologist as 'therapist': 'Against'

MacKay (2007) highlights a number of factors that may have contributed to the decline of EPs working therapeutically. In the context of the current case, there are a number of elements worth consideration that arguably exemplify the wider concerns for EPs working in a therapeutic manner; primarily, supervision of therapeutic practices and the efficiency and 'value' of EPs working in this mode.

Supervision: While arguments have been presented which suggest that EP core competencies are consistent with the skills required for CBT (e.g. Squires, 2010), at present, therapeutic practice is a choice for the practitioner psychologist; albeit popular – Atkinson et al, (2013).

Given the wide variety of therapeutic modalities that an EP *may* be involved in it is likely that favoured approaches develop for an individual practitioner. As such, there is considerable inequity between EPs as to their skill-set and familiarity towards specific therapeutic approaches: Cognitive Behavioural Therapy, Solution Focussed Brief Therapy, Counselling, etc.

While this is, on some levels, positive for the profession (in terms of demonstrating a wealth of proficiencies), for supervision it is potentially problematic. Specific questions relating to a particular approach may not be answerable directly during the typical supervision that an EP receives - requiring additional supervision (senior or peer) to be sought. This is consistent with guidance provided by the DECP:

"Supervision of [therapeutic] work embraces all the [EPs] skills mentioned [for typical supervision]. It will also involve specialist knowledge, competence and experience on the part of the supervisor. Hence if an EP were using a specific technique, such as Cognitive Behaviour Therapy (CBT), they should access specialist supervision"

(DECP supervision guidance, 2010)

EPs involved in therapeutic practice must therefore consider *how* they might access specialist supervision, and who might provide it. This is a potential barrier to work of this nature, and should be of primary consideration: indeed this concern is noted in Atkinson et al (2013): *"Both supervisor and supervisee need to "know the limits of*

their practice and when to seek advice or refer to another professional" (Health Professions Council (HPC), 2009, p. 7). This may have financial and time costs for all involved – a consideration for the expenditure required for therapeutic interventions

Efficiency and Value for Money: The current educational landscape is changing rapidly – in part due to a reform of the way in which school funding is allocated (Department for Education, 2013). In summary, the changes mean that a number of Local Authority services which were funded previously by direct Government financial support will no longer be subsidised in this way: schools will have more autonomy in how their budget is allocated. For the educational psychologist, this adds a further level of complexity: while Statutory obligations remain unaffected, *other* aspects of the EP role will likely require additional funding – therapeutic work included.

However, *'the idea of schools purchasing therapeutic services raises a number of ethical and logistical issues'* (Atkinson et al, 2013, p. 64) yet *'if mental health issues in educational settings are not addressed by educational psychologists through a fresh commitment to therapeutic work then they will be bought in from other sources.'* (Mackay, 2007, p 3.). This is likely to be a professional challenge going forward, and there remains no current consensus as to the conclusion.

The newest draft of the Special Educational Needs Code of Practice (October, 2013) suggests that emotional health of children and young people is a specific priority; '*The local authority **must** set out in their local offer a description in broad terms of the special educational provision…for supporting emotional and social development'* (p. 45) however, educational psychologists are not named specifically as being the professionals tasked with supporting this endeavour:

"Where more specialist provision is required, schools, colleges and early years providers should have clear arrangements in place with local health partners and other organisations for making appropriate referrals to Child and Adolescent Mental Health Services (CAMHS). This might include schools and colleges commissioning specialist CAMHS directly"

(p. 64)

Given these changes, educational psychology services will need to determine if, or where, there is a continuing role for EPs in meeting the national priority of supporting emotional and social development.

Proficiency: There is a developing need to demonstrate the value of a therapeutic service to commissioning bodies. If EPs are going to stake claim to therapeutic practice, robust practice mechanisms and evaluation methods must develop to ensure competency is guaranteed. This may require reforms at a 'service' level to

ensure compliance with regulating bodies; a cost/benefit analysis is likely to be required to determine whether therapeutic work is a sound investment/decision.

Service priorities: It is a long-standing discussion that EPs have competing demands on their time both in the UK (Atkinson et al, 2013) and internationally (Suldo et al, 2011; Yeo and Choi, 2011): if therapeutic work is to become part of staple practice, wider service priorities will need to develop to reflect this. Given that EPs are often working to capacity, does therapeutic practice occur at the 'expense' of other activities? If yes, then to the detriment of which other activity? These are questions worthy of further discussion, particularly at this juncture of significant change.

Discussion

There are plainly a number of reflections that the practitioner psychologist must be aware of when considering therapeutic practice yet no straight-forward answers. Therapeutic practice, it seems, remains an individual-specific choice, dependant on a number of variables. However, given the dramatic changes that appear to be occurring nationally, this might be an appropriate time for the EP profession to determine collectively if 'we' are eager to work in this mode, and then devise a strategy as to how therapeutic work may become a 'core' part of business.

For Ben, although concerns persist, available evidence and evaluation suggests that the current intervention has demonstrated a level of success. This outcome appears consistent with other research in this specific domain, and illustrates further support that CBT *may* be an appropriate and efficacious intervention when working with young people described as selectively mute.

More research is needed clearly to develop confidence in this intervention strategy, although initial findings seem positive – indeed this would appear to be a reasonable position given the demonstrated parallels between selective mutism and other anxiety difficulties, and the high level of confidence in CBT as an intervention for other manifestations of anxiety.

This study highlights further the impact that SM can have on the emotional, social and behavioural development of a young person; the potential barriers that arise in terms of accessing education and also any subsequent outcomes that may be achieved. These difficulties are clearly within the remit of the educational psychologist, further supporting the value of practitioner psychologists operating within a framework of therapeutic practice, however the notion of the EP working at an individual, therapeutic 'level' brings with it the same concerns that have been endemic within the history of the profession – perhaps more so now given the increasing demands to demonstrate impact, efficacy, and 'value for money'.

Appendix 1: Table showing the developmental history of (S)elective mutism in the DSM:

DSM Version	***Diagnostic Label***	***Essential Diagnostic Criteria***
DSM-III (1980)	Elective Mutism	• Continuous *refusal* to speak in almost all social situations.
DSM-III-TR (1987)	Elective Mutism	• Persistent *refusal* to speak in 1 or more social situations. • *Refusal* to talk is not related to symptoms of social phobia.
DSM-IV (1994)	Selective Mutism	• Persistent *failure* to speak in specific social situations. • *Failure* to talk should not be the result of an organic inability to understand language or a lack of knowledge of, or comfort with, the spoken language in the social situation.
DSM-IV-TR (2000)	Selective Mutism	
DSM-V (2013)	Selective Mutism	• Diagnostic criteria are largely unchanged, though SM is now considered aligned with an anxiety disorder.

Note: A similar developmental trajectory is noted in the *'International Statistical Classification of Diseases and Related Health Problems'* (ICD-10), though the transition from 'elective' to 'selective' occurred later in 2010, but for the same reasons as cited).

Appendix 2: DSM-IV-TR Criteria for Selective Mutism:

DSM-IV-TR criteria for Selective Mutism

1. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.

2. The disturbance interferes with educational or occupational achievement or with social communication

3. The duration of the disturbance is at least 1 month (not limited to the first month of school).

4. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

5. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder.

Appendix 3: Pre-intervention measures (Strengths and Difficulties Questionnaire, Revised Child's Anxiety and Depression Scale)

"Emotional Distress = High"

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the [redacted] six months or this school year.

Child's Name [redacted]

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☑
Restless, overactive, cannot stay still for long	☐	☑	☐
Often complains of headaches, stomach-aches or sickness	☐	☑	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☑
Often has temper tantrums or hot tempers	☐	☐	☑
Rather solitary, tends to play alone	☐	☑	☐
Generally obedient, usually does what adults request	☐	☑	☐
Many worries, often seems worried	☐	☐	☑
Helpful if someone is hurt, upset or feeling ill	☐	☑	☐
Constantly fidgeting or squirming	☑	☐	☐
Has at least one good friend	☐	☐	☑
Often fights with other children or bullies them	☑	☐	☐
Often unhappy, down-hearted or tearful	☐	☑	☐
Generally liked by other children	☐	☐	☑
Easily distracted, concentration wanders	☐	☑	☐
Nervous or clingy in new situations, easily loses confidence	☐	☑	☐
Kind to younger children	☐	☐	☑
Often lies or cheats	☑	☐	☐
Picked on or bullied by other children	☑	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☑	☐
Thinks things out before acting	☐	☑	☐
Steals from home, school or elsewhere	☑	☐	☐
Gets on better with adults than with other children	☑	☐	☐
Many fears, easily scared	☑	☐	☐
Sees tasks through to the end, good attention span	☑	☐	☐

Signature [redacted] Date [redacted]

Parent/Teacher/Other (please specify:) [redacted]

Thank you very much for your help

© Robert Goodman, 2005

School

Date: [redacted]

Name/ID: [redacted]

RCADS

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

		0	1	2	3
1.	I worry about things	Never	Sometimes	Often	Always
2.	I feel sad or empty	Never	Sometimes	Often	Always
3.	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4.	I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5.	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6.	Nothing is much fun anymore	Never	Sometimes	Often	Always
7.	I feel scared when I have to take a test	Never	Sometimes	Often	Always
8.	I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9.	I worry about being away from my parents	Never	Sometimes	Often	Always
10.	I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11.	I have trouble sleeping	Never	Sometimes	Often	Always
12.	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
13.	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14.	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15.	I have problems with my appetite	Never	Sometimes	Often	Always
16.	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17.	I feel scared if I have to sleep on my own.	Never	Sometimes	Often	Always
18.	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19.	I have no energy for things	Never	Sometimes	Often	Always
20.	I worry I might look foolish	Never	Sometimes	Often	Always
21.	I am tired a lot 7:45 wake up?	Never	Sometimes	Often	Always
22.	I worry that bad things will happen to me	Never	Sometimes	Often	Always

fish + chips

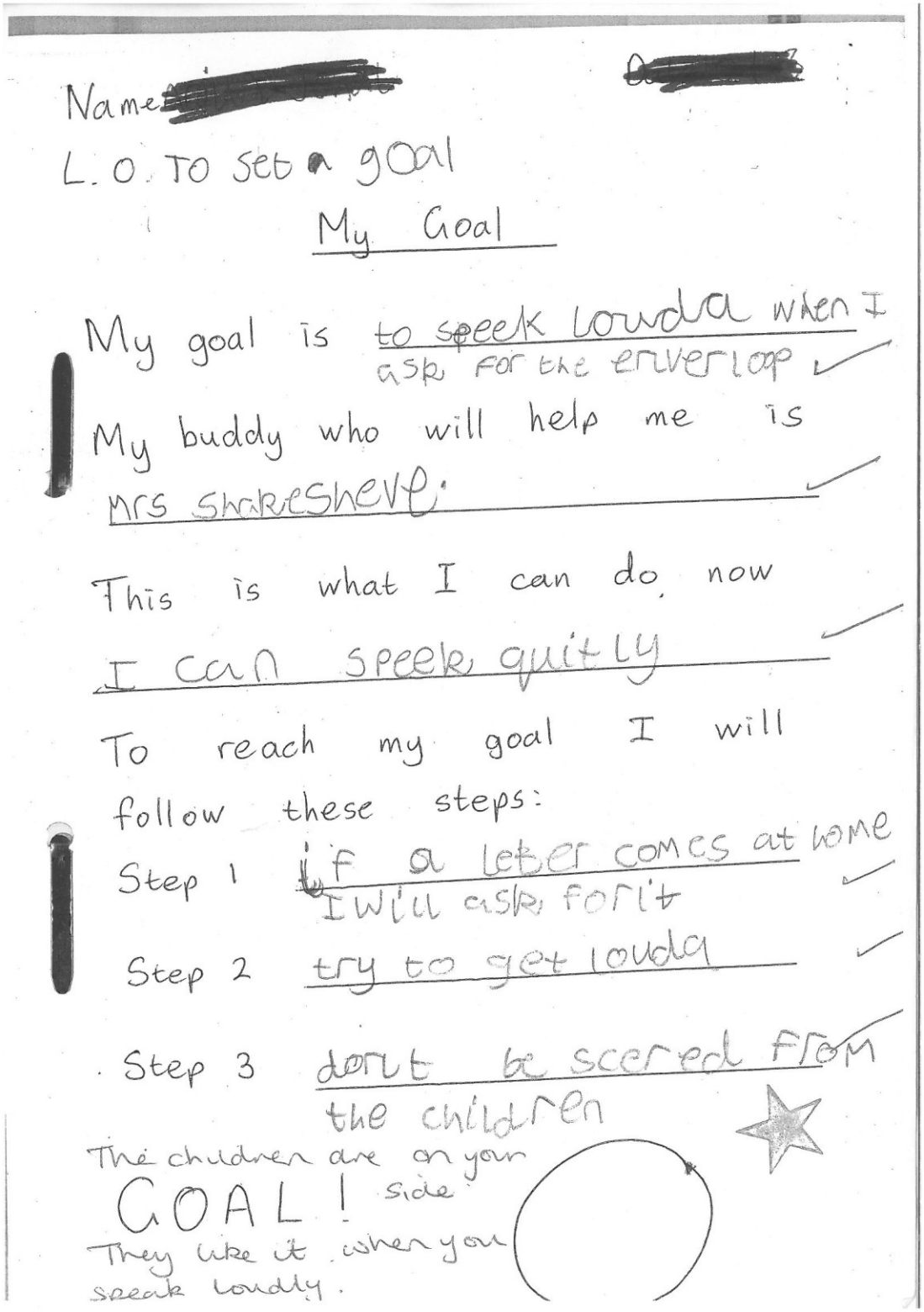
© 1998 Bruce F. Chorpita, Ph.D.

23. I can't seem to get bad or silly thoughts out of my head.	Never	**Sometimes**	Often	Always
24. When I have a problem, my heart beats really fast	Never	**Sometimes**	Often	Always
25. I cannot think clearly	**Never**	Sometimes	Often	Always
26. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	**Often**	Always
27. I worry that something bad will happen to me	Never	**Sometimes**	Often	Always
28. When I have a problem, I feel shaky	Never	Sometimes	**Often**	Always
29. I feel worthless	**Never**	Sometimes	Often	Always
30. I worry about making mistakes	Never	**Sometimes**	Often	Always
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening	**Never**	Sometimes	Often	Always
32. I worry what other people think of me	**Never**	Sometimes	Often	Always
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	**Sometimes**	Often	Always
34. All of a sudden I feel really scared for no reason at all	**Never**	Sometimes	Often	Always
35. I worry about what is going to happen	**Never**	Sometimes	Often	Always
36. I suddenly become dizzy or faint when there is no reason for this	Never	**Sometimes**	Often	Always
37. I think about death	**Never**	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	Never	Sometimes	**Often**	Always
39. My heart suddenly starts to beat too quickly for no reason	Never	**Sometimes**	Often	Always
40. I feel like I don't want to move	Never	**Sometimes**	Often	Always
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	**Never**	Sometimes	Often	Always
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	**Never**	Sometimes	Often	Always
43. I feel afraid that I will make a fool of myself in front of people	**Never**	Sometimes	Often	Always
44. I have to do some things in just the right way to stop bad things from happening	**Never**	Sometimes	Often	Always
45. I worry when I go to bed at night	**Never**	Sometimes	Often	Always
46. I would feel scared if I had to stay away from home overnight	Never	**Sometimes**	Often	Always
47. I feel restless	Never	**Sometimes**	Often	Always

© 1998 Bruce F. Chorpita, Ph.D.

Appendix 4: Non-verbal environmental anxiety measure

Appendix 5: Young Person's Perspective:



Name [redacted] [redacted]

L.O. To set a goal

My Goal

My goal is to speek lowda when I ask for the enverlop

My buddy who will help me is Mrs Shakeshevf.

This is what I can do now

I can speek quitly

To reach my goal I will follow these steps:

Step 1 if a leter comes at home I will ask for it

Step 2 try to get lowda

Step 3 dont be scered from the children

The children are on your GOAL! side

They like it when you speak loudly.

Appendix 6: Example of Monitoring Measures

Child Outcome Rating Scale (CORS)

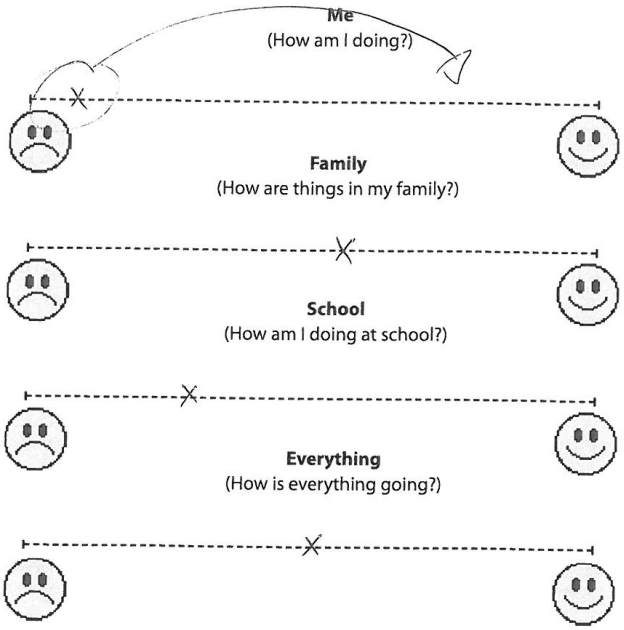
(Ages 6 to 12)

Name [redacted] Age (Yrs):____ Session # 1 Date: 29/4/13

Who is filling out this form? Please check one: Child_____ Caretaker_____

If caretaker, what is your relationship to this child? EP

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*



SCORING

Each line is 10cm.

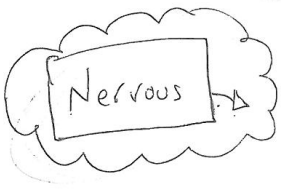
Score with ruler e.g. 3.5cm = score of 3.5.

Write the scores for each of the four lines here in the margin.

Add the four scores for a total score.

Plot overall score on the graph

The information on this page is for illustration purposes only. Please go to http://scottdmiller.com and follow the link for "Performance Metrics" to download the measure



25

© 2003, Barry L. Duncan, Scott D. Miller, & Jacqueline A. Sparks

Appendix 7: CBT resources from Stallard (2004)

THINK GOOD – FEEL GOOD



The magic circle



Think about something you have done recently which you **really enjoyed**. Write or draw in the circles below:

- what you **DID**
- how you **FELT**
- what you were **THINKING**.

What were you **THINKING?**

'This is fun'
'I can't wait to get past this level in candy crush'

What were you **DOING?**
(place, people, activity)

Playing games on my Ipad

How did you **FEEL?**

Relaxed, happy, excited



The negative trap



Think about one of your **most difficult situations** and write/draw:

- what **HAPPENS**
- how you **FEEL**
- what you **THINK** about when you are in that situation.

What I **THINK:**



People will laugh at me and I will get embarrassed. Everybody will look at me!

What I **DO:**



Stop speaking.
Get nervous,
Shake

How I **FEEL:**



Sick / light headed,
headache
hot

THINK GOOD – FEEL GOOD



Challenging core beliefs

Select one of your core beliefs and over the next week record **any evidence**, no matter how small, that would suggest that this core belief is not always true.

CORE BELIEF:

'If I start to speak now, people will laugh at me / stare at me'

EVIDENCE THAT DOES NOT SUPPORT IT:

The class doesn't look / laugh at other people when they speak,

People don't look at me when I whisper,

My friends are nice at won't embarrass me,

The teacher would not let other people laugh at me,

My friends want me to speak and will help me.

Appendix 8: Post Intervention Measures: Strength and Difficulties Questionnaire (SDQ) / Revised Child Anxiety and Depression Scale (RCADS):



Strengths and Difficulties QUESTIONNAIRE

TO BE COMPLETED BY A MAIN CARER OF A CHILD AGED BETWEEN 4 AND 16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain, or the items seem daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name [redacted] Male/Female Date of Birth _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	✓
Restless, overactive, cannot sit still for long - developing to be restless when worried about school	☐	✓	☐
Often complains of headaches, stomach-aches or sickness	☐	✓	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	✓
Often has temper tantrums or hot tempers - sometimes frustration	☐	✓	☐
Rather solitary, tends to play alone likes own space but sometimes plays with sister	☐	✓	☐
Generally obedient, usually does what adults request - some repetition required	☐	✓	☐
Many worries, often seems worried	✓	☐	✓
Helpful if someone is hurt, upset or feeling ill	☐	☐	✓
Constantly fidgeting or squirming - not	✓	☐	☐
Has at least one good friend	☐	☐	✓
Often fights with other children or bullies them	✓	☐	☐
Often unhappy, downhearted or tearful can get tearful easily	☐	✓	☐
Generally liked by other children	☐	☐	✓
Easily distracted, concentration wanders not very focussed, especially homework	✓	☐	☐
Nervous or ~~clingy~~ in new situations, easily loses confidence can be nervous in all familiar	✓	☐	☐
Kind to younger children	☐	☐	✓
Often lies or cheats	✓	☐	☐
Picked on or bullied by other children - don't think so.	✓	☐	☐
Often volunteers to help others (parents, teachers, other children) ask teachers	☐	✓	☐
Thinks things out before acting - no - can rush	☐	☐	✓
Steals from home, school or elsewhere	✓	☐	☐
Gets on better with adults than with other children	✓	☐	☐
Many fears, easily scared	✓	☐	☐
Sees tasks through to the end, good attention span	✓	☐	☐

Please turn over – there are a few more questions on the other side ...

STRENGTHS AND DIFFICULTIES 5a

Date: [redacted]

Name/ID: [redacted]

RCADS

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

1. I worry about things	Never	Sometimes	Often	Always
2. I feel sad or empty	Never	Sometimes	Often	Always
3. When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6. Nothing is much fun anymore	Never	Sometimes	Often	Always
7. I feel scared when I have to take a test	Never	Sometimes	Often	Always
8. I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9. I worry about being away from my parents	Never	Sometimes	Often	Always
10. I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11. I have trouble sleeping	Never	Sometimes	Often	Always
12. I worry that I will do badly at my school work	Never	Sometimes	Often	Always
13. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14. I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15. I have problems with my appetite	Never	Sometimes	Often	Always
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. I feel scared if I have to sleep on my own.	Never	Sometimes	Often	Always
18. I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19. I have no energy for things	Never	Sometimes	Often	Always
20. I worry I might look foolish	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I worry that bad things will happen to me	Never	Sometimes	Often	Always

© 1998 Bruce F. Chorpita, Ph.D.

23. I can't seem to get bad or silly thoughts out of my head.	Never	Sometimes	Often	Always
24. When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25. I cannot think clearly	Never	Sometimes	Often	Always
26. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. I worry that something bad will happen to me	Never	Sometimes	Often	Always
28. When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29. I feel worthless	Never	Sometimes	Often	Always
30. I worry about making mistakes	Never	Sometimes	Often	Always
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening.	Never	Sometimes	Often	Always
32. I worry what other people think of me	Never	Sometimes	Often	Always
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
35. I worry about what is going to happen	Never	Sometimes	Often	Always
36. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. I think about death	Never	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
39. My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. I feel like I don't want to move	Never	Sometimes	Often	Always
41. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
43. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
44. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. I worry when I go to bed at night	Never	Sometimes	Often	Always
46. I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
47. I feel restless	Never	Sometimes	Often	Always

© 1998 Bruce F. Chorpita, Ph.D.

References:

Achenbach, T. M., & Rescorla, L. (2001) **Manual for the ASEBA school-age forms and profiles.** Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

American Psychiatric Association (APA). (1980). **Diagnostic and statistical manual of mental disorders (3rd ed.**). Washington, DC: American Psychiatric Association.

Andersson, C. B., & Thomsen, P. H. (1998). Electively mute children: An analysis of 37 Danish cases. **Nordic Journal of Psychiatry***,* 52: 231-238.

Anstendig, K. (1998). Selective Mutism: A Review of the Treatment Literature By Modality From 1980-1996. **Psychotherapy: Theory, Research, Practice, Training**, 35: 381-391.

Atkinson, C., Squires, G., Bragg, J., Wasilewski, D. & Muscutt, J. (2013). Effective delivery of therapeutic interventions: findings from four site visits. ***Educational Psychology in Practice*** 29: 54-68.

Axline, V. (1947). **Play Therapy.** New York: Ballantine Books.

Beck, A. (1993) Cognitive therapy: Past, present, and future. **Journal of Consulting and Clinical Psychology**, 61: 194-198.

Beidel, D.C., & Turner, S.M. (2007). **Shy children, phobic adults: The nature and treatment of social anxiety disorder.** Washington, DC: American Psychological Association Press

Bergman, R. L., Piacentini, J., & McKracken, J. T. (2002). Prevalence and description of selective mutism in a school-based sample. **Journal of the American Academy of Child and Adolescent Psychiatry***,* 41*:* 938-946.

Black, B. B., & Uhde, T. W. (1992). Elective mutism as a variant of social phobia. **Journal of the American Academy of Child and Adolescent Psychiatry,** 31: 1090- 1094.

Black, B. B., & Uhde, T. W. (1995). Psychiatric characteristics of children with selective mutism: A pilot study. **Journal of the American Academy of Child and Adolescent Psychiatry,** 34: 847-855.

Bringhurst, D. L., Watson, C. W., Miller, S. D., & Duncan, B. L. (2006). The reliability and validity of the Outcome Rating Scale: a replication study of a brief clinical measure. **Journal of Brief Therapy***,* 5: 23-30.

British Psychological Society Division of Educational and Child Psychology (DECP) (1999) A framework for psychological assessment and intervention. **Division of Educational and Child Psychology Newsletter,** 89: 6-12.

Butler, A.C., Chapman, J.E., Forman, E.M., & Beck, A.T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. **Clinical Psychology Review**, 26(1): 17-31.

Butler, R. and Green, D. (2007) *The Child Within: Taking the Young Person' Perspective by Applying Personal Construct Psychology* Oxford: Butterworth-Heinemann

Cameron, R.J. (2006) Educational Psychology: the distinctive contribution. **Educational Psychology in Practice** 22:(4), 289-304.

Campbell, A., & Hemsley, S. (2009). Outcome Rating Scale and Session Rating Scale in psychological practice: Clinical utility of ultra-brief measures. **Clinical Psychologist***,* 12: 1-9.

