PROFESSIONAL PRACTICE REPORTS

by

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INTRODUCTION TO VOLUME TWO

Volume Two of this thesis consists of four Professional Practice Reports (PPRs) exploring phenomena relevant to the field of educational psychology research and practice. The Trainee Educational Psychologist (TEP) carried out these projects whilst on work placement at an EP Service within the East Midlands during the 2nd and 3rd years of the Doctoral programme at the University of Birmingham. Each PPR is presented in a chapter, forming the second half of the thesis.

The EPS is situated within a Local Authority of a large county, which contains areas which are both rural and ethnically diverse. It has two bases located in the north and south of the county. The EPS operates a partially traded model of service in which the LA commissions EPs to carry out work that contributes to its statutory duties and schools can buy in additional time to meet the diverse needs of their pupils.

The first PPR comprises of a critical literature review of the research exploring explanations for Developmental Co-ordination Disorder (DCD) to illuminate how best to support children and young people (CYP) with difficulties of this kind. PPR2 presents a case study of the application of a manualised Cognitive Behavioural Intervention for CYP within a school setting. The intervention was used to address the needs of a 13-year-old experiencing anxiety and its efficacy and feasibility was evaluated. The 3rd PPR aimed to evaluate the benefits of a Group Theraplay intervention designed to support mothers to develop secure attachments with their children. It was carried out in a community setting with mothers who had experienced domestic violence. The fourth and final PPR explored the beliefs and practices of locally-based EPs on the issue of consultation with children

PPR1: The validity and usefulness of explanations for the aetiology and impact of Developmental Co-ordination Disorder (DCD) on children and young people.

Developmental Coordination Disorder (DCD) is defined in the Diagnosis and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) as a condition of significant impairment in the development of motor coordination, which interferes with academic achievement and/or activities of

daily living (ADL). Research into its aetiology and effects has traditionally adopted a bio-medical approach. The validity and usefulness of traditional models used to explain the aetiology and effects of DCD was compared with bio-ecological, biopsychosocial and resiliency models. It was concluded that biological factors were important in understanding the aetiology, effects and impact of DCD but should be considered within a wider framework which would be more useful to practitioners.

PPR2: A case study of the transfer of the 'Think Good Feel Good' manual into practice; a Cognitive Behavioural approach for children and young people

The Think Good Feel Good (TGFG) manual by Stallard (2005) was used to plan and deliver a largely Cognitive Behavioural Therapy based intervention to a young person who was aged twelve years experiencing anxiety-related difficulties. A case formulation was devised using guidance and tools offered in the TGFG clinician's guide. Various adaptations were made so that the intervention was age-appropriate and met the young girl's learning needs. A Revised Child and Adolescent Anxiety and Depression Scale (RCADS) was administered pre- and post- intervention alongside scaled questions and indicated a small decrease in anxiety. The young person's evaluation of the sessions was favourable and suggested that she found the intervention helpful. An evaluation of this CBT approach and recommendations for future anxiety interventions delivered by Educational Psychologists in school settings was discussed.

PPR3: Group Theraplay for mothers and children who have experienced domestic violence: an exploratory study.

There is a pressing need for evidence-based interventions to support mothers and children who have experienced domestic violence. 'Moving on Through Play' is a group-based intervention for mothers and children who have experienced historic domestic violence; an intervention based on the principles of Group Theraplay. This research project set out to explore what worked across a group of mother's experiences of 'Moving on Through Play' and what might be improved, to what extent the hoped for outcome domains resonated with this group of mothers and how the emerging narratives illustrated

that domains were (or were not) experienced. A focus group was used to collect qualitative data from which themes emerged, through the process of thematic analysis, contributing to the evaluation of this intervention. The results indicated that the group members had positive experiences within the 'Moving on Through Play' sessions and that the experience had a wider impact on the mothers' lives and the relationships with their children. The role of Educational Psychologists within this field as practitioners and researchers was discussed to develop the evidence-base and provide the best support for this vulnerable group.

PPR4: A descriptive study of Educational Psychologist's beliefs and practices surrounding consultation with children

The profile of the child's Voice has been raised both internationally and nationally with implications for all professionals involved in making decisions in the best interests of CYP. This study aimed to capture descriptive information on EP beliefs and practices relating to consulting with CYP at a local level and what factors might support or constrain this practice. The findings suggest that EP's beliefs were supportive of consultation with children and that most CYP were consulted with. Areas for further exploration are highlighted in order to address possible constraints to this practice and develop EPs strengths in this area.

PROFESSIONAL PRACTICE REPORT 1

The validity and usefulness of explanations for the aetiology and impact of Developmental Co-ordination Disorder (DCD) on children and young people.

Abstract

Developmental Coordination Disorder (DCD) is defined in the Diagnosis and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) as a condition of significant impairment in the development of motor coordination, which interferes with academic achievement and/or activities of daily living (ADL). Research into its aetiology and effects has traditionally adopted a bio-medical approach. The validity and usefulness of traditional models used to explain the aetiology and effects of DCD is compared with bio-ecological, biopsychosocial and resiliency models. The bio-ecological developmental model is in support of the idea that DCD has a developmental trajectory and acknowledges that needs are not static and unchanging. The biopsychosocial model considers the multidimensional nature of DCD in a wider framework of health and wellbeing which encourages a broader, more holistic assessment of need. The resiliency model categorises multiple factors into risk and protective factors that impact on children with DCD, which can be useful for professionals designing interventions. It was concluded that biological factors are important in understanding the aetiology, effects and impact of DCD but should be considered within a wider framework. Recent research exploring impact and outcomes provides further evidence that DCD cannot be fully explained using a bio-medical model of disability.

1. Introduction

There is much debate and controversy surrounding Developmental Coordination Disorder (DCD) which was first introduced in the Diagnosis and Statistical Manual Revised third edition in 1987 (American Psychiatric Association). It is a term used to describe children with motor coordination difficulties and is defined in the Diagnosis and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) as a condition of significant impairment in the development of motor coordination, which interferes with academic achievement and/or activities of daily living (ADL).

Critiques of research into developmental disabilities such as Morton (2004) highlight the misconception that behavioural indicators can be treated as synonymous with biological markers for disability. Furthermore, researchers adopting the bio-medical model tend to suggest DCD can be explained by a single causal pathway, despite the heterogeneity of the group and consensus that co-morbidities between DCD and other disabilities are very common. Recent research has explored the wider impact of DCD for children with this disorder and highlighted outcomes that can't be fully explained by the bio-medical model.

Jokic and Whitebread (2011) argue that traditional approaches to understanding DCD have assumed that performance difficulties could be attributed to a sensorimotor impairment. They points out that these assumptions have not been supported empirically and have no sound theoretical basis as they are not consistent with current theories of motor learning. This perspective reflects the growing recognition of the multidimentional nature of this disorder calling for a more diverse approach to supporting children with DCD.

A potential role for an Educational Psychologist (EP) could be in assisting in the assessment and modification of the learning environment, through joined up work with other professionals. EP's are also well placed to empower parents and children affected by DCD, giving them a voice and ensuring a child and family centred approach. As applied psychologists working in real-life contexts, a multifactorial analysis, using in depth qualitative information could help highlight potential risk and protective factors. EP's have a knowledge and understanding of psychosocial factors in the learning context, such as metacognition and affect and so will be able to assist in individualised intervention designs.

Historically dyspraxia is a widely used term, and is still used by some professionals. The term praxis describes our learned ability to allow us to plan, organise and execute purposeful, skilled movement. Currently DCD is regarded as synonymous with the term Dyspraxia, and for the purposes of this review will be considered as such; Gibbs et al (2007) comments that there is a common consensus in the literature that the difference between the terms is semantic and references in the literature to these terms fail to distinguish between the two with any clarity. The process used to search for research literature for this review *was iterative;* a topic was explored, the literature reviewed, the topic refined further, and reviewed again. Both the terms DCD and dyspraxia in my search for research literature. I found that the majority of research carried out in the last ten years used the term DCD to describe this group of motor difficulties. Lingham et al (2007) used the DSM-IV criteria to estimate the prevalence of DCD in a representative UK population sample of children aged 7 years as 1.8%.

2. The bio-medical model

The biomedical model is based on the assumption that disease and disorder can be fully explained by reducing a phenomenon into its physiological 'parts'. It takes the reductionistic view that all phenomena are best understood at the lowest level of natural systems (e.g., cellular or molecular). Hatala (2012) argued that the bio-medical model has relegated illness and healing to a physiological framework with limited attention to psychosocial factors.

2.1. Behavioural indicators vs. Biological markers

There is currently a lack of consensus about the aetiology of DCD, although many causes have been proposed. A top-down approach is largely taken in which researchers have hypothesised causes for DCD based on knowledge of how parts of the brain work together. As the motor cortex is strongly implicated in the planning and execution of movement, it is widely believed that DCD is associated if not caused by a dysfunction in this area of the brain. There are currently no biological markers for DCD and a dependence on behavioural indicators, described by Vaivre-Doivet et al (2011) as soft neurological signs. This makes it difficult for researchers to provide reliable and valid evidence for a biological cause of DCD.

Vaivre-Doivet et al (2011) adopted a top-down, bio-medical approach in an attempt to describe the aetiology of DCD. They proposed that soft neurological signs of DCD (behavioural indicators) such as low muscle tone, the slowness and the quality of motor actions, was indicative of a dysfunction of the cerebellum-thalamus-basal ganglia circuit (see Table 1). Table 1 highlights several areas of the brain which are implicated at different stages

of motor co-ordination. Conclusions drawn about the aetiology of DCD based on analysis of typical behavioural indicators may be unreliable with questionable validity; for example, behavioural indicators may be secondary effects of DCD rather than primary causes directly linked to the brain's neurology.

Table 1: DCD caused by dysfunction of the cerebellum-thalamus-basal ganglia circuit as proposed by Vaivre-Doivet et al(2011).

Stages of motor co-ordination	**Areas of the brain implicated**
Sensory-perceptual input needed to interpret information from the environment and for the intention of a motor action.	• Limbic cortex • Thalamus • Pre-frontal cortex
↓	
A motor plan is formulated. This depends on accurate analysis of sensory-perceptual information.	• Basal ganglia • Thalamus • Prefrontal area • Areas associated with the parietal and temporal lobes
↓	
A motor 'program' is built in which the special and temporal parameters needed for successful execution of movement are determined.	• Basal ganglia • Thalamus • Neo-cerebellum • Premotor and motor cortex
↓	
Executing the movement, which involves	• Cerebellum

sensori-motor feedback control loops.

- Motor cortex
- Red nuclei
- Vestibular nuclei
- Spinal cord
- Muscles

Research adopting the bio-medical model tends to construct DCD as a within person disorder with a specific cause. Causal pathways are hypothesised based on the correlational analysis of the patterns of 'abnormalities' and cluster analysis of the underlying core difficulties across different categories of DCD. Vaivre-Doivet et al used both correlational data and cluster analysis to make causal inferences and thus group children with DCD in terms of their 'abnormalities' in motor planning and programming. Morton (2004) argues that correlational data should not be used to infer a cause as one cannot be certain of the direction of causation or if another, underlying variable could be responsible for causing this correlation. Aldenderfer and Blashfield (1984) warned that cluster analysis will *always* place an object into a group and the interpretation of results from cluster analysis is based on personal judgement rather than any formal statistical procedure. Everitt (1979) argued that cluster analysis encouraged "naive empiricism" in which as many variables are included as possible in the hope that a meaningful structure will be created.

2.2. Co-morbidity

The European Academy for Childhood Disability (EACD) (2011) acknowledged that co-morbidity tends to be the rule rather than the exception when regarding children with DCD

and suggested the idea that a common aetiology between DCD, ADHD, learning disorders, and autism is plausible. A large twin study by Martin et al (2010), however, demonstrated that co-morbidities between these four developmental disorders were only confirmed in the most severe cases. Kaplan et al (2001) proposed the term 'Atypical Brain Development' was a better alternative to DCD. They argued that instead of constructing a 'syndrome' to attempt to categorise children with motor co-ordination difficulties, we should instead adopt a 'symptoms' approach.

2.3. Within-Group Variability

Vaivre-Doivet et al (2011) concluded that there was evidence to better define subtypes of "pure" dyspraxia within a population of DCD children. Despite Vaire-Doivet et al's attempts to clarify the causes and subtypes of DCD and differing perspectives there is still much disparity in the research. The subtypes Vaire-Doivet et al identified could be contested by evidence from other studies which have used different sampling methods and different parameters by which to carry out a cluster analysis. Inconsistencies in research findings may be due to sample variation or could be used as evidence for the existence of discrete subtypes. Studies that have used positron emission tomography (PET) and magnetic resonance imagery (MRI) have highlighted a number of atypical characteristics in children with DCD but these are not homogenous across the group and the abnormalities they have highlighted has been non-specific (EACD, 2011).

Dewey et al (2001) and others offer an alternative perspective by proposing that the specific pattern of cognitive deficits will depend on the extent and the location of the underlying neurological abnormality, leading to a broader, more flexible approach to categorising difficulties.

2.4. The medicalisation of children with DCD

There appears to be an underlying belief held by those that adopt the bio-medical model, that one day advances in technology will make it possible to identify underlying biological markers for seemingly complex disabilities which will further explanations which have a neurological and genetic basis. At present, a diagnosis of DCD communicates to us that a child has a difficulty with motor skills, but it is likely that the overall profile of their difficulties will vary. If so, the existence of a common underlying aetiology is debatable. Sugden and Chambers (2005) commented that an underlying aetiology, such as visuo-spacial disorder or planning disorder which explains the overall syndrome would be difficult to validate, given the heterogeneous nature of this group.

The lack of consensus within bio-medical research throws into question the usefulness and validity of a label of DCD for children experiencing motor coordination difficulties. Gibbs et al (2007) argued that the concept of motor difficulties has been inappropriately medicalised when children with motor co-ordination difficulties could be simply described as being at one end of a normal distribution. It may be more valid to conceptualise developmental disability on a continuum rather than as disorders in discrete categories. Similar debates in ADHD and dyslexia research have led some to reject the biomedical model in favour of a psychosocial approach to developmental disorders such as DCD.

Coghill et al (2005) argued for the use of a developmental causal modelling framework which suggests multiple causal pathways interacting at different system levels to explain the aetiology of ADHD as proposed by Morton and Frith (1995). The framework Coghill et al proposed considers the interactions, mediations and moderations between a child's biology

and the environment in which they develop. This framework could be applied to DCD to give less reductionist and alternative causal explanations recognising its complex nature.

3. Bio-ecological developmental model

Sugden et al (2008) argues for the use of a bio-ecological model of development and disability, similar to the one proposed by Coghill et al (2005). The bio-ecological developmental model is a theoretical model of gene–environment interactions in human development, proposed by Bronfenbrenner and Ceci (1994); an extension of Bronfenbrenner's ecological systems theory. It considers the bidirectional influences between an individual and the environmental context in which development occurs.

Lingham et al (2007) found a higher prevalence of children with DCD from a lower socioeconomic background, lower birth weight and a gestation of less than 37 weeks. An explanation for the trend Lingham et al (2007) identified could be explored by investigating how a child's biology interacts with their environment and how this influences their development of perceptual and motor skills. Magalha˜es et al (2011) carried out a review of research and recommended that there should be more of a focus on mapping out the developmental trajectory of DCD by using data from longitudinal studies. Magalha˜es et al (2011) commented that research tends to make cross-sectional comparisons between groups rather than within-participant data from longitudinal studies. Although the bio-ecological developmental model encourages the exploration of interactions between within person factors and environmental factors, it tends not to include psychosocial factors, reducing disability into interactions between a child's physiology and environment. Research adopting this model tends to identify environmental factors as peri-natal, pre-natal and post-natal

factors, ignoring wider social influences. A criticism shared with the bio-medical model. This could lead to a narrow view of the difficulties experienced by children with DCD.

Sugden et al (2008) argues that a bio-ecological developmental model could consider gene-environment interactions as part of a matrix of risk and protective factors. The evidence for this model is largely correlational in nature and Sugden does not develop this model in any great depth; for example, by isolating key risk and protective factors which have a greater effect on the trajectory of DCD. Sugden et al acknowledge that we need to know more about environmental factors, such as family and peer relationships. Sugden highlights the usefulness of the bio-ecological developmental model in designing interventions with more of an individualistic approach, suggesting the need for child and family centred interventions. This would readdress the influence of the 'professional' medical perspective, allowing for different perspectives and evidence bases to be considered.

The resiliency and biopsychosocial approaches could be considered as a better alternative to the bio-medical model and a more comprehensive framework than the bio-ecological developmental model.

4. Resiliency model

Resilience is a broad concept related to positive patterns of adaptation in the context of adversity. Resilience researchers have sought to identify the factors associated with good adaptation in those expected to struggle because of genetic or environmental risk. Research has focused on identifying potential assets or protective factors which impact on the outcomes for children defined as at risk.

Coghill et al's model also encourages us to consider the influence of risk and protective factors on the aetiology and effects of the condition. Very little research has looked at the risk and protective factors of DCD and how these factors might mediate or moderate the developmental trajectory of the condition, as well as a child's broad outcomes. Sugden et al (2008) commented that interventions should consider reducing the negative effects of DCD, however there are few studies that have explored how risk and protective factors influence the trajectory of the condition.

Lingham et al's (2007) findings suggest that environmental factors, such as socioeconomic background, play an important role in the development of DCD, if in the absence of these factors, the prevalence of DCD is lower. These factors can therefore be described as risk factors, increasing the likelihood of a child having DCD. The influence of a lower socioeconomic background on the development of motor co-ordination skills should be explored to help establish how socioeconomic status affects the developmental trajectory of motor coordination skills and which aspects of a lower socioeconomic background are likely to have the greatest mediating affect.

Missiuna et al (2006) carried out a relatively small study, in which they asked 10 adults with DCD judged as 'resilient' to identify what they found helpful in managing their condition. The strength of this study was a unique positive approach in a field of research in which the focus is on the negative effects and deficits of the individual. The researchers adopted a 'bottom-up' methodology, in which the views and opinions of adults with DCD were sought. The study did not seek to explore mechanisms of change from a bio-medical perspective, instead exploring psychosocial factors that might set those resilient adults apart from similar

adults with less successful outcomes. As the sample size is small, and few other studies have taken a similar approach, these results are difficult to generalise.

5. A biopsychosocial approach

A biopsychosocial model proposes that biological, psychological and social factors all play a significant role in human functioning in the context of disability and disease. Santrock (2007) argued that health is best conceptualised as a combination of biological, psychological, and social factors rather than solely in biological terms.

A technical approach is often adopted with children with DCD, whereby the importance of within-child factors, such as their functional skills is emphasised. Hunter-Carsch (2001) offers a similar argument when proposing a psychosocial approach to dyslexia, an equally complex disorder. Hunter-Carsch describes the current construct of a person with dyslexia as being the 'objectified subject' of criteria rather than an active 'co-explorer', arguing that the voice of the professional often has more power than the voice of the learner. Hunter-Carsch proposed that this approach empowers learners through the recognition of broader contextual factors. Instead of leaving the child with a diagnosis, their awareness of these factors should be raised and they should be supported in constructing their own interpretation of what DCD means to them so they are able to describe and explain their difficulties to others. This might have a positive impact on self-concept, decrease the risk of social isolation and exclusion and contribute to a better understanding of how children with DCD can compensate for their difficulties. It can be convenient, however, for a shared understanding which is associated

with having a particular label; for example, a label of DCD can be used by professionals to signpost interventions that have been found to help children with similar difficulties.

Morton (2004) proposes that psychosocial pathways lead to an interpretation of disadvantage rather than cause. The ability to compensate for deficits will vary as even if individuals share a common organic cause, cognitive factors are variable and act as an intermediary between the brain (organic causes) and behaviour (manifestation of symptoms of DCD). Although Morton is keen to point out that there is a difference between vulnerability (based on risk and protective factors) and cause, Morton proposes an association between protective factors and good outcomes for children with a developmental disability. Differences in vulnerability between those with DCD could, in part, explain some of the variability which exists in children with DCD. The interaction of risk and protective factors could act as mediatory factors at cognitive, social and emotional levels of explanation.