Yeo, L.S. and Choi, P.M. 2011. Cognitive-behavioural therapy for children with behavioural difficulties in the Singapore mainstream school setting. *School Psychology International*, 32(6): 616–631.

Chorpita, B. F., Moffitt, C. E., Gray, J. A. (2005). Psychometric properties of the Revised Child Anxiety and Depression Scale in a clinical sample. **Behaviour Research and Therapy**, 43: 309-322.

Cleave, H., (2009). Too anxious to speak? The implications of current research into Selective Mutism for educational psychology practice **Educational Psychology in Practice** 25(3): 233-246

Cohan, S. L., Chavira, D. A., & Stein, M. B. (2006). Practitioner review: Psychological interventions for children with selective mutism: A critical evaluation of the literature from 1990-2005. **Journal of Child Psychology and Psychiatry***,* 34: 847-856.

Cummings, C. M**.,** Caporino, N. E., Settipani, C. A., Read, K. L., Compton, S. N., March, J.,Sherrill, J., Piacentini, J., McCracken, J., Walkup, J. T., Ginsburg, G., Albano, A. M., Rynn, M., Birmaher, B., Sakolsky, D., Gosch, E., Keeton, C., & Kendall, P. C. (2013). The therapeutic relationship in cognitive-behavioral therapy and pharmacotherapy for anxious youth. **Journal of Consulting and Clinical Psychology.** Advance online publication.

Cunningham, C. E., McHolm, A., Boyle, M. H., & Patel, S. (2004). Behavioral and emotional adjustment, family functioning, academic performance, and social relationships in children with selective mutism. **Journal of Child Psychology and Psychiatry**, 45: 1363-1372.

Dow, S. P., Sonies, B. C., Scheib, D., Moss, S. E., & Leonard, H. L. (1995). Practical guidelines for the assessment and treatment of selective mutism. **Journal of the American Academy of Child and Adolescent Psychiatry,** 34: 836-845.

Dummit, E. S., III., Klein, R. G., Tancer, N. K., Asche, B., Martin, J., & Fairbanks, J. (1997). Systematic assessment of 50 children with selective mutism. **Journal of the American Academy of Child and Adolescent Psychiatry,** 36: 653-660

Duncan, B.L., Miller, S. D., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. **Journal of Brief Therapy***,* 3: 3-12.

Duncan, B. L., Sparks, J., Miller, S. D., Bohanske, R., & Claud, D. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children, adolescents, and caretakers. **Journal of Brief Therapy***,* 5: 66-82.

Dunsmuir, S. M., Leadbetter, J. (2010). **Professional Supervision: Guidelines for Practice for Educational Psychology.** British Psychological Society.

Freud, A. (1946). **The psychoanalytic treatment of children**. London: Imago.

Fung, D. S. S., Manassis, K., Kenny, A., & Fiksenbaum, L. (2002). Web-based CBT for selective mutism. **Journal of the American Academy of Child and Adolescent Psychiatry**, 41(2): 112–113.

Garcia, A. M., Freeman, J. B., Francis, G., Miller, L. M., & Leonard, H. L. (2004). Selective mutism. In T. H. Ollendick & J. S. March (Eds.), **Phobic and anxiety disorders in children and adolescents: A clinician's guide to effective psychosocial and pharmacological interventions** (pp. 433-455). New York, NY: Oxford University Press.

Gilbert, P. & Leahy, R. (Eds.) (2007). **The therapeutic relationship in the cognitive behavioural psychotherapies**. London: Routledge.

Goodman R (2001) Psychometric properties of the Strengths and Difficulties Questionnaire (SDQ). **Journal of the American Academy of Child and Adolescent Psychiatry**, 40: 1337-1345.

Greig, A. (2007) A framework for the delivery of cognitive behaviour therapy in the educational psychology context. **Educational and Child Psychology***,* 24**:** 1, 19-35.

Hayden, T. L. (1980). Classification of elective mutism. **Journal of the American Academy of Child and Adolescent Psychiatry***,* 19: 118-133.

Health and Care Professions Council (2009): **Standards of proficiency for practitioner psychologists.**

Heimberg, R.G., & Becker, R.E. (2002). **Cognitive-behavioral group therapy for social phobia: basic mechanisms and clinical strategies Treatment**. New York: Guilford Press

Hofmann, S. G., Smits, J. A. J., (2008) Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. **Journal of Clinical Psychiatry**, 69: 621-632

Houghton, S. & Saxon, D. (2007) An Evaluation of large group CBT psycho-education for anxiety disorders delivered in routine practice. **Patient Education & Counselling**. 68:107-110

Imich, A., (1998). Selective Mutism: The implications of current research for the practice of educational psychologists. **Educational Psychology in Practice** 14(1): 52-59

In-Albon, T., & Schneider, S,. (2007). Psychotherapy of childhood anxiety disorders: A meta-analysis. **Psychotherapy and Psychosomatics** 76(1): 15-24.

Johnson, M., & Wintgens, A. (2001). **The selective mutism: resource manual**. Speechmark Publishing Ltd

Kearney, C.A., & Vecchio, J. (2006). Functional analysis and treatment of selective mutism in children. **Journal of Speech and Language Pathology – Applied Behavior Analysis***,* 1: 141-148.

Kehle, T. J., & Bray, M. A. (2010). Selective mutism. In A. Canter, L. Paige, & S. Shaw (Eds.), **Helping children at home and school: Handouts for families and educators III***.* Bethesda, MD: National Association of School Psychologists.

Kelly, G. A. (1955). *The psychology of personal constructs* . New York: Norton. Reprinted by Routledge (London), 1991.

Kolvin, T., & Fundudis, T. (1981). Elective mute children: Psychological development and background factors. **Journal of Child Psychology and Psychiatry***,* 22(3): 219-232.

Kopp, S., & Gillberg, C. (1997). Selective mutism: A population based study: A research note. **Journal of Child Psychology and Psychiatry,** 38: 257-262.

Kristensen, H. (2000). Selective mutism and comorbidity with developmental disorder/delay, anxiety disorder, and elimination disorder. **Journal of the American Academy of Child and Adolescent Psychiatry,** 39*:* 249-256.

Kristensen, H., & Torgersen, S. (2001). MCMI—II personality traits and symptom traits in parents of children with selective mutism: A case control study. **Journal of Abnormal Psychology***,* 110: 648-652

Kumpulainen, K., Rasanen, E., Raaska, H., & Somppi, V. (1998). Selective Mutism among second graders in elementary school. **European Child and Adolescent Psychiatry***,* 11: 71-78.

Kumpulainen, K. (2002). Phenomenology and treatment of selective mutism. **Therapy in Practice**, 16: 175-180.

Lowenstein, L. F., (1978). A summary of the research on elective mutism. **Actapaedopsychiatry***,* 44: 17–22

Mackay, T,. (2007). Educational psychology: The fall and rise of therapy. **Educational and Child Psychology,** 24: 1, 7-18.

Mackay, T. & Greig, A. (2007) Editorial. **Educational and Child Psychology***,* 24: 4-6.

Manassis, K., Fung, D., Tannock, R., Sloman, L., Fiksenbaum, L., & McInnes, A. (2003). Characterizing selective mutism: Is it more than social anxiety? **Depression and Anxiety** 18: 153-161.

Manassis, K., Tannock, R., Garland, E. J., Minde, K., McInnes, A., & Clark, S. (2007). The sounds of silence: Language, cognition, and anxiety in selective mutism. **Journal of the American Academy of Child and Adolescent Psychiatry,** 46: 1187-1195.

Miller, S. D., Duncan, B.L., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. **Journal of Brief Therapy,** 2: 91-100.

NICE (2011). **Common Mental Health Disorders: Identifi cation and Pathways to Care** . Clinical Guideline 123. London, UK: National Institute for Health and Clinical Excellence. Available at www.nice.org.uk.

Ooi, Y. P., Raja, M., Sung, S.C., Fung, D. S. S., & Koh, J. B. K. (2012). Application of a web-based cognitive-behavioural therapy programme for the treatment of selective mutism in Singapore: a case series study. **Singapore Medical Journal**. 53(7): 446-450.

Otte, C (2011). Cognitive behavioral therapy in anxiety disorders: Current state of the evidence. **Dialogues in clinical neuroscience** 13(4): 413–21.

Rapee, R. N., & Heimberg, R. G,. (1997). A cognitive-behavioral model of anxiety in social phobia. **Behaviour Research and Therapy.** 35: 741–756.

Remschmidt, H., Poller, M., Herpertz-Dahlman, B., Hennighausen, K., & Gutenbrunner, C. (2001). A follow up study of 45 patients with elective mutism. **European Archives of Psychiatry and Clinical Neuroscience,** 251(6): 284-296.

Reuther, E. T., Davis III, T. E., Moree, B. N., & Matson, J. L. (2011). Treating Selective Mutism Using Modular CBT for Child Anxiety: A Case Study. **Journal Of Clinical Child & Adolescent Psychology**, 40(1): 156-163

Rhode, G., Jensen, W. R., & Reavis, H. K. (2010). **The Tough Kid Book**. Eugene, OR: Pacific Northwest Publishing.

Schwartz, R. H., & Shipon-Blum, E. (2005). ‘Shy’ child? Don't overlook selective mutism. **Contemporary Pediatrics**, 22: 30–34.

Schwartz, R. H., Freedy, A. S., & Sheridan, M. J. (2006). Selective mutism: Are primary care physicians missing the silence? **Clinical Pediatrics**, 45(1): 43-48.

Professional Practice Report 3: Supporting the Development of *"Harmful Sexual Behaviour"* (HSB) Policy and Practice in a West Midlands Local Authority (LA): Primary School Perspectives

Abstract

Research concerning *'Harmful Sexual Behaviour'* (HSB) presented by children and young people (C&YP) has increased in output over recent years (Hackett et al., 2005).

However, when compared to research which relates to adult sex offenders, the amount of existing literature from non-adult populations remains sparse: that which is available focusses primarily upon C&YP in a criminal or judicial context and this has implications for the development of policy and practice across other domains.

Within the minimal research which is available, it is agreed universally that when C&YP engage in HSB, swift, evidence based intervention and support is required (Smith et al., 2013). Despite this consensus, there is a significant 'gap' between research and practice, particularly within school settings (Brown et al., 2011). The current paper contributes to the emerging research base relating to non-criminal contexts through investigating HSB in 'mainstream' primary schools.

Through semi-structured questionnaires, five primary school Head Teachers were approached in relation to the prevalence, identification and assessment of, and response to HSB in their settings. Further, participants were asked to identify training requirements relating to HSB, and how these needs may be met by the host Local Authority (LA), situated within the West Midlands conurbation of the United Kingdom.

Responses (n=5) suggest considerable variance between provisions: some settings report HSB being a priority for school development (n=2); others suggesting they perceive HSB to occur so rarely that it is not a significant concern (n=3). There was also a distinct difference between management and intervention with HSB: some settings reporting a professed 'appropriate' level of training and therefore manage any difficulties via their internal mechanisms and staff, while other settings approach 'external' agencies to provide support. Each school surveyed suggested that they would engage in further training offered by the LA.

The conclusion of the present study stresses that there appears to be no consistency in practice currently. These findings are considered within the context of the host LA developing HSB policy for professionals; parallels are also drawn with national guidance provided by the NSPCC.

Finally, a summary of the current circumstances in the host LA is provided to ensure that when policy is developed it is representative of, and appropriate to, identified need and consistent with available, albeit limited, research evidence. Recommended 'next steps' are outlined to ensure the research has utility for the host LA, alongside consideration of the implications for practitioner psychologists.

Section 1: Rationale and Working Context

'Given the potential for harm…and the needs and vulnerabilities of many of these children, there is an urgent need to…develop processes and services for responding effectively [to harmful sexual behaviour]'

(Hutton & Whyte, 2006, p. 116)

Introduction

Lately there has been increasing practitioner awareness about 'Harmful Sexual Behaviour' ('HSB') exhibited by Children and Young People ('C&YP'), summarised in a recent report by the 'National Society for the Prevention of Cruelty to Children' ('NSPCC'): *'Over the past few decades, C&YP who have sexually harmed others have attracted increasing attention from researchers and policy makers' (*'NSPCC', 2013, p.1).

Significant media spotlighting and Government initiatives (e.g. 'Be Safe Service', 2013; 'Assessment – Intervention – Moving on' ('AIM'), 2000) have also augmented its prominence within the public domain: *'It is relatively recently that western societies have acknowledged that children and adolescents are capable of perpetrating sexually abusive behaviour'* (Hickey et al., 2008, p.241).

Regrettably, despite this upsurge in recognition of childhood HSB, the amount of research available which explores the concept remains minimal, particularly in non-judicial or non-criminal contexts (Hutton & Whyte, 2006). More specifically, very little research is available from an educationalist's perspective, even though school and education professionals are argued to be 'well-placed' to identify emerging atypical behaviours that could indicate HSB risk (St. Amand et al., 2008).

This is a noteworthy deficit in research and is posited to be due to a number of factors: a proposed under-reporting of incidence (Bladon et al., 2005), the challenges of a perceived *'moral panic'* in relation to precocious childhood sexual development (Bancroft, 2003), and a general reluctance to broach this sensitive topic (Brown et al., 2011).
Nevertheless, these background circumstances present an ongoing difficulty for practitioners attempting to deliver or support evidence-based services for the managing of emergent HSB; it is this context which provides the predominant rationale for the current study.

The present paper engages actively with this emerging research domain, and attempts to contribute data from a psychological and educational perspective: this is achieved through exploring 'mainstream' primary school perspectives on, and current practices relating to, the prevalence, assessment and management of HSB.

Defining 'Harmful Sexual Behaviour'

Given the overtly delicate nature of childhood HSB as a subject for discussion, and the aforementioned limitations found presently within research, it is unsurprising that there remains some debate as to how HSB exhibited by C&YP ought to be conceptualised (e.g. Hackett, 2004): these debates, particularly relating to when behaviour with sexual elements becomes 'harmful', are endemic within research (Righthand & Welch, 2001)[1].

Nevertheless, with mindfulness of this ongoing discussion ever-present, it is important for transparency to provide for the reader, from the outset, the definition of HSB adopted for the current study; this is largely a researcher decision as many definitions are available (Hackett et al., 2005) and at this point there is no universally accepted description (Vizard, 2013).

Accordingly, the explanation provided by the 'NSPCC' - the leading UK based organisation formed to protect C&YP from all forms of abuse, and the only charity granted statutory 'power' to intervene in cases of mistreatment - was selected; this seems a defensible decision given the prominence of this organisation in relation to safeguarding C&YP more generally. Their conceptualisation suggests that:

"Harmful sexual behaviour involves one or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults." (Rich, 2011, p.7 NSPCC definition)
This definition is used consistently throughout this current research paper, both when considering existing literature through the critical 'review', and when developing tools for data collection. Now, with a working definition provided and the wider research background sketched briefly, it is appropriate to describe more fully the local context within which this current study was completed.

Local Context and Policy

In recent years, within the Local Authority (LA) where this research is placed, a draft policy has been developed which aims to direct and support the work of, and provide evidence based guidance for, social care and educational professionals working with HSB across the city.

The development of this policy was necessitated following '*the [imminent] transfer of labour from the NSPCC to LA professionals in regard to HSB'* (Herriotts-Smith, 2013, p. 31). Previously the NSPCC were commissioned directly by the LA to provide

[1] Necessarily these debates are considered expansively within the literature review section of this current report (Section 2.0)

support for C&YP exhibiting HSB activity across the city, alongside their schools and families. With the anticipated withdrawal of this specialist, dedicated agency (due, in part, to emergent budgetary restrictions at the LA level) it was likely that discontinuity would be noted by children and families at serious risk, and, by association, professionals working with them.

Accordingly, the primary objective for this burgeoning LA initiative is to prevent such a disconnect via developing specific pathways for accessing support, along with assembling a service wide consensus on suggested models for assessment and intervention.

Once this is in place, the secondary aspect of this nascent policy is that, where appropriate, opportunities for direct training of professionals to recognise contemporary theoretical and practical challenges relating to HSB are to be offered: if well placed professionals are aware, to a greater degree, about HSB, the likelihood of early identification (and therefore swift intervention and support) is augmented.

This budding framework is parallel with guidance provided by the NSPCC which emphasises early-intervention, a consistent and co-ordinated approach, and highly-trained personnel:

'Ensuring a well-trained workforce is the final principle at an organisational level; a need for systematic assessments and interventions [being the first]'

(Smith et al., 2013, p.21)

While clearly in relative infancy, the local policy has already begun to offer a structure for professional practice, likely improving confidence and competence for the council workforce: socio-cultural analytic research completed by a Trainee Educational Psychologist ('TEP') (Herriotts-Smith, 2013) also provides supporting evidence for its perceived value, through outlining initial perspectives of professionals involved in the practical 'delivery' of HSB services.

One group anticipated to be involved comprehensively in the initial identification of HSB are 'well placed' staff that work in schools; in order to adhere to best practice principles relating to early intervention (Hackett et al., 2005; NSPCC, 2013), these professionals are a key element of the emerging LA initiative.

It follows that, before guidance, direction and training be 'rolled out' to school-based professionals, there is a need to be clear about the present circumstances for HSB in educational settings: yet, at this point in time, there is poor awareness of schools' current level of understanding, confidence and competence in relation to this topic. No existing research has been completed which attempts to uncover present operational practices.

It is to exploring these circumstances that the current research focusses, with intentions to clarify *what schools and their staff already know, their current level of competence* and *what they need to know* in order to improve practice. This ensures that all future policy and practical developments are representative of identified need.

Yet, while in theory providing 'best practice' guidance would seem to be a straightforward process, the reality is that HSB research – and associated practical direction - is both complicated and largely without consensus.

Accordingly, before presenting findings for this current investigation it is appropriate to consider the contemporary landscape for HSB research in terms of underpinning theory, conceptualisation, and wider practical difficulties. This is completed via a comprehensive literature review and it is to this goal that the paper now turns.

Section 2: Critical Literature Review: Contemporary and Historic Discourse in Relation to Harmful Sexual Behaviour

Introduction, Prevalence and Wider Context

In 1992, a landmark paper was produced by the 'National Children Home' (NCH) (now *'Action for Children'* charity) which outlined the current national and local circumstances in relation to HSB across the UK. This report is seen widely as the catalyst for the aforementioned increase in research and practitioner attention (Smith et al., 2013), and provides the foundation for the current literature review: it is important to determine how much progress has occurred since this seminal paper, and where current challenges are faced.

Despite this universally acknowledged upsurge in researcher and practitioner interest (Brown et al., 2011), associated development of practice relating to HSB, since the 'NCH' report, has proved challenging across a number of key benchmarks (Hempel et al., 2011): *'comparing the [current] situation to that described by the earlier NCH enquiry, Hackett et al (2005) found…variability in volume, content and quality of services [for HSB] across different local authorities'* (Smith et al., 2013, p.6).

In addition to the widespread variability of available support, the reported incidence of HSB remains considerable: 1 in 20 C&YP report to have had experience of HSB (NSPCC, 2013) and of the 6400 individuals found guilty of, or receiving a caution for, sexual offences in 2004, 17% were between 10 and 17 years of age (Cooper & Roe, 2012). Additionally, Radford et al (2011) identified via a national survey (and then follow-up interviews - p.24), that a high proportion of the inappropriate sexual behaviour *or* abuse experienced and subsequently reported by 0-17 year olds was committed by known peers (approximately two-thirds).

Though these figures appear troublingly high, it is also likely that given the sensitive nature of the subject, incidence rates are broadly under reported (Hickey et al., 2008): there is, some researchers argue, a 'moral panic' relating to HSB (Levine, 2002) which has impacted upon not only the progress of research in this domain, but also an accurate representation of prevalence.

Additionally, there is also a statistical skew in terms of gender: boys are over represented, both in objective figures relating to HSB (NSPCC, 2013), and within studies which investigate the topic (Hickey et al., 2008).

Various hypotheses are available to explain this occurrence: some (e.g. Hetherton, 1999) suggesting that cultural attitudes towards female sexuality are contrary to the phenomenon of female perpetrated sexual misconduct, which subsequently leads to less reporting of the behaviour and inevitably less researcher attention, while others (e.g. Hickey et al., 2008) posit that there exists a genuine phenotype variance across genders.

Despite this inconsistency across statistical data, the NSPCC maintained in 2013 that C&YP exhibiting HSB *ought to* be viewed as generally diverse in terms of age, gender and ethnicity. Broadly, the assertion is that while official statistics present a skew, a panoply of factors may be responsible for this, and until a more accurate depiction of prevalence is available it is prudent to consider C&YP who engage in HSB as diverse – not a phenomenon ascribed to a specific demographic.

It is also now widely acknowledged that C&YP who engage in HSB should not be considered in the same light as adult sex offenders (Hempel et al., 2011; Helmus et al., 2012): the vast majority of older research was completed from a law-breaking start point (e.g. Hagan et al., 2001; Langstrom, 2001; Righthand & Welch, 2001) using adult models in an attempt to extrapolate and thus understand the behaviour in C&YP.

Though well intentioned, this outdated research has proved unconvincing with regards to understanding the fundamental nature of the phenomenon; it is only recently that research from other perspectives has been considered, and some progress has been made in developing a holistic picture of the occurrence (e.g. Vizard et al., 2007; Hacket, 2007).As the current research aims to have utility for the host LA, it is necessary to provide a critical overview and appraisal of these emerging perspectives.

Accordingly, the following section is split into three distinct sections, reflecting up-to-date developments within the domain: (i) HSB as a concept – challenges with definition and conceptualisation alongside psychological theories which attempt to offer insight into the phenomenon (ii) contemporary difficulties faced by professionals

working within this domain in relation to identification and assessment, and (iii) appraisal of available evidence-based identification and intervention strategies.

(i) Contemporary Theoretical Challenges: Definition and Conceptualisation of HSB

There remains a *'persistent absence of consensus regarding appropriate terminology'* (NSPCC, 2013, p.7), relating to HSB in literature, and many different conceptualisations can be found: *'young people who display sexually harmful behaviour'* (HM Government, 2010); *'sexually inappropriate or aggressive behaviour'* (Welsh Assembly Government, 2006); *'young people who sexually abuse'* (Youth Justice Board, 2008) among others (Scottish Government, 2010; Northern Ireland Department of Health, Social Services and Public Safety, 2003).

Some researchers, (e.g. Lovell, 2002) suggest that *'sexually harmful behaviour'* is the 'preferred' conceptualisation as it depersonalises the individual but emphasises the problematic behaviour instead. Contrastingly, the NSPCC, the leading UK authority on HSB guidance, utilise *'harmful sexual behaviour'* as their conceptualisation as noted earlier in this paper. This definition prioritises the *harm* that HSB can bring, rather than any 'sexual' element (largely due to the view that HSB may be an indication of wider unidentified need; Hutton, 2010)

Though there are some similarities between each definition and conceptualisation, the subtle difference between them arguably changes how the phenomenon is approached (Hackett et al., 2005). Indeed, this lack of consensus about how HSB is understood highlights the first challenge found when attempting to demarcate the phenomenon fully: simply, *'there is no generally agreed understanding of what 'normal' sexual development is'* (NCH, 1992, p.3).

Though this assertion is made in the iconic NCH (1992) paper, the position remains largely the same in contemporary literature (e.g. Coren et al., 2012): there is some doubt about the threshold for when behaviour with sexualised elements becomes *harmful*, and also at what point typical sexual development (and subsequent behaviour) becomes atypical. This is an important consideration for practitioners working within this domain; *"there are sometimes perceived to be difficulties in distinguishing between normal childhood sexual development and experimentation, and sexually inappropriate or aggressive behaviour"* (HM Government 2010, p 304)

For the immediate and longer term, this is a concerning finding: emerging research is now beginning to posit that engaging in HSB in childhood may be a catalyst for sexual offending as an adult, and thus there is likely to be a level of causation (e.g. Burton, 2000) - emphasising further the need for early, accurate identification and support in childhood to prevent recidivism:

'Many adolescent sexual offenders report being children with sexual behaviour problems'

(Burton, 2000, p.46)

Additionally, with the advent of new communication methods, there are arguably more opportunities for C&YP to engage in HSB, for example through 'sexting': '*the creating, sharing and forwarding of sexually suggestive nude or nearly nude images'* (Lenhart, 2009, p.2) again underlining the pressing need for professionals to understand when typical behaviour becomes problematic perhaps across new, emergent technologies.

Contemporary thinking (e.g. Hackett et al., 2005; NSPCC 2013; Vizard, 2013) suggests that, unsurprisingly, the boundary at which *typical*, *age appropriate* sexual behaviour becomes 'harmful' is not always discernible by behaviour *in isolation* (Boyd & Bromfield, 2006): an individual's developmental history, family circumstances, intellectual development and culture are all relevant to understanding presenting behaviour (Goodyear-Brown et al., 2012).

Indeed, controversies relating to consent, power imbalances and developmental 'appropriateness' are common in research, and predictably, social and cultural factors / experiences / exposure, along with peer pressure and, in some cases, sexual abuse, can influence the rate in which knowledge of sexual practices occurs (NSPCC, 2013; Hickey et al., 2008; Helmus et al., 2012).

Nevertheless, while this may be true, concrete guidance is required in order to support practitioners in identifying and managing HSB. The prevailing contemporary framework (NSPCC, 2013) suggests that it is suggested for practitioners to view HSB on a spectrum, taking in to consideration all the variable factors noted in research:

Table 1 showing the proposed 'Continuum' of HSB (NSPCC, 2013)

Healthy	Problematic	Harmful
Mutual Consensual Choice Exploratory No intent to harm Fun/humorous No power differential	Not age appropriate One off incident Peer pressure Spontaneous No intent to harm Level of understanding Acceptance of responsibility Others not scared to tell	Not age appropriate Planned, secretive, use of force, coercion Power differential (size, age, status, strength) Others anxious, scared to tell Blames others Frequent or increasing frequency Compulsive Other issues such as poor peer relationships, challenging behaviours, anger

However, to adopt a critical position: it could be argued that even though some assistance can be found through this continuum, there continues to be an emphasis for the practitioner to 'judge' if an exhibited behaviour is healthy, problematic or harmful; to whom, for example, does the verdict fall for 'age appropriateness'.