Chambers (2005) commented that the link between motor impairment and functional skills is difficult to quantify. This difficulty could be linked to variability in mediatory factors, which would depend not just on genes and biology but on environmental and interactional factors which could affect the developmental trajectory of DCD. Chambers proposes that factors significant to the learning situation for a child with DCD, will include variables such as self-concept, motivation and social emotional variables. Although these variables are not causes of DCD, they could be considered as resiliency factors, mediating the effect DCD has on learning and development.

6. Effects

The Diagnosis and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) states that a child or young person must meet two inclusionary and two exclusionary criteria to be identified with DCD. The inclusive criterion states that motor performance should be significantly below that expected given the person's age and intelligence and should interfere with academic performance and/or activities of daily living. The exclusive criterion states that other conditions, such as cerebral palsy, should be ruled out and that impairments are over what one would expect if significant learning difficulties are present. Although this was a useful way of categorising effects, and criteria are often explicitly referred to by researchers in papers, it should be pointed out that the term 'effects' is used quite broadly within this research field. Researchers may refer to 'effects' when they are referring to the impact of DCD on children rather than to the relationship between a primary cause and effect. This further highlights the lack of consensus within the literature as to the aetiology of DCD and that 'effects' such as those referred to in the DSM-IV criteria are often behavioural indicators making it difficult to distinguish between an effect which can be directly linked to a cause, or to the impact of DCD on children's outcomes.

6.1. Motor difficulties

The DSM-IV criteria states that an impairment in the development of motor coordination is needed for a diagnosis of DCD (DSM-IV). The European Academy for Childhood Disability (EACD) (2011) carried out a meta-analysis of 128 studies comparing children with DCD to typically developing children. Statistical analysis found that the largest effect sizes indicating the largest differences between these groups were for the kinematic parameters associated

with reaching and catching and target directed reaching within and outside of personal space. Large effect sizes were also found for gait, static balance, and moderate effect sizes for visuospatial and verbal working memory.

As motor coordination can only be measured using behavioural indicators, this leaves the judgement of an 'impairment' down to professionals such as paediatricians and occupational therapists. There is no definitive assessment for this criteria and this partly explains the variance within this heterogeneous group, although the Movement Assessment Battery for Children (M-ABC) is widely utilised.

6.2. Activities of Daily Living

Under the DSM-IV criteria, for a diagnosis of DCD, motor coordination difficulties must interfere with activities of daily living (ADL). Magalhaes et al (2011) carried out a review of all literature between 1995 and 2008 in which the activity limitations and participation of children with DCD were described. The findings are summarised in figure 1; the most common themes across the literature was the effects on participation in play and classroom activities, activities of daily living, participation in sport and social skills. Speech and language issues and psychological issues related to life satisfaction and feelings associated with motor awkwardness were also reported. Magalhaes et al (2011) highlighted the issue of researchers' use of non-standardised measures for the assessment of motor coordination. Not all researchers use the DSM-IV criteria to select participants and so the cut-off points for participants to include and exclude in research varies widely. Magalhaes's research excluded non-English papers; it would have been interesting to compare and contrast effects between different cultures to see if some effects could be explained by cultural factors. Furthermore,

the assumption is made that cultural variance between papers written in the English language would not be significant. Countries such as Australia and the United States may place a greater importance on team sports affecting the impact of DCD on participation in sport on psychosocial factors, such as self-efficacy and social inclusion.

Magalhae's research highlights the need for further research into the relationship between motor, language, and social skills impairments and their impact on participation and activity limitations. The impact of limitations to play-based activities on the development of language, social skills and cognitive skills would also be of interest as early play experiences are important for most areas of development. The time at which motor difficulties begins to impact on play and participation in activities requiring physical skills will also be significant in understanding the developmental trajectory of DCD. If children with DCD have lower levels of participation in play and physical activities this could exasperate symptoms of DCD and further inhibit progress in the development of motor coordination skills. Furthermore Kennedy-Behr and Mickan (2013) found evidence to suggest play is more important in developing prosocial behaviours than in typically developed children and suggested the social benefits of play to children with DCD in particular. EP's as researchers could use methods such as play-based and dynamic assessment to explore and compare the play of children with DCD and typically developed children. Dynamic Assessment could be used to determine the level of mediation (teaching) needed to progress play on to the next level if play skills were identified as an area of need.

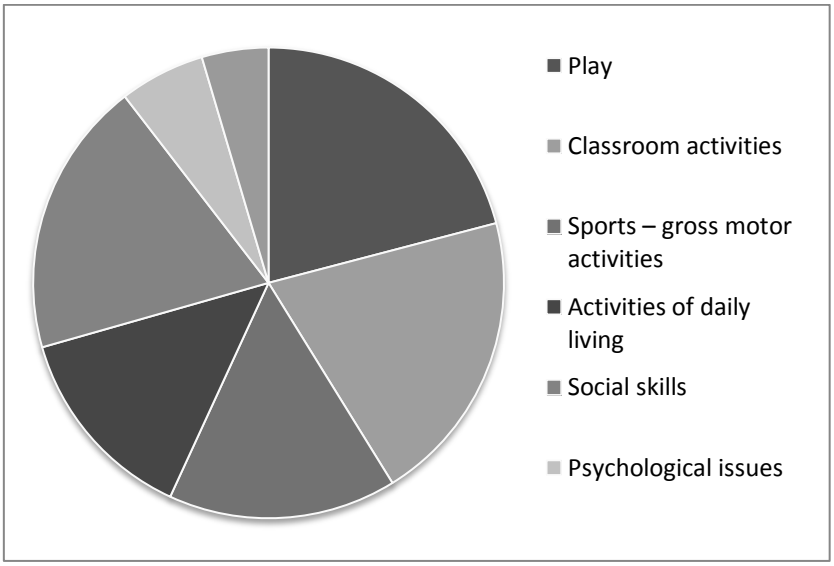


Figure 1: common themes for the effects on participation in sport and social skills for children with DCD.

The EACD (2011) commented that a literature search of research investigating the levels of activity and participation of children with DCD yielded only five studies. They concluded that DCD does lead to impaired functional performance in activities of daily living. The EACD state that the impact of motor coordination problems on physical activity engagements throughout life are influenced by social, cultural, physical environment and individual factors. It is hypothesised that participation levels may lead to poor self-efficacy and lower life satisfaction in adolescents with DCD, based on evidence that children with DCD show less physical activity; especially participation in team sports.

Piek et al found that participation levels of children with DCD affected the family system, having the most effect on the parents and that parents had concerns about their child's participation in wider society. They found a significant correlation between motor ability and anxiety disorders, with behavioural difficulties and difficulties in social interactions found to be persistent in a long-term follow-up. The significance of levels of participation on the

outcomes, self-efficacy and life satisfaction of children with DCD and their families is difficult to establish based on so few studies, but findings to date suggest that further research is required in this area to determine what factors are involved. Establishing protective and risk factors specifically in participation could help Educational Psychologists assess and support individuals at risk of low participation in a preventative capacity.

There appears to be a widespread exclusion of the child's voice in DCD research, which suggests findings may reflect the perspectives of adults involved in the case of a child with DCD but not of the child experiencing the disorder. Educational Psychologists (EPs) are well placed to use methods such as Person-Centred Planning to enable young people to have a voice throughout the process of assessment, identification and intervention. This would help establish what was working for a child with DCD, what was not working and their perception of their needs. This would help personalise support rather than adopting a 'one size fits all' approach.

6.3. Academic Performance

The inclusive criteria from DSM-IV used to diagnose DCD states that DCD should interfere with *academic performance* and/or Activities of Daily Living (ADL). As with an assessment of the interference of motor difficulties with ADL, the difficulties with defining interference with academic performance has also been highlighted. The DSM-IV offers no further guidance for professionals responsible for making this judgement and so there is wide variation in the ways this interference is measured. This variance may help to explain the heterogenous nature of children with DCD. This criterion implies that there is a relationship between DCD and academic performance, which has led some researchers to look for cause-

effect relationships between the two. Morton (2004) warned against describing behaviour; in this case academic performance as if it was a cognitive mechanism and argued that nothing is determined as there are so many sources of internal and external variation. Morton argued that often researchers confuse risk factors with causal factors when in fact they are contingencies; their presence may increase the likelihood of an outcome, making an outcome probable, but not certain. Some research within the field of DCD investigating the academic performance profiles of children with DCD refer to cause-effect relationships as if it were possible to infer with reliability a biological cause by investigating associations and correlations between variables indicated by certain behaviour and performance indicators. This may lead to misconceptions among professionals and families about the relationship between risk factors and presenting difficulties; they may underestimate the potential for change if they equate risk factors with biological causes.

6.3.1. DCD and Memory

Alloway (2007) investigated components of the working memory; visuospacial memory and verbal memory, for children with DCD aged 5 to 11 years. Alloway stated that findings indicated a 'pervasive memory deficit in all memory measures' (p.20). Performance levels for children with DCD in verbal working memory measures were slightly lower and for the visuospatial short term and working memory tasks, mean scores were significantly lower.

Alloway used a rigorous selection criteria using both the DSM-IV and Movement Assessment Battery for Children. The sample size of 55 children with DCD used is relatively small. In addition, within group variability in performance on tasks dependent on visuospatial memory and also variance in reliability measures will have impacted on the overall reliability and validity of findings.

The use of the word ‘deficit’ is used frequently throughout Alloway’s article and children with DCD are constructed as at a disadvantage due to these ‘deficits’. The word ‘deficit’ is suggestive of a biological model and that memory difficulties are linked to within child factors. Alloway adopted a positivist perspective, inferring a link between DCD and types of memory, such as visuospatial memory, by a method of deductive reasoning, but without a sound theoretical grounding; a plausible mechanism is not explored. Alloway presents correlational data which is inadequate evidence for a causal link between DCD and memory difficulties. Difficulties associated with establishing a causal pathway for DCD makes testing cause-effect mechanisms problematic.

Chen (2013) investigated the everyday memory of children with DCD with a similar age range (5 to 9 years). Chen also found within group variance with about half of the group showing evidence of everyday memory deficits, primarily in verbal and visual memory tasks, which appeared to be mediated by verbal IQ. In contrast to Alloway’s findings, Chen’s findings suggested children with DCD had *better* spatial memory than typically developed children, although Chen attempted to explain this by hypothesising that children with DCD were more familiar with the clinical environment in which the memory tests were carried out and so had increased motivation. Chen did not consider that motivation may serve as a protective, mediating factor in memory performance worthy of further investigation. Apart from the mention of motivation, psychosocial factors were not explored. Instead Chen proposed that DCD and verbal IQ are linked and recommended further research in this area. A link between these two variables is suggestive of a within child deficit and biological cause, explaining both memory deficits and motor co-ordination problems.

When considering that the meta-analysis carried out by the EACD (2011) found moderate effect sizes for visuospatial and verbal working memory, it is likely that in some cases there may be an association between DCD and some aspects of memory, but more research is needed to establish the nature of this relationship. The reliance of behavioural indicators, over biological indicators as well as the dependence on correlational data in this field of research makes it unlikely that a shared biological cause for DCD and memory could be established with a high degree of certainty. Exploring the psycho-social factors that may directly or indirectly influence memory and the development of memory functions may help illuminate ways for Educational Psychologists to support children with DCD in compensating for difficulties with memory on an individual basis and it should not be assumed that all children with DCD will have memory difficulties.

6.3.2. DCD and handwriting skills

Research has typically focused on the academic performance of children with DCD compared to the performance of typically developed children in the areas of literacy and handwriting. Handwriting difficulties, such as slow and untidy writing, are cited as one of the most common reasons for referral of children with DCD to health professionals (Prunty, 2013). Prunty (2013) compared the handwriting performance of children with DCD with the performance of children without DCD across a range of handwriting tasks. Prunty found children with DCD produced less text than their peers. This was due to an increased time spent pausing and not due to a difference in the speed of pen movements. Children with DCD also had less legible writing. Prunty explored explanations for these differences in the literature such as physiological differences; for example reduced strength, endurance and/or a

lack of tonic stiffness. Prunty, however, stated that there was no evidence for physiological differences in his sample. It is acknowledged that there is yet to be sufficient evidence for a link between motor 'deficit theories' and ecologically valid tasks such as handwriting and Prunty instead proposes that cognitive abilities, such as executive functioning might explain these differences. As with Alloway's and Chen's samples, boys are overrepresented and conclusions are drawn from the performance of a small sample of children with DCD which limits the generalisability of Prunty's findings. Other psychosocial factors which may mediate the relationship between DCD and handwriting, such as handwriting self-efficacy are not considered.

6.3.3. DCD and numeracy skills

The potential impact of DCD on maths performance was investigated by Pieter (2012), an area in which there are few studies. Performance of children with DCD on number fact retrieval and procedural calculation tasks was compared with age-matched control children. Pieter found that the performance of children with mild DCD differed significantly to children with severe DCD. It was also found that children with mild DCD had a developmental delay in number fact retrieval of 1 year and those with severe DCD had a delay of 2 years. Although standardised maths tests were used, only two maths skills were tested, making generalisations to general numeracy skills unreliable. Pieter used a rigorous selection criteria for participants, using the criteria from the DSM-IV as well as scores on the Movement Assessment Battery for Children (M-ABC). Despite these measures Pieters commented that there was wide variation within groups. Groups had been divided based on scores on the M-ABC, which was used to provide cut off's between 'mild' and 'severe' DCD. These are only arbitrary and have no clinical significance. Wide variation within children with DCD selected for research is a

commonly cited occurrence within the literature, which throws into question the ways in which children with motor coordination difficulties are categorised in research and how that impacts on the validity, reliability and generalisability of findings.

7. Wider impact of DCD on children's outcomes

Research into the effects of DCD has widened to include the impact of DCD on the psychosocial and emotional wellbeing for children with this disorder. Viholainen et al (2013) hypothesised that the mechanism linking motor skills and psychosocial wellbeing could be self-concept. They investigated whether the self-concepts of school-related physical education, reading, and mathematics mediated the relationship between motor skills and wellbeing in adolescence. This research adopted a positivist approach, isolating self-concepts for three academic subjects as mediating variables with a design which did not allow for the discovery of other mediating variables. This was likely to have increased the probability of confirmation bias. Viholainen found a strong association between motor skills and conduct problems in adolescent girls and proposed that an intervention to improve motor skills might help. An intermediatory variable could hypothetically have been responsible for the association between motor skills and conduct problems. If so, then an intervention aimed at changing this variable might be more effective than targeting motor skills.

This research highlights the limitations of a top-down, deductive approach which does not allow for the exploration of multiple factors. Similar research investigating psychosocial impacts have used deductive reasoning (e.g. Liberman (2013); Poulsen et al (2008)). Although few interpretivist studies have been carried out in this field, they are more likely to adopt an approach of inductive reasoning, whereby observations are made and from those

observations generalisations can be formulated, such as research carried out by Peters and Henderson (2008). This research approach may allow for a greater consideration of the complexity of DCD and encourage deeper analysis. Research on children with DCD and developmental disorders in general has been criticised for attempting to reduce complex phenomena likely to be influenced by multiple variables and therefore research should explore multiple levels of analysis (Jokic (2011), Morton (2004), Masten & Obradovic (2006), Coghill et al (2005), Sugden et al (2008).

Jokic and Whitebread (2011) found evidence for the importance of metacognition and self-regulated learning in successful completion of a learning task, linking learning behaviour to social and emotional factors. They argue that there is a growing body of evidence to show that metacognitive and self-regulatory skills are readily modifiable. This approach may fall under the umbrella of positive psychology as instead of focusing on the a deficit model of DCD in which biological causes are difficult to change, Jokic and Whitebread highlight how children with DCD can compensate using cognitive strategies.

Peters and Henderson (2008) carried out qualitative case studies with the aim of addressing unresolved issues in understanding DCD by exploring the experiences of each child as they were identified with DCD, formally diagnosed and how they responded to interventions. They argued that tests used to identify DCD are often not objective and at best generalisations can only be made to a heterogenous group of young people with movement difficulties. Peters and Henderson also take an approach which does not focus on deficit and question whether we need to understand the aetiology of motor difficulties in order to treat it.

8. Conclusion

The importance of biological factors in the aetiology and effects of DCD cannot be ignored, however, there has been an overdependence on the biomedical model to explore this phenomenon.

The bio-ecological developmental model encourages professionals and researchers to explore the developmental trajectory of DCD and recognise the limitations of considering a child's difficulties at one point in time. It does not go far enough in explaining how psychosocial factors interact with DCD. Consideration of biopsychosocial factors will prompt Educational Psychologists to consider a wide range of factors contributing to a broader, more holistic assessment of the needs of a child with DCD. The resiliency model is also a useful framework as it assists in the categorisation of multiple factors into risk and protective factors that impact on children with DCD, which can be invaluable for professionals designing interventions for children with DCD and in preventative work.

Biological factors are important in understanding the aetiology, effects and wider impact of DCD, however, considering biological factors within a wider framework provides the most valid and useful explanation of its causes and impact.

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PROFESSIONAL PRACTICE REPORT 2

A case study of the transfer of the 'Think Good Feel Good' manual into practice; a Cognitive Behavioural approach for children and young people

Abstract

The Think Good Feel Good (TGFG) manual by Stallard (2005) was used to plan and deliver a largely Cognitive Behavioural Therapy based intervention to a young person who was aged twelve years experiencing anxiety-related difficulties. A case formulation was devised using guidance and tools offered in the TGFG clinicians guide, such as the 'Common Beliefs' questionnaire. Parents were involved to a modest extent as part of a systemic approach. Various adaptations were made so that the intervention was age-appropriate and met the young girl's learning needs. A Revised Child and Adolescent Anxiety and Depression Scale (RCADS) was administered pre- and post- intervention alongside scaled questions and indicated a small decrease in anxiety. The young person's evaluation of the sessions was favourable and suggested that she found the intervention helpful. An evaluation of this CBT approach and recommendations for future anxiety interventions delivered by Educational Psychologists in school settings is discussed.

Literature review

In 2004 the prevalence of emotional disorders, such as anxiety and depression, in children and young people aged 5-16 years was estimated at 4% (Office for National Statistics, 2005). The National Institute for Health and Care Excellence (2013) recommended that children and

young people with anxiety-related disorders are first offered evidence-based psychological interventions, such as Cognitive Behavioural Therapy to treat anxiety.

The effectiveness of CBT for children experiencing anxiety-related difficulties

A Cochrane Review (James et al, 2013) evaluated the outcomes of 41 Randomised Controlled Trails (RCT) in which CBT programmes were delivered to 1806 children and young adults experiencing anxiety symptoms of mild to moderate severity in university, community clinics and school settings. The evidence from the review suggested that CBT was significantly more effective in reducing anxiety symptoms in children and young people compared to no therapy. However, the treatment gains on a CBT programme were found to be no greater than treatment gains from other 'active therapies' such as self-help books. The evidence was limited by the small number of studies that met the inclusion criteria, limiting comparative analysis. There were also a limited number of studies that looked at the longer term outcomes following CBT. Recommendations for future research included the need to look in greater detail at the factors that increase the effectiveness of CBT and adaptations for different age groups.

Cartwright-Hatton et al (2004) carried out a systematic review, also restricted to RCT's of CBT for child and adolescent anxiety disorders. The large and very variable range of instruments used in these studies made them difficult to compare. Cartwright-Hatton et al included ten, of the twenty-two RCT's found, in their systematic review. They concluded that CBT was an effective intervention when compared to no-treatment controls, finding it had a strong positive effect on diagnostic outcomes. Cartwright-Hatton et al had intended to include trials which had randomised participants to CBT or an active control group (participants receiving another active treatment), however only two studies were found. This highlighted

the gap in research for comparative studies which use an active control group, making it difficult to validate claims that CBT is any more effective than other treatments. Cartwright-Hatton et al suggested that anxiety should not be treated as a unitary disorder in research, pointing out that when treating adults, different anxiety disorders benefited from different treatment approaches.

Adapting CBT interventions for school settings:

In order to look for relevant research for this case study a search of the literature for peer reviewed journal articles published between 2000 and 2014, was carried out using the databases 'Web of Science (ISI)', 'ERIC-ProQuest', 'Cambridge Journals Online', 'Applied Social Sciences Index and Abstracts (ASSIA)', 'AMED (EBSCO)'. The search terms 'anxiety and children', 'anxiety and children and CBT' and 'OCD and children' were used.

Most studies looked at the effectiveness of CBT delivered in clinical settings for reducing anxiety, but fewer studies investigated the efficacy of CBT delivered in school settings, an issue highlighted by Chiu et al (2013) and Silverman et al (2009- quoted in chiu). Fewer studies still look at the efficacy of CBT delivered by Educational Psychologists.