Further, given the aforementioned difficulties with C&YP being reluctant to report inappropriate behaviour, might the true extent of any harm be minimised when reported *by* the young person, thus making it more challenging for professionals to determine if the behaviour was harmful.

These are fundamental questions to which no concrete answer can be found in contemporary literature: the subjectivity of HSB remains pervasive and all guidance is unclear insofar as supporting practitioners to determine *what HSB is* (Vizard, 2013). Without question there are some behaviours which immediately cause concern, however it is those behaviours which are less obvious which may ultimately be overlooked (NSPCC, 2013; Vizard, 2013).

This is also the case with regard to emergent technologies: 'the *rapid adoption [of these technologies has] required policy makers, teachers, regulators, parents and industry to scramble [with existing guidance] to keep up if they are to…minimise harms'* (Ringrose et al, 2012, p.9), however again general guidance appears lacklustre: *'it seems that, despite the embedded nature of online activities in everyday life for well over a decade, teachers, police officers and, particularly, clinicians and social workers have received too little guidance [in identification and management]'* (Ringrose et al., 2012, p.59).

It is therefore a defensible, yet distressing, assertion that there remains no perceptible direction or consensus as to *when* sexual behaviour becomes damaging or inappropriate, it is largely practitioner judgment which determines the interpretation of the behaviour (Smith et al., 2013), and the endemic difficulties with this would seem clear.

Paradoxically, given these continued difficulties in separating HSB from typical development, it would seem tempting to perceive that this limited understanding is a consequence of the aforementioned historic researcher apathy, or due to much existing research being largely an extrapolation of adult models. However this is not the case: contemporary thinking suggests that HSB is a complicated and multi-faceted phenomenon (Hutton & Whyte, 2006) and concrete definitions are therefore unlikely.

Contemporary Psychological Theories of HSB

As has been noted thus far through this current paper, there remain some debates as to when typical sexual development and behaviour becomes harmful; practical guidance is also limited in terms of assisting this process. Alongside this stable feature of existing literature, there is also some persistent discussion as to *why* HSB emerges, and whether there are any factors which may influence C&YP to engage in the behaviour.

There is some evidence that formative experiences may predispose a young person to developing and exhibiting HSB (Hawkes, 2009), and some proposed 'risk factors' (Calder et al., 2001; Vizard et al., 2007; Hawkes, 2009), have been posited. Broadly, there is evolving recognition that specific types of maltreatment or developmental 'disturbances' during formative years *may* have a causal relationship with emergent HSB (Hawkes, 2009).

For example, Vizard et al (2007) - at the time the study with the largest sample of C&YP with a history of displaying HSB - identified that:

'The [majority of] the [research] sample had experienced extremely emotionally deprived and abusive upbringings, with family instability and dysfunction.

(p. 59)

Emerging from their findings, the researchers were able to develop a matrix of the most common developmental circumstances that correlated with later HSB. They consequently posited five core areas of development that appeared consistently disrupted for these C&YP:

Table 2 showing Proposed Developmental Influences related to HSB (adapted from Vizard et al., 2007)

Developmental Interference	Proportion of Sample
Dysfunctional family environment	A significant majority (86%) of C&YP in the sample had been removed from their home because of abuse, neglect or family breakdown. Each family had one or more of: *'parental mental health problems, paternal criminality, marital difficulties or separation, and subsequent absenteeism of the father'* (p. 69)
Aggressive socialisation	66% had experienced physical abuse, and in the remainder 28% had witnessed domestic abuse or had a violent father convicted of aggressive offences.
Inappropriate sexualisation	71% had experienced sexual abuse; of the remainder 21% had either been brought up with inappropriate sexual

	boundaries or had sexual offenders within the wider family.
Neuropsychological Difficulties	73% of the sample had learning difficulties, developmental delays, language difficulties or executive function deficits.
Mental Health Difficulties	75% of the C&YP in the sample had mental health difficulties *'even when conduct or attention problems were excluded'* (p. 70). These difficulties included: sleep disruption, nightmares, enuresis, encopresis, self-harm, or eating problems.

The consistency and frequency of these difficulties prompted the researchers to assert with conviction that these five areas were likely associated with later HSB.

Other studies (Hackett, 2004; Hickey et al., 2006) identified similar results, providing some confidence in the relationship between early life difficulties and later HSB; to add further support for these developmental risk factors, retrospective studies (e.g. Hawkes 2009; Vizard 2006; McCartan et al. 2011) offer data which suggests 23-40% children who sexually harm others have often suffered abuse and neglect themselves.

Accordingly, there is some emerging evidence of a link between specific developmental circumstances and childhood HSB. However, given the sensitive nature of this topic and the uncertainty relating to the conceptualisation of HSB noted earlier, it is important to provide a sceptical appraisal of these assertions.

There are two main critiques available: firstly, poor explanations for those C&YP who, despite no recognisable formative difficulties, go on to engage in HSB, and secondly the converse – individuals who have experienced significant and multiple types of trauma who then do not exhibit HSB.

Unsurprisingly there are no concrete rebuttals available to these critiques, though various hypotheses are present: for example, Howe (2005), Lemma (2004), and Lemma and Levy (2004) describe how 'attachment style' may be associated with an individuals' ability to contain and reflect on any formative trauma and thus be a protective or risk factor for emergent HSB. Yet, as with much research which attempts to describe causal links between early attachment and later emergent difficulties, critiques relating to the authenticity of this relationship are common: '*attachment variations [might be considered as] directly causing certain outcomes, [yet] early attachment has no privileged causal status'* (Sroufe, 2005, p. 365). Consequently, caution should be noted when considering this explanation.

An alternative hypothesis (Hawkes, 2009) suggests that emergent HSB might be a reaction to a poor response from parents/caregivers to C&YP's 'typical' sexual

development: '*[even] developmentally normal sexual behaviour by [the participants in the study] was not understood by caregivers, who tended to react as though the child was a sexual threat or in some other way a sexual peer'* (p. 3). Simply, C&YP receiving an angry or distressed response to 'normal' sexual development or exploration might develop an unhealthy understanding of *all* sexual conduct and thus develop atypical behaviours as a consequence, though again it has proved challenging to establish this link convincingly.

Overall, while contemporary guidance suggests C&YP being subject to *'multiple, prolonged and repetitive abuse'* (NSPCC 2013, p. 3) is the most significant causal feature for later HSB, a number of questions remain unanswered: it unknown whether there are 'dose' effects (does *more* abuse, in terms of frequency, intensity or duration, have an impact on later emergent HSB?), is trauma of a certain type *more likely* to predict HSB, are there 'combinations' of developmental difficulties which predict HSB more accurately and, for what reason does HSB not *always* occur following early trauma. Exploration of these questions is a contemporary research priority:

'The task for future research is to identify and empirically establish the developmental trajectories and associated vulnerability factors that characterize young sexual abusers.'

(Vizard et al., 2007., p. 71)

Evidently research is in an early stage and significant uncertainty remains; however it is encouraging that researchers are beginning to consider the phenomenon from developmental or psychological perspectives, rather than via a lens of criminality as was the case historically.

At this point is should be clear that there are still a number of challenges present within research relating to HSB; expectedly – perhaps as a consequence - practical challenges have also been faced when attempting to develop broader support services: *'despite some advances in understanding and provision of services, there [are] still many issues to be addressed [relating to HSB practice]'* (Hackett et al., 2005 in, Smith et al., 2013, p.6). These practical challenges are now considered.

(ii) Assessment

Given the amount of time C&YP spend in an educational environment, much concerning HSB is likely to emerge within, or be identified through, a young person's learning setting (Smith et al., 2013): it follows that practitioners in these settings being aware of potential risk markers can support the prevention of, or early-intervention in, cases of HSB (Brown et al., 2011).

However, an additional consideration for many schools and wider LAs is that the mechanisms in place to support C&YP with HSB continue to be in their infancy despite a long-standing recognition of the need to develop services.
Indeed, in the NCH's seminal 1992 paper, the importance of assessment in particular was stressed: recommendations provided in this report emphasised that assessment ought to be a holistic process, and professionals involved should be mindful of highlighting a young person's strengths and individual circumstances *alongside* their HSB, whilst *also* being cautious of the risk the young person may pose to their family and/or wider contexts (Brown et al., 2011). When HSB is a concern for a young person, often it is an indication of wider unmet needs or difficulties (Hutton, 2010) and this should be considered in the assessment process.

Since the NCH report there been a determined effort to prevent C&YP undergoing numerous assessments (Smith et al., 2013): integrated, collaborative approaches remain viewed as a principal feature of work with this population. It is broadly agreed that *'assessment frameworks'*, common across professional services, might ensure consistency in approach (Stafford et al., 2011).

Worryingly, very recent investigations in England and Wales have shown that detailed, well-communicated, multi-agency assessments remain relatively uncommon (HM Inspectorate of Probation, 2013), and therefore the NCH ideals remain unrealised.

Nevertheless, standardised tools have developed, or are developing, perhaps as a response to this finding: their use is growing rapidly across the UK (Smith et al., 2013). A brief summary of common assessment methods seems appropriate and is provided in Appendix 1.

Broadly, at this point in time, presented evidence would suggest that there is no 'gold standard' assessment framework; strengths and weaknesses are present for all.

There also remains no specific assessment tool tailored towards non-standard populations, e.g. minority ethnic groups or children with a learning difficulty (Smith et al., 2013) – given the emerging research related to the heterogeneity of individuals involved in HSB, alongside the frequently noted learning difficulties within the population (Vizard et al., 2007), this is a concerning gap. Further caution is therefore required by practitioners when using existing assessment methodologies; it is for the reflective practitioner to remain cognisant of these critiques in order to present an accurate formulation of presented difficulties.

Consideration has been given, thus far, to the difficulties in understanding when sexualised behaviour becomes *harmful* and in identifying potential risk and/or protective factors during development.

Further, once a local, context-specific conceptualisation is decided, difficulties then with operationalising the construct in terms of identification and assessment are pervasive: assessment tools exist, and are growing in utility, however there is no 'gold standard' approach and little consistency evident in practice across LAs thus presenting a potential barrier for multi-agency working. Clearly this has an impact on any subsequent intervention. It is difficult to provide a more robust appraisal of the challenges related to assessment given the relatively limited number of available approaches; this, understandably, has a direct impact upon any subsequent intervention.

(iii) Intervention

There remains a need for evidence based defensible practice when intervention is concerned. Unsurprisingly, with the current trend running throughout this review, there also remains little guidance as to specific intervention approaches (Brown et al., 2011, p. 29):

'Hackett et al. (2005) found an absence of guidance on intervention for practitioners with only one document out of over 100 analysed containing a reference to a specific model of intervention.'

(Hackett et al., 2005, in Brown et al., 2011, p. 29)

There is a general consensus that interventions should be tailored towards a young person's HSB *alongside* their broader needs (Smith et al., 2013), however, there remains no favoured intervention approach: *'our findings suggest that procedures and guidelines to support good practice do not always make explicit suggestions and recommendations, particularly regarding…intervention approaches'* (p. 4). This, given the heterogeneity of the HSB group, maintains that individualised, bespoke support is necessitated (Hutton, 2010).

In the main, this individualistic approach is delivered through the use of evidence based, 'general' psychological principles, augmented by *specific* knowledge developed through the HSB research evidence (Hawkes, 2009) on a case-by-case basis. Elements of Cognitive Behavioural Therapy (CBT) and Multi-Systemic Therapy are used frequently, embedded through individual, group or family based approaches. A review can be found in Smith et al (2013), though evaluation of efficacy is challenging due to the patent heterogeneity of the population and uncertainty relating to the fidelity of any therapeutic approach; *'with interventions… there was an absence of guidance, due in part to lack of evaluation of their effectiveness'* (Hackett et al. 2005 in Smith et al., 2013, p. 26).

Though necessary, an individualised approach is time-consuming. While 'case' specific formulation is likely to produce a more accurate appraisal of the challenges - from which appropriate intervention can be determined – the lack of robust

evaluation of effectiveness leaves professionals struggling to determine the most suitable approach (Smith et al., 2013; YJB, 2008). For service users, some evidence suggests general dissatisfaction with the quality and availability of 'intervention' services (Hackett et al., 2005), though this is largely an unexplored area of research.

Again, a great deal of the burden appears to be on the particular practitioner (Hackett et al, 2005): it is, broadly, the decision of the specific caseworker to determine, from their professional experience or personal preference, *which* intervention approach to select, and *how* it should be delivered. Some significant research studies (e.g. Brown et al., 2011) have highlighted grave concerns related to the current situation in regard to intervention: '*the provision of interventions for [C&YP] who have experienced [or perpetrated] sexual abuse is inadequate'* (p.11)

This is broadly in line with other findings throughout this review which suggest, ultimately, that across all facets of HSB practice there is work to be done; national and local approaches are growing to meet this developing need and are improving in sophistication but there appears to be some way to go (Smith et al., 2013). With this defensible conclusion noted, the current research hopes to contribute to this emerging domain.

With the reader now aware of the contemporary challenges found in literature relating to HSB, there clearly remains a need for many LAs to develop practice. Ultimately that is the goal of the burgeoning policy in the host LA. The current paper now turns to its practical investigation: identifying current operational practices within mainstream primary schools.

Section 3: Methodology

The Current Study, Research Questions and Design

The current study adopted a broadly qualitative methodology (Coolican, 2009), and aimed to:

(i) Contribute to the broader understanding of HSB in non-criminal settings (an existing 'gap' in the wider literature) by working within mainstream primary schools,
(ii) explore the existing understanding of HSB within these settings, including prevalence, identification methods, and intervention approaches used currently, and,
(iii) determine existing levels of training and competence in addressing the needs of C&YP presenting with HSB, and how the LA can contribute to developing practice.

These aims were developed to be context specific so that the findings would have utility for the host LA (Appendix 2 for interview framework developed).

The study was completed in a large, urban LA in England; this was the location in which I was on supervised practice placement as a TEP. Five primary schools (the schools for which I am the link TEP) were approached directly to participate in the research and subsequently meetings were held with members of the Senior Leadership Team (SLT); these members of staff would likely have the responsibility relating to strategic decisions on how HSB was approached and managed.

A 'semi-structured interview' (*'an interchange of views between two or more people on a topic of mutual interest'* – Cohen, 2007, p. 267) was selected as the data gathering method; this approach is viewed widely as valuable for gaining insight into a phenomenon, particularly in research adopting a social constructivist perspective.

As I was the TEP assigned to the schools surveyed, I felt as though the interpersonal relationship between me and the SLT would facilitate honest and candid discussion, providing the predominant rationale for this methodological decision:

"[Using interviews in] research marks a move away from seeing human subjects as simply manipulable, and data as somehow external to individuals, and towards regarding knowledge as generated between humans, often through conversations"
(Cohen et al., 2007, p.267)

Though there was no precedent for this study, the methods of data collection developed were grounded within key papers within this domain (NCH seminal paper, 1992; Smith et al., 2013), and sought to be structured insofar as providing a framework for discussion, as opposed to being rigidly adhered to: the 'interview' is a process that both parties must contribute to, or more plainly, a conversational exchange rather than a monologue (Cohen et al., 2007).

As a foundation for the data collection, on the basis of previous national research (e.g. Hackett et al, 2005; Brown et al., 2011; Smith et al., 2013), local studies (Herriotts-Smith, 2013) and through using various statistics available (NSPCC, 2013), it was hypothesised that each setting would have had occurrences *of some level* of HSB; however, due to no structured local (and limited national) guidance existing currently for identification and intervention, it was also postulated that little consistency would be present across settings. These assumptions, embedded within and elicited from the previous literature review, permeate the remainder of this paper.

Epistemology

As is hopefully clear from the previous pages which outlined the variable conceptualisation of HSB, the current study adopted a generally social constructivist perspective particularly to emphasise that there are few 'concrete' assertions that can be made within this domain of research. The social-constructivist position acknowledges the inherent flexibility of 'artefacts' or emergent phenomena found

within the social landscape (Andrews, 2012), and posits that 'knowledge' is created (as opposed to discovered) through social exchange and shared meaning.

It seems defensible to argue that HSB is not objectively 'real', but becomes evident once meaning is ascribed to the presenting features of the behaviour (Caplan, 2013); many of the terms and conceptualisations associated with sexual behaviour, particularly in childhood, are socially embedded and understood: *'what is sexual in one context may not be so in another; an experience becomes sexual by application of socially learned meanings' (Caplan, 2013, p. 2).* This epistemological position is therefore evident in the following practical research.

Section 4: Present Research Findings

Semi-Structured Interview parts (1) and (2): Current Circumstances

Of the five schools sampled, two suggested that they had had, in the last academic year, an incident of HSB that correlated with the NSPCC definition provided earlier in this paper: both incidents related to the use of inappropriate sexual language, one via social media ('Twitter'), the other via overheard conversations in the school playground.

These concerns were both identified by chance: a teacher being informed about the inappropriate behaviour being presented on the social media platform and, in the other incidence, dialogue eavesdropped. There was no systematic / structured identification approach utilised (this is in line with findings on a national level – Hackett et al., 2005; Brown et al., 2011; Smith et al, 2013):

'It is difficult to identify HSB overall. We have found particular difficulties with modern technology, e.g. 'Twitter'. There was this thing, a 'hashtag', #rapeface, where children were posting pictures of themselves pulling this face as if they were being raped. I didn't even know what a hashtag was, but I was so shocked when I saw it in the newspaper!'*

*(*School 1)

Both schools felt that their designated *'Child-Protection'* lead would be the most appropriate individual from within the school to take responsibility for supporting C&YP involved in HSB - and delivering follow-up training to staff. This person, in both settings, had – at the point of interview - received no specific training in relation to HSB; it was perceived that their 'general' child-protection training would likely be sufficient in supporting HSB specifically.

As a first response to identified HSB, these schools contact 'external' agencies (i.e. NSPCC, LA educational psychology service, social services) for 'expert' guidance; when pressed to identify why these services were the first point-of-contact, the SLT

across both settings suggested that it was, primarily, due to the perception that these professionals were highly trained in working with difficult behaviours and therefore would be able to provide direction to school staff.

Alongside this seeking of more specific expertise, a 'universal' response is provided through their internal school structures, for example through: delivering a whole school-based assembly outlining/reinforcing appropriate behaviour, ensuring closer monitoring of any pupils involved (or suspected of being involved), and offering an anonymous 'thoughts' box where children can raise concerns that might relate to inappropriate behaviour.

Both schools felt that the action taken, internally and through external services, was appropriate for the presenting concern (this assertion supported by the behaviour not recurring). Both schools suggested that they were 'reassured' by the consultation provided by the educational psychology service in particular, and were confident that any guidance was evidence based and robust:

'The opportunity to speak with an external consultant EP, who is familiar with the school community, was fully supportive in helping us manage the HSB'

(School 2)

This appraisal, while positive towards the educational psychology service, largely suggests that the school systems in place for managing HSB are in their infancy, and this is a predictable result given the contemporary circumstances for HSB guidance.

The remaining three schools suggested that, in their settings, HSB was not a pressing concern:

'*HSB is not a priority for our school development because it is such a rare occurrence, and it is difficult to separate HSB from typical, age-appropriate exploration'*

(School 3)

Further, for the three schools where HSB incidents had not occurred, *if* an incident did present itself, the schools response would be through internal mechanisms: universal response through an assembly / class based educative session on appropriate sexual behaviour and reinforcing, for staff, the need to be vigilant.

All three schools would, again, seek evidence based support and guidance through LA services: educational psychology service, social services and behavioural support primarily. The LA services would be approached to both provide guidance in terms of training staff in the most appropriate response, alongside, circumstance-dependent, therapeutic support for the children and/or family involved; this is

concurrent with findings from Youth Justice Board (2008) in terms of most frequent response to HSB presentation.

Each of these three schools, intriguingly, also emphasised the esoteric notion of 'experience' in contributing to the identification of HSB. Though they each concurred with the definition of HSB provided, they noted that a *'gut feeling'* relating to the inappropriateness of any presenting behaviour was their primary method of identifying difficulties. This '*feeling'* was established through their knowledge of a young person and their wider family (i.e. a young person's developmental history/ exposure to inappropriate sexual behaviour).

This nuanced and subjective understanding of appropriate child sexual development and behaviour did not correlate with any wider, evidence-based, structured framework, but rather simply emerged from:

'Knowing what a child and family are like and then being aware of any changes [with regard to atypical behaviour] that might occur'.

(School 4)

Broadly, these 'real world' findings would correlate with the literature presented earlier in this paper: there is some difficulty in schools with separating 'appropriate' sexual behaviour and development from that which is harmful (Boyd & Bromfield, 2006); methods of identification and assessment are not consistent across settings (Hutton, 2010); settings often do not follow a specific framework (Hackett et al., 2005/ Hackett, 2007), and the response is often not tailored to the individual (Brown et al., 2011). The implications of these findings are considered further in the *'discussion'* section, but should be of note for the host LA.

Questionnaire part (2): Training Needs.

The aim of this part of the questionnaire was to determine the *current* level of training regarding HSB, and how any identified need might be supported by the LA. All schools completed this section.

The first question asked Head Teachers to estimate the current training level of staff in school in relation to HSB (Likert scale 1).

			School 1 & 3	**School 5**	**School 2 & 4**					
0	1	2	3	4	5	6	7	8	9	10

Likert scale 1 showing self-reported training level of staff relating to HSB (with '10' being the 'best')

Some criticisms are noted relating to the efficacy and representativeness of a Likert scale, particularly the structure of data elicited being ordinal in nature (e.g. Norman, 2010): broadly, while the response categories have a 'rank' order, the intervals between values on the scale cannot be presumed equal, or interpreted as such by respondents and this affects the objectivity of the measure (Jamieson, 2004).

Nevertheless, given the 'exploratory' nature of this study, the desired outcomes and the sample size (n=5), the choice to select this tool is defensible:

'Likert data [are valid] with small sample sizes…unequal variances, and with non-normal distributions, with no fear of "coming to the wrong conclusion". These findings are consistent with empirical literature dating back nearly 80 years. The controversy can cease (but likely won't).

(Norman, 2010, p. 630)

The above finding argues that each setting suggested that a training *need* was evident, though some existing knowledge was present across the settings. From this question, participants were asked to consider *how this training might be offered*.

Encouragingly, each setting was very enthusiastic and supportive of LA endeavours to develop HSB training: though there was variation in terms of whether HSB was a 'priority' for school development (no, n=3: yes, n=2), each setting suggested that, were training to be offered, school staff would be encouraged to attend.

All settings suggested that training offered at a central level would be preferred: while there was a consensus that identification and vigilance towards HSB was a shared responsibility, given the relative infrequency of incidents, it was considered that *the whole* staff group attending training would not be a valuable or efficacious approach:

'In an ideal world it would be something that I would send all my staff on, but being realistic, it would be better for 2 or 3 members of the team to go, and then feedback – like a cascade effect – to the wider staff group via a 'workshop'. This seems to me to be a more effective use of time.'

(School 3)

Broadly, all settings identified that a training need was present to a lesser or greater extent, and there was a positive response to the suggestion of the LA offering training in line with national guidance (NSPCC, 2013). There was no opportunity for the staff interviewed to discuss the *content* of what would be present in the training, though given answers to the earlier section of the questionnaire it seems defensible to suggest that specific input on identification and intervention approaches would be

valued, alongside training on when typical behaviour becomes inappropriate or harmful.

It is now appropriate to consider these findings in the context of the host LA, and to provide specific recommendations for meeting this emergent need.

Section 5: Discussion: Limitations, Implications and Conclusions for the LA and wider *'Educational Psychology'* Practice.

Conclusions and Implications

This current study has highlighted the existing circumstances in relation to HSB in five mainstream primary schools; the findings suggest that there is considerable inequality across settings. This is an unsurprising outcome given the national picture outlined in the current study's literature review, alongside the relative infancy of this domain of research:

'Lack of explicit guidance may increase the chances of inconsistency within and across local authorities'

(Smith et al., 2013, p. 6)

The current section provides implications for the host LA, and recommendations to ensure that the research has demonstrable utility. This is offered on two 'levels': practical guidance for developing policy in the host LA, and a consideration of the underlying theoretical principles that should permeate future work relating to HSB. Limitations of the current research are also considered, alongside discussion of the role of the practitioner psychologist.

Recommendations

The current research highlighted that, presently, there is poor clarity in relation to the assessment and intervention methods that are available both within school settings and across the wider LA. While the discourse evident in this current study largely suggested that each setting felt 'confident' in their HSB practice, given that little uniformity in approaches was found, this is unlikely to be an accurate appraisal.

Accordingly, there is a general requirement for more regularity across all facets of HSB practice. This will require agencies and professionals, in particular those likely to have involvement with HSB, to work in a *cohesive and unified* way. This is largely recognised as 'good practice' (NSPCC, 2013).

To ensure this consistency develops successfully, there are a number of recommendations that can be implemented:

Assessment & Identification

Although some challenges are present with the theoretical tenets that underpin the existing assessment methods (e.g. AIM/AIM2, J-SOAP and ERASOR) – ultimately a service-wide decision is required as to which assessment tool(s) is/are favoured. To assist in this process (and to ensure robust, evidence based practice), careful appraisal of the supporting / refuting evidence for each assessment tool is required (of which the current literature review may provide a foundation).

Best practice guidelines (HM Inspectorate of Probation, 2013; NSPCC, 2013) would suggest that a battery of assessment tools are available for practitioners to utilise on a case-by-case basis, however this may be counter-productive to the wider aims of developing *consistency* in assessment approaches across the LA.

The assessment measure(s) chosen should correlate strongly with the developing research findings (e.g. Youth Justice Board, 2008; Brown et al., 2011; Smith et al., 2013), and have demonstrable utility at identifying both risk of HSB emerging, but also the likelihood of recidivism.

Although there is no 'gold standard' assessment, likely due to the inherent variability of sexual development and the arguably socially constructed nature of sexual behaviour more generally, practitioners utilising well-evidenced psychological principles, *alongside* structured assessment measures, are likely to experience more success at identifying and supporting HSB.