Miller et al (2010) reported the findings of a school-based locally developed universal CBT intervention for children aged 7 to 12 years in the US. 'Taming Worry Dragons' was developed by Garland and Clark (2000) as a group-based treatment programme for use in clinical settings. It focused on assisting children to learn and practice tools to help reduce anxiety such as thought-stopping, distraction, changing self-talk and exposure. This manualised programme was translated for use in school classrooms as a preventative programme to reduce anxiety in those children experiencing symptoms suggestive of low levels of anxiety. Miller et al found no reduction in anxiety symptoms, suggesting that this

programme was not as effective for children experiencing lower levels of anxiety compared to a clinical sample and it did not translate effectively to a classroom setting of larger numbers of children, delivered by teachers (not clinicians).

Chiu et al (2013) investigated the effect of a modular CBT programme delivered to 40 children, aged 5-12 who were randomly assigned to either CBT or a waiting list and experienced greater success transporting a programme to the school setting when compared to Miller et al's findings. The 'Building Confidence' programme was delivered by clinicians in schools to children assessed as having a DSM-IV diagnosis for an anxiety disorder. A positive treatment response was found in 95% of participants who received CBT compared to 16.7% on the waiting list. The strength of this study is the use of blind evaluators of outcomes. It also adopted an integrated approach in which teachers and caregivers received modules on CBT, although the added value of this approach was difficult to determine. Chiu et al admitted that, a limitation to research in this field was that the CBT programme was not compared to another active treatment so it is unclear if it would have outperformed other treatment approaches. The findings suggested, however, that a programme developed and tested in clinical settings could retain its potency when transferred across to a school setting.

A similar study was conducted by Ginsburg et al (2012), involving 29 young people with a clinical diagnosis of anxiety disorder, in which clinicians delivered a modular CBT programme in a school setting. Ginsburg et al compared the CBT programme to other therapeutic interventions, such as art and play-based interventions ('Usual Care' comparison group). Interestingly, a significant reduction in anxiety symptoms was found in response to the CBT treatment but no difference in response rate when compared to 'Usual Care'. It was reported, however, that therapists who used more CBT structure elements, with a greater competence in delivery of CBT experienced more positive treatment responses.

Stallard (2013) reported that the variability in the treatments effects of studies of school-based mental health programmes suggested that factors other than the programme content were important. Stallard suggested that factors which are likely to moderate treatment effects included child gender, age, ethnicity and symptom severity and factors which mediated them were likely to be leader training, delivery and supervision, as well as pupil engagement.

Elkins (2011) suggested that delivering CBT in a school setting had many advantages, such as fitting the treatment to the child's everyday routine and providing the opportunity to treat school centred problems. Elkins also outlined a number of challenges to the delivery of CBT in this setting; for example, Elkins recognised that those practitioners delivering CBT in schools would be constrained by time and resources. Furthermore, Elkins highlighted issues with the adequate transportability of CBT from a clinical setting, where it was developed and is mostly practiced, to a school setting and issues with adapting CBT to meet the cognitive, emotional and social needs of each child.

CBT delivered by EP's

Educational Psychologists would be well placed to meet the challenges outlined by Elkins as they have the training and experience in adapting programmes to meet a child's needs and most have training in using CBT approaches in therapeutic interventions. These factors are likely to improve the fidelity of the CBT programme delivered in school settings.

Atkinson et al (2013) explored the role of Educational Psychologists (EPs) in delivering therapeutic interventions and the features that ensured their effectiveness. They found the service context to be a key emerging theme influencing the provision of therapeutic interventions to children and young people (CYP), stating a possible tension between positive outcomes for CYP and a need for services to generate income through commissioned

services. This view is shared by Pugh (2010) who commented that statutory and assessment services were more commercially viable so could constrain the practice of EPs delivering CBT based interventions in schools.

Stallard (2010) evaluated the 'FRIENDS for Life' anxiety prevention programme based on CBT principles which aimed to increase awareness of anxiety increasing cognitions and replace them with more helpful, balanced cognitions. Stallard concluded that there was evidence for the effectiveness of EP's delivering FRIENDS, which was also concluded by Liddle and Macmillan (2010). Although initial findings were promising; Stallard highlighted the need for more UK based research in this area.

Rait et al (2010) recommended more locally based research into the benefits and limitations of the various CBT interventions now available to practitioners for CYP. They commented that there was an increasing availability of child-friendly materials and workbooks and that EPs needed to be aware of the conceptual framework of a particular CBT approach and its evidence of success with different age ranges, types and severity of difficulties.

Think Good, Feel Good: A Manualised Cognitive Behavioural Approach for Children-

Stallard (2005), an experienced clinical psychologist, developed a manual or 'workbook' to deliver CBT to children and young people with a focus on the process of child-focused CBT rather than a focus on specific strategies to use. Stallard adapted CBT for use with children and young people in a way that was coherent with CBT principles and theoretically robust. The three chapters of the manual explored the three domains of CBT; cognitions, emotions and behaviour. Stallard did not intend his programme to be prescriptive but aimed to raise the key issues to be considered and offer guidance on how they could be integrated into therapy to maximise the effectiveness of the intervention.

Hypotheses

I explored a pupil's response to a targeted intervention delivered in the school setting. I believed that delivery of a Cognitive Behavioural programme based on guidance and materials from the manual Think Good, Feel Good would reduce signs and symptoms of mental health difficulties experienced by a 12 year old pupil with learning difficulties (referred to in this report under the pseudonym of Sarah).

Case selection

An appropriate case was identified through discussions with my supervisor. He was carrying out assessment work to explore Sarah's learning, emotional and mental health needs. Sarah was recently discharged from the Child and Adolescent Mental Health Services (CAMHS) as she had been reluctant to engage in individual or group sessions due to her anxieties around meeting new people. The Primary Mental Health Worker who had initially assessed Sarah and in a report had concluded that she was experiencing '*anxiety-related difficulties'* was keen that Sarah would continue to receive therapeutic support after her discharge. She stated that if Sarah continued to experience high anxiety levels after the implementation of an intervention it was advised to re-refer back to CAMHS. At the onset of my work with Sarah, my supervisor had concluded from an initial, but incomplete assessment, that Sarah was experiencing learning difficulties impacting on her attainment and she was experiencing anxiety.

Ethics

The British Psychological Society (BPS) Code of Ethics and Conduct (2009) was used as a guide to making ethical decisions for this study. Sarah was given a consent form explaining that participation was voluntary, that she had a right to withdraw at any time, that data would

be anonymised and remain confidential and details of the intervention (see Appendix 1 for information and consent form). Sarah was only allowed to participate on the basis of her mother's consent. Sarah's age and learning needs were considered during the information giving and consent process. A meeting with Sarah, her mother and the Head of Year was used as an opportunity to provide further explanation about confidentiality and anonymity and to check Sarah understood these concepts. It was important that Sarah would not come to harm as a result of the intervention, so I chose an approach I could deliver without going outside my competency with my level of training and that I received weekly supervision throughout the intervention. Steps were taken to ensure that weekly meetings were held in a private room to ensure confidentiality. On one occasion I had to remind the school that a private room was needed when Sarah and I were expected to meet in an open space in which we could be overheard. On another occasion I was required to break Sarah's confidentiality following a disclosure due to safeguarding concerns. Our therapeutic relationship did not appear to be affected following this break of confidentiality; at the time I reminded her of the initial meeting we had had whereby I had explained when confidentiality would need to be broken, she was able to recall this discussion and accepted the reasons I gave for breaking her confidentiality.

Case formulation

Stallard (2005) proposed that therapeutic work began with case formulation which he defined as '*the shared understanding of the child's problems presented within a cognitive behavioural framework'* (p.3). In this case this shared understanding was facilitated using visual prompts to help Sarah visualise the connections between a situation, how she behaved, thoughts and feelings (see appendix). Working collaboratively in order to formulate the problem was

sometimes constricted by Sarah's willingness to explore family factors; on a number of occasions she stated that she did not want to talk about her family any further and appeared overly concerned that I have a good impression of her mother and sister in particular. There were aspects of the formulation that Sarah did not agree with, and left out of our collaborative formulation but are presented in figure 1, such as family factors. Stallard (2005) offered the template, 'The Negative Trap' which was used to devise maintenance formulations for Sarah's fears, in which individual triggering events were identified and thoughts feelings and behaviours tracked (see figure).

The 'Common Beliefs' worksheet (Stallard, 2005) was used in order to explore Sarah's core beliefs underpinning her thoughts, feelings and behaviour. The 'Common Beliefs' worksheet is based on the Schema Questionnaire for Children which was designed to assess 15 early maladaptive schemas developed by Young (1990) in his work with adults, with each statement on the worksheet relating the maladaptive schemas. Sarah rated statements on a 10-point scale (1= Don't really believe at all, 10=very strongly believe).

Stallard and Rayner (2005) found the Schema Questionnaire for Children (described as 'Common Beliefs' in the TGFG programme) correlated with Young's Schema Questionnaire to a modest extent, however commented that a limitation would be the fact that the assessment is made at only one point in time and one can't be sure of the stability of thought patterns, especially in children and young people. The developmental appropriateness of some of the schemas was also questioned, especially those related to the excessive emotional closeness and involvement with parents. Sarah was likely to be still developing her independence; she rated the statement, 'It is important that my parents/carers are involved in everything I do' as 8 out of 10, which is probably a reflection of her developmental state more than of a maladaptive schema.

I found the questionnaire to be quick to administer and developmentally appropriate; for example, use of the visual 'Thought Thermometer' helped Sarah rate statements on the 'Common Beliefs' worksheet. Sarah rated the statement 'Bad things happen to me' as 10 out of 10 and she spontaneously commented that if the statement were 'Bad things happen to other people' she would have also given the rating of 10 out of 10. This reflected a core belief that appeared to be significant in Sarah's anxiety and OCD traits; many of her behaviours appeared to be motivated by her maladaptive belief that she was keeping herself and her family safe.

The Revised Child Anxiety and Depression Scale (RCADS) was used to measure aspects of Sarah's mental health pre and post-intervention, recommended by the Child Outcomes Research Consortiuum (CORC) and the National Institute for Health and Care Excellence (2013) and suitable for use with 8-18 year olds. The initial version of the RCADS was adapted from the 56-item Spence Children's Anxiety Scale (SCAS; Spence, 1997). In addition to the 38 SCAS anxiety items, new items related to the DSM-IV criteria for depression and anxiety. Children score items from 0 to 3 corresponding to 'never', 'sometimes', 'often' or 'always'. Chorpita et al (2000) found the RCADS to be a reliable and valid measure of depression and anxiety as constructed by the DSM-IV and concluded that it might be useful diagnostically. I used the RCADS as a measure of change following a CBT intervention rather than as a diagnostic tool. Chorpita et al inferred that the RCADS was likely to be more sensitive to change than other measures, arguing that it measured anxiety (and depression) more precisely and was less saturated with measures of other traits. This was supported by Mathyseek et al (2013) suggested that changes in anxiety symptoms measured by the RCADS were very likely to reflect true changes in anxiety levels. Sarah's pre-intervention scores can

be found in table one indicating above average total anxiety and higher anxiety in the domains of 'generalised anxiety', 'social phobia' and 'obsessions/compulsions':

Table 1: A table representing Sarah's pre-intervention raw scores and T-scores on the RCAD

	Raw scores	**T scores**
Separation anxiety	8	68
Generalised anxiety	15	74
Panic	7	55
Social phobia	19	62
Obsessions/compulsions	15	80
Depression	6	45
Total anxiety	64	72
Total anxiety and depression	70	67

*T scores average range 43-57

Sarah and I worked together collaboratively to set goals, which were used to measure progress against. We agreed to work on the goals, '*To find better ways of managing my fears'* (goal one) and '*To be able to understand why I get anxious and do the things that I do'* (goal two). When asked to rate her progress towards this goal in the first week as a baseline measure Sarah rated goal one and two as 2 out of 10.

Adapting TGFG for Sarah

Sarah had undergone an assessment with an EP at the time of my involvement giving an indication of Sarah's learning needs. I took steps to meet her learning needs and adapt the programme to Sarah's developmental stage; for example, through the use of acronyms, visuals to support language and memory prompts. We explored Sarah's negative automatic

thoughts, described in the TGFG manual as 'Thinking errors' and challenged and questioned them. The TGFG manual provided useful explanations of six thinking errors in a style of language that was easily accessible to Sarah and she could better identify with; for example, the two categories under the 'predicting failure' thinking error was described as 'The mind-reader' and 'The fortune-teller' and negative thinking was conceptualised as putting on a negative pair of glasses. To support Sarah's understanding of her thinking errors I used colourful pictures to represent each of the types of thinking error and coloured pen to annotate the pictures with personalised examples of Sarah's thinking errors as we discussed them. In subsequent sessions I took the pictures out on several occasions to prompt Sarah's memory and help her work out the thinking error she had made (see appendix).

The TGFG manual is not a prescriptive approach in which one must strictly adhere to a rigid programme, which allowed me to introduce CBT ideas from other sources. In order to support Sarah's memory of steps she could take to reduce her anxiety and to aid in cognitive restructuring I introduced her to the KICK acronym suggested by Scarpa et al (2013); the 'K' stands for '*Knowing I'm nervous'*, the 'I' for '*Irritating thoughts*' the 'C' for '*Calm thoughts*' and the final 'K' for '*Keep practicing*'. I used Socratic questioning to help Sarah think about each step in relation to an anxiety triggering event; for example challenging '*Irritating thoughts'* with '*Calm thoughts'*, such as '*How likely is it that this will happen?', 'Is there a more positive way of looking at it?*' and '*What would your friend XXX say?* Or *'How would she see it?*'(Friend XXX was identified as having a positive outlook and supported Sarah with helpful comments). Sarah was given a prompt card with this acroynm written on it and small enough to fit into her pencil case so that she could use it to remind her of steps decrease her anxiety.

Parental involvement

In the TGFG Clinician's Guide which accompanied the TGFG manual Stallard (2005) recommended involving parents to varying degrees. Stallard suggested that this could form part of a systemic approach to the 'problem', in which parental factors are accounted for in the onset, maintenance and treatment of mental health difficulties. Furthermore, Bronfenbrenner (1978) argued for the effectiveness of taking an approach to working with individuals that considered the ecological system levels they interacted with, rather than treating the client in isolation and ignoring contextual factors and so Educational Psychologists (EPs) adopt a systemic approach to their work. However, the evidence for the added value of parental involvement to CBT outcomes is inconsistent. Breinholst et al (2012) found no positive impact in involving parents in the treatment of anxiety-related difficulties. They concluded that the inconsistencies were due to variation in the parental factors measured but suggested CYP would benefit from CBT even if parents were not involved. In a recent UK based Randomised Controlled Trial Reynolds et al (2013) found low or high parental involvement in CBT made no significant difference to the outcomes of adolescents with OCD and concluded that perhaps parental involvement was less important to adolescents compared to younger children.

On the basis of the research evidence and recommendations in the TGFG manual I involved Sarah's mother to a modest degree, as a co-facilitator; providing her with the rationale for using CBT and information about the strategies that Sarah was learning. Sarah's mother attended a pre-intervention meeting, received two letters at 4 weeks and 8 weeks into the intervention and attended a post-intervention meeting and both parents received material from the TGFG manual explaining the cognitive model and ways they could help throughout the process. To extend the systemic support for Sarah further her Head of Year also attended pre and post-intervention meetings and I kept in close communication with her throughout the

intervention. Sarah was consulted on what she wanted to communicate to her mother by letter and she appeared to value the opportunity to communicate to her mother in this way (see appendix for copies of letters).

Adopting a flexible therapeutic approach to meet Sarah's needs within the wider framework of TGFG

Stallard (2005) recommended incorporating different therapeutic approaches and tools within a wider CBT framework, such as assessing a client's intention to change using the Stages of Change model proposed by Prochaska et al (1992), using a Motivational Interviewing approach devised by Rollnick and Miller (1991) to facilitate change and Socratic questioning.

I found the Stages of Change model useful when considering reasons for Sarah's resistance to experimenting with different strategies to manage her anxiety and completing homework tasks. Initially I considered Sarah to be at the 'Preparation' stage of change in which she was ready to make small changes and was prepared to experiment. I reconsidered this assumption as the sessions progressed and concluded that Sarah's behaviour was most indicative of the 'Contemplation' stage of change in which Sarah was able to identify some areas they would like to change but appeared unsure that this could be achieved. She tended to give reasons for why tasks could not be achieved and put up barriers rather than taking steps to begin to experiment. Motivational Interviewing was used to address Sarah's reservations with some success; for example, when Sarah did not want to be put in a situation in which she met new people, I commented *'You met with me and coped OK and you didn't know me to begin with'* and on another occasion, '*You just opened the door and asked those girls a question. You didn't know them but you seemed relaxed'*.

I used aspects of a Solution Focussed (SF) therapeutic approach alongside CBT, although this approach was not included in the TGFG manual. Myers (2008) described this approach as enabling people to build change into their lives and that change came from two principle sources; encouraging the client to describe their preferred future and also building on the clients existing skills, resources and successes. I asked questions such as '*What has gone well for you today? Let's share our successes'* and '*Can you think of a time when you were able to cope better?*' as a way of highlighting to Sarah that she did have the capacity to cope and times where she was succeeding to further motivate her to take steps to change. These questions tended to be used at the start of our sessions, when I had asked Sarah what kind of a week she was having and her responses suggested that she tended to focus on the negative aspects of her week and what she could not do or didn't go well for her. I found the SF approach was also useful when I encountered Sarah's resistance to my recommendations for coping strategies to help manage her anxiety. Myers (2008) stated that Solution Focused Therapy acknowledged a person's sense of agency, commenting that solutions had to be meaningful to the client and reached through co-construction. I found the most success with Sarah, and least resistance when I offered Sarah a number of options and possibilities that she could explore, reinforcing her sense of agency, rather than forcing her to engage with a strategy or approach she was resistant to; for example, it became evident Sarah would not engage with breathing exercises, but during one session when she had asked to go outside for some air I suggested a Mindful Listening practice, which she did engage with and reported to be more beneficial than the breathing exercises.