Intervention

There is limited national guidance relating to promoted intervention approaches. The *'Key Elements of Effective Practice'* (Youth Justice Board – YJB, 2008) provides some foundations from which to begin in the developing of evidence based robust intervention:

Elements of 'good' intervention - (Intervention guidance, YJB, 2008, p.16)

1. emotional competence skills, including management of anger and distress
2. general developmental assessment
3. changing cognitive distortions about sex and relationships
4. pro-social, emotional, cognitive and behaviour skills
5. risk assessment
6. gaining an understanding of the child's cycles/pathways to sexually harmful behaviours
7. sex education
8. life-space work (e.g. boundaries, interaction, social skills)
9. relapse prevention work
10. family work
11. consequences of further abuse/behaviour
12. the development of empathy

Effectively, once more, it is likely that the favoured intervention methods are *context specific*: simply, LAs, and practitioners within the LA, retain autonomy in the selection of their preferred intervention model.

What appears more crucial in the selection of the intervention is that it follows the evidence found in research:

'A rigorous approach to research evidence, combined with professional judgement, can provide the basis for effective practice in this field.'

(Hackett, 2004, p. 3)

Research supports some intervention approaches, and components within these approaches, as being more efficacious (Hackett, 2004) but, given the complexity of HSB, inconsistency in intervention efficacy is variable, and indeed likely:

'We are still in need of further research which can offer a more conclusive view on the 'treatment outcome' issues.

(Hackett, 2004, p. 3)

Simply, at this point in time, determining relative 'effectiveness' of one approach set against another is a false comparison: the way in which the intervention is delivered (1:1, community, group), practitioner 'commitment' and rapport with a young person, the relative 'expertise' of the practitioner and fidelity to the approach all impact strongly on intervention outcomes (Hawkes, 2009).

Further, Borduin & Schaeffer (2002) suggest that as HSB is determined by multiple factors, 'treatment' (intervention) must be flexible to ensure these factors are considered within a young person's particular context. Dogmatic approaches to intervention may be unhelpful, and applying specific approaches mechanistically is not supported as efficacious in the research (Hackett, 2004).

Accordingly, to further ensure that this current research has utility for the host LA, intervention principles are now provided – based on the literature reviewed for this paper, and consistent with contemporary guidance (NSPCC, 2013):

Intervention principles for host LA.

Intervention should be:

- Delivered by a practitioner with experience of *specialist training*;
- Targeted to *specific, measurable* 'outcomes';
- Underpinned by sound *psychological principles* and *robust evidence*;
- *Tailored* to an individual, *flexible* to their specific requirements while being embedded *in context*;
- *Supervised* by an *appropriately trained* practitioner; and,
- Evaluated to determine *efficacy*.

Given the variability of the phenomenon, it is likely that any psychological formulation, subsequent hypotheses and desired intervention approaches will need to be flexible in order to reflect the nature of the difficulty in question.

(Adapted from Hawkes, 2009)

The recommendations provided here may go some way to providing necessary rigour and defensible practice for the host LA when developing their HSB policy.

Largely, however, it is the case that little agreement can be found across the domain of HSB – the LA at the heart of this current research, through the policy which is under development, are contributing to the emerging paradigm for HSB practice. Though there remain many unknowns, utilising 'best practice' principles, alongside robust evaluation of, and reflection upon, any work undertaken will likely assist in the development of services for C&YP at risk of significant harm.

Limitations of the Study

On reflection, the current study suffers from three particular limitations which may affect its utility when attempting to operationalise the findings: data analysis method, generalizability and subjectivity (Coolican, 2009). These limitations should be considered if this current research is to be used when developing LA policy and training opportunities for HSB.

The first limitation relates to the generalizability of the findings. The schools approached for this current study are from a predominantly affluent district of a large, urban LA. It must be considered, however, that the wider socio-economic status of this LA is noticeably more deprived:

'Deprivation [in this LA] is higher than average and about 15,800 children live in poverty.'

*(*Local Census, 2012, p.1)

Thus the sample of schools in this current study may not reflect fully the wider context; ecological validity and generalizability must therefore be considered (Bryman, 2008) - a larger, perhaps more reflective, cross-section of participating schools is required were this research to be built upon.

The second limitation relates to the measures developed and used for data collection. Due to the questionnaire structure, responses were predictably subjective and related to the Head Teacher's (or SLTs) estimation (e.g*. 'how well trained are the staff?*'), rather than an objective 'reality'.

Though this was anticipated given the epistemological position for this paper, and arguably reflects wider difficulties with research into HSB (i.e. no shared consensus on what HSB *actually is*) it must be considered that there may be some variance between findings; there can be no certainty that each Head Teacher will have judged, for example, training levels/competence in the same manner, and thus there may be little consistency across these self-report scales. This should be considered when attempting to infer conclusions from these data.

One final point relates to the method in which the data was analysed. Though 'Content Analysis' (Miles and Huberman, 1994), 'Thematic Analysis' (Braun and Clarke, 2006) and 'Narrative Analysis' (Bamberg, 2012) were considered, ultimately 'Qualitative Description' (Sandelowski, 2000) was the selected approach to data analysis. While qualitative researchers have a number of theoretically and technically sophisticated methods available for analysing data, patently the approach selected should be relevant to the data under investigation.

The 'Qualitative Description' method involves me, as researcher, *'seeking descriptive validity, or presenting a representative account of 'events' that most people observing the same event would agree is accurate'*

(Sandelowski, 2000, p. 336)

Simply, as this paper was designed to be *'exploratory'*, it is not appropriate for me to put my own 'spin' on the data via interpretation, simply to present the findings 'as is':

'Although human beings can never, and will likely never want to, describe everything that is 'there', what [those undertaking qualitative description present] will be something that most observers would agree is in fact 'there'.'

(Sandelowski, 2000, p. 336)

The data analysis is more in-line with a description of *what was said* rather than interpreted in any inductive or thematic way; this was relevant simply due to the

nature of the study and the 'richness' of data available arguably not being detailed enough to deduce thematic elements.

To further support this decision, no concrete conclusions are inferred from the data; rather they provide *an approximation* of how things are on the ground. This study may possibly be considered a 'pilot'; the developed methods may be valuable as a framework for future research through approaching other schools across the city to gain a more representative sample. Broadly, the findings *assist* in developing a fuller understanding of HSB across the LA and are valuable to that end.

Closing Comments and Role of the Educational Psychologist

Throughout the process of this research it has become evident that there remains considerable ambiguity relating to HSB across many facets of the phenomenon: controversy with the underpinning theoretical conceptualisation and a lack of consistency in practice further compounds this position.

Necessarily, then, it is required of LAs to think creatively as to how HSB is supported, using professional, evidence based judgment while remaining cognizant of contemporary research (e.g. Smith et al., 2013).

Rather than closing this paper by providing *specific* roles for the EP, it seems evident that, at each step of policy development, the EP holds valuable skills that can support in the advance of robust, evidence-based practice: theoretical knowledge from psychological research, skills in appraising and synthesising data and then, as applied psychologists, embedding findings into practice. How this operates in practice will understandably be context dependent and necessarily adaptive in order to mirror the uncertainty present with HSB as a concept more generally.

It is worth considering, however, that while HSB related practice is arguably marginal in EPs work, given the recent increase in practitioner and research interest, this should not be assumed to continue. As such, it is required of the EP to be aware of current debates and controversies in relation to HSB in order to offer – insofar as is possible – evidence based guidance and recommendations.

It seems reasonable to suggest that any increase in EP work relating to HSB will be in supporting professions to distinguish between typical and a-typical sexual development. However, as this paper has identified, this is not a categorical distinction, and thus EPs should be cautious if asked to comment specifically about presented behaviour that may be sexual in nature. In order to safeguard the practitioner psychologist, some of the tools and assessments as covered in this paper might provide a framework to ensure robust practice in an emerging field.

Appendix 1: Approaches to Assessment in the United Kingdom

Smith et al (2013) found that the AIM/AIM2 ('Assessment – Intervention – Moving on', Youth Justice Board, 2000) specialist approach to assessment was used frequently (over half of the LA's surveyed, n = 18) to provide a framework for assessment of HSB. Unsurprisingly this investigation has some limitations: the research utilised only a minimal sample of LAs (20% in England, Scotland, Wales and 33% in Northern Ireland) and subsequent generalisations were made from the basis of these data (e.g. it may not be a fully reflective sample). Nevertheless, this study provides a relevant 'snapshot' of how things may be working in practice.

Other assessments such as ERASOR ('Estimate of Risk of Adolescent Sexual Offense Recidivism' (Worling & Curwen, 2001)) and J-SOAP ('Juvenile Sex Offender Assessment Protocol' (Prentky and Righthand, 2003)) have also been developed in recent years. The AIM/AIM2, J-SOAP-II and ERASOR are the tools used most frequently in UK LAs (Hempel., et al, 2011).

What, then, should be the preferred approach adopted by an LA? Disappointingly, there is no consensus: all currently available assessment measures have methodological flaws and/or insecure theoretical tenets.

AIM/AIM2

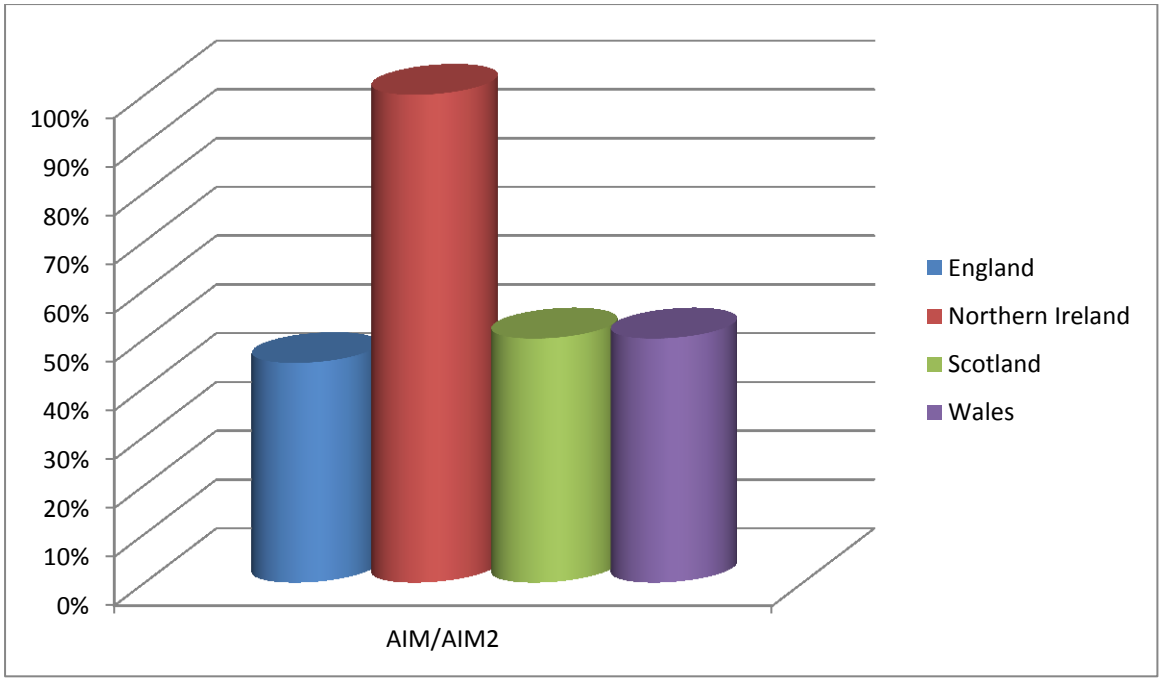
The AIM/AIM 2 framework aims to provide a common language and shared approach to assessment of sexual offending (Print et al, 2002), consistent with good practice guidance for multi-disciplinary, consistent approaches (NSPCC, 2013). The AIM project was set up to augment the way professionals respond to children and young people aged 10 – 17 who display HSB: the assessment structure considers HSB specific *and* developmental factors, the role played by parents and/or caregivers and the community and/or environment as dynamics that affect the young person's development.

A two-year evaluation found that there was a high degree of consistency between different professionals (Youth Offending Team, NSPCC, CAMHS) using the AIM/AIM 2 framework; AIM was considered in this study as a beneficial, clear and helpful process for practitioners (Griffin & Beech, 2004) to use when assessing HSB.
The use of AIM has also facilitated, in some LAs, the establishment of interagency protocols for multidisciplinary working with young offenders (e.g. Manchester). In this LA, following the introduction of the AIM methodology, the Police service developed their practice from using the 'Risk Matrix' (Hanson and Thornton, 2000), which was developed for use with adult offenders, to using AIM/AIM2 with young people. Findings were positive, though *not all* agencies in this LA adopted the AIM framework and thus concerns over complete inter-agency collaboration are noted (Griffin & Beech 2004): *'Some of the reasons are the extensive workloads carried by*

professionals; shift patterns; accessibility of agencies and internal protocols around information-sharing' (p. 83).

It appears from the findings in this study that adopting novel working practices and perspectives on HSB may require a cultural paradigm shift in understanding. More pragmatically, while the use of AIM/AIM2 consistently across agencies is parallel with good practice guidelines in terms of systematic assessments and multi-agency approaches (NSPCC, 2013, p. 34), the AIM/AIM2 assessment model, however, finds further inherent challenge with consistency and predictive validity not yet being fully reliable (Griffin and Beech, 2004) and a prescribed timescales for assessments being sometimes too short to work to (Youth Justice Board, 2011).

Nevertheless, this framework appears to be increasing in popularity across UK LAs (Hackett, 2005):



Graph 1: showing the percentage (of UK LA's surveyed, n= 18) using the AIM/AIM2 assessment framework (adapted from Smith et al., 2013).

J-SOAP-II

The J-SOAP-II is a checklist, developed to provide professionals with a tool to review systematically any risk factors, as identified through literature (e.g. Righthand et al, 2005), as being related to sexual offending behaviours. This tool can only be used with a relatively narrow section of the wider population (males aged 12 to 18), and the authors state that the J-SOAP-II should not be used in isolation, only being part of a holistic assessment (Prentky and Righthand, 2003).

Nevertheless, *'The J-SOAP-II is currently the most widely used and researched '*risk assessment' *instrument specifically designed to aid in the evaluation of the risk of sexual recidivism'* (Martinez, 2011). While this tool is used extensively, relatively little empirical research is available in relation to its predictive validity (Viljoen et al, 2008): in some studies the J-SOAP-II demonstrated considerable accuracy at predicting sexualised behaviour recidivism (Martinez, Flores, & Rosenfeld, 2007; Prentky et al., 2010; Rajlic & Gretton, 2010) and recidivism of non-sexualised behaviour (Rajlic & Gretton, 2010).

Contrastingly, other research identified the total J-SOAP-II score did not predict reoffending of any nature (Caldwell et al., 2008; McCoy, 2007; Viljoen et al., 2008): some critics (e.g. Viljoen et al, 2009) suggest that this discrepancy is due to the J-SOAP-II *'being designed to measure sexual and nonsexual offending among male adolescent sex offenders. Whether the same instrument should be used in assessing risk for sexual and nonsexual violence should be re-evaluated'* (p.19)

Nevertheless, 'popularity' aside, more research is needed in relation to this tool before concrete assertions can be made about its utility. The fact that this tool is only applicable to male populations is a further concern; there is already a skew in terms of research relating to male populations, further compounding difficulties in presenting an accurate picture of prevalence.

ERASOR

Worling and Curwen's (2001) ERASOR (*'Estimate of Risk of Adolescent Sexual Offense Recidivism'*) was borne out of dissatisfaction with previously available methods of assessing risk (e.g. Historical, Clinical, Risk Management-20 and Sexual Violence Risk-20; Boer et al., 1997; Webster et al., 1997) of HSB.

Broadly, it is a methodology designed to determine the risk of sexual 'violence' among young people (between the ages of twelve and eighteen) using 9 'static' items and 16 'dynamic' items all related to risk of HSB. The tool estimates risk for the short term (roughly 1 year), and medium to long-term risk cannot be derived (1< year) (Worling, 2004).

Empirical evidence suggests a mostly positive level of 'inter-rater' reliability and internal consistency (Viljoen et al., 2009; Worling, 2004); however support for the tool's predictive validity is less robust: some argue it to be only a moderate to strong tool for the prediction of sexual, 'nonsexual', and general recidivism (i.e. the likelihood of reoffending of any type) (Morton, 2003; Rajlic & Gretton, 2010; Skowron, 2005; Worling, 2004) yet paradoxically, Viljoen et al. (2009) and McCoy (2007) contest this view and argue against the validity of this measure for predicting recidivism more broadly.

As with the J-SOAP-II, further evidence is required to determine how robust this tool is.

As can be seen from this brief section, though there are emerging tools and assessment frameworks, there remains some fundamental methodological challenges across each approach. This is unsurprising given the relative infancy of practitioner interest in this domain, but provides a further challenge for LAs when attempting to develop practice.

Appendix 2: HSB Data Gathering Interview Schedule

'Harmful Sexual Behaviour'

Dear <School>.

Thank-you for agreeing to complete this questionnaire relating to *'Harmful Sexual Behaviour'* (HSB).

Although this may be an uncomfortable subject to investigate, recent research suggests that 'HSB' in schools is an area of increasing concern (Radford, 2011) and the need for early and appropriate intervention is of significant importance (Brown et al., 2011).

HSB is defined as:

"Harmful sexual behaviour involves one or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults"

(Rich, 2011, **NSPCC definition**).

As part of a wider strategy, Wolverhampton City Council Educational Psychology Service (EPS) is in the process of developing pathways for referral and/or intervention, alongside relevant training opportunities for schools to ensure that the management of these difficulties is appropriate and evidence based.

The aim of this current questionnaire is to investigate the present 'circumstances' in relation to the prevalence in schools, assessment procedures, management and (where appropriate) intervention for this population, along with the current level of knowledge/training in this area.

Any results will be used to inform the development of training opportunities in an attempt to develop robust and rigorous systemic practices to support this population.

This questionnaire is to be used as the initial 'data gathering' process – names, identifying features and/or specific case examples will, if used, be made anonymous via the use of pseudonyms.

Many thanks.

Chris Wood

Trainee Educational Psychologist, MAST 4

During the previous academic year (2012/13), were there any incidents within school that might be considered sexually harmful by the NSPCC definition (as above)?

a. Yes (*Please answer questionnaire '1'*)

b. No (*Please answer questionnaire '2'*)

Can ALL respondents please answer Questionnaire '3' which relates to future training directions of HSB?

N.B. Please do not use the names of any child or young person when answering these questionnaires; this is to protect anonymity and confidentiality.

Questionnaire ‘1’

1. Please describe briefly the circumstances of the situation relating to Harmful Sexual Behaviour:

---

2. How were these presenting issues first noticed, and what behaviours were observed?

---

3. What was the school response to these challenging behaviours?

---

4. If these difficulties were to be managed via internal systems and staff, would you feel that the school had an appropriate level of training and/or expertise in this area? If yes; why? If no; why not?

---

5. If these difficulties were supported by external agencies, which agencies were these and what was their response?

---

6. Do you feel that the action taken (either internally or by external sources) was successful in managing these presenting concerns? If yes; why? If no; why not?

Questionnaire ‘2’

1. If there were, in theory, any incidents that occurred in which harmful sexual behaviour was a factor, would this be managed internally through school systems and/or staff or via external agencies?

    - Internal ‘systems’ and processes,
    - External Agencies

2. If internally, what might be the response and who would be tasked with completing this?

---

3. If external agencies, which agency might be contacted and what would be requested from these services?

Questionnaire ‘3’

1. On the following scale, what is the current training level of staff in school in relation to HSB?

0----------5----------10

2. Is training on HSB something that would be considered a priority for the school?
   Yes
   No

3. If training were offered by the Local Authority in relation to HSB, would this be something that the school might engage with? If yes; why? If no; why not?

---

4. Would this be something that the whole school as a staff cohort might engage with (i.e. the training being delivered as an INSET) or would a designated person (people?) be more appropriate (i.e. the selected person attending training delivered at a Local Authority setting)? Please elaborate on your answer:

References

Andrews, T. (2012). What is social constructionism? **The Grounded Theory Review: An International Journal** , 11 (1), 39–46.

Bamberg, M. (2012). Narrative analysis. In H. Cooper (Editor-in-chief), **APA handbook of research methods in psychology** (3 volumes). Washington, DC: APA Press.

Bancroft, J. (2003). Introduction. In J. Bancroft (Ed.), **Sexual development in childhood**. Bloomington: Indiana University Press

Bladon, E. Vizard, E., French, L. & Tranah, T. (2005). Young Sexual Abusers: A Descriptive Study of a UK Sample of Children Showing Sexually Harmful Behaviours. **The Journal of Forensic Psychiatry & Psychology**. 16 (1). 109 – 126

Boer, D.P., Hart, S.D., Kropp, P.R., & Webster, C.D. (1997). **Manual for the Sexual Violence Risk – 20: Professional guidelines for assessing risk of sexual violence**. Vancouver, B.C.: The Mental Health, Law, and Policy Institute.

Borduin, C. M., & Schaeffer, C. M. (2002). Multisystemic treatment of juvenile sexual offenders: A progress report. **Journal of Psychology and Human Sexuality**, 13, 25-42.

Boyd, C., & Bromfield, L. M. (2006). **Young people who sexually abuse: Key issues**. ACSSA Wrap, 3.

Braun*, V.* and Clarke*,* V. (*2006*) Using thematic analysis in psychology. **Qualitative Research in Psychology**, 3 (2). 77-101

Brown, J., O'Donnell, T. and Erooga, M. (2011) **Sexual abuse: a public health challenge**. London: NSPCC.

Bryman, A. (2008), **Social Research Methods (third edition)** Oxford: Oxford University Press

Burton, D. L. (2000). "Were adolescent sexual offenders children with sexual behavior problems." **Sexual abuse: A journal of research and treatment** 12(1): 37-48.

Calder, M.C. (2001). **Juveniles And Children Who Sexually Abuse: Frameworks for Assessment**. Russell House Publishing: Dorset

Caldwell, M. F., Ziemke, M. H., & Vitacco, M. J. (2008). An examination of the sex offender regristration and notification act as applied to juveniles**. Psychology, Public Policy, and Law**, 14, 89-114.

Caplan (2013) **The Cultural Construction of Sexuality**. London: Routledge

Cohen, L., Manion, L. and Morrison, K. (2007) **Research Methods in Education (6th Edition).** London: Routledge Falmer

Coolican, H. (2009) **Research Methods and Statistics in Psychology**. London: Hodder and Stoughton Ltd

Cooper, C., & Roe, S. (2012). An estimate of youth crime in England and Wales: Police recorded crime committed by young people. **Home Office Research Report**. London: Home Office.

Coren E, Hossain R, Pardo Pardo J, Veras MMS, Chakraborty K, Harris H, Martin AJ. (2012). Interventions for Promoting Reintegration and Reducing Harmful Behaviour and Lifestyles in Street-connected Children and Young People: A Systematic Review. **Campbell Systematic Reviews**

Department of Health, Social Services and Public Safety (DHSSPS), (2003) **Guidance to assist Area Child Protection Committees develop strategies, policies and procedures to safeguard children who are assessed to be at risk of significant harm**.

Goodyear-Brown et al., P. (2012). **Handbook of child sexual abuse: identification, assessment, and treatment**. Hoboken, New Jersey: Wiley.

Griffin, H. and Beech, A. (2004) **'Evaluation of the AIM Framework for the Assessment of Adolescents who Display Sexually Harmful Behaviour'**, Available at: www.yjb.gov.uk/Publications/Resources/Downloads/AIM%20Full%20Report.pdf

Hackett, S. (2004). **What works for children and young people with harmful sexual behaviours?**. Barkingside: Barnardo's.

Hackett, S. et al (2005) **Services for young people who sexually abuse**. London: NSPCC, Youth Justice Board and National Organisation for the Treatment of Abusers

Hackett, S**.** (2007). Just how different are they? Diversity and the treatment of young people with harmful sexual behaviours. In **Children and young people who**

sexually abuse: taking the field forward. Calder, M. Lyme Regis: Russell House Publishing.

Hagan, M. P., Gust-Brey, K. L., Cho, M. E., & Dow, E. (2001). Eight year comparative analyses of adolescent rapists, adolescent child molesters, other adolescent delinquents, and the general population**. International Journal of Offender Therapy and Comparative Criminology**, 45(3), 314−324

Hanson, R. K. & Thornton, D. (2000) Improving risk assessment for sex offenders: A comparison of three actuarial scales. **Law and Human Behaviour**, 24, 119-136

Hawkes, C. (2009) **Sexually harmful behaviour in young children and the link to maltreatment in early childhood: conclusions from a UK study of boys referred to the National Clinical Assessment and Treatment Service (NCATS), a specialist service for sexually harmful behaviour**. London: NSPCC.

Helmus, L., Thornton, D., Hanson, R. K., & Babchishin, K. M. (2012). Improving the predictive accuracy of Static-99 and Static-2002 with older sex offenders: Revised age weights. **Sexual Abuse: Journal of Research and Treatment,** *24,* 64-101

Hempel, Inge, Nicole Buck, Maaike Cima, and Hjalmar van Marle. (2011) “Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next?” **International Journal of Offender Therapy & Comparative Criminology** 57 (2): 208-228

Herriotts-Smith, S (2013**) Harmful sexual behaviour: A sociocultural analysis of the developing policy and practice for educational psychologists in one local authority** Ap.Ed.&ChildPsy.D. thesis, University of Birmingham.

Hetherton, J. (1999). The idealization of women: Its role in the minimization of child sexual abuse by females. **Child Abuse & Neglect**, 23, 161-174.

Hickey, N., Vizard, E., McCrory, E. and French, L. (2006) **Links Between Juvenile Sexually Abusive Behaviour and Emerging Severe Personality Disorder Traits in Childhood**. **DSPD Programme: Dangerous People and Severe Personality Disorder**, Department for Health, Home Office and National Offender Management Service

Hickey N, McCrory E, Farmer E., (2008) Comparing the developmental and behavioural characteristics of female and male juveniles who present with sexually abusive behaviour, **Journal of Sexual Aggression**, 14, 241-252

HM Government (2010) **Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children**. London: Department for Children, Schools and Families (DCSF).

HM Inspectorate of Probation (2013) **Examining Multi-Agency Approaches to Children and Young People who Sexually Offend**. Available from: Justice.gov.uk

Howe, D (2005) Child Abuse and Neglect, **Attachment, Development and Intervention** Palgrave Macmilllan.

Hutton, L and Whyte, B. (2006) 'Children and young people with harmful sexual behaviours: First analysis of data from a Scottish sample'. **Journal of Sexual Aggression**, 12 (2), 115-125

Hutton, L. (2010). **"Treatment Options for Juvenile Sex Offenders: A Review of the Literature and Consideration of Existing Programmes."** Edinburgh: Criminal Justice Social Work Development Centre, University of Edinburgh

Jamieson, S. (2004). Likert scales: how to (ab)use them. **Medical Education**, 38(12), 1217-1218.

Långström, N. (2001). Long-term follow-up of criminal recidivism in young sex offenders: Temporal patterns and risk factors**. Psychology, Crime & Law**, 8(1), 41−58.

Lemma, A (2004) **On hope's tightrope: reflections on the capacity for hope**. In Susan Levy and Alessandra Lemma (eds) The perversion of Loss, Pychoanalytic Perspectives on Trauma. Whurr Publishers Ltd.

Lemma, A and Levy, S (2004) **The impact of trauma on the psyche: internal and external processes**. In Susan Levy and Alessandra Lemma (eds) *The perversion of Loss, Pychoanalytic Perspectives on Trauma*. Whurr Publishers Ltd.

Lenhart, A. (2009) '**Teens and Sexting: How and why minor teens are sending sexually suggestive nude or nearly nude images via text messaging'**. Pew Research Centre Report. http://pewresearch.org/assets/pdf/teens-and-sexting.pdf : Accessed 25 August 2014.

Levine, J. (2002) **Harmful to Minors: The Perils of Protecting Children from Sex.** Minneapolis: University of Minnesota Press

Lovell. E., (2002). **Children and Young People who Display Sexually Harmful Behaviour**. NSPCC, UK

Martinez, R., Flores, J., & Rosenfeld, B. (2007). Predictive validity of the Juvenile Sex Offender Assessment Protocol? II (J-SOAP-II) with inner city minority youth. **Criminal Justice and Behaviour**, 34. 1284-1295

Martinez, R. (2011). Validity of the Juvenile Sex Offender Assessment Protocol Revised (JSOAP-II) with a multiethnic sample of juvenile sex offenders released from juvenile justice commission placements. **Dissertation Abstracts International: Section B. Science and Engineering**, 72.

McCartan, F. M. et al (2011) Child and adolescent females who present with sexually abusive behaviours: a 10-year UK prevalence study. **Journal of Sexual Aggression**, 17(1): 4-14.

McCoy, W. K. (2007). **Predicting treatment outcome and recidivism among juvenile sex offenders: The utility of the JSOAP-II and ERASOR in an outpatient treatment program**. Sam Houston State University. Hunstville, Texas.

Miles, M. B., & Huberman, A. M. (1994). **Qualitative data analysis: An expanded sourcebook** (2nd ed.). Thousand Oaks, CA: Sage.

Morton, K. E. (2003). **Psychometric properties of four risk assessment measures with male adolescent sex offenders**. Unpublished master's thesis. Carleton University. Ottawa, Ontario, Canada.

National Children's Home (1992) **The Report of the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children**. London: National Children's Home.

Norman, G. (2010). Likert scales, levels of measurement and the 'laws'. **Advances in Health Science Education**, 15: 625-647

NSPCC (2013) **Harmful sexual behaviour: NSPCC research briefing.** London: NSPCC

Prentky, R. A. & Righthand, S. (2003). **Juvenile Sex Offender Assessment Protocol: Manual**. Bridgewater, MA: Justice Resource Institute

Prentky, R., Li, N. C., Righthand, S., Schuler, A., Cavanaugh, D., & Lee, A. F. (2010). Assessing risk of sexually abusive behaviour in a child welfare sample. **Behavioural Sciences and the Law**, 28, 24-45.

Print, B., Morrison, T. and Henniker, J., (2002). **Working with young people who display sexually inappropriate and abusive behaviour**. AIM project, Manchester

Radford, L. (2011) **Child abuse and neglect in the UK today**. London: NSPCC.

Rajlic, G., & Gretton, H. M. (2010). An examination of two sexual recidivism risk measures in adolescent offenders: The moderating effect of offender type. **Criminal Justice and Behaviour**, 37,(10), 1066-1085.

Rich, P. (2011) **Understanding, assessing and rehabilitating juvenile sexual offenders.** 2nd ed. New Jersey: Wiley.

Righthand, S & Welch, C. (2001). **Juveniles who have sexually offended: a review of the professional literature**. U.S Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Righthand, S., Prentky, R., Knight, R., Carpenter, E., Hecker, J. E., & Nangle, D. (2005). Factor analysis and validation of the Juvenile Sex Offender Assessment Protocol (J-SOAP). **Sexual Abuse: A Journal of Research and Treatment,** 17(1), 13-30.

Ringrose, J. (2012) **A qualitative study of children, young people and 'sexting': a report prepared for the NSPCC**. London: NSPCC.
Sandelowski, M. (2000). Reembodying qualitative inquiry. **Qualitative Health Research**, 12, 104-115

Smith, C., Bradbury-Jones, C., Lazenbatt, A., Taylor, J. (2013) **Provision for young people who have displayed harmful sexual behaviour: an understanding of contemporary service provision for young people displaying harmful sexual**. NSPCC: London.

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. **Attachment & Human Development**, 7(4). 349-367.

Stafford, A., Parton, N., Vincent, S. and Smith, C. (2011). **Child Protection Systems in the United Kingdom**. London: Jessica Kingsley.

St. Amand, A., Bard, D.E. and Silovsky, J.F. (2008) Meta-analysis of treatment for child sexual behavior problems: practice elements and outcomes. **Child Maltreatment**, Vol.13, 2. 145--166.

Viljoen, J., Scalora, M., Cuadra, L., Bader, S., Cha´vez, V., Ullman, D., & Lawrence, L. (2008). Assessing risk for violence in adolescents who have sexually offended: A comparison of the J-SOAP–II, J-SORRAT–II, and SAVRY. **Criminal Justice and Behaviour**, 35, 5–23

Viljoen, J. L., Elkovitch, N., Scalora, M. J., & Ullman, D. (2009). Assessment of reoffense risk in adolescents who have committed sexual offenses: Predictive validity of the ERASOR, PCL:YV, YLS/CMI, and Static-99. **Criminal Justice and Behaviour***, 36*, 981-1000.

Vizard, E. (2006) Sexually abusive behaviour by Sexually abusive behaviour by children and adolescents. children and adolescents. **Child and Adolescent Mental Health** 11, 2-8.

Vizard, E., Hickey, N., French, L., Vizard, E., Hickey, N., French, L., et al (2007) Children and adolescents who present with sexually Children and adolescents who present with sexuallyabusive behaviour: a UK descriptive study. **Journal of Forensic Psychiatry and Psychology** 17, 3.

Vizard, E. (2013**). Practitioner Review: The victims and juvenile perpetrators of child sexual abuse-assessment and intervention**. JCPP online.

Webster, C.D., Douglas, K.S., Eaves, D., & Hart, S.D. (1997). **HCR-20: Assessing Risk for Violence (version 2)**. Burnaby, British Columbia, Canada: The Mental Health, Law, and Policy Institute of Simon Fraser University.

Welsh Assembly Government (2006) **Safeguarding children: working together under the children act 2004**. Cardiff: Welsh Assembly Government.
Worling, J. R., & Curwen, T. (2001). Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Version 2.0). In M. C. Calder (Ed.), **Juveniles and children who sexually abuse: Frameworks for assessment** (372–397)

Worling, J. R. (2004). The Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR): Preliminary Psychometric Data. **Sexual Abuse: A Journal of Research and Treatment**, *16*, 235-254

Youth Justice Board (2008) **Annual report 2006/07**. London: Youth Justice Board.

Professional Practice Report 4: Professional Perspectives on the Purpose, Efficacy and 'Value' of *"Pupil Referral Units"* in a West Midlands Local Authority.

Abstract

Across the local authority (LA) in which this current research is situated, a considerable number of 'alternative provisions' (APs), distinct from 'mainstream' education settings, are available for children and young people (C&YP) for whom typical school has not been successful; most often this is due to *'behavioural, emotional and/or social difficulties'* (DfE, 2013).

The AP used most widely, nationally and locally, is the Pupil Referral Unit ('PRU'). The host LA has access to four separate PRUs, each developed to provide unique support services. Admission is gained via a number of routes, all requiring an educational psychologist (EP) having completed an 'assessment' to formulate each child's individual needs.

The psychological formulation process undertaken as part of this assessment is consistent with guidelines outlined by the *'Division of Educational and Child Psychology'* (DECP, 2002): initial hypotheses are generated and then evidence which can confirm or refute them is obtained. Once robust assessment is complete, decisions can be made as to where C&YP's specific needs may be met most appropriately. This model of operation for PRU access is common across England (Michael & Frederickson, 2013).

However this model of operation is not without challenge. A report by OFSTED (2011) suggested some serious concerns relating to AP (including PRUs) nationally, and, as a result, a Government review of the education available through these providers was completed by Taylor (2012). This report offered a bleak appraisal: *'[The Taylor report] is critical of the commissioning role played by many schools, PRUs…and LAs, but most of all it is critical of a flawed system that fails to provide suitable education…for some of the most vulnerable C&YP in the country.'* (p. 2).

With this assertion as a backdrop, the following study aimed to investigate whether Taylor's conclusion was accurate and how fully it represents the perspectives of professionals who work closely with PRUs in the host LA. Through a focus group comprising professionals within children's services, questions relating to the purpose, efficacy and perceived value of PRUs are posed. Responses are then interpreted using Braun and Clarke's (2006) *'Thematic Analysis'*.

Findings suggest that there is a generally favourable opinion of the PRUs, particularly in relation to the '*intensive'* and '*specialist'* support that can be offered; some points of concern relating to whether PRU education is 'inclusive' were also noted. Suggestions offered at the close of the paper are provided with the aim of developing further the services that are provided locally.

Section 1: Introduction:

"All that we're doing is making the big model smaller but actually we may need to make a different model of learning for some of these young people."

(FG Participant 1)

The National Context

School, and the wider educational journey, is a positive experience for many children and young people (C&YP); *'children [in school] are [mostly] able to thrive, achieve and reach their fullest potential'* (Hart, 2013, p. 196). However, it is by no means a certainty that *all* C&YP will have such an experience: there are some groups of C&YP who find themselves repeatedly out of school and/or at risk of permanent exclusion (Hart, 2013).

Indeed, across England there is growing concern related to the number of C&YP who do become excluded from their 'mainstream' school (Department for Education [DfE], 2013), either on a 'permanent' or 'fixed term' basis: in the year 2011/2012, the number of permanent exclusions rose to 5170, from 5080 in the previous academic year, a rate of roughly 7 pupils out of every 10,000, while fixed-term exclusions remained relatively stable but high at 304,370 nationally – approximately 4% of the school population (DfE, 2012).

The reason cited most commonly for these exclusions was 'persistent disruptive behaviour', though little clarity is provided as to what this might mean (Michael & Frederickson, 2013); this accounted for 33% of permanent exclusions and for 24% of fixed-term exclusions. Other reasons include: physical assault against another pupil (17%), verbal abuse or threatening behaviour against an adult (11%) and physical assault against an adult (10%).

Further, in these statistics, male pupils were around 30 times more likely to receive either permanent or fixed term exclusion, while C&YP with a statement of 'special educational needs' (SEN) were 80 times more likely to be excluded. C&YP with 'behavioural, emotional and social difficulties' (BESD), C&YP eligible for 'free school meals' (a proxy-indicator of financial hardship), and Looked-after Children (LAC) were also represented disproportionately.

Increasing exclusion rates present a concerning reality: a significant amount of research exists in which the negative effects of school exclusion are posited to be causally related to diminished long-term life outcomes; for example: isolation and social exclusion (e.g. Wright, Weekes & McGlaughlin, 2002); the unsurprising connection between performing poorly academically, as a direct result of exclusion (Daniels, 2011); the negative effect on adult employment prospects (Carlisle, 2013), and the increased risk of being engaged in criminal activity (Collins, 2013).

While these studies may be challenged for methodological integrity - the causal effect of exclusion is arguably difficult to infer due to the complexity of human development across the life course, and the many factors and/or 'systems' implicated (Bronfenbrenner, 1994; Slee, 2011) - research in this domain is developing rapidly and is broadly consistent (Hart, 2013).

Further, there is strong evidence to suggest a causal link between school exclusion and emergent difficulties *within* the years of compulsory education. Excluded C&YP are more likely to become involved in youth offending, engage in drug and alcohol misuse and have an increased 'susceptibility' to mental health difficulties (E.g. Hall-Lande et al., 2007; Culley, 2010). A correlation between emergent disruptive behaviour, exclusion and depression is also noted (Birchwood, 2013).

Although a number of other influences are undoubtedly related to the variability of long and short-term outcomes (e.g. parental education – Davis-Kean, 2005; economic stability – Elliott, 2013), the evidence to support exclusion as being a *considerable* factor affecting adversely the long-term developmental trajectory is well-established (Howard & Rabie, 2013).

Accordingly, as school exclusion can have such a profound and destructive effect across many developmental domains, it is for these C&YP at risk of exclusion, disaffection or non-participation in education that the local authority (LA) must think creatively in order to fulfil its 'duty of care', based upon the 1994 'Education Act':

[A LA must], for all children within their remit…provide a suitable education which is supportive of [children's] welfare, health and safety'

(Thomas, 2013, p. 25).

As a predictable consequence of this obligation, many alternative options to the typical school setting are available nationally and locally, developed specifically to meet this need; to support C&YP at risk of, or in receipt of, exclusion. There has emerged a broad range of these 'Alternative Provisions' (APs), ranging from *'therapeutic independent schools to training in car maintenance'* (Taylor, 2012, p. 5).

Unsurprisingly with such diversity there are many questions which immediately become apparent: do these facilities provide comparable education to mainstream settings, and, if not, what impact does this have on the C&YP who attend? More generally, if the educational experience within these alternative settings is *not* equivalent to mainstream provision, is the AP model of supporting C&YP out-of-education an appropriate 'solution' to the exclusion 'problem', and, perhaps more notably, why do an increasing number of C&YP find themselves 'excluded' from their mainstream setting in the first instance?

Broadly, these underlying research questions provided the rationale for the current small-scale research project, which sought fundamentally to provide 'real life' consideration of these debates through investigating professional perspectives on current operational practices for excluded C&YP in the host LA.

The Local Context and Educational Psychologist Role

This present research was completed in England by a trainee educational psychologist (TEP) on placement at a large, urban LA in the West Midlands. This LA is among the most deprived in the country: recent figures (Child Poverty Statistics, 2012) suggesting it as the 28th most disadvantaged LA in England on purely economic and financial markers.

Given that it has long been documented that socioeconomic disadvantage is a correlate of school exclusion (McCrae et al., 2003), it is defensible to assume that exclusion rates within this host LA are significant.

However there have emerged, over recent years (Hart, 2013), many mechanisms available to schools in general to disguise ('unofficial exclusions', 'part-time timetables') or avoid ('managed moves') exclusion data being recorded accurately (Centre for Social Justice – 'CSJ', 2011). C&YP being 'placed' in AP – before exclusion occurs - is also a prevalent mechanism (Michael & Frederickson, 2013). Accordingly there is a lack of transparency within the wider system, and firm exclusion records are available rarely:

'...If the exclusion rate is too high, Ofsted and the LA will be alerted and the school will have serious black marks against its record and incur financial penalties. However, if the school undertakes a managed move, or places C&YP in AP, there is no consequence for it. If you are quick and clever about it, there's never a black mark against the school's name… [These mechanisms] reflect far better and are far less transparent, making them an attractive option for schools'

(CSJ, 2011, p. 151)

Nevertheless, while cognisant of this poor transparency, during a 'professional practice placement' within the City's educational psychology service (EPS), it emerged quickly that the educational psychologist (EP) role in the host LA is not complicit in the strategy of 'placing' C&YP in APs without due cause; the EP retains the C&YP as the primary 'stakeholder', and thus APs are only sought if they are to be of benefit to the young person, not to disguise exclusion.

Rather, across the host LA, EPs endeavour to prevent exclusion, and the subsequent use of APs, through offering support to schools in developing systems and processes at a strategic level, alongside providing advice, primarily through consultation, relating to individual pupils: this, while wide-ranging, is largely consistent with the national understanding of the EP role (Michael & Frederickson,

2013) and is cited frequently as a 'distinctive' feature of EP practice (Cameron, 2006).

In general, EPs support schools *prospectively* to develop their educational provision for the range of C&YP 'on roll', thereby fostering an inclusive ethos, and ensuring that all C&YP can access education equitably irrespective of their individual circumstances. Ultimately this is to ensure that, insofar as is possible, each C&YP has a positive educational experience.

Predictably, given this close relationship with schools, C&YP and their families, there are some occasions in which unanticipated scenarios occur and the EP role becomes one of supporting C&YP at risk of, or in receipt of, exclusion: despite considerable forward planning, a general philosophy of trying to avoid exclusion, and the aforementioned prospective support provided to schools in order to minimise the likelihood of exclusion occurring, there are times in which exclusions *do* happen[2].

In these instances the EP necessarily adopts a *reactive* role in the host LA; considering for what reason has the exclusion occurred, and how best can adaptations be made so that it does not recur? This, again, is largely consistent with the role nationally (Billington, 2009).

What Happens if Exclusion Occurs?

If, despite all reasonable attempts at avoiding this problematic scenario, exclusion does occur, an EP (who arguably retains an holistic perspective of city-wide educational provision due to the host LA structure[3]), might be commissioned to complete an 'assessment' targeted specifically at outlining comprehensively the particular needs of the young person (DECP, 2002).

Once any 'assessment' is complete and any specific needs outlined, EPs endeavour to prevent further disruption to a child's education by identifying specific adjustments required within the mainstream setting upon their return or, when appropriate, ascertaining provision that may be more in-line with the precise needs of the excluded young person.

The ultimate aim of this process is to avoid C&YP being out of education long-term, or being 'in' education, and, due perhaps to the unsuitability of the provision attended, the child being excluded from the experience (*'socially excluded'* – Ainscow et al., 2006), and thus vulnerable to the negative consequences noted in the introduction.

One potential outcome of this process is that the C&YP become educated within a *'Pupil Referral Unit'* ('PRU') for a length of time: in general these settings are best

[2] As noted in the introduction, this is primarily a response to 'behavioural' difficulties.
[3] In this LA, while the EP has a 'patch' of schools to which they are allocated, they also retain city-wide knowledge through working across provisions which have a wider LA remit.

understood as educational provision for pupils who *'have been excluded, or are at risk of exclusion and for pupils who are sick, pregnant or without a school place'* (Michael & Frederickson, 2013, p. 408). Local guidance for the role of PRUs follows closely this conceptualisation (PRU Ofsted reports, 2012 - 2014).

According to a recent city-wide LA census (2011) the *most widely utilised* AP locally, as a consequence of exclusion, is the PRU and this 'popularity' of PRUs in the host LA correlates strongly with national circumstances[4]:

'the most common alternative provision in the UK is the PRU, with recent estimates suggesting that there are 24,000 secondary aged children currently educated in PRUs in England'

(Lawrence, 2011, p. 214).

Broadly, C&YP might attend a PRU during the EP's assessment period, allowing discussions to occur as to how best to meet the emergent needs of the young person, or, given the often high level of expertise found within PRUs, a longer-term placement in order to prepare the C&YP for a later return to mainstream education. This is how the framework is designed to operate *in theory* (Taylor, 2012), though practice may not necessarily reflect this:

'Once placed [in a PRU], children rarely get back to mainstream school, the curriculum is narrow, the teaching poor and pupils do not achieve academic success. Rather than improving behaviour, the atmosphere of the worst PRUs feeds their pupils' behaviour problems.'

(Taylor, 2012, p. 19)

Overall PRUs, quite clearly, attempt to meet the emergent need for C&YP for whom mainstream schooling has become at risk; however, is this necessarily a positive feature of the UK education landscape? Some critics (e.g. Mainwaring & Hallam, 2010) identify that children who attend PRUs are likely to foster a more negative perspective of themselves than equivalent children who attend a mainstream setting; broadly that attending a PRU reinforces that C&YP have 'a problem'.

Further, there has been identified a tacit viewpoint that *'PRUs are often thought of as a place where badly behaved children are sent'* (National Archives, 2005) with the other services that a PRU might offer less well recognised.

Although PRUs are a stable part of the education landscape, it is reasonable to assert that there are some ambiguities in relation to the service(s) that they provide, and how they are utilised by mainstream schools. Accordingly, through seeking the

[4] Indeed, when compared with the number of pupils at *all* other types of 'alternative provision' (n = 23,020 – Taylor, 2012) the PRU population is significantly larger, per setting, than that of other services.

views of education professionals who work closely with PRUs in the host LA, the current paper will attempt to provide consideration of the local circumstances for these settings.

A Note on Epistemology

At this point it is important to illustrate the epistemological and philosophical stance adopted for the following investigation.

Much of the discourse related to exclusion, as identified briefly thus far (e.g. the notion of C&YP *with* 'BESD') is socially constructed: *'BESD can be viewed as a socially constructed label which fulfils a social function…and is not representative of anything existing in reality'* (MacLeod & Munn, 2004, p. 170).

Although it depends on the conceptualisation of these constructs as to which social function they may serve (e.g. a Marxist perspective might point to the *economic* advantage of identifying individuals with additional needs, and their subsequent 'removal' from the school into a PRU, to improve its 'trading' profile), it is important to recognise the inherent variability of such terms; there is no objective, unwavering foundation for many of these labels (Michael & Frederickson, 2013).

Paradoxically an external reality exists in which these social-constructs operate, and as an *applied* psychology practitioner, it is within this framework (realism) that professional practice is embedded:

'Realism can be defined as a philosophical position that asserts the existence of an objective order of reality and the possibility of human beings gaining knowledge about that reality'

(Gutek, 1997, p.31)

Broadly, while deeper philosophical questions relate to the value and capriciousness of socially constructed labels (Lauchlan & Boyle, 2007), there is a need for the practitioner psychologist to be cognisant of the instability and subjectivity of these terms, but pragmatic in their professional practice of supporting C&YP with additional needs: as such a *realist* position was adopted for the following paper which reflects the pragmatism required for EPs working across real-world settings. Although the labels may not be objectively 'real', within the context of professional practice they hold significance and therefore must be considered sensitively.

Up until now the current paper has outlined the national context in which this current study is situated, alongside the local circumstances in terms of exclusion and associated support structures. The epistemological position of the study has also been provided so that the reader is aware of which 'stance' the research adopted.

Necessarily, as the aim of this study is to consider the PRU 'system', it is appropriate to consider from where this mechanism emerged (historical context) and also the current circumstances. A critical literature review is thus provided which considers these influences within the context of an ever-changing education landscape.

Section 2: Critical Literature Review

PRUs and Related Discourse

'There is unquestionably a need for further expansion of quality, flexible learning programs to cater for an increasing number of C&YP who find themselves disenfranchised from the mainstream schooling experience'

(Wilson et al., 2013, p.36)

'PRUs' became the collective description for a range of special 'units' which emerged frequently during the 1970s and 1980s. Largely their remit was to accommodate C&YP whose 'needs', for a number of reasons, were not able to be 'met' temporarily in a 'mainstream' setting (Solomon & Rogers, 2001).

Although contentious in the context of inclusion, the rationale for PRU settings existing is argued to be reasonable: addressing the needs of individual C&YP with additional needs using cross-curricular approaches and personalised learning (Leather et al., 2009). This aims to support development of basic literacy and numeracy skills; improve behaviour; refine personal care and social skills; foster a motivation for learning; and provide specific support for special educational needs, including BESD as relevant to each learner (Ofsted, 2007).

Indeed, it is not difficult to see why these settings present such an attractive prospect: teachers and schools struggling with the additional needs of C&YP (particularly BESD) are cited commonly throughout the literature as the primary catalyst for teacher anxiety and 'burn-out' (Ford, 2007; Robertson & Dunsmuir, 2012). Against this backdrop, it is unsurprising that requests for C&YP to be placed in PRU settings is the most frequent 'intervention' sought by overwhelmed school staff (Sutherland et al., 2008, p. 225-226).

However, while the range and accessibility of PRU settings may seem to imply that a specific, efficacious model of support is offered (and tacitly assured), in reality the picture is less clear: *'helping C&YP [in PRUs] is neither easy nor formulaic, as the range of provision may suggest'* (Thomas, 2013, p.27)

Due to this, there have been long-standing concerns expressed in relation to the 'quality' of the education provided in these settings (OFSTED, 1995), and over recent years these concerns have not abated (OFSTED, 2011; Taylor, 2012):

'[For some PRUs] the objective seemed to be keeping children happy and there was no academic challenge…the result is that children [left] school at sixteen…with reduced chances of succeeding at college or getting a job.'

(Taylor, 2012, p. 19)

Further, there have been concerns which relate to the supposed 'exit strategy' for C&YP engaging in PRU education. PRU placements are ideally short-term in nature (OFSTED, 2007) with re-integration back into a school a priority (C&YP with profound medical needs notwithstanding). However, this is achieved infrequently in practice:

'Placements seldom have end dates…where the onus was on the PRU to find and secure a school place this was often very difficult to achieve. Commonly, the LA and the PRU saw Key Stage 4 pupils, particularly those in Year 11, as unlikely to return to a mainstream or special school; as a result, the PRU placement became permanent.'

(OFSTED, 2007, p. 15)

Unsurprisingly, in line with these concerns, some critics (e.g. Leather et al., 2009) now suggest that due to the way in which some PRUs are argued to operate (a place for LAs to 'dump' C&YP with additional needs – Taylor, 2012, p. 6) that they are anti-inclusion, and that they subscribe to a 'remedial' service model for C&YP who do not *'fit or comply'* (p. 20) with traditional mainstream education:

'[The PRU model] suggests a medical conceptualisation: pupils 'with' a problem, who are then treated in isolation with whatever curriculum best suits them. [PRU education] does not seem to acknowledge or address any issues of inclusion or underlying causes of pupils' exclusion from the mainstream provision'

(Leather et al., 2009. p.21)

Is this a fair conceptualisation? Understandably, given the variance between PRU settings (both in terms of remit and 'quality' of the services that they provide), few concrete conclusions can be drawn.