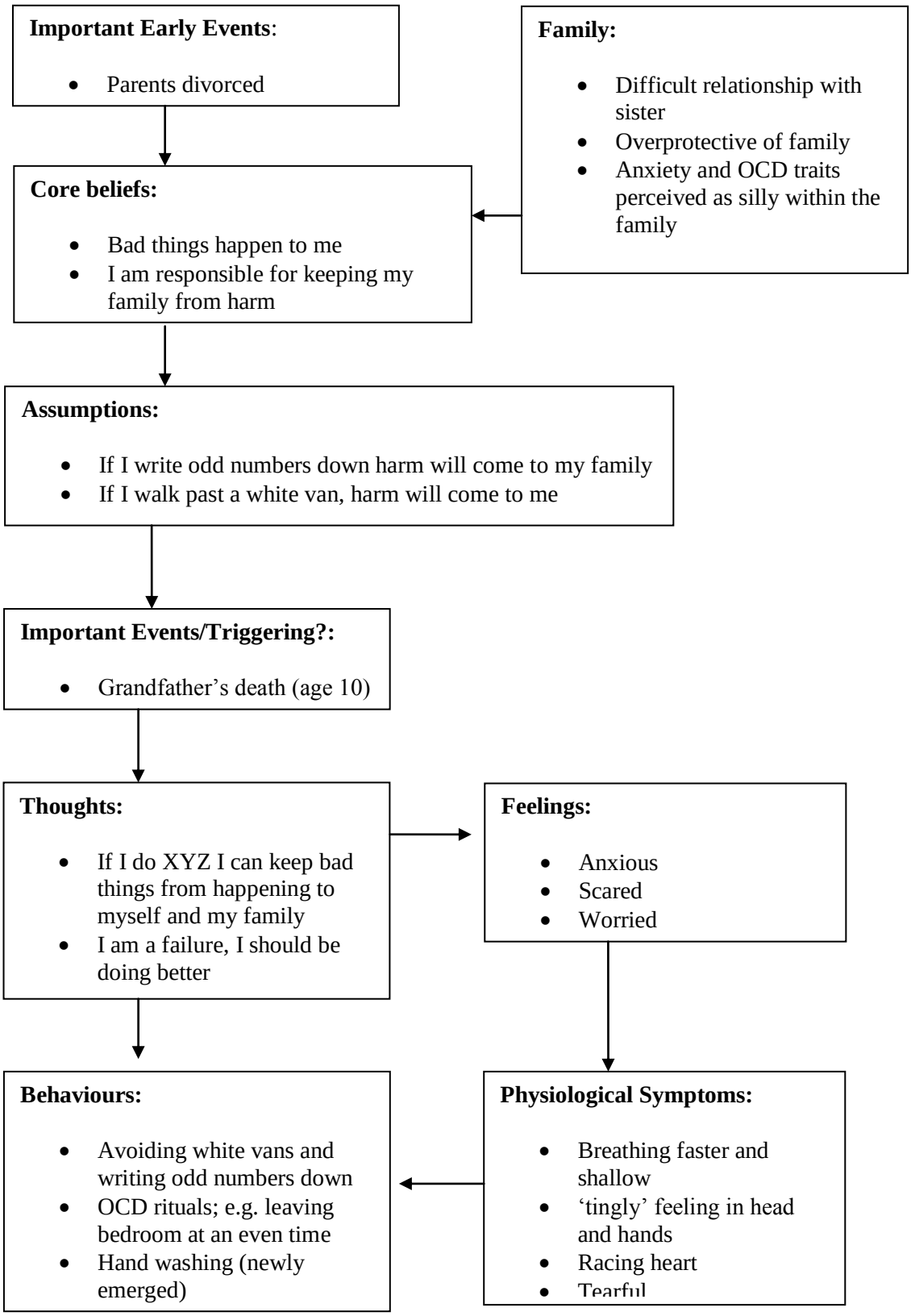

Important Early Events:
Parents divorced
Family:
Difficult relationship with sister
Overprotective of family
Anxiety and OCD traits perceived as silly within the family
Core beliefs:
Bad things happen to me
I am responsible for keeping my family from harm
Assumptions:
If I write odd numbers down harm will come to my family
If I walk past a white van, harm will come to me
Important Events/Triggering?:
Grandfather's death (age 10)
Thoughts:
If I do XYZ I can keep bad things from happening to myself and my family
I am a failure, I should be doing better
Feelings:
Anxious
Scared
Worried
Behaviours:
Avoiding white vans and writing odd numbers down
OCD rituals; e.g. leaving bedroom at an even time
Hand washing (newly emerged)
Physiological Symptoms:
Breathing faster and shallow
'tingly' feeling in head and hands
Racing heart
Tearful

Figure 1: a diagram representing formulation of Sarah's anxiety and OCD traits

Outcomes

Sarah attended a total of eleven sessions from November 2014 to February 2015. Table 2 shows the difference in scores at pre-intervention and at post-intervention obtained from the Revised Child Anxiety and Depression Scale (RCADS). The biggest decrease was achieved within the domain of 'social phobia' with scores indicating an 8 point decrease. A modest 3 point decrease occurred between pre- and post-intervention scores within the domains 'separation anxiety' and 'generalised anxiety'. A slight increase to 'obsessions/compulsions' was indicated (raw score increased from 15 to 16) and a larger increase was indicated within the 'social phobia' domain. Sarah's overall anxiety score had decreased by 2 points.

Table 2: A table representing Sarah's pre-intervention and post-intervention T-scores on the RCADS

	T-scores		
	Pre-intervention	**Post-intervention**	**Difference**
Separation anxiety	68	65	-3
Generalised anxiety	74	71	-3
Panic	55	63	+8
Social phobia	62	54	-8
Obsessions/compulsions	80	>80	+
Depression	45	45	0
Total anxiety	72	70	-2
Total anxiety and depression	67	66	-1

Sarah was asked to rate her progress towards the goals again in the last session '*To find better ways of managing my fears'* (goal one) and '*To be able to understand why I get anxious and do the things that I do'* (goal two). When asked to rate her progress towards this goal in the first week she had rated goal one and two as 2 out of 10. Following the intervention she rated goal one as 4 out of 10 (an increase of two points) and goal two as 6 out of 10; an increase of 4 points. An interim goal set on the 17th December *'To be better able to notice my thinking errors'* was rated 2 out of 10 when it was set and was rated at the end of the intervention as 6 out of 10; an increase of 4 points. Sarah's progress towards her goals is modest and suggested that her understanding of her anxiety and ability to notice her thinking errors had increased more than her perception of her ability to manage her fears.

Sarah was asked to fill out a session evaluation form adapted from the Experience of Service Questionnaire designed by the Commission for Health Improvement suitable for ages 12-18. The questionnaire was used to capture Sarah's views on a wide range of aspects of the therapeutic intervention, such as the facilities in which the sessions took place and how helpful she thought the sessions had been. Table 3 shows the questions/statements and Sarah's responses to them; Sarah was asked to chose either *'Yes', 'Only a little', 'Not really'* or '*Don't know*' for questions 1, 2, 4-7 and 11-12 and responded with '*Yes*' to all these questions. Other responses indicated that she felt she was treated very well in the sessions, felt the time of the sessions were convenient and that the place where the sessions were held were easy to get to. The only critical comment she made whilst filling out the form was that she would have preferred to use the same room each week and to be interrupted less frequently, and so described the facilities as '*Ok*' on the evaluation form rather than '*Comfortable*'. In the *'Any Further Comments'* section she wrote *'I would like more sessions please I like Janet and I feel she has been extremely helpful with everything. Thank you'*.

Table 3: Sarah's session evaluation responses

Questions/statements	**Response circled**
1. Did the people who saw you listen to you?	Yes
2. Was it easy to talk to the people who saw you?	Yes
3. How were you treated by the people who saw you?	Very well
4. Were your views and worries taken seriously?	Yes
5. Do you feel that the people here know how to help you?	Yes
6. Were you given enough explanation about the help available here?	Yes
7. Do you feel that the people here are working together to help you?	Yes
8. The facilities here are...	Ok
9. The time of my appointments was...	Convenient
10. The place where I had my appointments was...	Easy to get to
11. If a friend needed this sort of help, do you think they should come here?	Yes
12. Has the help you got here been good?	Yes

Discussion

I found the Think Good Feel Good (TGFG) manualised CBT programme a useful and easily accessible guide to delivering a therapeutic intervention within a school setting. Sarah reported that she found the sessions helpful and would recommend them to a friend. Her ratings in relation to her goals suggested that she had progressed further towards them, indicating an improved understanding and had developed more tools to better manage her fears. Furthermore, her scores for anxiety, as measured by the Revised Child Anxiety and Depression Scale had decreased to a modest extent. Use of the session evaluation form ensured that Sarah was given a voice in the evaluation process.

The flexibility of the TGFG programme allowed me to adapt the CBT programme to Sarah's age, developmental stage and mental health needs whilst adhering to CBT principles and key components. It was not overly prescriptive, so I did not have to use all the worksheets, but could choose them to personalise the programme for Sarah. The principles of CBT were adhered to, such as the necessity of case formulation, raising awareness of negative automatic thoughts, promoting coping self talk and helpful or alternative thoughts and experimentation. The manual incorporated a 'troubleshooting' aspect, which I found particularly useful in applying CBT in a real life situation in which I inevitably came across challenges.

As a Trainee Educational Psychologist with limited experience in delivering a cognitive behavioural approach, at times I came across uncertainties; for example, how to empower Sarah to engage with the experimentation phase of the process when my suggestions were met with resistance. The weekly supervision I accessed with a more experienced EP helped me to meet these challenges and also ensured that I was working within my competencies.

TGFG recommended using Motivational Interviewing alongside CBT, which brings into question what components of the programme brought about the most change in Sarah's case. Furthermore, I incorporated aspects of a Solution Focussed Approach, so it makes it more difficult to reliably attribute positive outcomes to CBT alone. The RCAD also has its limitations; it is a relatively new assessment tool, so research into its reliability and usefulness is limited, and norms are based on a US sample. Population norms for the aspects of anxiety measured by the RCAD may differ in the UK. Despite its limitations it appeared to have face validity and Sarah's reports on her scores suggested that it reflected the difficulties she was experiencing.

Future studies might consider the use of multiple assessments of anxiety, sensitive to change to improve the reliability of measuring the impact of CBT interventions. Furthermore, reliability could also be improved by triangulating the data from other sources to a greater extent, such as a young person's parents and teachers; those who could also be considered the 'problem holders'. This would also help to evaluate the impact of the intervention in terms of observable change rather than change in scores on an assessment of anxiety which may not equate to a perceived difference in anxiety in real life. In this case, a long term follow-up, as suggested by Cartwright-Hatton et al, would have explored the sustainability of change over time. Cartwright-Hatton et al suggested that anxiety should not be treated as a unitary disorder in research. This comment may be particularly relevant in the case presented in this project as Sarah presented with anxiety and the anxiety-related traits of obsessive and compulsive disorder.

More research is needed to explore the treatment fidelity of CBT delivered in school settings, and the extent to which the effectiveness of CBT, as evidenced by studies carried out in

mostly clinical settings, might be compromised due to the adaptations needed to meet a child's needs within a non-clinical setting.

It will be useful to explore the benefits (or not) of integrating parents to a greater extent; for example, inviting them to joint sessions with the child or young person. One could argue that the evaluation of the success of this intervention could have been extended to include the opinions of Sarah's parents and teachers, which would increase the reliability of the inferences made regarding the positive outcomes of the intervention. More comparisons are needed between CBT programmes involving parents to varying degrees.

Elkins (2011) highlighted the potential challenge of limited time and resources for delivering CBT interventions. One could argue that Educational Psychologists might bring about greater change if their time was invested in preventative and universal programmes, such as FRIENDS for Life rather than on individual, targeted interventions. When considering the scarce resources in the field of Child Mental Health and the high threshold for referral to specialist services, however, it is likely that there is always going to be a need to work with children who perhaps do not meet the threshold for Child and Adolescent Mental Health Services, but for which an intervention is needed and justified.

The findings of this case study are limited in terms of their generalisability but can be compared to other studies to highlight consistencies or conflicting findings. It is recommended that Educational Psychologists use their research skills to develop the evidence base for school-based CBT interventions. Case studies offer insight into the process of child focused CBT, which is especially useful in considering the adaptations needed to meet their varied needs. More large scale studies are also recommended, such as Randomised Controlled Trials, to evaluate the effectiveness of specific CBT programmes, such as TGFG, delivered in

the school setting. The significance of moderating or mediating factors such as the degree of training practitioners need to deliver a CBT programme that maintains treatment fidelity, the effects of parental involvement and the added value (or not) of CBT when compared to other interventions should also be considered in future research.

In conclusion, the Think Good Feel Good programme provided useful guidance for the planning and delivery of a programme based on CBT principles, which can be used by practitioners with an intermediate level of experience and knowledge of CBT for CYP. The programme allowed for the flexibility needed to adapt to different mental health difficulties, with suggestions for adapting it for different age groups and developmental stages. More research is needed to determine the effectiveness of CBT delivered in school settings and the moderating or mediating factors that influence outcomes.

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Appendix 1: informed consent

Parent information and consent form

I am a Trainee Educational Psychologist at the University of Birmingham, where I am supervised by XXX, Educational Psychologist. I also work for XXX Educational Psychology Service and receive supervision from XXX, Educational Psychologist.

One of the tasks that I need to complete, as part of my doctoral course, is a case study of a therapeutic intervention. The aim of the case study is to explore how a therapeutic intervention can help support a child or young person experiencing a mental health difficulty.

As part of the study, I would be interested in working with XXX, yourself and staff from XX School to gather information about the difficulties XXX is experiencing and evaluate if the therapeutic intervention helps to bring about change. This would include reading XXX's case file, working with XXX to provide the therapeutic support and speaking with you and school staff.

I will use this information to produce a written assignment, which will be submitted as part of my doctoral course. After this, I would happy to meet you and staff from XX School. This will provide an opportunity to discuss my findings.

You are under no obligation to participate in this piece of work and your child will remain anonymous in the assignment. You have the right to withdraw from the study at any time.

If you have any questions throughout this process, please do not hesitate to contact me on (number) or by email (janyika@XXX).

Please tick one of the options below….

☐ Yes, I wish to participate in this case study

☐ No, I do not wish to participate in this case study

Parent/guardians signature: _____

Date: _____

Signature of TEP: _____

Pupil information and consent form

I am a Trainee Educational Psychologist at the University of Birmingham, where I am supervised by XXX, Educational Psychologist. I also work for XXX Educational Psychology Service and receive supervision from XXX, Educational Psychologist.

One of the tasks that I need to complete, as part of my doctoral course, is a case study in which I help a child or young person who is experiencing difficulty to bring about positive change. The aim of the case study is to explore how this therapeutic approach can help support a child or young person experiencing difficulty to improve their wellbeing.

As part of the study, I would be interested in working with you, your parents and staff from XX School to gather information about the difficulties you are experiencing and evaluate if the therapeutic support I give helps to bring about change.

I will use this information to produce a written assignment, which will be submitted as part of my doctoral course. After this, I would happy to meet you to talk about my findings.

You are under no obligation to participate in this piece of work and you have the right to withdraw from the study at any time. All data will be anonymised so that no one will be able to identify you from my assignment. Our conversations in the therapeutic sessions will be kept confidential (unless you talk about anything that will put you or others at risk) and will not be shared with anyone.

If you are unsure of anything or would like more information please do not hesitate to ask me or talk to XXX at any point in this process.

Please tick one of the options below….

☐ Yes, I wish to participate in this case study

☐ No, I do not wish to participate in this case study

Pupil signature: _____

Date: _____

Signature of TEP: _____

Appendix

Dear ,

I am writing you to give some feedback about how Sarah is getting on with the weekly sessions she has been having with me at school. It is clear that family is very important to Sarah and that she would like you both to know what we have been finding out. Sarah is really keen to see change and she has been very honest and open in our sessions, which has helped us understand her anxiety more.

Sarah and I have talked about anxiety and how her beliefs about herself, others and the world are linked to her thoughts, feelings and behaviours. Sarah has been keeping a 'Thoughts diary' to help her monitor her thoughts, feelings and behaviour when she is stressed or anxious. I have set Sarah some 'homework' over Christmas. It will be useful to ask Sarah about her homework and remind her to do it although as I'm sure you understand she would prefer not to share her diary entries!

Sarah and I have talked about some of her compulsions to behave in certain ways, for example, her compulsions around even numbers and hope to explore the reasons why she might do these things in future sessions.

We have focused on developing Sarah's understanding of anxiety in the first few sessions and after Christmas hope to begin to test and challenge some of Sarah's beliefs and automatic thoughts at a pace that will not be overwhelming for her. She is learning to recognise her 'thinking errors'; unhelpful thoughts that can be unpleasant and stop us from doing things.

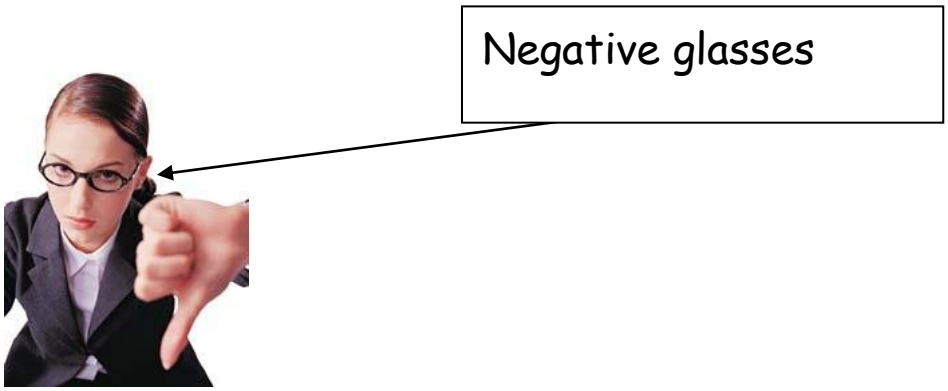
Sarah really appreciates and values the support you both give her by listening to her without being judgemental.

Will be in touch again soon. Have a good Christmas ☺.

Appendix

Thinking errors

The Downers



Blowing things up





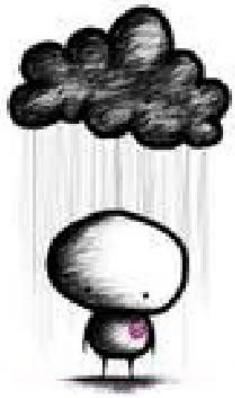


Predicting failure



Feeling thoughts





Setting yourself up to fail



Blame me!



PROFESSIONAL PRACTICE REPORT 3

Group Theraplay for mothers and children who have experienced domestic violence: an exploratory study.

Abstract

There is a pressing need for evidence-based interventions to support mothers and children who have experienced domestic violence. 'Moving on Through Play' is a group-based intervention for mothers and children who have experienced historic domestic violence; an intervention based on the principles of Group Theraplay. This research project set out to explore what worked across a group of mother's experiences of 'Moving on Through Play' and what might be improved, to what extent the hoped for outcome domains resonated with this group of mothers and how the emerging narratives illustrated that domains were (or were not) experienced. A focus group was used to collect qualitative data from which themes emerged, through the process of thematic analysis, contributing to the evaluation of this intervention. The results indicated that the group members had positive experiences within the 'Moving on Through Play' sessions and that the experience had a wider impact on the mothers' lives and the relationships with their children. The role of Educational Psychologists within this field as practitioners and researchers was discussed to develop the evidence-base and provide the best support for this vulnerable group.

1. Introduction

'Moving on Through Play' is a targeted intervention offered by the Educational Psychology Service (EPS) within the Local Authority in which this project is situated. It is a dynamic psychoanalytical approach to addressing attachment difficulties delivered by Educational Psychologists who apply Theraplay principles to help enhance the bond between mothers who have experienced domestic violence (DV), and their children. The EPS has found it to be an effective tool in addressing the needs of mothers and children who have experienced DV. The aim of this project was to help evaluate the 'Moving on Through Play' intervention to contribute to Theraplay's evidence base.

I set out to explore the following questions:

What has worked across the mother's experience of the group sessions and what might be improved?

To what extent did the hoped for outcome domains resonate with the mothers?

What narratives emerge to illustrate how these domains were (or were not) experienced?

2.Literature review

2.1.Domestic violence in the UK

A number of terms are used to talk about domestic violence, such as 'domestic abuse', although the term 'domestic violence' is still the most commonly used (Hester et al, 2006).

Definitions of domestic violence (DV) now include the element of coercive control which is often present but was omitted from earlier definitions. Barter-Godfrey et al (2010, p. 37) defined DV as:

'a pattern of controlling behaviour against an intimate partner or ex-partner, that includes but is not limited to physical assaults, sexual assaults, emotional abuse, isolation, economic abuse, threats, stalking and intimidation.'

The Office for National Statistics (2013) reported that in the years 2011 to 12, 7.3% women (1.2 million) and 5% men (800,000) in the UK reported experiencing DV. The number of incidents of DV is likely to be higher (Dar, 2013). It is estimated that at least 750,000 children a year witness DV (Department of Health, 2000).

Educational Psychologists may work with families who have experienced DV. Dodd (2009) highlighted the far reaching damage that DV had on children and its high prevalence arguing that it should be seen as a crucial issue for Educational Psychologists. Gallagher (2010) highlighted the usefulness of an ecological framework in understanding the complexity of DV; Educational Psychologists work within multiple ecological systems such as the home, education and community settings, so they are well-placed to deliver support to this client base.

2.2.Impact of domestic violence on mothers

Hester et al (2006) stated that the physical and emotional effects of DV can have a detrimental impact on a mother's relationship with her children. Hester et al (2006) reported that research suggested that mothers often experience a loss of confidence, felt emotionally drained, may take their frustrations out on their children or felt emotionally distant from them. Hester et al points out, however, that McGee's (2000) research has suggested when women leave the perpetrator they feel closer to their children.

2.3. Impact of domestic violence on children

Children who experience DV are at an increased risk of developing behavioural difficulties, emotional trauma and mental health difficulties in adult life (Hester et al 2000, 2007; Shipway, 2004).

Kitzmann et al (2003) made the distinction between the direct effects of witnessing DV; on a child's behaviour and emotional regulation and the indirect effects, such as a disruption to parenting. Hester et al (2006) highlighted that children's experiences of DV and reactions to it will vary but that they were more likely to experience emotional difficulties, such as anxiety or withdrawal. Kitzmann et al's (2003) meta-analysis of research on child witnesses to DV indicated that around 63% fared more poorly compared to a child that had not been exposed to DV. They also found evidence for children experiencing a higher negative affect and more negative cognitions.