For example, some research (e.g. Hart, 2013; Pirrie & Macleod, 2009; de Jong & Griffiths, 2006) suggests that the 'education' provided at PRUs is more comprehensive than solely that which can be found in academic subjects.

While academic progress is clearly a key endeavour for any 'good' mainstream school, some argue (e.g. Solomon & Rogers, 2001) that academic achievement is prioritised over development in other areas. Accordingly, PRUs are valuable as they can better support C&YP in *wider* areas (for example behavioural, emotional and social domains) and that they can offer 'protective' factors such as more robust and

reciprocal relationships with adults (perhaps due to the smaller group sizes) and *personalised* learning that matches C&YP's requirements more precisely:

'PRU tutors reported that, while academic achievement was an ideal, qualifications were their last priority – before they could embark on these there was a lot of work to be done on motivation, developing concentration and general behavioural improvement.'

(Solomon & Rogers, 2001, p.332)

Indeed more recently PRUs have gradually been considered as 'better placed' to deliver services that are suitably 'flexible' to accommodate the needs of some of the most vulnerable C&YP (de Jong & Griffiths, 2006). Additionally, The National Union of Teachers (NUT, 2012) largely rejects the criticisms from Taylor (2012), arguing – citing data from Ofsted (2011) - that:

'PRUs are hugely under-valued. PRU teachers are expert at engaging vulnerable and disaffected C&YP…their parents and carers. Teachers plan work carefully so that it relates to pupils' specific needs. PRU teachers and other PRU staff carry out a significant amount of work with families and liaising with other agencies. PRUs…work hard to support pupils with reintegration into mainstream schools. None of this is recognised by the Government.'

(p.2)

However, to be critical, this positive depiction is by no means guaranteed: for C&YP to derive maximum, long-lasting benefits from placement within PRUs, evidence (de Jong & Griffiths, 2006, p. 36; Humphrey & Ainscow, 2006, p. 327) suggests that collaboration with the C&YP's mainstream setting is essential to avoid C&YP feeling segregated, co-operation in developing student support networks for when C&YP return to their original school is paramount for successful reintegration, and that any strategies which develop while at a PRU are then embedded back into the mainstream provision.

Ultimately, the majority of evidence would suggest the success of a PRU placement is contingent on this collective approach. Research also largely supports PRUs being more successful if they are not conceptualised, either by schools or the wider community, as 'dumping grounds' for C&YP *'with a mandate to 'cure' their problems, train them in basic life skills and keep them out of jail'* (de Jong & Griffiths, 2006, p.32). Indeed, the NUT's (2012) response to Government affirms this position:

'The key issues facing PRU provision is not their quality but their lack of an integrated and co-ordinated relationship with mainstream schools.'

(p. 3)

This mitigating factor (supported by evidence), for the success of PRUs, is largely related to the mainstream school's conceptualisation of 'inclusion': are PRUs utilised as a short-term measure to provide assistance to the mainstream setting in understanding and supporting C&YP (with the aim of their returning to school), or as a method to avoid official exclusion, but, in reality, with the C&YP being 'excluded' from their mainstream provision.

This consideration leads neatly into the dominant ideology which underpins all discussion in this domain: the 'inclusion' debate. It is to this contentious subject which the current paper now turns, before then moving to the practical research completed for this study.

Inclusion

''Inclusion' – a word much more used in this century than in the last. It has something to do with people and society valuing diversity and overcoming barriers. But what exactly does it mean?'

(Topping, 2012, p.9)

When Warnock (1978) published her landmark paper relating to integration, she endeavoured to challenge the existing educational practices of the time, the 'segregation' of C&YP based on categories of 'handicap' (physical, learning or psychological disabilities which were deemed to require *'Special'* Schools). Her position suggested that '*pupils, no matter their particular needs…belong together with their same age in the educational mainstream'* (DES, 1978, p.7), and, given the inconclusive evidence, both historical (Ainscow, 1991; Lipsky & Gartner, 1997; Rouse & Florian, 1996) and current (e.g. Seal et al., 2014) that C&YP with additional or complicated needs achieve more success when segregated from the mainstream, the rationale for adopting this position is recognisable.

It follows that, since the publication of the now colloquially labelled 'Warnock Report', the agenda for *inclusion* has developed to become a dominant ideology (Alaimo & Kulg, 2002), providing the framework for social and educational policy in the United Kingdom; 'inclusion' is now seen habitually as *'a matter of human rights and a liberal society'* (Evans & Lunt, 2002, p. 2). Within this conceptualisation, for educational paradigms, it has been long argued that the goal of inclusive practice is to provide all C&YP with a sense of community, belonging and the right to learn a common curriculum with the same aged classmates (Ainscow et al., 2006).

While there have clearly been revisions relating to the conceptualisation of 'inclusion' and 'integration' since the Warnock report – and equating the Warnock view of integration with more contemporary perspectives on inclusion would be misleading - the ideals held within this report remain pertinent:

'…to consider how teaching and learning can best be brought about wherever there are children who have particular obstacles to overcome'

(Warnock, 1978, p.5)

However, the concept of inclusion has become ambiguous and 'lost' in many settings (Ainscow et al., 2006) and the practicality of operationalising the inclusion framework has not been straightforward; *'one might argue that the current push for the implementation of inclusive education is an example of where policy development and philosophical thought outpace practice'* (Hodgkinson, 2010, p. 61).

Meo & Parker (2004) suggest that PRUs are an exemplar of this difficulty and that PRUs perpetuate many aspects of exclusion by their existence; removing C&YP from their mainstream setting due to the complexity of the 'problems'.

In recent years, across some LAs, policy makers have attempted to develop a fully inclusive practice (e.g. Goodman & Burton 2010; Bennett 2006; Mooij & Smeets 2009): that is, endeavouring to embrace *all* C&YP within 'conventional' educational settings. Nevertheless, the success of this goal has been limited, with difficulties faced within many areas: *'in the main, the concerns raised by teachers regarding the inclusion of students…not only match concerns identified in current government policy but are also evident in policies introduced 20 years earlier'* (Goodman & Burton, 2010, p. 246)

For example, several studies have demonstrated that C&YP with special needs (including BESD) in mainstream schools are less accepted by their peer group (Kuhne & Wiener, 2000) have fewer friendships (Le Mare & de la Ronde 2000; Pijl, Frostad, & Flem 2008) and have limited social networks within the class (Soresi & Nota 2000; Yu, Zhang, & Yan 2005).

Paradoxically, from a critical perspective, it is unclear whether these difficulties are any less pervasive when C&YP attend alternative settings (Mainwaring & Hallam, 2010; Leather et al., 2009), and some research suggests that indeed these challenges are *more* prevalent in 'alternative' education providers:

'From Year 5 onwards fewer friendships and more abusive behaviour existed in [AP and PRUs]'

(Bunch & Valeo, 2004. p. 74)

With regard to academic progress and development specifically, Lindsay (2007), following a systematic review of available evidence for mainstream schools operating fully inclusive practice states that *'Just 1% of over 1300 studies published 2000–2005 addressed effectiveness of inclusion, and the results from these studies were only marginally positive overall'* (p. 16), suggesting little evidence that inclusive practice is demonstrably more effective in supporting development across academic domains.

A further meta-analysis of available studies suggests that: '*There is nothing to suggest that the commitment to inclusion in relation to pupils is likely to have a significant impact on their overall levels of attainment in mainstream schools'* (Kalambouka et al., 2005 p. 4).

Again, as a critique, some research (e.g. Nind et al., 2004) suggests the contradictory view – that to educate C&YP with similar difficulties together, in a separate setting (e.g. a PRU), is beneficial:

'There is evidence of impact [of PRU education] on both academic learning and community participation, as well as on C&YP's views of their own competence, acceptance and self-worth'

(Nind et al, 2004, p. 5)

Though it is not possible to review and critique each study of inclusive practice, taken as a whole, there remains considerable uncertainty as to which practice is 'best'.

This raises the principal questions: *why* is there such inconsistency in findings? Might the 'success' of inclusion be dependent upon a panoply of variables - of which many are difficult to control (e.g. attitudes, ethos, finance and 'practicality'). Some researchers now believe that this is the case.

Misinterpreting the Inclusion Philosophy

Cole (2005) posit that contributing factors in the poor success of inclusion are the requirements that any mainstream setting re-evaluates attitudes, ethos and its approach to delivering the curriculum; staff often require *additional* training to ensure that they can provide education for all C&YP that is appropriate to their individual requirements.

These factors, suggest this research, are a considerable challenge in terms of finance, time and practicality, which may make inclusion unfeasible in all but the most dedicated settings; it might be an 'easier' option for C&YP with additional needs to attend AP which might arguably be well placed to support such complexity.

Clough and Garner (2003) argue less positively from the position of school: they suggest that a significant barrier to embedding the inclusion ideology 'in practice' is that many educational establishments are not 'fit for purpose' to include all C&YP, due to a lack of knowledge, vision, will and resources – it is not that mainstream settings *can't* support every C&YP, more there is an unwillingness to develop practice to do so, and that the existence of AP reinforces this attitude.

More specifically in relation to BESD, some research suggests that there is an imbalance of understanding. Croll and Moses (2000) found that while many educational professionals were sensitive and proactive towards developing inclusive

education, pupils with BESD were less well supported: *'for these pupils, exclusion rather than inclusion was commonly followed as a practical response to (not) dealing with issues*' (Thomas, 2013, p.7), with BESD being conceptualised as a 'choice' rather than an additional need.

It is perhaps this inconsistent understanding which leads to such frequent exclusion and thus the AP 'solution' is a predictable consequence. Indeed, Jordan et al., (2010) found that while teachers and school settings more generally agreed, in principle, with the inclusion agenda '*less than one third believe that it can be successful with the resources available* (p. 259).

On a more philosophical level, some critics, e.g. O'Brien (2002), suggest that full inclusion is idealistic. He stresses there has been a persistent focus on the inclusion 'philosophy', rather than addressing the practical concerns surrounding the implementation of the theory, and that there is a danger that individuals with the greatest level of need, arguably the most vulnerable learners, are becoming lost within the political and ideological doctrine; simply, while the theoretical debate relating to the value of inclusion is important, there is a risk of the child's 'voice' being '*drowned out by inclusion policies dominated by adults'* (Hodgkinson, 2010, p. 63). This is a further worrying reflection.

Does this reality provide a stable foundation to justify, in some circumstances, the existence of alternative provision, and PRUs more specifically? As with other literature within this broad domain, there is no clear answer.

Inclusion: At What Cost?

The position outlined thus far may indicate that differing interpretations surround practitioner understanding of 'inclusion'. It is largely agreed (Michael & Frederickson, 2013) that school systems moving towards a more inclusive ethos is a desirable development, alongside their attempting to provide educational provision which is more reflexive to the needs of each pupil (Thomas, 2013).

However, suggesting a universal approach (that *all* children should be educated in 'mainstream' settings) risks oversimplifying a nuanced argument (Tomlinson, 2005); there is an evident continuum of individual need, and differing skill-sets and competence within each mainstream setting.

Indeed Warnock, writing in 2005, clarified the position that inclusion is not reducible to *'all children under the same roof'*: there remain some C&YP who demonstrate a need above, or different from that which a mainstream school can realistically accommodate (Thomas, 2013; Norwich, 2008) and therefore inclusion should be best understood as *'including all C&YP in the common educational enterprise of learning, wherever they learn best'* (Warnock, 2005). This, as noted earlier, is likely a response to a misrepresenting of Warnock's original ideals to support schools in

removing, or circumventing, any barriers perhaps present for C&YP in their learning enterprise.

Generally the contemporary position suggests that C&YP have an overriding 'right' to '*appropriate'* education, not steadfastly in mainstream settings: *"'Inclusion'* is not *a mechanism for relocating educationally disadvantaged youngsters in mainstream rather than in alternative settings [at all costs]"*" (Laluvein, 2007, p. 35). This more nuanced conceptualisation of 'inclusion' arguably supports the existence of AP, developed to support schools in meeting the needs of all C&YP.

Given the complexity of 'inclusion', alongside the controversy relating to PRUs noted in this literature review, a more delicate and individualistic understanding of inclusion appears logical: understanding that some mainstream settings *'may not provide effective education for all young people with special needs, including BESD'* (Michael & Frederickson, 2013, p. 408), while recognising that this is by no means *always* the case – individual need being assessed to determine *where is* best for each C&YP to be educated (Gavine, 2001), with EP assessment often making a valuable contribution to decision making, implementation of recommended provision and monitoring and evaluating impact (Billington, 2009).

There appears to be a fine distinction between schools utilising PRUs in order to meet the needs of C&YP more comprehensively, and contrastingly using the PRUs as a method to segregate C&YP with additional needs (particularly BESD) from the mainstream; there are consequently no concrete inferences that can be drawn from the literature. It would be defensible to suggest that the 'success' of inclusion is contingent upon the way in which the philosophy is interpreted and then operationalized, and thus nuanced differences are likely across each educational organisation (school, PRU, AP, LA, etc).

At this point of the current paper, with the conceptual, historical and practical considerations relating to PRU education, inclusion and integration now considered, it is important to provide for the reader a summary and synthesis of the research presented in the preceding literature review. Research questions which underpin the practical study at the heart of this paper are embedded within, and elicited from this synthesis, and necessarily provide a framework for the practical investigation soon detailed.

Broadly, the small-scale inquiry which follows sought to explore practitioner perspectives on how these long-standing considerations of inclusion, exclusion and PRUs manifest within a 'real world' context. As noted in the literature review, there is little consensus as to the current status of the inclusion agenda, the optimal method to support C&YP for whom a placement within a mainstream setting has become unstable or in jeopardy, or the value which APs (PRUs in particular) bring to the education landscape.

Accordingly, with the wider climate of educational policy in a state of flux – in no small part due to significant Special Educational Needs' reforms on a national level – it seems to be an appropriate time to investigate the local perspectives on current operational practices.

Consequently, the research questions which underpin the following small-scale project emerge organically from the preceding literature review:

1) What are the current circumstances in relation to inclusion, exclusion and PRUs in the host
   LA?

2) Are PRUs used effectively, what services do they provide, and do they function in-line with how they are designed to operate?

Although these questions are unlikely to be *answered* comprehensively, they serve to provide a direction and structure for the following research.

Section 3: The Current Study

Qualitative Data Collection: Rationale for Focus Group

Staff from a LA multi-agency support team ('MAST') participated in a semi-structured focus group (FG) discussion relating to the local PRU provision: *'At the simplest level, a FG is an informal discussion among a group of selected individuals about a particular topic'* (Wilkinson, 2004, p. 345).

The participants of the FG had varying levels of involvement with C&YP: some being primarily involved in the 'education' element of a young person's life, e.g.: Education Welfare Officers (EWOs) whose role is to support regular school attendance through identifying attendance difficulties and possible solutions; Educational Psychologists (EPs) whose role is to support the positive psychological well-being of young people and to assist in overcoming barriers to education, and Parent Support Advisors (PSAs) whose role is to engage with parents of young people who may be having difficulty in school in an attempt to develop strategies within the home that may facilitate an improvement in the difficulties noted at school.

Some professionals have only a tertiary involvement in the direct education of young people, however are still involved in the multi-agency decision making process and thus contributed to the research, e.g.: 'MAST' Social Workers whose role is to provide assistance and advice to support families with a variety of social and educational welfare challenges; MAST manager whose role is to co-ordinate operations within the MAST, particularly fostering positive relationships and managing expectations of schools; Positive Activities for Young People (PAYP) whose role is to engage with young people in positive activities within their community, and finally the MAST operational support advisor whose role is to

provide administrative support to the team while often being the first 'point of contact' for service users.

Structure of Focus Group:

Table 3 showing the FG structure

Professional Role	N
Educational Psychologist	1
Social Worker	1
Administrator	1
Education Welfare Officer	1
Multi-Agency Team Manager	1
Parental Support Advisor	1
Positive Activities for Young People caseworker	1

The primary function of a FG is to create the opportunity to extract and discuss co-constructed perspectives on a desired topic; though, due to the semi-structured nature of this data-gathering approach, there is the added value of the dynamic interaction between individuals in the group. This is likely to *'enable in-depth, inductive and naturalistic qualitative data gathering in a synergistic environment'* (Lawrence, 2011, p.216) that can often result in a more insightful and less superficial discussion about the topic at hand. Further to this, there is less concern relating to demand characteristics: as participants are involved in a flexible and naturalistic discussion, they are more likely to give true views, rather than aim to appease the facilitator as in a one-to-one context.

Critiques of the FG approach can also be found in the literature. Cohen et al (2011) note concerns relating to the significant increase in popularity of this approach, alongside challenges to the assumption that they offer a methodologically robust method of data collection. Thomas (2009) cautions the facilitator to be aware of the possibility of 'risky-shift' phenomenon: individuals (participants), when involved in a *group* process may be susceptible to offering more extreme views than they perhaps hold individually in an attempt to be accepted members of the group.

Paradoxically, there is also the risk that some individuals within a group *do not* express their true feelings relating to a topic, due to the risk of their opinion being dissonant with the general consensus (Cohen et al., 2011). It is important for the facilitator to be aware of these risks and attempt to mitigate their occurrence and/or

potential effects by being actively aware of their possible emergence, and develop appropriate data gathering tools to safeguard against this eventuality.

Clearly, given the tendency for group processes to be susceptible to a misrepresentation of an individual's views, there is a need for a defensible rationale for the selection of this data gathering method.

As should be clear from the literature review which underpins work in this area, alongside the local structure of the *multi-agency* team, decisions and or/negotiations relating to a young person attending alternative education settings are not made in isolation. These 'everyday' discussions are, themselves, a 'group process' from which a decision emerges.

As such, it would seem that a focus group might provide a more accurate representation of the how discussions relating to AP work in practice – it would seem defensible that the views and perspectives donated during the focus group might be more in-line with those to be found in the 'real world' context, providing more confidence that data elicited is ecologically valid. Broadly, using a focus group allows, in this instance, a good approximation of the real-world artefact under investigation.

Development of data-gathering tools and the recruiting of participants.

In close collaboration with a specialist senior EP, a FG schedule was developed (Appendix 1). The aim of developing a schedule was to provide some level of structure to the proposed FG while simultaneously allowing participants the freedom to discuss openly the topic at hand.

Appropriate 'prompts' were also developed to ensure that the allotted FG time was used appropriately –if the discussion ceased to flow, the prompts could be used to stimulate further conversation. The use of prompts could also be used to mitigate against individuals within a group becoming too dominant and skewing the discussion by propounding their own particular view point (Robson, 2002); a potential limitation of the approach noted previously. A written consent form was also developed (Appendix 2). This consent form ensured that participants were able to understand fully the nature of the research in which they were to participate.

To recruit participants, individuals within a multi-agency support team were approached and invited to engage with the research; these professionals have varying levels of interaction with the PRU settings as noted.

There was no obligation to join the FG; participation was completely voluntary, and not contributing to the FG would have no negative consequences for an individual.

Participants were informed via the consent document that the FG audio would be audio taped and later transcribed by the group facilitator, and that some comments may be used in a report that would be shared with the LA and University of

Birmingham – although confidentiality was assured and no participant would be identifiable by their responses. In total, seven participants, each from a different professional background agreed to take part in the research.

Data were abstracted from the audio recording and interpreted via 'Thematic Analysis' (Braun & Clarke, 2006). A step-by-step account of this process, alongside the rationale for the selection of this qualitative data analysis approach, is now provided.

Data Analysis

There are a number of approaches available for completing analysis of qualitative data (Robson, 2002). One approach used frequently is that of *'Thematic analysis'* (Braun & Clarke, 2006), with the popularity of this approach likely being attributable to its compatibility with a variety of epistemological and theoretical orientations alongside providing flexibility for interpreting the findings of a qualitative study.

The primary aim of this method is for data to be analysed systematically and then collated into emerging 'themes':

'Thematic analysis, as its name suggests, involves identifying particular themes which occur in the material which is being studied. Those themes may emerge from the data as they are analysed, taking the form of recurrent statements, attributions or assumptions which people make.'

(Hayes, 1997, p.171)

This approach is favoured because it gives a structure to the analysis of data that could be viewed as disparate. It is only through following systematic procedures that themes and recurrent patterns emerge. The following table highlights an example of the systematic procedure consistent with the thematic analysis method:

Table 4 showing the broader TA process from Hayes (1997)

Prepare data for analysis- transcribe interviews or notes.
Read through each interview, noting items of interest.
Sort items of interest into proto-themes.
Examine proto-themes and attempt an initial definition.
Take each theme separately and re-examine each transcript carefully for relevant material for that theme.

Using all of the material relating to each theme, construct each theme's final form: name, definition and supporting data. Select the relevant illustrative data for the reporting of the theme. *(adapted from Hayes, 1997 ,p.178)*

Consistent with the process as outlined in Braun & Clarke (2006), a description of the analysis process used to in the current study is now provided.

Step 1 – 'Familiarising yourself with the data': The data elicited through the FG were recorded on a Dictaphone. These data were then transcribed by the facilitator (Appendix 3 for exemplar). This is suggested to be the preferred method of capturing the data, and the transcription process can be considered as an initial step of the data analysis procedure (Braun & Clarke, 2006).

Once the data were transcribed, I listened to the recording and followed the text to ensure accurate reproduction; I then read through the written data again to further reinforce familiarisation. Upon reading the text for a third time, initial, more 'obvious' themes or items of interest were noted using a code system.

Step 2 - Generating initial codes: Once the possible codes were noted, I then re-read the transcript while being cognisant of data that might fit within the original 'possible' codes. According to Braun and Clarke, a code is: *"the most basic segment or element of the raw data that can be accessed in a meaningful way regarding the phenomenon"* (2006, p.88).

Consistent with the procedure as suggested in the Braun and Clarke (2006) text, I was hyper-vigilant to spot any data that might be relevant to the proposed 'codes': accordingly, some data were coded more than once as they could be attributed to more than one 'code'; I also began to extract passages from the transcript that would illustrate the codes, further reinforcing (or refuting) the existence of the emerging themes (Appendix 4).

At this point I had transcribed the data, developed initial 'codes' and then searched through the data to determine extracts that were relevant to each proposed 'code'.

Step 3: Searching for themes: Having coded all of the data, I wrote the name of each of the codes on paper and began to collate these into potential themes.

Step 4- Reviewing themes: Having completed the first steps systematically, it became clear that some 'themes' had emerged from the data. It was important to then determine whether these themes, while at face value appeared accurate, were representative of the data being analysed. This is completed by again reading the

data and determining whether the themes proposed are representative of the dataset.

This time-consuming, yet precise process requires the data analyst to become considerably familiar with the data; while themes may appear evident, it is important that the analyst does not accept the themes immediately and resolutely, rather takes a 'break' from the data and returns perhaps days later to re-assess if the themes remain accurate. Upon returning to the themes, I was confident that they provided an accurate representation of the data under analysis.

With the reader now aware of the study's design, before providing the 'findings' and subsequent explanation, it is important that initial limitations are outlined to ensure self-reflection; simply, all studies have limitations, however this does not mean necessarily that the data do not have value, rather that there are some caveats required in their interpretation.

Limitations

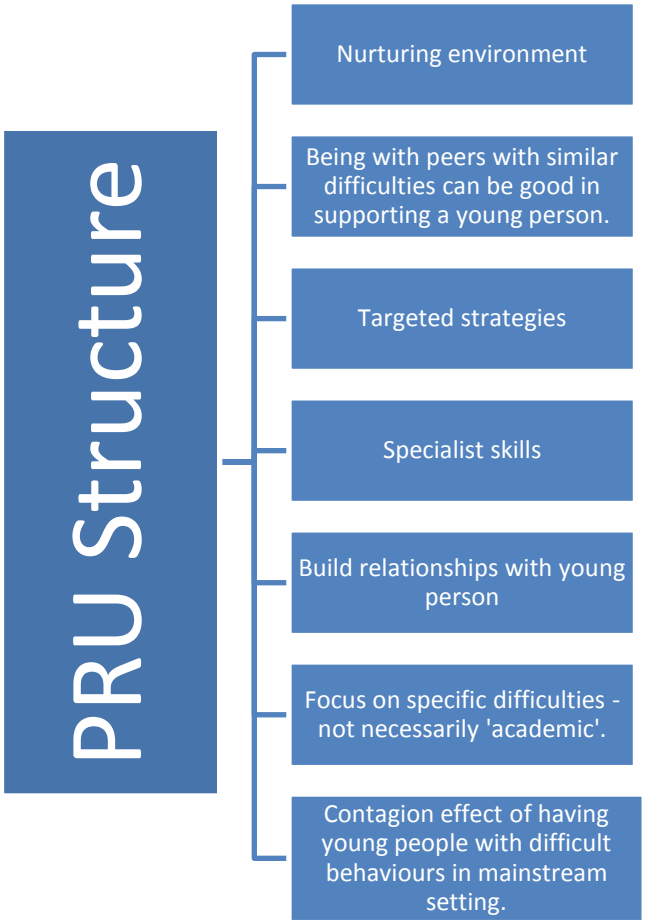
There are three main limitations to this current study:

> FGs are inherently variable and subjective, as identified in the section which related to the selection of this method. Though, as steps were taken in order to reduce this variability, and through my maintaining an awareness of the less robust elements of this data gathering method throughout, some confidence can be had that, where possible, threats to validity were minimised.
>
> Only one of the multi-agency teams was included in the FG (from 8 possible). This might skew the data elicited, and not provide a holistic picture of how PRUs operate (and professional perspectives of their role) across the City. To further support the findings of this study, the recruitment of other professionals who work closely with the PRUs would be recommended, from other localities within the City.
>
> Thematic Analysis has a number of critiques: subjectivity of the analysis process (might a different researcher identify different themes?); there remains a lack of clear and concise guidelines (Mays et al., 2005), and how *'the moment of creative insight that yields pattern recognition and emergent themes resists formulaic description'* (Lapadat, 2010, p. 928). Simply, the point at which a 'theme' emerges is not objective, meaning that analyst interpretation is likely when investigating data. However, for the purposes of this study TA is valid as any 'findings' are to be presented as an *approximation* of reality, used to illustrate considerations relating to the topic under investigation. Caution should be noted when inferring conclusions from the data for this reason, though the data serves to provide a picture of current circumstances in the host LA.

Overall, the following findings are presented to 'illuminate' a depiction of how operational practices might work; it is not envisaged that the following findings are considered concrete and invariable.

Section 4: Findings and Interpretation

Theme 1: PRU Structure



As identified through the literature review which underpins this current report, there remains persistent discussion relating to the way in which C&YP with additional needs, or those for whom a placement within mainstream school has become untenable, are supported. As noted, the PRU has developed to become the dominant form of AP used nationally, though as Taylor (2012) asserts, some confusion relating to the role that they fulfil – and how their services are delivered - has meant that there is significant variability in quality.

Given these background circumstances, it is unsurprising that all participants in the FG discussed freely the nature and structure of the PRU framework both in the host LA and more widely. This discussion emerged organically, insofar as it was not

preceded by any particular prompt offered by the facilitator; arguably this provides further support for the selection of a FG as the data collection method – the group dynamic was generally equal, with no participant being overtly dominant.

In particular during this discussion, participants identified a number of features that they perceived as being available more comprehensively through a PRU environment:

> The opportunity for C&YP who attend PRUs to be part of smaller groups, which participants believed facilitates the opportunity for 'intensive' support to be provided alongside the opportunity for more robust staff-pupil relationships to develop;
>
> Staff within the PRU environment were *specialists* who were likely to be more highly trained to support the specific needs of C&YP, than *generalists* who were likely found within a mainstream setting. These staff were also perceived to be more 'used to' the difficulties presented frequently in PRU settings, and;
>
> Due to the smaller groups, the highly trained specialist staff, and the nurturing nature of the setting, C&YP who attend were more able to work on specific difficulties through *targeted* strategies, alongside less focus on academic development.

Contrastingly, some concern was noted about a potential 'contagion' effect of social learning – C&YP vulnerable to imitating potentially challenging behaviours that they might observe being exhibited by peers. Necessarily, consideration of these emergent exchanges is now provided.

Smaller Groups

In general, FG participants stressed that they felt a 'smaller' environment with fewer pupils was a 'core feature' of a PRU which distinguished it from a typical mainstream setting, and there was a consensus that this was a strong 'selling point'. Participants in the FG also identified that – through discussion with school-based staff – a recurring rationale for C&YP to attend a PRU was that the larger mainstream setting may be 'overwhelming', further underscoring – the participants asserted - the necessity for PRU settings to be available.

In addition to this, it was felt that due to the structure of PRUs in the host LA, a 'nurturing environment' was more likely. When pressed to consider further what was meant by a 'nurturing environment', FG participants identified that the staff within the setting might have less responsibility in terms of developing academic progress, therefore allowing more opportunity for staff to focus on building relationships with the C&YP in order support them with any wider difficulties (i.e. behavioural, emotional, social, mental health or medical difficulties).

This is an interesting point for reflection; it might be inferred from the discussion that there is a general acknowledgment that C&YP who attend PRUs are likely to receive

less support across academic domains, but that this is a predictable occurrence because they are likely to receive additional assistance in other areas. Interestingly, participants in the FG have arguably identified a lesser-discussed aspect of PRU education, or the AP landscape more widely.

For example, while Taylor (2012) identified that there were some PRU settings in which a young person's academic development was a priority, he asserted that this was infrequent: *'some PRUs do not pay sufficient attention to improving academic attainment for their pupils'* (p. 10), and further *'it is of course essential that children in PRUs re-engage with education, that their social and emotional needs are met and their behaviour is improved, but at times this is at the expense of academic rigour'* (p.11). This might be a consequence of PRU's historic flexibility when delivering academic standards (i.e. no obligation to follow the National Curriculum), or perhaps due to the general perception of what a PRU might be used for (i.e. supporting behavioural difficulties).

Nevertheless, it would appear that Taylor's assertions are reflected in views of professionals in this host LA; though there might be an argument for C&YP receiving more intensive support for other difficulties while at a PRU, it would seem reasonable to suggest that professionals are aware, and perhaps uncomfortable, with how detrimental this might be to academic progress.

With regards to the 'additional' support available through a PRU, though participants could identify the 'intensity' of such assistance was likely to be above that found in a mainstream setting, little clarity as to what this meant for the C&YP was provided, or indeed how this support might be delivered differently to a mainstream setting.

In essence, the nature of the discussion which took place during the focus group related more to the 'practicalities' of alternative education - emphasis was placed on the *number* of C&YP who attend these settings rather than the *type* of support available: *'they have less children there, don't they from a mainstream school and they can offer intensive support because of this'* (FG Participant 3) and *'[I] suppose the small groups makes them more nurturing and they're able to start building relationships more than they could do in mainstream schools'* (FG Participant 4).

This is a largely unsurprising theme. As noted in literature, there has been a long-standing level of uncertainty in relation to the *purpose* of PRUs. While it is broadly acknowledged that there are likely to be less C&YP in attendance, the rationale for this, some researchers assert, seems tacit: *'the purpose of the PRUs [is] often unclear [for professionals] with children remaining at the PRU for an indefinite amount of time and with few plans for re-integration to mainstream'* (Browne, 2013, p. 22). This might indeed be a reflection of not only the diverse range of PRU settings available, but also their variability in ethos, quality, and rationale (Taylor, 2012). However, this is clearly an important reflection for practitioners who might 'refer' to these alternative settings, and was evident in the FG dialogue for the

current study; professionals appear to have a broad understanding of the nature of PRU settings, but have less specific knowledge of the services on offer.

Overall it would be defensible to infer from the transcripts that there is a broad recognition that referrals to PRUs are done so in order for C&YP to receive 'specialist support', though identification of what type of specialist support – or how this might be delivered - seemed less cogent. Further consideration of this is provided in the final section of this report.

Specialist Skills

A smaller yet frequently recurrent theme also occurred in which the 'specialist skills' of staff within the PRUs were considered. It was generally regarded that staff within the PRU system have a more specific skill-set which makes them 'better able' to support C&YP with particular difficulties; an emerging theme suggested that due to the overarching inclusive ethos of the PRU settings, that a more 'targeted' approach could be taken for C&YP with atypical challenges:

'I suppose [that they are] more nurturing…and they can also hone in on particular difficulties that children have.'

(FG Participant 3)

An exemplar of this would be a tangential discussion relating to C&YP who are pregnant. The perspective was offered that these C&YP might feel excluded within their mainstream school, and that staff within a typical school environment might not have the particular expertise required to support these C&YP specifically. It was broadly agreed that staff in a PRU might have both the *knowledge* of how to assist pregnant teenagers practically, alongside the requisite skills in providing emotional support: *talking to them about their [circumstances] and sometimes about things that the curriculum may not have time to fit in. That's good isn't it really?'* (FG Participant 2)

This discussion - of staff within PRUs being specialists - is divergent from the present reality across a lot of PRU settings. Taylor (2012), in his review of AP and PRUs, identified that: *'Many PRUs have described losing high-quality staff who leave in order to train or qualify as a teacher elsewhere. This is unfortunate because the skills required to teach effectively in a PRU are eminently transferable to mainstream or special schools'* (p.20).

This would indicate that while there is a general perception – elicited via the FG - that staff within PRUs are more 'specialist', the reality might be that there is a difficulty with recruitment or retention of staff with these specialised attributes; the expertise found in PRUs may be more equitable to a typical mainstream setting.

Accordingly, there may be some discrepancy between the *perception* of what occurs in PRUs and the current reality.

Inclusion

FG participants highlighted some of the most significant considerations required for PRU settings: inclusion. Participants noted that it was not necessarily a positive feature of the PRU services that they would 'step in' to prevent C&YP from being excluded; there was brief discussion that, were PRU settings not available, the host school may be encouraged to 'do more' before looking to AP.

It was largely suggested that, on some occasions, that the mainstream setting *could* have 'done more' to support a C&YP, and that the availability of PRUs (and AP more generally) facilitated the mainstream setting taking the 'easy' option by effectively excluding a C&YP to an alternative education provider.

This was clearly in line with some of the research considered earlier in this paper relating to inclusion / exclusion, and whether schools viewed alternative provision as a 'dumping ground' (Taylor, 2012) for C&YP. In addition, as noted in the literature review there are some researchers (e.g. Cole, 2005) who suggest that as schools attempting to develop inclusive practice is challenging in terms of finance and practicality, AP is an attractive, more straightforward, option.

More worryingly, the professionals involved in the FG identified that, on some occasions, C&YP might move frequently between alternative provisions and PRUs either due to the provisions being unsuitable for the C&YP who attend, or to avoid official exclusion (as noted in the introduction to this paper). This might be a reflection on the diverse 'quality' of PRUs, as noted by Taylor (2012).

Further consideration of this point is provided in the final interpretation section of this report.

A further prominent discussion in the FG, related to 'inclusion', suggested that there may be a 'contagion effect'; that is, C&YP who attend PRUs may 'learn' negative or challenging behaviours from their peers, and that this may make their placement back at mainstream even more vulnerable.

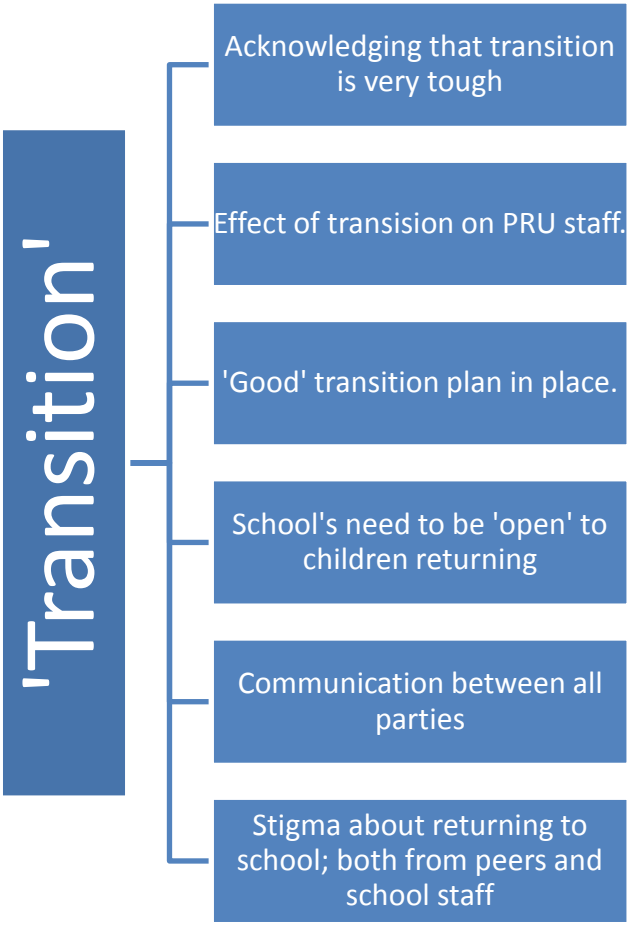
This again is broadly related to the inclusion debate: is it appropriate to educate C&YP with *similar* difficulties within the same setting? As the literature review to this paper identified, there is no neat conclusion to this question:

'*When you have a PRU aren't you then just bringing children together that have similar difficulties into a smaller space? But then isn't it that the job is to try and manage those difficulties in the real world? It's a bit like being in a prison , do you know what I mean, in that they're there and they learn from each-other as well…'* (FG Participant 4).

Paradoxically, some professionals felt that C&YP being supported with peers that have similar difficulties could be a positive and protective factor: the sharing of strategies which help children 'cope' with the difficulties that they face, and a generally inclusive ethos to be found within PRU settings.

Arguably the long-standing, wider considerations relating to inclusive education are evident within this host LA – the final section of this paper will consider implications of these thematic elements; largely it would seem that professional perspectives on whether PRU education is inclusive are inconsistent. Broadly this 'theme' would indicate that current circumstances in the host LA mirror those to be found when PRUs are considered nationally.

Theme 2: Transition



One of the most persistent difficulties noted within literature relating to PRUs is that of transition; both transitioning *into* a PRU, but also a transfer *back* into a mainstream setting: *'I suppose for all the PRUs it's about the transition support that goes in when they go back to mainstream school and making sure that the move back is suitable for their needs [for it to be successful].'* (FG Participant 5)

Some wider discourse would suggest that PRUs are considered 'dumping grounds' for C&YP with challenging needs (e.g. Taylor, 2012), and this contributes to poor reintegration: *'[C&YP attend PRUs] with little information shared about the child's needs, with little or no assessment, with poor ambition or expectation for progress or likely reintegration into mainstream schooling'* (Taylor, 2012, p. 6)

Encouragingly, through the FG, a significantly strong theme emerged in which the *importance* of transition was stressed, particularly that a strong 'transition plan' was in place. Sub-themes thus related to:

> The ethos of the mainstream school setting, viewing the PRU placement as a short-term measure with reintegration likely, albeit often difficult, rather than considering the PRU setting as a mechanism to avoid permanent exclusion;
>
> A general requirement for consistent, open communication between all parties involved, ensuring that placement reviews are frequent and that C&YP who attend PRUs are not 'forgotten' about, and;
>
> The impact on PRU staff of a 'revolving door' policy; as noted there is an emergent difficult with recruitment and retention for PRU staff, and the frequent instability of C&YP placements there may be a contributing factor.

Again further consideration of these points is required.

Schools need to be open to children returning.

As has been the theme throughout this report, there is some discussion as to the nature of PRU placements – particularly the relationship that C&YP retain with their original school while attending alternative provision. Though there is some discourse which suggests that PRUs are considered 'dumping grounds', throughout the FG data gathering exercise it was clear that professionals who work with PRU settings feel that the host school (i.e. the school from which the C&YP 'comes from') ought to ensure that the door is not closed to C&YP returning. Broadly, that schools retain the view that the young person who attends the PRU *remains* a pupil of their school, and that – insofar as is possible and feasible – the young person should be welcomed back once their tenure at the PRU is completed:

'I think that they should be working in collaboration with the schools…keeping in touch. I don't think they should just let the child go there and don't have any contact until the transition plan. I think they should keep in constant liaison and have updates and feedback on how things are going'

(FG Participant 2)

This, again, is broadly in line with some of the themes which emerged when the wider literature was considered earlier in this report. Largely, evidence suggests (de Jong & Griffiths, 2006, p. 36; Humphrey & Ainscow, 2006, p. 327) that schools working in collaboration with the PRU settings is one of the key factors in facilitating

positive results; logically, the transition plans and mechanisms are of huge importance to the C&YP in ensuring that they feel settled in their new provision while reducing the C&YP feeling as if the door is closed on them returning back to their mainstream setting:

'Transition is very important in the vast majority of cases isn't it? If there's a good transition plan in place then… [the placement may be more successful]'

(FG participant 2)

This is in line with Taylor's (2012) recommendations in relation to the nature of placement in AP, ensuring that expectations are clear from the outset:

'When schools decide to send a pupil to AP they share all relevant information with providers, agree the nature of the intervention and set targets for the pupil.'

(p. 24)

The FG participants also discussed protective factors that can improve the likelihood of a successful transition: transparent communication between all parties; a supportive ethos both for the PRU itself (acknowledging that transitioning to a new provision can be tough for the C&YP) and also a supportive ethos in the mainstream setting is paramount to C&YP 'transitioning back':

Yeah, you can't just put them back and expect them to be like back to normal when having so much time out.'

(FG Participant 2)

On balance, even though professionals acknowledged the disruption that a school-move can cause, it was felt that the advantages that a PRU placement can bring will be beneficial to C&YP and less damaging than the alternative – exclusion: this is in line with the literature review presented earlier in this paper.

Communication

Expectedly, in order to ensure that any transition (in either direction) is as successful as possible, a theme emerged from the FG that frequent communication is paramount. In addition, the likelihood of C&YP reengaging with mainstream education was reported to be positively affected by PRU and mainstream school staff clearly explaining the re-integration process to the C&YP (what will happen and the expectations required when re-integrating back) and giving them reassurance about their re-integration:

'I don't know I mean one school that I can name looks something like that but another school continues to say 'no, these are our pupils; they're going to a PRU for a while, the doors open for when they're ready'. So I think it's kinda dependant on the inclusion attitude of the school, really, and I think they can be very different.

I think there's a role possibly for us to play in this at the point of, uhm when we take these young people to panel because we, the PRUs will ask us, well what is the exit plan? So we need to be sure we know what the school wants and whether that's an exit, or you know, a fresh start in a different school so we know where were going, and if it is that they are due to come back, then we need to ensure that there is, you know, that connection is maintained so that it's, you know, the child isn't forgotten by the school.'

(Exchange between FG Participant 3 and 5)

FG participants noted that the 'review' system – a safeguarded, regular and consistent opportunity for all professionals involved with a young person to meet and discuss the efficacy of the current PRU placement, any further support required, and the long-term 'exit strategy' – was a considerably important element of any placement in AP. This was universally viewed as an important element, though some FG participants noted that, on occasion, there were conflicting perspectives presented during a review, particularly with PRU staff being unsure of the long-term strategy of the PRU place. FG participants also noted that there had been a drop in frequency and efficiency of these review meetings, further compounding the uncertainty of *why* the PRU placement had been sought originally.

Impact on PRU staff.

Interestingly FG participants identified that PRUs operating a 'revolving door' policy (frequent admissions and reintegration) might disrupt the structure and efficacy of the PRU's services; not only this, a theme emerged from within the FG about the impact of frequent admissions on the staff who work within the PRU.

Clearly, as noted earlier, one of the key 'selling points' for the PRU service is that staff are able to build a strong relationship with the C&YP, however, this is juxtaposed with not only the difficulties that staff might face when trying to engage with C&YP with complicated difficulties but also how, if C&YP only attend the provision for a short period of time (as would be more in line with the model of how PRUs ought to work), the time-limited nature of any intervention. Simply, for some of the C&YP who attend PRUs, it is likely to take significantly longer for the therapeutic rapport to develop – this might not always be possible given the structure of the setting.

This is a poorly explored hypothesis and there was – from the literature review completed for this current paper – no research which sought to gain the views of PRU staff in relation to this; this might be an area worthy of further research.

Stigma

Though it was generally regarded across the FG that PRUs offer a valuable service, for which C&YP with complicated difficulties may benefit, the FG participants did

note that they often had concerns relating to the 'stigma' which may be felt by C&YP taken from their mainstream school to spend time in a PRU.

In particular, FG participants noted that this was a difficult balance: for some C&YP they felt as though – once transition back into a mainstream setting had occurred – that the reputation gained from PRU attendance was difficult to minimise: *'I think most teenagers particularly would be quite embarrassed about going to these places and might prefer to stay in the mainstream school'* (FG Participant 5).

Paradoxically, some members of the FG asserted that they felt that, particularly for PRUs which supported primarily with BESD, that there was a level of reputation to with some C&YP aspired:

'I've come across the situation as well where, some…it's like they want to refer themselves [to a PRU] by creating a [negative] image of themselves [in school], almost like creating their statement if you like 'this is me, I'm going to go there'

(FG Participant 6).

This is also an interesting reflection; within the research considered for this current paper there was a general consensus that C&YP *do not want* to attend a PRU (e.g. Mainwaring & Hallam, 2010) however the counter position – that some C&YP might behave in such a way as to pave the way for their PRU placement – was not considered.

This might be a reflection of the PRU's reputation within the local community of the host LA, or perhaps the aspiration among C&YP to attend a PRU to be with their friends who may already be in attendance. Again, this is a further hypothesis for exploration.

In summary, the FG themes identified within this current section were insightful insofar as understanding the perspectives of professionals involved in working with PRUs. Much of the discourse was unsurprising given the preceding literature review; it would appear that many of the present operational practices within the host LA are in-line with strengths and difficulties noted nationally.

Nevertheless, it is important that this research has some demonstrable utility for the host LA, and it is to providing concise summaries of each theme – alongside practical recommendations – which the following, final section, focuses.

Section 5: Discussion and Recommendations

The primary aim of this research was to consider the purpose, efficacy and perceived value of the PRU services in a West Midlands LA. The literature review presented at the beginning of this paper highlighted a number of long-standing, controversial perspectives within the corpus of research literature.

While the current research makes no claims to provide comprehensive answers to these pervasive concerns, some defensible conclusions can arguably be inferred from the FG analysis: fortuitously, much of the debate highlighted in the research review is broadly in line with the thematic analysis completed.

Overall, from both the literature review and practical investigation at the heart of this paper, it would be defensible to infer that there remains no consensus relating to many of the topics discussed.

In general the FG identified that PRU settings are valuable insofar as providing a smaller, more specialised and nurturing environment in which academic progress is important but wider developmental domains are highlighted equally. FG participants

Further, it is perceived that staff working in a PRU setting are more specialist insofar as having the requisite skills needed to support the diverse needs of pupils who attend. This, in combination with the overall structure of the PRU service provides a beneficial service for C&YP with complex difficulties. Not only this, it was noted broadly that there might be a level of peers support available, particularly if the C&YP who attend a PRU have similar difficulties; this might well contribute to PRUs, in their own right, providing 'inclusive' education.

However, there remains some points for further consideration, most of which are in line with long-standing and national concerns relating to PRU education. FG professionals identified that they were unsure of the *specific* support that could be provided in PRUs, acknowledging that there might be a misunderstanding between the perception of what was on offer and the reality.

Further, FG participants identified that there was serious consideration required for each C&YP who might attend a PRU setting: are they likely to develop further complicated attributes from being placed with peers who may have more complex difficulties; there needs to be additional consideration of the transition process, both in terms of the stigma for a C&YP returning to a mainstream school *and* the conceptualisation of why a pupil may attend a PRU (i.e. schools should not view PRUs as 'dumping grounds'), and; there is still no consensus as to whether PRU education is broadly inclusive or whether it further contributes to exclusionary, segregationist practices.

More specifically, with regards to transition, the FG participants identified that there were occasions in which they felt that a 'mainstream' setting could have 'done more' insofar as supporting children before looking to PRU provision; however, embedded within this is the mainstream school's culture, ethos and 'willingness' to attempt to meet the needs of all learners within their setting. An apt quote which captures wholly both the complexity of this relationship was provided by Participant 5:

'One criticism that has been levelled at the PRUs from schools because they get to the point whereby, uhm, you know, this kid is going to a PRU and they're at the end of their time and the schools are saying, well 'we've had no reviews, we don't know what the progress is and, we are not ready to have them back so…' and that's a tension between the PRU and the school with the poor child stuck in the middle thinking that they're ready to move on but schools aren't ready to accept them back.'

It is defensible to state that while this current research has elicited and highlighted the views of professionals who work frequently with PRU settings, there remains a significant amount of work to be completed insofar as developing operational practices within the host LA, though undoubtedly some positive features are present.

Accordingly, in order that this research has value for the host LA – and given the professional orientation of the researcher - reflections for the educational psychologist become evident.

Reflections for the EP

The current research has highlighted some pervasive difficulties relating to the way in which PRUs are utilised; professional perspectives of the services that PRUs offer; difficulties with transition and the relationship between mainstream settings and alternative providers, and; continuing uncertainty with how PRUs relate to broader conceptualisations of 'inclusion'. More optimistically, it is clear that professionals perceive PRUs as offering a valuable, distinct and broadly efficacious service despite some vagueness as to 'what goes on there'.

Emergent considerations for practitioner psychologists become obvious. It would seem defensible to suggest that 'awareness raising' in its broadest sense would be valuable: given that this research has identified that there is some professional confusion as to the *type* of service offered by each PRU, it might be for EPs in the host LA to audit what is available and then offer guidance to professionals who may have a more tertiary relationship with alternative education settings.

Further – as noted in the introduction to this paper – EPs in the host LA are recurrently commissioned to provide an 'assessment' of a young person's 'needs' in order to facilitate placement at a PRU. This, it would be reasonable to assert, is an opportunity for EPs to further refine the alternative provision landscape in the host LA: robust, evidence based assessment from which clear, time-limited recommendations emerge, would provide clarity in terms of 'expectations' both from

the PRU and referring mainstream school. This would likely have the additional benefit of challenging expectations as to the role a PRU fulfils, in line with recommendations from Taylor (2012).

Although these two recommendations are explicitly 'practical', further philosophical considerations emerge organically: though the emergent circumstances of alternative provisions, and the related discourses, are complicated (particularly the conceptualisation of C&YP as demonstrating needs 'too challenging/difficult/complex' for a 'mainstream' setting and thus needing AP, e.g. Hamill & Boyd, 2002; Farouk, 2012), the wider debates surrounding inclusion are long-standing, and permeate many strands of an EP's professional practice.

Accordingly, this research has highlighted that the AP model of operation offers the assiduous practitioner a number of ethical and practical dilemmas: what would happen if 'alternative' providers such as PRUs did not exist (are they used because they *do* exist?), has the mainstream setting *really* tried all that is feasible to meet C&YPs needs, and is it a comfortable position for the EP to adopt as being the 'gatekeeper' for admission to specialist services which might be antithetical to the inclusion agenda? Further, if a young person is to attend a PRU setting, what role does the EP play in monitoring this placement and facilitating an eventual return to mainstream education?

Though it is not within the scope of this current research paper to offer concrete conclusions to these reflections (indeed, it would seem unlikely that any firm recommendations are available given the complexity and long-standing controversy relating to 'inclusive' education), it is clearly worthwhile for the practitioner EP to consider their own personal role in the mainstream / AP landscape, and how they contribute to emergent discourse and practice.

Appendix 1

Multi-Agency Perspectives on the Purpose, Value and Efficacy of “Pupil Referral Units” in a West Midlands Local Authority.

XX as a Local Authority, has access to a number of ‘alternative’ provision providers; ranging from College, vocational training and 4 distinct Pupil Referral Units. These ‘PRUs’ cater for a variety of difficulties; behaviour, medical, complex psychological / social / emotional needs and specialist environments / services (e.g. Hospital tuition and teenage pregnancy).

Admission to these centres is completed primarily through a referral system; educational psychologists can ‘make’ a referral to these centres, on behalf of a young person, if the young person’s specific needs may be met more fully in one of these environments.

Unsurprisingly, this referral is not completed in isolation. Perspectives from other professionals are sought as to the suitability and appropriateness of a referral; can a referral to a specific provision meet the needs of a young person more completely than their current education provider (often a mainstream school)?