Hester et al (2006) reported that a number of survey studies which suggested that mothers shared the view that DV had had an adverse effect on their children. They highlighted a number of factors that influence the impact of DV on a child such as levels of parental stress and the frequency and duration of the DV. Martinez-Toreya et al (2009) assessed the mother-child dyads of children exposed to DV and children who were not exposed at 2, 3 and 4 years. They found that children exposed to DV were 3.7 times more likely to develop internalising and externalising problems, however, positive adaptation in the face of adversity was common (54%).

Martinez-Toreya et al (2009) found maternal depression and parental stress more commonly occurred in the most vulnerable children. Kitzmann et al (2003) recommended that future research explore the moderating and mediating factors that influence the impact of DV on children. Many of the studies they analysed had not considered extraneous variables or.

Martinez-Toreya et al (2009) highlighted the need for the use of multi-informants, so that researchers were not dependent on reports from mothers, and to examine the developmental trajectory to see how a change in protective factors influenced adaptation.

2.4.Domestic violence and attachment

Hester et al (2006) commented that the quality of the attachment between mother and child influenced the impact of DV on the child and that a secure attachment appeared to increase resiliency. Barter-Godfrey et al (2010) report that therapeutic approaches found helpful and useful were those that were developmentally appropriate for the child and an intervention that was attachment-based, such as Theraplay.

Humphreys et al (2011) and Barter-Godfrey et al (2010) argued that the strengthening or recovery of a mother-child relationship in the aftermath of DV should be prioritised. Humphreys et al (2011) commented that in the past the impact of DV on the mother-child relationship had been minimised in research but that with wider recognition of the detrimental effects of DV in attachment and the protective effects of an enhanced attachment had influenced the types of support offered to mothers. Jouriles et al (2011) investigated the effects of an intervention which included positive child-management skills and emotional support on children aged four to nine experiencing clinical levels of conduct problems. This study was more methodologically robust than most other intervention studies in this area of research as Jouriles et al compared the intervention with a comparison group in which only emotional support was offered to mothers. They found medium to large effect sizes in the reduction of conduct problems; a greater reduction than those found in the comparison group and a reduction in inconsistent and harsh parenting. In contrast, Martinez-Torteya et al (2009) found that positive parenting was not a significant predictor of children's adjustment

following DV, although the studies cannot be compared directly as the study by Martinez-Torteya et al (2009) was not an intervention study.

2.5.Domestic violence and group work

Hester and Westmarland (2005) highlighted the benefits of group work to help women become more self-aware, share their experiences of DV and to move on from DV by enabling them to deal with emotional issues associated with their experiences.

Barron et al (2008) offered this summary on the usefulness of group interventions for mothers who have experienced DV:

'Domestic abuse, in the long run, erodes self-esteem and social skills, destroys family intimacy, damages growing children, reduces parenting skills and creates intense feelings of shame, guilt, isolation and loneliness. In stark contrast to abuse, support groups lessen isolation and establish social bonds.' (Cosgrove et al., 2008, pp. 12)

2.6.Theraplay

Theraplay is an intervention designed to help parents and children build better relationships through attachment-based play. Booth and Jernberg (2010) described Theraplay as giving a child interpersonal		

experiences that are not congruent with an insecure internal working model challenging the brain to develop new, more adaptive internal working models. Booth and Jernberg argued that Theraplay accessed right brain structures by providing high levels of non-verbal, face-to-face emotional communications leading to the development of right brain structures. Booth and Jernberg cited evidence from Schore and Schore (2008) and Perry (2006) to back up claims concerning Theraplay, right brain development and affect regulation.Interaction Here and now experience Adult guidance Attunement Right brain language		

Multisensory experience Playfulness		

The search term ‘Theraplay’ AND ‘Domestic violence’ was used in a search for relevant research articles and books on the databases ‘British Education Index’, ‘Applied Social Sciences Index and Abstracts’, ‘EBSCO Child Development and Adolescent Studies’, ‘Social Sciences Citation Index’, ‘Cambridge Journals Online’, ‘JSTOR’, MEDLINE (Ovid)’ and ‘Social Sciences Citation Index (ISI)’. This extensive search produced one peer-reviewed journal article by Bennett et al (2006) on the use of Theraplay with families who had experienced DV. Bennett et al (2006) presented anecdotal evidence on the effectiveness of Theraplay for mothers who had experienced DV and their children in a sheltered setting during a short stay. Although it was concluded that the intervention had improved the quality of life for the mothers and children, they could not comment on the efficacy of the treatment in terms of positive short and long-term outcomes. They highlighted the need for more systematic evaluations of Theraplay and admitted the shortcomings of their research but argued that given the urgency of the needs for interventions for women and children in sheltered settings, professionals working in this area could not afford to wait until they knew more about what interventions worked best for them.

Allen (2011) reviewed the evidence base for Theraplay and its theoretical underpinnings. Allen argued that attempts to replicate prior caregiving experiences ran counter to Attachment Theory's focus on a child's cognitive developmental status and emphasis on promoting healthy developmental pathways in the *current* context. Allen reported that there was only one published controlled study on Theraplay, citing a study carried out by Siu (2009) in which children who attended Theraplay sessions were compared those on a waiting list. Sui found Theraplay only marginally effective in decreasing internalising problems (d= 0.26). Allen concluded that interventions such as Theraplay were "evidence-informed" rather than evidence-based. Contrary to this argument, the California Evidence-Based Clearing House (2009) awarded Theraplay with the status of "evidence-based" and cited two published peer-reviewed studies which utilised a form of control group.

Dodd (2009) found that therapeutic group work, that included elements of Theraplay, was effective in helping to enhance the psychological well-being of the mothers and their young children and in promoting positive bonds between mother and child. Toon and Rowley (2013) found evidence for the effectiveness of a group Theraplay approach in helping mother and child move forwards from abuse through connectedness, positive experiences of play, developing the positive identity of the mother and in developing positive parenting within the LA in which the study is based.

3.Method

3.1.Qualitative Evaluation

Qualitative evaluation is the study of causality within a context and has the potential for disclosing complexity through the use of holistic methods (Shaw, 1999). Miles and Huberman

(1994) described qualitative evaluation as an interpretative approach in which the main task was to explicate ways people in particular settings come to understand, account for and take action. Lincoln and Guba (1986) described qualitative evaluation as a type of formative evaluation which is undertaken to determine the value (merit and/or worth) of an entity and that value was context dependent. Lincoln and Guba argued that refinement, improvement and alterations could be made through a process of disciplined inquiry.

3.2.Rationale for focus group method

A focus group was chosen as the method by which the mother's experiences of the Theraplay group would be explored and the research questions answered.

Steward et al (2007) identified a number of common uses for focus groups, which correlate with our rationale for using a focus group. We sought to generate an impression of the programme and we hoped that the focus group would assist with the interpretation of quantitative data obtained. A focus group offered an opportunity for group members to probe into each other's reasons for holding a particular view. It was important that as well as evaluating the programme through quantitative means, that the group members had the opportunity for their voices to be heard in the research process. Barbour and Kitzinger (1999) and Kidd and Parshall (2000) suggested that focus groups had proved useful in accessing the views and experiences of those considered to be 'hard to reach' or at risk of social marginalisation. Barbour (2005) commented that focus groups offered participants a relatively safe environment when the participants were homogenous and so shared a similar reference point and Litosseliti (2003) identified their usefulness in exploring complex or sensitive topics. Freeman (2006) argued that the method sought to promote a safe environment for self-disclosure, which is particularly important for the context of this research.

The participants in this study attended ten group sessions; five sessions in which the mothers learnt about and practiced Theraplay and five sessions to which their children were invited.

The focus group was held at the end of the programme. The group members had all experienced DV so could identify with each other and had all participated in the Theraplay sessions so had a level of familiarity with one another. It was hoped that this would create an environment in which they felt more able to express their points of view and share their experiences.

3.3.Focus group method

Redmond and Curtis (2009) offered some useful guidance on the design of a focus group protocol (See Appendix 2 for Focus Group Protocol). Introductory and closing statements were used to ensure participants were guided through the process. A semi-structured focus group was chosen to ensure that the data obtained was focused and would answer the research questions. Participants' level of comfort was considered when ordering questions; the warm up question was designed to be easy to answer and less directive. Ground rules were established at the start to ensure that every participant had the opportunity to contribute in a safe and respectful environment.

Questions were both directive and non-directive. Kidd and Parshall (2000) believed that non-directive questions were important in order to go beyond identifying what was well or ill received, but would lead to the expression by participants of what aspects of their experiences were anticipated or unanticipated, their responses to various aspects of the focal situation (in

this case participation in the programme) and in developing an understanding of the processes underlying responses in the context in which they were obtained.

A record was made of who spoke and in what order along with notes on body language.

3.4.Participant Selection

All five participants were attending the 'Moving on Through Play' programme at the time of selection and were selected purposefully to contribute to its evaluation. The group leader reported that attendance was higher than usual so we hoped to take advantage of the opportunity to capture the mothers' views.

3.5.Ethics

Packer-Multi (2010) outlined a number of considerations in working with vulnerable groups. They recommended that the impact of discussion on sensitive issues on feelings be considered and participants be debriefed before and after the group. It was suggested that the question of how to make participants feel relaxed and comfortable was addressed. Packer-Multi also recommended making it clear to participants that they were under no pressure to contribute. These recommendations were discussed with the group leader and moderator in the planning stage and implemented.

The British Psychological Society (BPS) Code of Ethics and Conduct (2009) was used as a guide to making ethical decisions for this study. Participants were given a consent form explaining that participation was voluntary, that they had a right to withdraw at any time, that data would be anonymised and remain confidential and that participation would involve and that they would be debriefed (see Appendix 1 for information and consent form). An oral description of the purpose of the study, what would be expected from participation and a

further opportunity to confirm consent preceded the focus group.

4.Findings

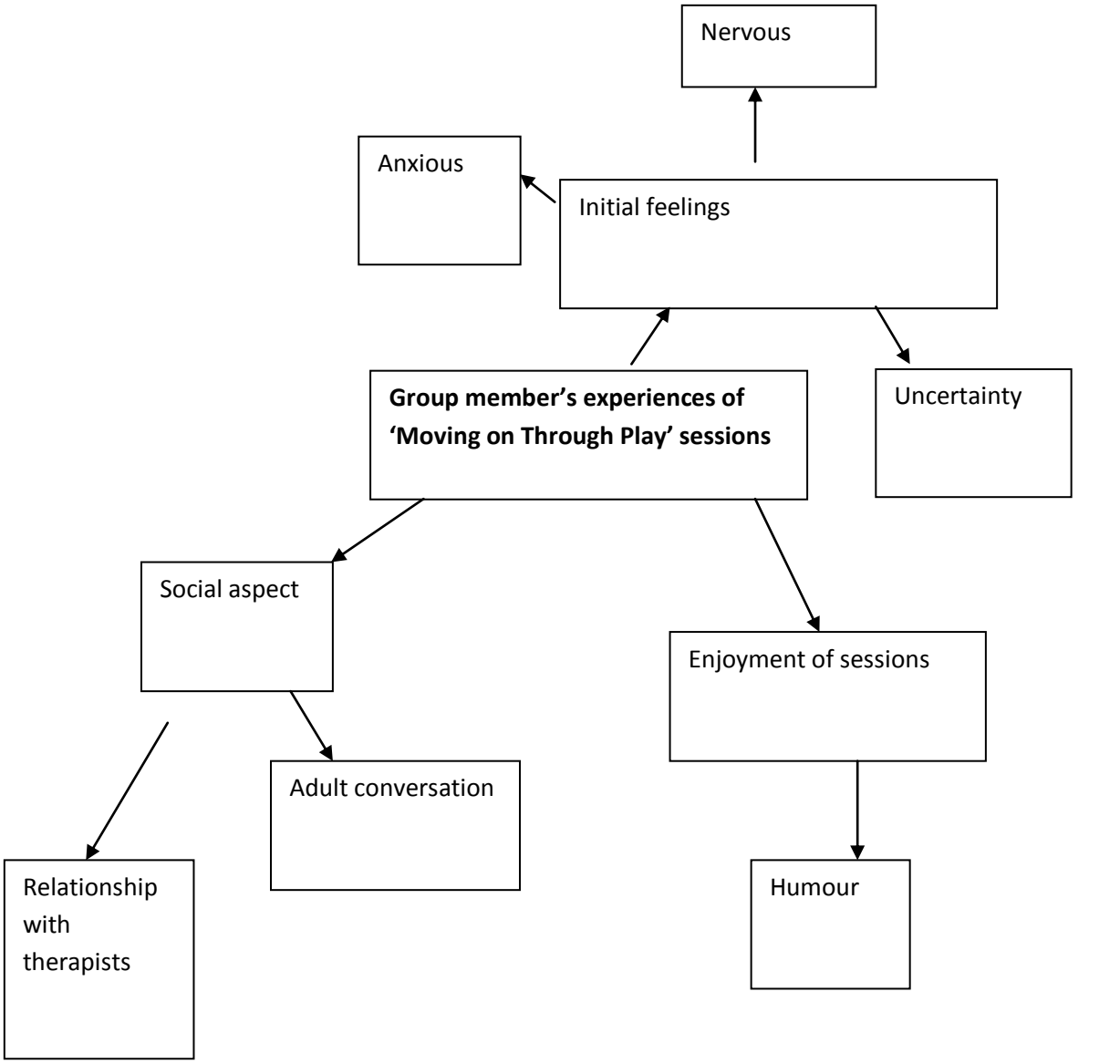
4.1.Thematic analysis

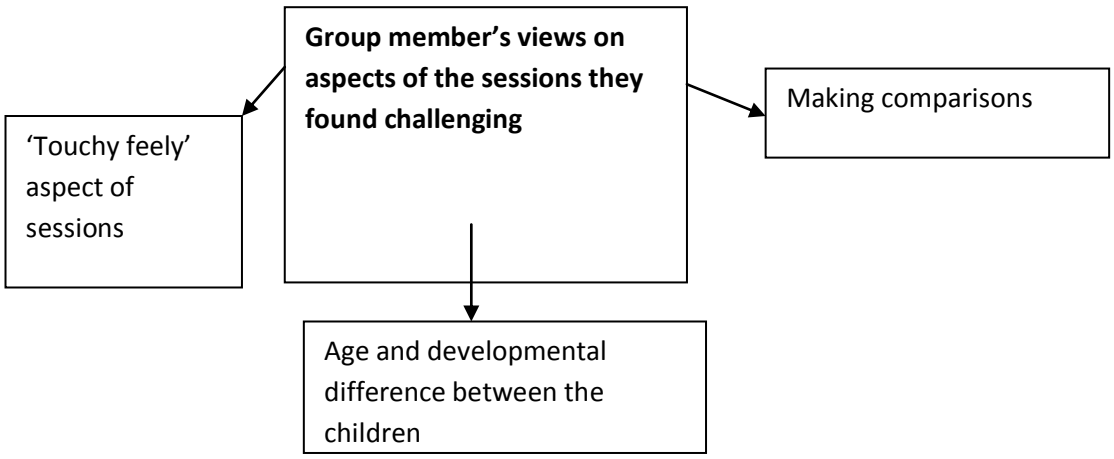
Thematic analysis is a process for encoding qualitative information in order to identify themes; patterns that describe and organise the data and allow us to interpret aspects of the phenomenon (Boyatzis (1998)). Boyatzis (1998) described the purpose of thematic analysis as helping us to make sense out of seemingly unrelated material in a systematic way. Useful and meaningful codes were derived from the transcript and themes communicated in the fewest words possible (see Appendix 3 for codes and figure 1 for thematic maps). These were interpreted within the conceptual framework of group Theraplay and theories associated with attachment interventions.

The mothers were anonymised as P1, P2, P3, P4, P7, the two Educational Psychologists/Theraplay therapists as P9 and P8, and the Children's Centre Worker as P6. P9 led this focus group as the focus group mediator. Table 2 shows which participants contributed to which questions can be found below. It indicates that of the mothers, P7, P3 and P4 were the most vocal of the group, contributing to seven or more of the nine questions. P1 and P2 were least vocal, both contributing to three or less questions:

	Mothers					Children's Centre Worker	Therapist/EP	Therapist/EP/focus group mediator
Participant Questions	P1	P2	P3	P4	P7	P6	P8	P9
1			X	X	X			X
2			X		X			X
3		X	X	X	X		X	X
4		X	X	X	X			X
5	X			X				X
6			X	X	X			X
7			X		X			X
8	X		X	X	X	X	X	X
9		X		X	X	X	X	X

Table 1: a table representing of participants contributions to the focus group questions


Nervous
Anxious
Initial feelings
Group member's experiences of 'Moving on Through Play' sessions
Uncertainty
Social aspect
Enjoyment of sessions
Adult conversation
Relationship with therapists
Humour


Group member's views on aspects of the sessions they found challenging
Making comparisons
'Touchy feely' aspect of sessions
Age and developmental difference between the children

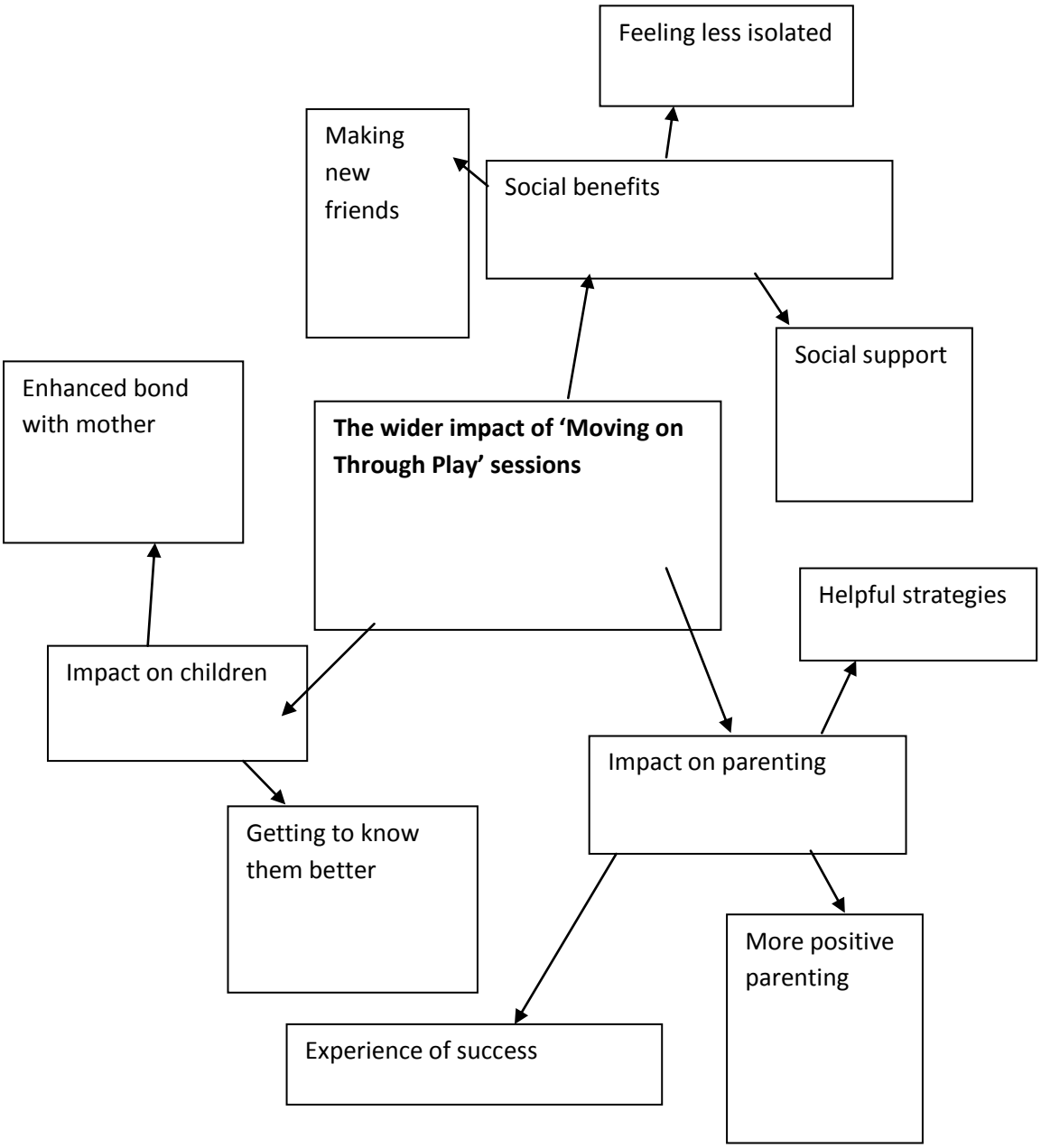


Figure 1: Thematic maps derived from analysis of the focus group transcript

4.1.2. Superordinate theme: Group members experience of the 'Moving on Through Play' sessions

Theme: initial feelings (anxious, uncertain, nervous)

Three parents describe initially feeling nervous or anxious about meeting new people and some mothers expressed an uncertainty as to what to expect in the first few sessions. This may have been linked to uncertainty about the mother's perception of their ability to apply what they had learnt:

> 9: think back to when the sessions began; what were you're first impressions?
>
> 4: ...anxious about the group and what it was going to be like
>
> 3: yeah meeting new people
>
> 7: yeah [nodding] I was feeling really anxious.

Theme: social aspect of sessions

The social aspect of the group sessions appeared to be valued and a more detailed discussion of the benefits of the group sessions to the mothers' social wellbeing will be discussed under the superordinate theme, 'The wider impact of 'Moving Through Play sessions'.

Subtheme: Adult Conversation

References were made to enjoying the opportunity at the beginning of each session for informal conversation with other adults.

> 7: I think being like a single parent like, me and XXX (other group member) was saying you know sometimes you feel like- it's just its amazing to be with your kids but it's just child talk all the time so to talk to adults- it's like I find myself sometimes not taking a breath- get it all in! You know!

Subtheme: relationship with therapists

There was evidence that the mothers' relationship with the therapists was positive; they were held in positive regard and felt supported by the therapists. References to the therapists by the mothers suggested that they were perceived with affection and as supportive to the mothers.

P1 described how when she experienced some success it was accompanied by self-sabotaging thoughts and how she appreciated the support she received from the therapists during these times of self-doubt:

> 1: it was nice you sort of realised that when you start getting there you think of things to bring you down again.

Theme: enjoyment of sessions

Some mothers explicitly referred to the fact that they and their children had enjoyed the sessions. Comments made about the end of the programme suggested that they were sad that it had finished.

> 4: I don't think I'd change anything to be honest, I've quite enjoyed it. XXX (child's name) didn't at the beginning but I've quite enjoyed it

Subtheme: humour

There were 28 incidences of laughter noted throughout the transcript; the ease at which group members joked with one another and from my general impressions of the group suggest that humour had become an integral component of the sessions. The following excerpt is an example of the good humour shared by group members:

P9: ... Anyone else want to say anything about that?...

3: I've come to realise that I actually like chocolate!

[laughter]

That's really bad! I'm going to get fat now!

Playfulness is a key component of Theraplay and humour may have helped encourage playfulness in interactions. It may have also served a social purpose by helping to establish rapport between participants and identify themselves as group members. Bennett et al (2006) discussed the fun element of Theraplay for women in a sheltered setting and argued that the fun aspect of the sessions was more important than serious discussion in terms of relationship-building and cultivating good and positive feelings.

4.1.3.Superordinate theme: the wider impact of 'Moving on Through Play' sessions

Theme: Social benefits

Subtheme: Making new friends

Group members found that a positive aspect of 'Moving on through Play' was the opportunity to make new friends:

> 7: and I really have met some lovely people here and I hope it does carry on that we meet up and stuff-

Subtheme: Feeling less isolated

Group members reported feeling less isolated and more aware that others had shared their experiences and feelings which may have helped normalise the mother's feelings. P4's comments suggested that feeling this connection to the other members helped her feel more relaxed and less stressed:

> 4: I think experiencing that I'm not the only one that has difficulties like... but um other people have the same problems it's not just me... just knowing that you know...I'm not the only one in this boat!

Subtheme: social support

Group members' comments were supportive and complementary of each other; for example, supporting parents experienced challenge within or outside the sessions. P1 was appreciative of the support received from the group during a challenging session:

> 1: I was going to say it helped- I felt really- personally I felt really supported as well because when he was I felt I mean...I just felt that he was the one that was playing up...and when I did panic it was nice that everyone really supported me though that...that did help.

Theme: impact on parenting

Subtheme: more positive parenting

Group sessions helped teach more positive parenting strategies and expose parents to other, more positive parenting styles, encouraging self-reflection. Participants' comments suggested they realised that they did not always have to resort to shouting in order to discipline children effectively:

> 4: erm yeah I feel as if I don't really have to shout as much to get their attention

Subtheme: Learning helpful parenting strategies

Some mothers identified that strategies learnt in the sessions had helped address specific problems, such as the usefulness of the games in helping to contain an overly active or excited child:

> 2: the... calming down games have made ...between after school and dinner... a lot easier... 'cause I can just bring him down and he's more settled and then I'm more relaxed I'm not.

Theme: Impact on the children

Subtheme: mothers getting to know their child better

Some reports from parents indicated that they had learnt something about their child that they had not known before, or that they had learnt what strategies were supportive for them. P3 and P2's accounts suggested that they attributed their child's more positive engagement in a group to the structures in place. Bennett et al (2006) reported that mothers valued the emphasis on structure in Theraplay as they believed it supported them in their parenting role.

> P3: ...and he enjoyed a lot more that what I thought he would and to see him participate with the other kids and actually join in whereas he's quite...well they say he might have ...autism so it was really nice to see that in a room with structure... -he felt comfortable

Subtheme: Enhanced bond between mother and child

The group member's success at applying what they had learnt to their parenting and decreased levels of stress appeared to have helped enhance the bond between mother and child, having a positive impact on the child's behaviour and interaction with them.

Some participants reported a greater level of comfort with physical contact and were better able to show their love and affection with their child.

> 4: they listen more... I feel as if I don't really have to shout as much to get their attention they can take their deaf ears off and put their listening ears on!

P4 noticed that her child appeared to listen more and her account suggests her and her son's level of attunement and reciprocity between them may have been enhanced, as she describes how it appeared easier for her to get his attention:

Theme: Experience of success

The group members made many references to experiencing success in using the strategies and games they had learnt and the skills they had developed. It appeared important to the mothers, as they appeared initially uncertain and doubtful as to whether they could successfully apply what they had learnt. It appeared to have increased their confidence in their parenting ability.

P4 experienced initial uncertainty but later accounts suggest that she had experienced success. Her use of the word 'actually' in this context emphasises that the fact that she had managed to calm her child down had surprised her:

4: he'll sort of be up here [gestures with hand above head] to down here [moves hand down] he goes to sleep easier 'cause I've managed to **actually** bring them down

4.1.4. Superordinate theme: mothers' views on aspects of the sessions that they found challenging

Theme: age and developmental differences between the children

When the group members were asked to identify if there was anything they'd change about the sessions P2 stated that she felt a group in which her child was closer in age to the other children may have been more appropriate. The discussion that followed between the group members and therapists introduced debate into a discussion which was mostly consensual up to that point. In the following excerpt P2 raises this issue and although it is acknowledged by the therapists; P8 argued that P2 had coped with the age difference and argued that the activities had been challenging enough for her child:

2: the only thing I'd change perhaps is have more age focussed groups

P2's hesitation in response to P8's challenge and her change in body language at the time suggested that she experienced discomfort in expressing a different point of view to the therapist but not enough to prevent her from expanding on the point she had made. This suggests she felt safe enough to express her point of view in this context.

Theme: the 'touchy feely' aspect of sessions

Group members expressed their initial discomfort at some of the Theraplay activities involving touch. Touch is an integral component of Theraplay and the group was expected to practice on each other before applying what they had learnt with their children. Although four of the five mothers admitted to finding these activities challenging, three group members acknowledged that it had been helpful and their comments suggested that they were now more comfortable with touch. Interestingly, Bennett et al (2006) were most concerned with touch and children suggesting that they might find this aspect difficult or distressing if they had experienced physical or sexual abuse. Bennett et al (2006) did not consider the impact of touch on the mothers who had experienced DV. When asked what the group did not enjoy about the sessions, Participant 3 admitted that she didn't enjoy touching people that she did not know, but that as she got to know the other group members felt more comfortable touching them:

> 3: I didn't enjoy...me personally the touch- so much touchy feely- because I'm quite an anxious person... um...with people that I didn't know. Now!...[slaps thighs of those sitting next to her] [laughter from around the room]

P7 suggested that her discomfort was associated with some of her '*issues*'; probably a reference to her experiences of DV, although she stated that she understood the purpose of initially practicing on adults:

> 7: obviously you was demonstrating- [to practice touch on adults] is fine because obviously you want that closeness and nurturing but to practice it first with adults obviously with some of the issues I've got was a little it... uncomfortable

However, when asked if she had noticed anything about her relationship with her child since completing the group she reported that she felt more comfortable with being tactile with her child.

Theme: comparing parenting styles and children

Whilst it was acknowledged that the group format provided opportunities to learn from others and reflect on personal parenting styles by making comparisons, comments from some group members suggested that at times this was challenging.

Mothers indicated that they had learnt about other ways of disciplining their child through learning about other perspectives on parenting and discipline and observing others interactions:

P1 described times during group sessions where comparing her child unfavourably to the other children in the group had lead to feelings of panic, but that she felt supported by the group during this crisis of confidence:

> 1:...I just felt that he was the one that was playing up the most it seemed like everyone else was being really good and XXX (child's name) was just the one who was being a nightmare and when I did panic it was nice that everyone really supported me though that... that did help.

5.Discussion

This research project set out to explore what has worked across the mother's experience of the group sessions and what might be improved, to what extent the hoped for outcome domains resonated with the mothers and the emerging narratives to illustrate how these domains were (or were not) experienced. The results as represented in figure 1 indicate that the group members had positive experiences within the 'Moving on Through Play' sessions and that the experience had a wider positive impact on their lives and the relationships with their children. The emerging themes suggested that although the group members initially felt anxious and nervous to meet new people and work with their children in this group setting, they found the sessions to be enjoyable, with opportunities for adult conversation and learning in a safe environment of playfulness and humour.

The wider impact of the sessions included the experience of success in applying the strategies learnt in their interactions with their children and success in adopting a more positive parenting approach. Participants comments suggested that the bond between mothers and children had been enhanced and in addition to an improved relationship, group members had

valued the opportunity to make new friends, felt less isolated with an improved perception of social support.

Group members had found aspects of the intervention challenging, such as the 'touchy feely' aspect of Theraplay and the age and developmental appropriateness of the games for some of the children. The mothers tended to make comparisons between themselves and their children, and the other mothers and children. There was no evidence that these challenges related to poorer outcomes or that the mothers experienced an inappropriate level of challenge. In some cases it was evident that this level of challenge was justifiable as it helped to develop parenting skills; for example, the focus on touch was likely to have cultivated a more nurturing, loving attachment between mother and child. Several participants reported feeling more comfortable with touch and were more tactile with their children as a result.

The emerging themes share similarities with Bennett et al's (2006) anecdotal findings working with mothers and children in a shelter. Bennett et al found the mothers quality of life was enhanced, and the themes that emerged from this focus group would suggest that the mothers experienced a number of positive outcomes in their relationship with their children and in social and emotional domains. Toon and Rowley's (2013) locally based evaluative study, is a useful comparison to this study as it was situated in the same locality, also evaluated a 'Moving on Through Play' focus group and asked the mothers similar questions. Toon and Rowley discussed the emerging theme of social connectedness and aspects of the narrative offered for in this theme parallel with these findings, such as feeling less isolated and better able to cope due to enhanced social networks. Our study analysed data systematically and in depth, helping to validate the conclusions drawn from similar studies.

One could argue that some of the participants appeared to dominate the discussion (for example P7, P4) whilst others remained silent or participated to a lesser extent (e.g. P1, P2) (see table 1 for a representation of participant contributions to focus group questions). This may have led to a 'false' consensus and a misrepresentation of the 'group' view, when in fact individual views were represented to a greater extent, a potential limitation identified by Litosseliti (2003). There was a danger that participants may have said what they thought the focus group leader wanted them to hear, which could introduce bias into the data. It's worth noting that the quieter participant, P2, felt comfortable enough to comment on what she'd improve about the programme. This suggested that she felt comfortable enough to contribute and it is possible she may have not chosen to participate in earlier questions because she either agreed with the views expressed.

As the sample was not representative and involved a very small number of participants, generalisations based on the focus group information are difficult. The analysis of focus group data is very context dependent and is influenced by situational factors. In order to increase its validity and generalisability it could be considered alongside other evaluative studies in this area in order to help verify conclusions drawn. It is important to acknowledge, however, that the results are indicative; they illustrate this particular social phenomenon in depth. In spite of the limitations of focus groups, the data obtained provides a rich and in depth picture of the experiences of this group of mothers within the sessions and the impact those experiences had on their relationship with their children and wider wellbeing. Furthermore, the research base in this field, with this vulnerable group is limited, so one could argue that this adds value to our findings.

The Educational Psychologist was known to the participants and had run the 'Moving on Through Play' sessions which may have compromised the validity of responses by

introducing bias. Semi-structured questions and probes were used to remind the EP not to make judgement statements that might have affected responses. In addition, the group members may have made more contributions to discussion due to the group member's level of comfort and familiarity with the group leader.

This focus group is reproducible and can be replicated and used to evaluate other 'Moving on Through Play' interventions (a protocol of questions and guidance on suggested probes to use is included in appendix 1). It is recommended that the focus group is repeated to enhance the dependability of the findings.

The systematic analysis of data undertaken, the coherent narrative of each theme and accompanying illustrated examples offer rich constructions of this phenomenon and a useful insight into this intervention. There is sufficient detail included in the thematic analysis to allow the reader to judge the findings as credible.

Focus group data should be considered in the context in which it was collected, whereby the group dynamics, group member interactions and interactions with the researcher are likely to have influenced the data and consequently emerging themes. There is a pressing need for evidence-based interventions to support mothers and children who have experienced DV and the issue of providing the best support to this vulnerable group has increased in profile. Educational Psychologists are in a position in which they are able to deliver such interventions and evaluate them rigorously. It is recommended that Educational Psychologists publish further research in this field to contribute to this research field to ensure that interventions for this group continue to develop from a sound evidence base.

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Appendices

Appendix 1: information and consent form

Parent information and consent form

I am a Trainee Educational Psychologist at the University of Birmingham, where I am supervised by Dr Jane Leadbetter, Educational Psychologist. [redacted]

[redacted]

[redacted]

One of the tasks that I need to complete, as part of my course, is an evaluation of a programme delivered by Educational Psychologists.

As part of the study, I would be interested in working with you to gather information to help inform future 'Moving on Through Play' group work using the information gathered from the focus group you will be attending at the end of your group sessions. The focus group will be recorded (voices only) and then I will look at the meaning of what was said by the participants to get an idea of what the groups experiences were of the programme.

I will use this information to produce a written assignment, which will be submitted as part of my doctoral course.

You will remain anonymous in the assignment (you will not be able to be identified from the assignment as no real names will be used) and you are under no obligation to take part. You have the right to withdraw from the study at any time.

If you have any questions throughout this process, please do not hesitate to contact me on [redacted]

Please tick one of the options below….

☐ Yes, I wish to participate in this evaluation

☐ No, I do not wish to participate in this evaluation

Parent/guardians signature: _____

Date: _____

Signature of TEP: _____

Appendix 2: focus group protocol

Focus Group Protocol

Opening statement

Welcome participants

Review purpose of the focus group: e.g. "We've asked you to take part in this focus group because we would like to know what the experience has been like for you and what, if any, difference this project has made to you. We would really like to hear from everyone.

Ground rules (may not need all of these as they may have been established at the start of the group sessions):

- There are no wrong answers, everyone's opinions and experiences count.
- Please can you make sure others are done talking before you jump in, and avoid side conversations.
- If several people want to talk at once I'll try to keep track of those waiting. Feel free to raise your hand if you don't think I'm aware that you would like to talk.
- To protect the confidentiality, what's said in this room stays in this room –especially specific details or experiences.
- Please can you make sure your mobile phone is turned off or on silent?
- This is a voluntary activity. You may choose not to answer any questions, and you are free to leave at any time.

Warm up question

1.Think back to when you first began the sessions. What were your first impressions?

Probe: what were your initial thoughts?

Key questions

2.How would you describe your experience of being part of this group?

Probe: what did, or didn't you enjoy about the group?

3.Have you noticed anything about yourself as a mother since taking part in the group?

4.Have you noticed anything about your child since taking part in the group?

5.Have you noticed anything about your relationship with your child since taking part in the group?

Probe: have you noticed anything about your interactions with your child since taking part?

6.In what way, if any, is your life different because of your participation in the sessions?

7.What did you like best about the group?

8.What, if anything, would you change?

Wrap up question

9.Is there anything we should have talked about, but didn't?

General probing questions:

Would you explain further?

Would you give me an example of what you mean?

Would you say more?

Is there anything else?

Does anyone else have anything to add to what has already been said?

Has anyone had a different experience?

...go on...

(not to use words like "correct" or "good" as may communicate a judgement)

Closing statement

Recap discussion

Thank participants

Summarise next steps: e.g. “We are going to listen back to your responses and see what key messages have come out of the group discussion. Your responses will be anonymised so that you can’t be identified from our record of the discussion. We will use this data to help plan for future group work and evaluate how effective the project has been”.

Appendix 3: thematic analysis of focus group transcript

	Cycle 1 initial codes	Initial themes	Cycle two themes
9: ...what [laughter] stop it! [laughs]...think back to when the sessions began, What were you're first impressions?			
3: nervous	Nervous	Nervous	Nervous
9: you were nervous			
3: [points to other group members]...who the hell are these?	Curious to find out about other group members	Curious	Curious
9: yeah OK			
3: oh my god she's on the course!			
7: oh er!			
9: [laughter] ok so you were feeling nervous			
3: yeah			
9: ok and was that when you first arrived?			
3: and anxious	anxious	Anxious	Anxious
9: and anxious about the group and what it was going to be like			
3: yeah meeting new people	Anxious to meet new people		
7: yeah [nodding] I was feeling really anxious. Thats XXX speaking by the way!	anxious		
9: [laughter] you don't have to- look you're numbered! [laughter]. So so you were feeling anxious that was the initial feeling. Anybody else want to add to that?			
4 (?): Curious	Curious	Curious	Curious
9: Curious...Mmm ok [thoughtful] anything else? [pause] so so it's that first impression is that what we want or do we want our impressions of that first session how that felt?			
What do you think about that first session? When it got going did you think 'Oh this is the same as other groups or-'			
4: excited but nervous	Excited Nervous	Excited Nervous	Excited Nervous
9: did you?			