A suitable answer to this question relies fundamentally on the professionals involved in the referral process being fully aware of the service that the Pupil Referral Centres offer.

The aim of this current focus group is to explore the current understanding of the PRUs’ services;

- What services do these provisions offer which makes them distinct from mainstream education providers;
- What particular needs are supported within these settings, and how is this achieved;
- What role do the PRU settings play in facilitating positive outcomes for children and young people and;
- Are these settings successful in their endeavours / how is success evaluated?

Through a ‘focus group’ – ‘*a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research’* (Powell & Single, 1996 p. 499) – I am hoping that we can have a discussion about the current circumstances with the PRUs, using the above questions as a framework.

In any report that is generated, names and job role will be confidential so that anonymity is protected and nobody can be identified by their responses. I anticipate that this will take roughly 45 minutes.

1) What services are offered by the pupil referral units, and how does this differ from traditional mainstream education?

Prompts: behaviour management, emotional and social support, complex psychological difficulties, teenage pregnancy, home and hospital tuition

2) What particular needs are met in these settings? How are the settings different / similar in the service that they provide?

Prompts: how are 'needs' met more effectively in these environments, and what additional support is offered? How is a decision made as to which provision is most appropriate for a young person? How are the settings similar / different? Are they – any overlap?

3) How is progress managed when a young person attends a PRU? Is there an exit strategy? Are the placements typically long (1 year +), medium (2 terms) or short term (6-10 weeks)?

Prompts: what does a typical placement look like? Pre / post intervention measures? Regular reviews?

4) What happens if a placement 'breaks down'?

Prompts: how as a key member of the case are you informed about this? What is the response required? Are you kept 'in the loop' about any on-going difficulties or contacted at crisis point?

5) Overall, how do you value the services offered by the PRUS? Any particular strengths and/or weaknesses?

Prompts: has your experience of working with the PRUs been positive? Perhaps outline specific cases with successes? How could the service be improved?

Thank-you for taking part!

Chris Wood – Trainee Educational Psychologist

Appendix 2: Consent Form



UNIVERSITY OF BIRMINGHAM

My Name is: _____

Please circle your answer to each question.

I agree to participate in the research project through contributing to a Focus Group Yes No

I agree to the audio recording of the Focus Group . Yes No

3. I understand I can say I do not want to be part of the project at any time, and can withdraw should I so wish, with no risk of any adverse consequence. Yes No

4. I agree to the inclusion of my comments in a report that will be shared with other people, and understand that confidentiality will be assured in the writing of this report. Yes No

5. I understand my contributions may be used in written reports of this study, but my name will not be used, and care will be taken to ensure that neither other participants nor I could be identified within the reports. Yes No

6. If I have a question, I know whom to ask and how to contact them. Yes No

7. I understand that any information will be used only by individuals who have an active role in the research (Researcher, University of Birmingham Supervisor and Placement Supervisor), and that the research

data will be stored in a secure manner. Yes No

8. I understand that if I say something that indicates a risk of harm to someone, you would need to report this, following

routine Local Authority Safeguarding procedures Yes No

(http://www.wolvesscb.org.uk/)

Signed / Date:

Appendix 3: Transcript: Focus Group PRUs

C: What services are offered by the PRUs and how does this differ from mainstream education?

B: They are kind of like an alternative provider in that they take smaller groups because they have less children there, don't they, from a mainstream school and they can offer intensive support because of this. It also depends on the nature of the PRUs because you have some which are for behaviour difficulties, some which are for medical difficulties and psychological difficulties, the hospital PRUs so it's all in the nature of the referral.

A: I suppose the small groups makes them more nurturing and they're able to start building relationships more than they could do in mainstream schools and they can also home in on particular difficulties that children have, and they have kind-of a set of plans or strategies to support that, those difficulties.

C: So, say if we were talking about <the Psychological / hospital> PRU, and perhaps a specific difficulty like teenage pregnancy, what might, or what do we think they might offer for an expectant mother, that might be different to a mainstream school?

S: Well you would have the health support offered there on the site, wouldn't you, and they would get time out of their day to go and attend all the necessary appointments. So there's that, but I'm a bit confused, because when you have a PRU aren't you then just bringing children together that have similar difficulties into a smaller space? But then isn't it that the job is to try and manage those difficulties in the real world? It's a bit like being in a prison, do you know what I mean, in that they're there and they learn from each-other as well…

A: there is that as well, yeah

R: but there is also an opportunity to look at the behaviours and work with them more intensively to modify those behaviours with different strategies and in a smaller, safer environment which can be better than in a mainstream school…

A: I think that works particularly well with the first, the infants' stage 1 at the K centre, and I think we have had some really successful young people who have gone through who perhaps may have been really struggling with mainstream but perhaps a year or 15 months there and they actually become so much stable and they learn these strategies and, I think that the learning of these strategies is greater for the younger children than it is perhaps for the older children. I always have reservations of putting the older children into the K centre because I sometimes feel that they probably can, you know, through social learning, learn more of the negative behaviours…but I think it is particularly successful for the younger ones.

B: do you want us to elaborate on the teenage pregnancy specifically?

C: if you think that is an important service that they provide, then yes.

B: I was thinking that they would be in like a smaller group and not in a big school with all the stairs and with children that could ridicule them and whatever so at least for them they are out of that environment which is potentially quite harmful to them I would think.

R: I think that there is a safety aspect to it and I think that, for like the mainstream schools, they would *prefer* children to go to the O centre to be educated because of the health and safety and also the possible risks to them in staying in mainstream.

S: and there is the social aspect as well because they will be with other children who have similar difficulties.

A: that's right. And there is the emotional aspects because they are young aren't they? They'd probably have some difficulties with anxiety which the PRU can help support perhaps better than a mainstream, larger environment?

S: there is a difficulty that children who attend the PRUs, for whichever reason, then have to try and transition back into mainstream school and this can be really difficult for them. Because, for example, not only have they had a baby, or had some other difficulty, they then have to go back to mainstream and everybody knows that they have had that difficulty and children are expected to carry on in a way.

R: and with teenage pregnancy specifically they don't have maternity leave which can make it difficult for them psychologically.

A: I think they only have four weeks actually!

R: so then the spell of time at the PRU can be quite short for whatever reason and then they have to go back to mainstream.

B: I think once they have turned up and they look right again then children soon forget that the child has difficulties, it's only when there is the physical change like a baby bump, that children keep getting reminded that there is something different about them. So, I think it is better for them to go into a smaller environment, do you?

R: I think that they get, uhm, they've got the opportunity to talk about issues and they, you know, may not get that in mainstream with somebody sitting down and saying and telling them about their challenges and supporting them through their difficulties. It is very much a nurturing environment for them.

B: and they probably get people coming in don't they? Talking to them about their difficulty and sometimes about things that the curriculum may not have time to fit in. That's good isn't it really?

R: And they can be with other young people who don't have the same difficulty so they can support each other.

C: If there, say, is a difficulty and a youngster is attending the O Centre, do we overall think that is a good thing? Is that a good thing for inclusion or are these types of difficulties things that a mainstream school should make reasonable adjustments for?

B: No I don't think so, I think it's better for the smaller environment, I do.

R: I don't know, I'm a bit mixed on that one. I mean back in my day when I was at school they stayed in school. You know, as far as possible, unless there are any medical issues the expectation is that they stay in mainstream.

S: some things were used as an excuse to, you know, get out of P.E. So yeah, it's very different now, I think that we have moved away from that, but now it's like, you know, segregating them to go off. So if it was pregnancy, it's like, not only are you pregnant, but you not have to go to this special place, and then after things have become more settled you just go back into the mainstream school. You are not having the same experiences that peers are having.

R: I suppose for all the PRUs it's about the transition support that goes in when they go back to mainstream school and making sure that the move back is suitable for their needs.

H: Yeah, you can't just put them back and expect them to be like back to normal when having so much time out.

B: I think most teenagers particularly would be quite embarrassed about going to these places and might prefer to stay in the mainstream school.

C: It's an interesting point that H made there about, in general, how kids are being transitioned back into mainstream and how that is managed. How is that managed usually and is that typically a successful thing?

B: Transition is very important in the vast majority of cases isn't it? If there's a good transition plan in place then…

S: Sometimes there is a reduced timetable to start off with and depending on what age they are they might have connexions involved with them as well and, uhm, to think about their life after school.

H: It must be difficult for the staff at these places, particularly those who look after children with psychological difficulties as there is a level of dependency…because you have got them for that short period of time and they're going through a really difficult time anyway, staff have got to be nurturing and what's the balance to get it right and not set them up to fail when they do go back?

Appendix 4: Coding

Code 1: PRU Structure

Exemplar Data extracts:

‘They take smaller groups because they have less children there, don’t they, from a mainstream school and they can offer intensive support because of this’ (FG Participant [P] 2)

‘I suppose the small groups makes them more nurturing and they’re able to start building relationships more than they could do in mainstream schools and they can also home in on particular difficulties that children have, and they have kind-of a set of plans or strategies to support that, those difficulties’ (p.3)

‘But there is also an opportunity to look at the behaviours and work with them more intensively to modify those behaviours with different strategies and in a smaller, safer environment which can be better than in a mainstream school…’ (p. 5)

‘I was thinking that they would be in like a smaller group and not in a big school with all the stairs and with children that could ridicule them and whatever so at least for them they are out of that environment which is potentially quite harmful to them I would think.’ (p. 2)

‘No I don’t think so, I think it’s better for the smaller environment, I do.’ (p.2)

‘Mmm that’s right, all that we’re doing is making the big model smaller but actually we may need to make a different model of learning for some of these young people.’ (p. 3)

‘If they expect a lot of them to kind of go straight to a classroom where they, you know, find it difficult to engage, to go to a smaller classroom sometimes they’re not quite ready for that straight away.’ (p. 3)


Smaller group / Intensive support
• Nurturing environment
• Contagion effect of having young people with difficult behaviours in mainstream setting
• Being with peers with similar difficulties can be good in supporting a young person.
• Targeted strategies
• Specialist skills
• Built relationships with young person
• Focus on specific difficulties

Code 2: Transition

Exemplar Data extracts:

‘Transition back into mainstream school and this can be really difficult for them. Because, for example, not only have they had a baby, or had some other difficulty, they then have to go back to mainstream and everybody knows that they have had that difficulty and children are expected to carry on in a way’ (p. 4)

‘I suppose for all the PRUs it’s about the transition support that goes in when they go back to mainstream school and making sure that the move back is suitable for their needs.’ (p. 5)

‘It’s an interesting point that Hayley made there about, in general, how kids are being transitioned back into mainstream and how that is managed. How is that managed usually and is that typically a successful thing?’ (p. 1)

‘Transition is very important in the vast majority of cases isn’t it? If there’s a good transition plan in place then…’ (p. 2)

It must be difficult for the staff at these places, particularly those who look after children with psychological difficulties as there is a level of dependency…because you have got them for that short period of time and they’re going through a really difficult time anyway, staff have got to be nurturing and what’s the balance to get it right and not set them up to fail when they do go back? (p. 6)

‘I’m not sure about how they do that in all cases as it depends on the situation, but I think the transition plans seems to be slow in an attempt to reintegrate gently. But I don’t know I get the feeling that there’s an assumption that, I know because I’ve been asked, they say…well… we need an assessment to say whether the young person should stay with us otherwise we cease our input with them. So I haven’t been aware of the transition, like for teenage pregnancy, whether there’s a specific protocol. Sometimes the centre has a big effect in that their interests change, don’t they?’ (p. 3)

‘So, would you say that, is that something more generally about any pupil that goes to any PRU, for any reason, that their return to school is challenging…because of that reintegration. Is it actually a good thing to take them away for that period of time but then having to go back?’ (p. 1)

‘I still think that it is a good thing because a lot of them need the intensive support and then if the transition is done right, as you say, it’s going to have a good positive result.’ (p. 2)

‘I think age comes into that as well though because like you said earlier the younger ones seem to stand a better chance and I’ve had some successful cases there. I’ve

never had a young person come out of the older behavioural PRUS successfully…and go back in to mainstream.' (p. 6)

'You can't change the home environment you can't change everything can you, you can only do as much as you can and it's still up to them to turn themselves around a bit. They can have the support from people but if they're not willing to do that, sometimes they're not ready to go back are they I suppose?' (p. 2)

'Yeah but, it depends on probably the origin of the behavioural difficulty. I mean if it based on attachment difficulty with the carers then unless you are working on changes within the home then perhaps you are not going to get them back in to school without difficulty.' (p. 3)

'I don't know I mean one school that I can name looks something like that but another school continues to say 'no, these are our pupils; they're going to a PRU for a while, the doors open for when they're ready'. So I think it's kinda dependant on the inclusion attitude of the school, really, and I think they can be very different.' (p. 3)

Codes:



References:

Ainscow, M. (1991) **Effective Schools for All**. London: Fulton

Ainscow, M., Booth, T., & Dyson, A. (2006). Inclusion and the standards agenda: negotiating policy pressures in England. **International Journal of Inclusive Education**, 10(4-5), 295-308.

Alaimo, K & Klug, B (2002) **Children as Equals: Exploring the Rights of the Child**. Lanham, MD: University Press of America

Bennett, P. L. (2006). Helpful and unhelpful practices in meeting the needs of pupils with emotional and behavioural difficulties: a pilot survey of staff views in one local authority. **British Journal of Special Education,** 33(4), 188-195.

Billington, T. (2009) Open Dialogue: `Working with children: psychologists at the boundaries of knowledge and experience´, **The Psychology of Education Review**, 33 (2), 3-11

Birchwood, J (2013) **Volume 1: An investigation of the relationship between disruptive behaviour and depressive symptoms in young people who attend pupil referral units -**Ap.Ed.&ChildPsy.D. thesis, University of Birmingham.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology.**Qualitative research in psychology**, 3(2), 77-101.

Bronfenbrenner, U. (1994). Ecological models of human development. **International Encyclopedia of Education**, 3 (2). Oxford: Elsevier.

Browne, L (2013) **Emancipatory research with children in Pupil Referral Units: a Foucauldian perspective on policy and practice***.* Professional doctorate thesis, University of East London.

Bunch, G. & Valeo, A. (2004). Student attitudes towards peers with disabilities in inclusive and special education schools. **Disability & Society**, 19(1), 61- 76.

Cameron, R. J. (2006). Educational psychology: The distinctive contribution. **Educational Psychology in Practice**, 22(4), 289-304.

Carlile, A. (2013). Some Conclusions and Recommendations. In **Permanent Exclusion from School and Institutional Prejudice** (pp. 191-196). SenseP ublishers.

Centre for Social Justice (2011) **No Excuses: A review of educational exclusion**. London

Clough, P & Garner, P (2003), 'Special Needs and Inclusive Education'. in S Bartlett & D Burton (eds), **Education Studies: Essential issues**.. SAGE, pp. 72-93.

Cohen, L., Manion, L., & Morrison, K. (2011). **Research Methods in Education**. Routledge.

Cole, B. A. (2005). Mission impossible? Special educational needs, inclusion and the re-conceptualization of the role of the SENCO in England and Wales.European **Journal of Special Needs Education**, 20(3), 287-307.

Collins, C. S. (2013). **Applying an ecological perspective to variations in school exclusion levels**. University of Leeds.

Croll, P. & Moses, D. (2000) Ideologies and Utopias: education professionals' views of inclusion. **European Journal of Special Needs Education**, 15, 1-12.

Culley, L. (2010) Exclusion and inclusion: Unequal lives and unequal health. **Journal of Research in Nursing,** 15 (4), pp. 299-301

Daniels, H. (2011) Exclusion from School and Its Consequences. **Psychological Science and Education**. (1) 38-50

Davis-Kean, P. E. (2005). The influence of parent education and family income on child achievement: the indirect role of parental expectations and the home environment. **Journal of family psychology**, 19(2), 294.

de Jong, T., & Griffiths, C. (2006). The Role of Alternative Education Programs in Meeting the Needs of Adolescent Students With Challenging Behaviour: Characteristics of Best Practice. **Australian Journal of Guidance and Counselling**, 16(01), 29-40.

Department for Education (2013) **Permanent and fixed period exclusions from schools in England: 2011 to 2012 academic year**: London

Elliott, W. (2013). The effects of economic instability on children's educational outcomes. **Children and Youth Services Review,** *35*(3), 461-371.

Evans J. & Lunt I. (2002) Inclusive education: Are there limits? **European Journal of Special Needs Education**, 17 (1), 1-14.

Farouk, S. (2012). What can the self-conscious emotion of guilt tell us about primary school teachers' moral purpose and the relationships they have with their pupils? **Teachers and Teaching: Theory and Practice**, 18(4), 491-407.

Ford, J. (2007). Educational supports for students with disabilities and significant behavioural challenges: Teacher perceptions. **Australasian Journal of Special Education**, 31(2), 109-127.

Gavine, D. (2001). The assessment of special educational needs in Scotland – retrospect and prospect **Scottish Educational Review**,33(1), 72-83.

Goodman, R. & Burton, D.M. (2010) 'The inclusion of students with BESD in mainstream schools: teachers' experiences of and recommendations for creating a successful inclusive environment', **Emotional and Behavioural Difficulties**, 15 (3) 223 - 237.

GREAT BRITAIN. **Education Act**, 1994. London: HMSO.

Gutek, G (1997) **Philosophical and Ideological Perspectives on Education**. 2nd Edition. Allyn and Bacon.

Hall-Lande, J.A., Eisenberg, M.E., Christenson, S.L., & Neumark-Sztainer, D. (2007). Social isolation, psychological health, and protective factors in adolescence. **Adolescence**, 42(166), 265–286.

Hamill, P and Boyd, B (2002) Equality, fairness and rights - the young person's voice. **British Journal of Special Education**, 29 (3). pp. 111-117.

Hart, N (2013) What helps children in a pupil referral unit (PRU)? An exploration into the potential protective factors of a PRU as identified by children and staff, **Emotional and Behavioural Difficulties,** 18(2), 196-212

Hayes, N. (1997). **Doing qualitative analysis in psychology.** Psychology Press.

HMRC (2012) **Child Poverty Statistics: The revised local child poverty measure**

Howard J. & Rabie S. (2013). Are the rights of children and young people to reach their potential severely compromised by school exclusion? **Community Practitioner** 86(4)

Humphrey, N., & Ainscow, M. (2006) "Transition club: facilitating learning, participation and psychological adjustment during the transition to secondary school." **European Journal of Psychology of Education** 21(3)

Hodkinson, A. (2010). Inclusive and Special Education: Inclusive and special education in the English educational system: historical perspectives, recent developments and future challenges. **British Journal of Special Education**, 37(2), 61-67.

Jordan, A., Glenn, C., & McGhie-Richmond, D. (2010). The SET project: Effective teaching and its relationship to teachers' epistemological beliefs and inclusive teaching practices. **Teaching and Teacher Education**, 26, 259-266.

Kalambouka, A., Farrell, P., Dyson, A. & Kaplan, I. (2005) **The impact of population inclusivity in schools on student outcomes**: London, University of London Institute of Education,

Kuhne, M., & J. Wiener. 2000. Stability of social status of children with and without learning disabilities. **Learning Disability Quarterly** 23: 64–75.

Lapadat, J. (2010). Thematic analysis. In A. Mills, G. Durepos, & E. Wiebe (Eds.), **Encyclopedia of case study research**. (pp. 926-928). Thousand Oaks, CA

Le Mare, L., and M. de la Ronde. 2000. Links among social status, service delivery mode, and service delivery preference in LD, low-achieving and normally achieving elementary aged children. **Learning Disability Quarterly** 23: 52–62

Laluvein, J. (2007). **Parents and teachers talking: A community of practice? Relationships between parents and teachers of children with special educational needs.** Unpublished PhD thesis, Institute of Education, University of London, United Kingdom

Lauchlan, F., & Boyle, C. (2007). Is the use of labels in special education helpful?. **Support for Learning**, 22(1), 36-42.

Lawrence, N (2011) What makes for a successful re-integration from a pupil referral unit to mainstream education? An applied research project, **Educational Psychology in Practice: theory, research and practice in educational psychology**, 27:3, 213-226

Leather, M. F., Chedzoy, S. M., & Avramidis, E. (2009). **An Exploratory Case Study of 'Successful' Pupil Referral Unit (PRU)**.

Lindsay, G. (2007) Educational Psychology and the effectiveness of inclusion/mainstreaming. **British Journal of Educational Psychology**, 77, 1-29

Lipsky, D.K., & Gartner, A. (1997). **Inclusion and school reform: Transforming America's classrooms. Baltimore**, MD: Brooks

MacLeod, G. & Munn, P. (2004) Social, Emotional and Behavioural Difficulties: A different kind of special education need? **Scottish Educational Review**, 36(2) 169-176.

Macrae, S., Maguire, M., Milbourne, L. (2003). School Exclusion: Exclusion from Sch ool. **International Journal of Inclusive Education**, 7(2), 89-101.

Mainwaring, D. & Hallam, S (2010) "Possible Selves' of young people in a mainstream secondary school and a pupil referral unit: a comparison', **Emotional and Behavioural Difficulties** 15 (2), 153-169.

Mays N., Pope C., & Popay J (2005) Systematically Reviewing Qualitative and Quantitative Evidence to Inform Management and Policy-Making in the Health Field. **Journal of Health Services Research and Policy** 10(Supplement 1):6–20

Meo, A.I. & Parker, A. (2004), 'Teachers, Teaching and Educational Exclusion: Pupil Referral Units and Pedagogic Practice', **International Journal of Inclusive Education**, 8 (1) 103-120.

Michael, S., & Frederickson, N. (2013). Improving pupil referral unit outcomes: pupil perspectives. **Emotional and Behavioural Difficulties**, 18(4), 407-422.

Mooij, T., & Smeets, E. (2009). Towards systemic support of pupils with emotional and behavioural disorders. **International Journal of Inclusive Education**, (13)6, 597-616

Nind M, Wearmouth J, Collins J, Hall K, Rix J, & Sheehy K (2004) **A systematic review of pedagogical approaches that can effectively include children with special educational needs in mainstream classrooms with a particular focus on peer group interactive approaches**. In: Research Evidence in Education Library. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Norwich, B. (2008). Special schools: What future for special schools and inclusion? Conceptual and professional perspectives. **British Journal of Special Education**, 35(3), 136-143.

O'Brien, T. (2002). **Enabling Inclusion: Blue Skies . . . Dark Clouds?** London: The Stationery Office.

Ofsted (1995). **Pupil Referral Units: The First Twelve Inspections**. London: OFSTED.

Ofsted (2007) **Pupil referral units: Establishing successful practice in pupil referral units and local authorities.** London: Crown Copyright

Ofsted (2011). **Alternative Provision** London: Ofsted [online]. Available: http://www.ofsted.gov.uk/resources/alternative-provision

Pijl, S.J., P. Frostad, & A. Flem. (2008). The social position of pupils with special needs in regular schools. **Scandinavian Journal of Educational Research** 52: 387–405.

Pirrie, A. & MacLeod, G. (2009) Locked Out: researching young people excluded from special schools and Pupil Referral Units **Emotional and Behavioural Difficulties**, 14(3), 185-194.

Powell R.A. & Single H.M. (1996) 'Focus Groups'. **International Journal of Quality in Health Care**, 8(5): 499−504.

Robertson, C., & Dunsmuir, S. M. (2012). Teacher Stress and Pupil Behaviour Explored Through a Rational-Emotive Behaviour Therapy Framework. **Educational Psychology: An International Journal of Experimental Educational Psychology** 32(7), 1-18

Robson C (2002) **Real World Research.** Blackwell, (2nd edition)

Rouse, M. & Florian, L. (1996) Effective inclusive schools: a study in two countries, **Cambridge Journal of Education**, 26(1), 71-85.

Seale, J, Nind, M and Parsons, S (2014) **Editorial. Inclusive research in education: contributions to method and debate.** [in special issue: Understandings and Enactments of Inclusive Research: Progress and Sticking Points in Developing Participatory and Emancipatory Research in the Field of Education] **International Journal of Research and Method in Education**, 37, (4)

Slee, R. (2011). **The irregular school: Exclusion, schooling and inclusive education.** Taylor & Francis.

Solomon, Y. & Rogers, C. (2001) Motivational Patterns in Disaffected School Students: insights from pupil referral unit clients**. British Education Research Journal** 27(3) pp331-345

Soresi, S., and L. Nota. 2000. A social skill training for persons with Down's syndrome. **European Psychologist** 5: 34–43.

Sutherland, K. S., Lewis-Palmer, T., Stichter, J., & Morgan, P. L. (2008). Examining the influence of teacher behavior and classroom context on the behavioral and academic outcomes for students with emotional or behavioral disorders. **The Journal of Special Education**, 41(4), 223-233.

Taylor, C. (2012). **Improving alternative provision**. London

The British Psychological Society, Division of Educational and Child Psychology (2002).
Professional Practice Guidelines.

Thomas, G. (2009) **How to do your case study: a guide for students and researchers**.London: Sage

Thomas, G. (2013) **Education: a very short introduction.** Oxford: Oxford University Pres

Tomlinson, S. (2005). Race, ethnicity and education under New Labour. **Oxford Review of Education**, 31(1), 153-171.

Topping, K. (2012). Conceptions of inclusion–widening ideas. **What works in inclusion**, 9-19.

Warnock Committee (1978) **Special Educational Needs: the Warnock Report**. London. D.E.S.

Warnock. M. (2005) **Special Educational needs: a new look**. London.

Wilkinson, S. (2004). Focus groups: A feminist method. In S.n. Hesse-Biber & M.L. Yaiser (eds.), **Feminist perspectives on social research** (pp. 271–295). new York: Oxford university Press.

Wilson, K., Stemp, K., & McGinty, S. (2013). Re-engaging young people with education and training: What are the alternatives?. **Youth Studies Australia**,30(4).

Wright, C., Weekes, D. & McLaughlin, A. (2002) **'Race', Class and Gender in Exclusion from School**. London: Falmer Press.

Yu, G., Y. Zhang, &R. Yan. 2005. Loneliness, peer acceptance, and family functioning of Downloaded Chinese children with learning disabilities. **Psychology in the Schools** 42: 325–31.