7: I thought it went quite well. Obviously some of the erm tasks that we were going to be taking home I was a little bit like how was this going to work with my children	Uncertainty, unsure it would work	Uncertainty as to whether strategies/ games would work	Uncertainty as to whether strategies/games would work
but when I did it it was quite successful	Experience of success	Experiencing success with applying strategies, skills, games	Experiencing success with applying strategies, skills, games
9: yeah OK. Ok so that's good. Good. Ok so so going more broadly how would you describe your experience of being part of this group?			
7: Met some nice friends.	Making new friends	Made new friends	Made new friends
Got to see you guys and how you work. I think you're crazy XXX (P9)	Getting to know therapists a positive experience	Positive relationship with therapists	Positive relationship with therapists
[laughter from around the room]			
3: you're the only person I know that can smile like that on a Monday morning!	Getting to know therapists a positive experience	Positive relationship with therapists	Positive relationship with therapists
[laughter]			
7: and text us at 12 O'Clock at night!	Getting to know therapists a positive experience	Positive relationship with therapists	Positive relationship with therapists
[laughter]			
9: Um and um ok and what about- so great! I'm glad that the whole social thing was good. What about what did you enjoy about the group or didn't enjoy about the group?			
4: I think experiencing that I'm not the only one that has difficulties like	Developing awareness that difficulties shared with others	Developing awareness that not only one to	Developing awareness that not only one to experience difficulties parenting

		experience difficulties parenting	
not so much controlling but I suppose putting strategies in and stuff like that with erm games I was thinking 'oh my god what's XXX (childs name) going to be like'	Worry about how her child would react to theraplay games	Uncertainty as to whether strategies/games would work	Uncertainty as to whether strategies/games would work
but erm other people have the same problems its not just me	Developing awareness that not alone in experiencing problems/difficulties	Developing awareness that not only one to experience difficulties parenting	Developing awareness that not only one to experience difficulties parenting
9: yeah so you didn't feel alone			
4: no			
9: ok good yep			
4: Seeing XXX (child's name) actually wanting to take part eventually	Enjoyed seeing child experiencing success	Enjoyed seeing child experiencing success	Enjoyed seeing child experiencing success Child more engaged
9: yeah that was lovely			
4:Eventually! After like hours of nothing! [laughs]	Relief that child had made progress	Relief that child had made progress	Relief that child had made progress
9: yep ok so you enjoyed seeing XXX take part			
3: I enjoyed seeing XXX (childs name) take part	Enjoyed seeing child participate in sessions	Enjoyed seeing child participate in sessions	Enjoyed seeing child participate in sessions
and he enjoyed a lot more that what I thought he would and to see him participate with the other kids and actually join in whereas he's quite...well they say he might have social autism	Childs enjoyment was somewhat unexpected	Getting to know child better	Getting to know child better
so it was really nice to see that in a room with structure-	Child responded well	Enjoyed child	Enjoyed child respond

	to structure	respond positively to structures put in place	positively to structures put in place
9: yep			
3: -he felt comfortable-	Child comfortable in sessions due to structure	Structure had a positive effect on child Getting to know child better	Structure had a positive effect on child Getting to know child better
9: yep [nodding]			
3: -because we're in nursery we're- cause with his eating habits as well you're all sat down and you're all had snacks together, he joined in whereas in nursery they just go whenever they want so he never has snack			
so it was nice to see	Enjoyed seeing child experience success	Enjoyed seeing child experience success	Enjoyed seeing child experience success
that giving him structure that structure worked for him.	structure identified as a successful strategy	Sessions helped to identify structure as successful strategy	Sessions helped to identify structure as successful strategy
9: yep...yep			
[other group members make sounds that suggest they are actively listening, e.g. 'Mmm...']			
9: ok thank you. Anyone else about –so I'm still asking you what you did and didn't enjoy about the group?			
3: I didn't enjoy...me personally the touch- so much touchy feely- because I'm quite an anxious person	Initially did not enjoy 'touchy feely' element to sessions	Initially did not enjoy 'touchy feely'	Initially did not enjoy 'touchy feely'
9: yeah			

3: um...with people that I didn't know.	Discomfort touching those perceived as strangers at the time	Discomfort touching those perceived as strangers	Discomfort touching those perceived as strangers
Now!...[slaps thighs of those sitting next to her]	More comfortable with touch now	More comfortable with touch now Now has got to know other mothers, more comfortable with touching them	More comfortable with touch now Now has got to know other mothers, more comfortable with touching them
[laughter from around the room]			
8: so if we did the group for twenty four weeks you'd be-			
3: yeah!			
[laughter]			
7: no think that was obviously when we was going round in a circle it was that obviously that me and XXX (name of other group member] we expressed at the time that we was a bit like holding grown ups hands and then doing pizza's on the backs and things you know when you do do it with a child which obviously you was demonstrating-	Discomfort at touching other adults	Discomfort at touching other adults	Discomfort at touching other adults
9: yeah			
7: is fine because obviously you want that closeness and nurturing but to practice it first with adults obviously	Understanding of why touching important- for nurture and closeness	Understood why needed to practice touch Understood importance of touch for nurture and closeness	Understood why needed to practice touch Understood importance of touch for nurture and closeness

with some of the issues I've got was a little it-	Difficulties with touch due to DA history	Difficulties with touch associated with DA history	Difficulties with touch associated with DA history
9: yeah			
7: uncomfortable but-	Discomfort with touching adults	Uncomfortable with touching adults	Uncomfortable with touching adults
2: -especially adult strangers	Discomfort with touching adult strangers	Uncomfortable with touching adults who are strangers	Uncomfortable with touching adults who are strangers
9: yeah yeah			
2: which we pretty much were at the time			
9: yeah			
2: it's just that I'm not a touchy feely person anyway so it was a bit-	Was not in nature to be 'touchy feely'	Not in mother's nature to be 'touchy feely' so felt uncomfortable	Not in mother's nature to be 'touchy feely' so felt uncomfortable
9: so that was uncomfortable	Discomfort with 'touchy feely' aspect of sessions		
2: yeah			
4: XXX's (child's name) not touchy feely. He hated anyone touching him. He doesn't like being touched, he's one of these 'this is my space you do not come in my space' sort of thing you know he is one of these that if he wants to hug you or touch you then he will come to you for it and its sort of like when people come to him to give him a hug he's a bit like 'No!'	Perceived as not in child's nature to be 'touchy feely' Child resistant to touch	Perceived as not in child's nature to be 'touchy feely' Child resistant to touch	Perceived as not in child's nature to be 'touchy feely' Child resistant to touch
9: yeah			
4: and I didn't like walking up here because it was a bliming nightmare! all uphill! Couldn't get a taxi 'cause I had to do the school run first	Difficulties getting to location	Difficulties getting to location	Difficulties getting to location

7: I really enjoyed seeing Layton obviously when he did the last swing because obviously every week he looked at it but didn't want to do it but then in the end he did it so that was nice for me	Enjoyed seeing child experience success in sessions	Enjoyed seeing child experience success	Enjoyed seeing child experience success Child more engaged
9: yeah			
7: and I really have met some lovely people here and I hope it does carry on that we meet up and stuff-	Making new friends	Made new friends Hopes to continue to meet up with group in future	Made new friends Hopes to continue to meet up with group in future
4: -Oh you're lovely XXX [7}!		Positive regard for other group members	Positive regard for other group members
9: [laughs]			
7: I know			
9: I so have you noticed anything about yourselves as mothers, as a mother, since taking part in the group?			
[nervous laughter from group members]			
3: I love it when we're all quiet when it comes to us!		Identification on with the group	Identification with the group
7: I suppose a bit more confident to show what parent I am and I'll not be judged?	Increased confidence Feeling that parenting not judged	Increased confidence in parenting Feeling less judged as a parent	Increased confidence in parenting Feeling less judged as a parent
3: yeah			
7: you know because like I remember the first time I walked in and XXX (other group member) said 'I don't like to tell XXX (her child) off because I don't like to upset him' and I just sat there and thought 'oh my god' you know what- as a parent you know you've	Comparison of parenting styles with other mothers Judging others	Comparing parenting styles with those of other	Comparing parenting styles with those of other mothers

got to tell your child off	parenting	mothers Judging others parenting	Judging others parenting
but now actually getting to know her and how she is with XXX (her son) yes she doesn't yell and scream at him but there is still that discipline of 'No that's not right'? so you do-in a group- it's like how is that going to work? You know you've gotta- but I've learnt that I'm not screaming and bellowing no more well try and sit down and play a game and if it doesn't work I'll say 'Right that's it we'll put it away then until you are ready to' you know	Developing awareness that there are other, more positive ways to discipline	Developing awareness that there are other, more positive ways to discipline	Developing awareness that there are other, more positive ways to discipline
so it's been quite nice to learn like I said, each of us parenting so...and be on a level I suppose	Can have different parenting styles but still be equally good parents	Can have different parenting styles but still be equally good parents	Can have different parenting styles but still be equally good parents
9: yeah... yeah anybody else about anything about themselves as a mother?			
4: I feel more relaxed [touches P3 on arm]	More relaxed	More relaxed	More relaxed
9: do you?			
4: yeah			
9: Mmm			
4: just knowing that you know...I'm not the only one in this boat!	Developing an awareness that problems/difficulties shared with other mothers	Developing awareness that not only one to experience difficulties parenting	Developing awareness that not only one to experience difficulties parenting
9: yeah...yeah			
4: and you will be here with me by my side!	Support from other mothers important	Perceived support from other mothers	Perceived support from other mothers
It's made certain times of the day easier, 'cause Aiden after school he's very tired and he's one of these that gets hyper when he's			

tired?			
9: yeah yeah			
2: which...I've no idea why... if you're tired you sit down and be tired			
9: yeah			
2: but its- the sort of calming down games have made that after school- between after school and dinner have made that a lot easier	Strategies and skills learnt have helped with 'problem' times of the day Child more settled	Strategies/ games/skills learnt have helped address specific difficulties Child more settled	Strategies/games/skills learnt have helped address specific difficulties Child more settled
9: yeah			
2: 'cause I can just bring him down	Bringing child 'down' (decreasing levels of excitement/arousal) to help settle	Bringing child 'down' (decreasing levels of excitement /arousal) to help settle	Bringing child 'down' (decreasing levels of excitement/arousal) to help settle

Appendix 4: Additional illustrative examples of themes and subthemes

Theme: Initial feelings

Uncertain:

9: What do you think about that first session? When it got going did you think 'Oh this is the same as other groups or-'

4: excited but nervous

4: I think experiencing that I'm not the only one that has difficulties like not so much controlling but I suppose putting strategies in and stuff like that with erm games I was thinking 'oh my god what's XXX (child's name) going to be like' but erm other people have the same problems it's not just me

7: Obviously some of the erm tasks that we were going to be taking home I was a little bit like how was this going to work with my children?

Theme: Social aspect

Subtheme: relationship with therapists

9: ...so what did you like best about the group?

4: seeing you're beautiful face! [looks in P9's direction, affectionate tone]

[laughter from group]

9: thank you!

4: you're welcome!

9: ...how would you describe your experience of being part of this group?

7: ... Got to see you guys and how you work. I think you're crazy XXX (P9)

[laughter from around the room]

3: you're the only person I know that can smile like that on a Monday morning!

[laughter]

7: and text us at 12 O'Clock at night!

[laughter]

Theme: enjoyment of sessions

2: I had a lot of fun... and XXX's (child's name) had a lot of fun

Comments about end of programme:

3: and it's our last day! [exaggerated sad tone]

7: sadly it's become part of my routine so I'm really sad that it's not going to carry on you know

Theme: social benefits

Subtheme: making new friends

9: how would you describe your experience of being part of this group?

7: Met some nice friends.

4: it was nice to get to know them a bit better even though I already knew them a bit it was nice to get to know them better

Subtheme: feeling less isolated:

7: Have my days when I think 'Oh god, when is it bed time!' you know,

4: I think every mother can't wait till bedtime. I think when it gets to like 4 O'clock is it bed time yet?

Theme: impact on parenting

Subtheme: more positive parenting

7: I've learnt that I'm not screaming and bellowing no more well try and sit down and play a game and if it doesn't work I'll say 'Right that's it we'll put it away then until you are ready to' you know

Subtheme: learning helpful parenting strategies

P4 referred to her success in using Theraplay strategies to calm her child down when overexcited:

4: he goes to bed easier at night

9: really?

4: yeah. Apart from the waking up taking about dragons! [laughs] I find that he- now I've kind of learnt how to bring them down... he'll sort of be up here [gestures with hand above head] to down here [moves hand down] he goes to sleep easier.

Theme: Impact on the children

Subtheme: getting to know their children better P4 referred to her success in using Theraplay strategies to calm her child down when overexcited:

> P2: I find that XXX (child's name) is more- I didn't notice before but he's more- he's better when we're doing the group things as opposed to the one on one and I always thought that he liked the one on one but I realise how much he... [pause]...I can't think of the word... I realise he seems better when he's in a group which is nice because you know it's very much one on one with the pair of us so it's nice to see him in a group- so it was nice to see that giving him structure that structure worked for him

Subtheme: enhanced bond between mother and child

This example illustrates the reciprocity between the child's feelings and the mothers and how one can influence the other:

> 2: It's made certain times of the day easier, 'cause Aiden after school he's very tired and he's one of these that gets hyper when he's tired?... but its- the sort of calming down games have made that after school- between after school and dinner have made that a lot easier 'cause I can just bring him down and he's more settled and then I'm more relaxed.

When asked what P3 liked best about the group she reported that her child had become more 'touchy feely'. Her account suggests that mother and child's level of comfort around touch

may have increased and that her child had become more affectionate towards her suggesting also that the bond between them had enhanced:

> P3: he's become more touchy feely, he's always wanted his cuddles and um he's become a lot more touchy feely with others now, he'll come up and put his nose on my nose and just stare into my eyes and go [mimes actions]- you know for a couple of minutes since doing those games so you know it's been really nice

Superordinate theme: mothers' views on aspects of the sessions that they found challenging

Subtheme: age and developmental differences between the children

> 4: she's obviously like older than...than all of them and it would be a bit harder with XXX (sibling of focus child) 'cause the games are sort of like a bit young for her [pause] so it's sort of like trying to put them into practice with XXX would be kind of like difficult because she's like 5 but she's more someone who's about 7? And she's so grown up for her age so trying to put some of these games into practice was a bit harder with her 'cause she's sort of like 'it's a boring it's a babies game' 'cause she sort of like needs more of a challenge

Theme: the 'touchy feely' aspect of sessions

> 7: so yeah it's nice, I've learnt to be more tactile and not panic about it

Theme: comparing parenting styles and children

7: you know because like I remember the first time I walked in and XXX (other group member) said ‘I don’t like to tell XXX (her child) off because I don’t like to upset him’ and I just sat there and thought ‘oh my god’ you know what- as a parent you know you’ve got to tell your child off but now actually getting to know her and how she is with XXX (her son) yes she doesn’t yell and scream at him but there is still that discipline of ‘No that’s not right’? so you do- in a group- it’s like how is that going to work? You know you’ve gotta- but I’ve learnt that I’m not screaming and bellowing no more well try and sit down and play a game and if it doesn’t work I’ll say ‘Right that’s it we’ll put it away then until you are ready to’ you know.

Professional Practice Report 4:

A descriptive study of Educational psychologists' beliefs and practices surrounding consultation with children

Abstract

The profile of the child's voice has been raised both internationally and nationally and brings with it implications for all professionals involved in making decisions in the best interests of children and young people (CYP). This small scale study aimed to capture descriptive information on Educational psychologists' (EP) beliefs and practices relating to consultations with CYP within a Local Authority and what factors might support or constrain this practice. The findings from this study suggest that EPs beliefs were supportive of consultation with children and that most CYP's were consulted. Areas for further exploration are highlighted in order to address possible constraints to this practice and develop EPs strengths in this area.

1. Introduction

The 'Pupil's Voice' has received considerable attention as a result of pressure groups and charities acting as advocates for children's rights, such as Save the Children, international influence in the form of the United Nations Convention on the Rights of the Child (UNCRC, 2010) and national influences such as guidance and surveillance in this area by the Human Rights Joint Committee. Furthermore, legislation such as the Children and Families Act (2014) and the statutory Special Educational Needs and Disability (SEND) Code of Practice (2014) has emphasised the importance of consulting with children, to include those with Special Educational Needs, stipulating what should be adhered to as a requirement by law for those who work with children.

In light of the relevance of the policies and legislations surrounding consultation with children this study set out to describe how educational psychologists are consulting with children and to illuminate the factors that might influence this practice. The literature review explored the beliefs and practices surrounding consultation with children and this is followed by a statement of the research aims and outline of the methodology used to meet these aims. Descriptive quantitative and qualitative data is presented and the main findings and their implications are explored in the discussion.

Obtaining the 'voice' of the child is described by Norwich (2006) as eliciting the views and preferences of children. Ingram (2013) suggested that a child's views might be obtained so that an EP can analyse the extent to which these views might be causing or maintaining the child's difficulties. Ingram (2013) described how children's views could be volunteered by the child or inferred by a psychologist's assessment of the child, which might include discussions with other adults.

The United Nations Convention on the Rights of the Child (UNCRC, 2010) outlined the active participation of children in the decision-making process on matters that affect them. The UNCRC (2010) stated that children's views should be given 'due weight' and that adults working to bring about change for children should act on children's views. This is distinct from the act of obtaining a child's views but then not taking account of them in decision-making.

Ingram (2013) argued that children's views could be heard but not acted upon. It is argued that obtaining children's views could form part of a passive process if no action is taken in light of the child's views. Norwich (2006) stated that active participation of the child could be obtained through shared negotiations and decision-sharing with children. Ingram (2013)

suggested children be empowered by their active participation in the decision-making process, whilst also offering insight that could be useful in problem-solving.

Norwich (2006) categorised children's participation as formal and informal. Norwich (2006) stated that formal participation is when the child's participation is the explicit aim of the activity. It is argued that a consultation with a child, could be categorised as a formal participation process if the aim of the consultation is obtain a child's views and then involve them in problem-solving or decision-making.

2. Literature review

2.1 Political context and policy

The UK signed up to the United Nations Convention on the Rights of the Child (UNCRC, 2010) and in 2010 the government promised to give due regard to children's rights in the development of law and policy. Article 12 of the UNCRC (2012) states that children capable of forming their own views should have the right to express those views and that they should be given due weight in accordance with the age and maturity of the child.

The SEND Code of Practice (2014): 0-25 years stated that Local authorities must ensure the child's parents or the young person are fully included in the Education, Health and Care needs assessment process from the start, are fully aware of their opportunities to offer views and information, and are consulted about the content of the plan. This reflects the Children and Families Act's (2014) insistence on the Local authorities legal duty to involve children and young people with special educational needs and disabilities in decision-making processes:

> **'Local authority functions: supporting and involving children and young people**
>
> In exercising a function under this Part in the case of a child or young person, a local authority in England must have regard to the following matters in particular—

(a)the views, wishes and feelings of the child and his or her parent, or the young person;

(b)the importance of the child and his or her parent, or the young person, participating as fully as possible in decisions relating to the exercise of the function concerned;

(c)the importance of the child and his or her parent, or the young person, being provided with the information and support necessary to enable participation in those decisions;

(d)the need to support the child and his or her parent, or the young person, in order to facilitate the development of the child or young person and to help him or her achieve the best possible educational and other outcomes.' (Children and Families (Act 2014) Chapter 6: Section 19)

2.2 Beliefs underpinning consultation with children

There are a number of beliefs and principles underlying EPs' practices with children, some of which lead to empowering children and young people (CYP), and others which can lead to the marginalisation of CYP's views and the prioritisation of adult views in decision-making processes.

Greig et al (2014) commented that empowerment was based on the idea that we all have a right to be treated equally and make decisions of our own free will. This principle conflicts with beliefs that children do not have the knowledge and skills to make sensible, informed decisions and that allowing them to do so may put them at risk. Davey (2010) defined participation as a process where someone influences decisions about their lives, leading to change. Greig et al (2014) extended this definition and applied it to work with children and young people, stating that it was a continual interaction between the young person, the context and the adult where negotiation enabled young people to express how they want to be involved in decision making.

Greig et al (2014) set out the ethical and political issues regarding research with children and young people. They highlighted a number of dilemmas for practitioners consulting with children relating to beliefs surrounding the need to protect CYP, their abilities as a consultee and the reliability of CYP accounts. Greig et al (2014) stated that there were issues surrounding when a CYP was old enough to be consulted, if they have the knowledge and understanding to contribute, how adults might influence their views and the issue of protecting CYP from difficult decisions.

Alderson (2000) also outlined a number of beliefs held by adults about children and young people that either constrain the practice of consulting with children, or support and encourage this practice (see table 1). The positive and negative influences of changing social structures on how we view children, over time, is acknowledged, with a tension existing between better protection and provision for children and a greater level of coercion and rigid control over children who can be viewed as inadequate or irresponsible.

Table 1: Beliefs about consulting with children that either support or constrain this practice (Alderson (2000)

Supporting factors	In principle, it is the right thing to do.
	There are benefits in consulting young children.
	It is educational to consult children.
Constraining factors	In principle, it is the wrong thing to do.
	There are potential harms in consulting young children.
	It is an abuse of education to consult young children.

Norwich and Kelly (2006) also found child protective values were constraining factors in enabling CYP with Special Educational Needs to express their views. They collated information provided by local authority officers, head teachers, teachers, teaching assistants

and Special Educational Needs Co-Oridinators (SENCOs) to illuminate constraining factors. Examples of beliefs obtained included the belief obtaining views would be too onerous on the child and that this practice could potentially damage children's self-esteem by drawing attention to their weaknesses. Norwich and Kelly (2006) found that the perceived cognitive capabilities of the child could be a constraining factor as some participants suggested CYP might not understand the task or lack self insight. Difficulties in the communicative capabilities of the child were also highlighted as a constraining factor. The study is limited in terms of its generalisability to EPs' beliefs about consulting with children but highlights beliefs held by school staff and LEA officers that may constrain EP practices particularly when the work is commissioned by these organisations.

Alderson (2000) argued that in order to facilitate consultation with children practitioners working with children needed an awareness of and responsiveness to beliefs guiding practices and how they are positioned in relation to the children and young people they come into contact with.

2.3 A critique of current practice

Greig et al (2014) highlighted the need for authenticity and to go beyond tokenistic gestures when consulting with children. Armstrong et al's (1993) study highlighted children's views on the extent to which they were listened to and involved in the decision-making process when working with psychologists. Armstrong et al's (1993) findings from interviews with 29 children suggested that participants rarely believed a genuine attempt had been made to involve them in the assessment process and that lack of information on the purpose, process and outcomes had led to some children experiencing anxiety when working with educational psychologists. Armstrong et al (1993) found that the lack of information given to CYP about

EPs during a statutory special educational needs assessment process, led to them relying on their own assumptions and beliefs to guide them in interpreting this process, or relying on parents views which could also increase their anxieties. This study may lack relevance to the current statutory process, and may have limited generalisation to the present day, however, it highlighted the potential negative consequences of not consulting with children in decision-making concerning their education.

Lundy (2007) also argued that there needed to be better progress in involving children in matters that affected them with a recognised gap between the UK's international commitments to listen and involve children in decision-making, and what happened in practice in relation to educational decision-making. Lundy (2007) suggested that often children were asked for their views and then not told how they had been used in the decision making process or whether they had any influence or not.

Armstrong et al (1993) explored EPs practices in assessing special educational needs and found that educational psychologists used psychometric tests in assessment considerably but placed little emphasis on gaining the child's perspective and insight into their difficult experiences. Armstrong et al (1993) warned that distrust of psychologists intentions could lead to refusal to co-operate in assessments, although no evidence was offered for this inference. This argument was also expressed more recently by Ingram (2013) who suggested that battling against a child's resistance and refusal to co-operate was often counterproductive. Ingram (2013) argued that if adults perceived working with children as an opportunity to question their own assumptions which could be beneficial for EPs in helping them to gain insight into the child's background knowledge and assumptions and also empowering for children and young people.

Birnbaum (2015) suggested that less consideration was given to how to involve children at the pre-assessment or post-assessment stages of EP involvement. Birnbaum (2015) devised a pre-assessment letter to ensure children were informed about the assessment process and found that 75% of children liked to receive the letter, and a further 59% felt that the letter had decreased worries.

Mercieca and Mercieca (2014) suggested that listening to young children's views was often perceived as more problematic than listening to older children's views. Moss (2006) suggested that older children were consulted more often as they were considered more capable of expressing their views when compared to younger children whose development was often viewed by professionals as incomplete. Dexter et al (2011) interviewed child clinical psychologists and found that they viewed young children with a sense of otherness and held the belief that children become more influential the older they get. Dexter et al (2011) suggested that there was an underlying belief that the more adult-like they became, the more able they were to participate. The extent to which this belief is generalisable to EP's is questionable due to differing perspectives between EP's and clinical psychologists, which may influence the extent to which children are involved in the consultation process.

Dexter et al (2011) argued that using the developmental capabilities of CYP as a reason for not consulting with them avoided the responsibility to challenge power imbalances which exist between adults and children. Furthermore, Dexter et al (2011) suggested children's behaviour could be viewed as a within-child problem further disempowering a child who may already be in a position of relative powerlessness. Ingram (2013) stated that it was potentially most disempowering to assume children are not able to access their own views as they are not afforded a position from which to challenge EPs interpretations.

Ingram (2013) highlighted the dangers of interpreting children's views within theoretical frameworks which often assume a mismatch between the views of a child and an assumed objective truth; for example, a cognitive-behavioural approach may assume individuals make errors in thinking or develop irrational views leading to maladaptive behaviour. This may lead to views being ignored or not taken at face value which is potentially disempowering. Dexter et al (2011) suggested that consulting children helped to create a decentred account of problems which were not located in any single individual.

Ingram (2013) summarised the rationales for EPs consulting with children arguing that it:

- Supported CYP's rights to express views.
- Could be therapeutically beneficial.
- Views offered valuable insight contributing to problem-solving.
- Views could be considered as contributory factors to perceived problems.

Lundy (2007) argued that adhering to children's rights as outlined in Article 12 of the UNCRC (2012) fostered a positive school ethos and produced better citizens, but was also a legal and moral duty which should be embedded and integrated into practice.

In summary, commentary in this area of practice suggests that practitioners working with children should consider their beliefs regarding consulting with children, the power relationship existing between themselves as the adult and the children and young people they work with and the theoretical frameworks utilised in practice. Some beliefs and practices risk children's participation becoming tokenistic and are potentially disempowering for children, leading to further marginalisation of children's views .

2.4 Approaches and practices in consulting with children

There are a variety of approaches and practices used in consulting with children and the literature will be examined to evaluate the effectiveness of current practices. Ingram (2013) offered a useful overview of the theoretical stances and models in relation to children's views, evaluating the usefulness of each. An approach based on critical realismwas offered as most useful in supporting decision-making as it invited children to contribute views or theories about what is working well for them. Within this framework EP's are able to make interpretations which might go beyond the experience of the child to devise testable theories about what works for whom in what circumstances. Ingram (2013) does not offer commentary on the challenges EP's might face in gaining access to children's views and how to overcome them or the challenge of consultations with children, but does highlight how children's views can be used in a problem-solving framework.

Simmons et al (2015) demonstrated the value of involving CYP in activities that were not confined to individual assessments . They invited 606 CYP aged between 6 and 17 years of age to imagine, draw and discuss an ideal school that promoted their wellbeing. Simmons et al (2015) concluded that CYP produced rich, nuanced accounts which could be used to inform school improvement. This approach shared similarities with the Ideal Self; an activity derived from Personal Construct Psychology (PCP). Moran (2014) described a number of ways in which PCP has been developed as a way to capture the views of CYP on a number of different topics, such as the Ideal Classroom. In this particular example, the tool of drawing and discussion in focus groups was used to capture the views of CYP which could be collectively used to bring about organisational change which would enhance students' wellbeing.

Lundy (2007) offered an interpretation of how Article 12 of the UNCRC (2010) could be used as a model for practice. Lundy (2007) conceptualised children's rights in a number different

ways. The expression of a view was conceptualised as providing CYP with ‘Space’ or the opportunity to express a view. Lundy argued that children must be facilitated to express their views was conceptualised as ‘Voice’. The right to have views given due weight was conceptualised as ‘Influence’ to describe howthe view must be acted upon, as appropriate, and the conceptualisation of ‘Audience’ to describe how the view must be listened to. Lundy (2007) offers a useful model or framework for considering what needed to be done to honour children’s rights, however, the details and specific’s of how to obtain the views of children at different levels and with different needs is lacking.

Hobbs et al (2000) argued that we need to find ways to position ourselves so that we can hear children’s stories and so that these stories can challenge our own practice with them. Mercieca and Mercieca (2014) suggested that the Mosaic approach, devised by Clark and Moss (2001) supported practitioners in achieving this stance. The Mosaic Approach emphasises the process of dialogue, reflection and action in empowering participants to have a voice in changes that will affect them as well as encouraging adults to reflect on the limitations of their understanding of children’s lives. It offers specific practices that can be used to elicit children’s views such as the ‘Camera Tour’ and ‘Magic Carpet’ (further details can be found in table 2). The Mosaic Approach offers an in depth and detailed methodology for capturing the views of young children, however, in practice EP’s are likely to be constrained by time pressures and whether schools will commission EP’s to employ this method.

Table 2: The Mosaic approach (Clark, 2005):

Activity	**Description**
Observation	Qualitative data collected
Child interviewing	Short structured interviews conducted one to one or in a group
Photography and book making	Children’s photographs of ‘important things’ and books
Camera Tours	Tours of a place, such as school or home,

	directed and recorded by the children
Map making	2D representations of a place using children's own photographs and drawings
Interviews	Informal interviews with practitioners and parents
Magic carpet	slide show of familiar and different places

Mercieca and Mercieca (2014) agreed with Lundy (2007), arguing that practitioners needed to create space in order for children to be heard and that EP's should allow themselves to be surprised and allow the unexpected, rather than making assumptions about a child's lived experiences. There are a variety of methods available to EPs for consulting with children, which Ingram (2013) suggested was underpinned by an eclectic range of theories.

The degree to which consulting with children may be supported or constrained by an EP's beliefs and methods and approaches used in consulting with children, as identified by the literature will be described in this study in relation to EP's on a local level.

3. Research aims

Primary aim:

- To capture descriptive information on EP beliefs and practices relating to consulting with CYP at a local level.

Secondary aims:

- To explore EP views on supporting and constraining factors in consulting with children.
- To consider at the extent to which EP beliefs are conducive to consulting with children and are likely to support this practice.

- To consider the extent to which EP beliefs converge and explore possible reasons for divergence.
- To compare EP's use of various tools and methods for consultation.
- To explore the regularity of consulting with children in EP practice.
- To consider how practice might change with the context in which EP's practice.

4. Methodology

4.1 Descriptive study

The purpose of a descriptive study was described by Last (1988) as a study designed with the sole purpose of describing variables without considering causal hypotheses.

A descriptive study was chosen, in which quantitative and qualitative data would be captured in order to gain a representation of the beliefs and practices of Educational psychologists that would be useful for the purpose exploring what EP beliefs and practices were on a local level in order to encourage reflexive practice; for example, reflecting on EP views on constraints on consulting with children could lead to addressing these constraints in order to minimise them. Sandelowski (2000) commented that knowing a phenomenon or experience required us to know the facts about that phenomenon at the most basic level before we can explore a phenomenon further.

Sandelowski (2000) argued that descriptive studies involved an interpretation of data which was low inference, so was likely to result in easier consensus or agreement among researchers that the description is an accurate portrayal of the phenomenon. This approach is in contrast to more interpretive methods such as phenomenology and narrative study in which the data is interpreted to a greater degree resulting in the researcher moving further away from the data.

This transformation of the data may result in less consensus or agreement that the interpretation is an accurate description of the phenomenon as each researcher is likely to introduce bias, interpreting phenomenon through their own individual lenses. Sandelowski (2000) argued that descriptive summaries were valuable as end-products in themselves; for example, to answer questions of special relevance to practitioners and policy makers, and also as entry points for further study.

a. Method

Questionnaires were chosen in order to collect a large sample of data on a wide range of issues relating to the topic area; they are quick to administer and so more EPs were expected to have the time to participate in the study, compared to, for example, a method needing a longer time commitment from participants and it was more convenient for them to participate. A questionnaire allowed for a high degree of anonymity to help ensure more honest responses to questions of a more sensitive nature such as those relating to EPs beliefs about CYP, an advantage pointed out by Munn and Drever (1999).

A semi-structured questionnaire was used to collect data for this research, which comprised of statements and questions, including two open-ended questions (see appendix for questionnaire). Section A was comprised of two closed questions used to capture descriptive information such as whether they were qualified or a trainee EP and how many years they had been practicing. Section B consisted of statements 1 to 19 to which EPs were asked to respond on a rating scale to each statement, from strongly disagree (score of 1) to strongly agree (score of 6). Statements were adapted from statements offered by Alderson (2000) as discussion points to elicit professional's beliefs about children that might influence practice. Section C comprised of closed questions which were used in order to derive information on

EP practices in relation to working with CYP. Closed questions were chosen for this section for ease of comparison between respondents.

Most questions yielded quantitative description in order to obtain data on pre-selected variables. The two open-ended questions, however, were included in order to gain a fuller description of the factors influencing the practice of consulting with children and to validate and verify patterns that emerged from quantitative data, such as useful and supporting tools for consultation (see table1 for questions linked to research aims). Munn and Drever (1999) pointed out that open-ended questions could be used to develop respondents own ideas, allow the researcher to discover the unexpected and also challenge assumptions that may have been made.

Table 1: a table showing how sections and specific questions/statements met the specific information requirements to fulfil aims.

Primary aims	Secondary aims	Questions asked on questionnaire in relation to aims
Primary aim: to capture descriptive information on EP beliefs and practices relating to consulting with CYP.	To explore EP views on supporting and constraining factors in consulting with children.	Section C: *'What difficulties have you encountered in consulting with children? Please indicate factors that reduce the extent to which you consult with children or prove to be challenging in consulting with children.'* *'What factors support you in consulting with children? Please indicate factors that facilitate consultation with children or factors you have found useful in consulting with children.'*
	To consider at the extent to which EP beliefs are conducive to consulting with children and are likely to	Section B- statements about beliefs concerning CYP responded to on a rating scale (i.e. strongly agree, agree,

	support this practice.	somewhat agree, somewhat disagree, disagree and strongly disagree)
	To consider the extent to which EP beliefs converge and explore possible reasons for divergence.	Section A and B data analysed to explore if patterns of responses to section B are linked to data obtained from section A.
	To compare EP's use of various tools and methods for consultation.	Section C open-ended question*: 'What factors support you in consulting with children? Please indicate factors that facilitate consultation with children or factors you have found useful in consulting with children.'* Closed question*: 'What methods do you use to consult with children?'*
	To explore the regularity of consulting with children in EP practice.	Section C: Closed question: *'How regularly do you consult with children?'*
	To consider how practice might change with the context in which EP's practice.	Section C: Closed questions: *'At what stage (s) do you tend to consult with children as part of **commissioned** work?'* *'At what stage (s) do you tend to consult with children as part of **statutory** work for EHC's?'*

4.3 Sample

Participants comprised of EP's from an Educational Psychology Service in the East Midlands who attended a County EP meeting in April 2015. This purposive sampling method did not result in a random sample, however, researcher bias influencing sample selection was avoided as the researcher did not know who, of the 40 team members, would turn up to the meeting.

Sandelowski (2000) suggested that a purposeful sampling technique was well-suited to descriptive studies as it enabled the researcher to obtain cases considered as information-rich for the purposes of study. A purposive sampling technique could be defended in this case as it resulted in a number of participants which represented over half of the EP's in the service (55%), enabling the researcher to capture more descriptive information on EP's beliefs and practices on a local level, which was likely to be more representative than if another method had been employed that may have resulted in a smaller sample size. Twenty-three of a total of forty EP's attended the meeting, of which twenty-two agreed to participate (96%).

4.4 Ethics

The British Psychological Society's (BPS) Code of Ethics and Conduct (2009) was used as a guide to making ethical decisions for this study. The study was introduced to the participants with an oral description of the study's purpose and what was expected of participants if they chose to participate. Participants were asked to read the information provided in written form to ensure consent was informed (see appendix). EPs were ensured anonymity and confidentiality and the right to withdraw at any time and had the opportunity to take the questionnaires away with them to fill out (or not). Participants did not have to hand the completed questionnaire to the researcher but added the questionnaire to a pile at the back of the room to ensure privacy.

4.5 Administration

The questionnaires were administered whilst the researcher was present in the room so that the researcher could answer queries and assess the extent to which the questionnaire was easy to complete and unambiguous, in the absence of a pilot study. A pilot study was unable to be carried out due to time restraints. EPs appeared to find some statements in 'Section B'

ambiguous and so in consideration of this feedback and on further reflection the statements 9, 10, 12 and 16 were omitted from analysis. EP feedback during administration is discussed further in the Discussion section.

5. Findings

5.1 Descriptive Statistics

The sample consisted of 22 members of the Educational Psychology Service, of which 18 were fully qualified Educational psychologists (EPs) (82% of total sample) and 4 were Trainee Educational psychologists (TEPs) (18% of total sample).

The majority of the sample had been practising Educational Psychology for 15-24 years (36.4%) with the smallest proportion of the sample having practiced for 25 years and over (13.6%) (see table 2).

Table 2: a table representing number of years of practice for EPs in the sample

Number of years practicing	Frequency	Percent
1-5	6	27.3
6-14	5	22.7
15-24	8	36.4
25+	3	13.6

5.2 Educational psychologists' beliefs in relation to consulting with CYP

Responses to fifteen questions from section B (Questions 1-8, 11, 13-15, 17-19) were analysed, of which six were reverse scored (Questions 11, 13, 14, 15, 17, 18, 19), giving a total maximum score of 90.

Table 3: a table showing range and variance of responses to questions in section B

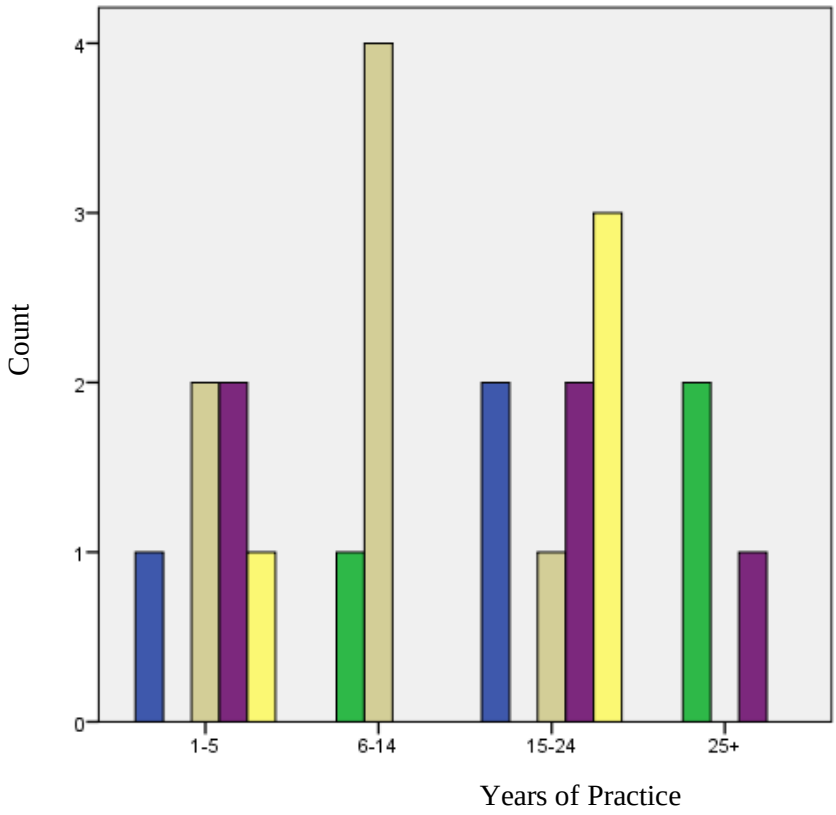
Question	Range	Variance
1	1	0.87
2	2	0.398
3	2	0.303
4	2	0.444
5	1	0.253
6	1	0.184
7	2	0.539
8	2	0.614
11	2	0.348
13	3	0.719
14	3	0.748
15	2	0.433
17	4	1.680
18	3	0.894
19	3	0.714

The median of participants total scores was 77.5 with a range of 15. A skewness score of 0.076 (below cut off point of 1) indicated that scores were not significantly skewed suggesting that scores were evenly spread across this range.

Questions 1-8 produced the least amount of variance in scores with a range of 2 (either scoring 5 (Agree) or 6 (Strongly agree)) for statements relating to giving a child a voice and consulting with them. This suggests that participants beliefs were convergent and supportive of consulting with children.

Questions 11, 13-15, 17-19 were associated with beliefs that might possibly constrain the extent to which participants consulted with children. Participants scores on questions 13, 14, 17, 18 and 19 varied to a greater degree when compared to variance in questions 1-8, with the greatest variance produced by question 17 '*Children need to feel that adults have total control- even if we do not'* (variance = 1.680, range = 4) (see table 3).

The possibility that scores on question 17 were associated with the other variables (how regularly EPs consulted with children, years of practice and whether they used more than one method for each child) was explored using the multi-dimensional chi-square test. Multi-dimensional chi-square tested for the strength of association between scores on question 17 and how regularly they consulted with children (X^2=3.111, p=0.539) and how regularly they used more than one method to consult with children (X^2=4.421, p=0.352), with results indicating no significant associations. The multidimensional chi-square test was used to test the hypothesis that years of practice was associated with the extent to which participants agreed or disagreed with this statement (see figure 2). The level of significance, or p value, was 0.06 which was greater than the rejection threshold of 0.05 so I cannot be sure enough that the strength of the association was not down to chance. It was concluded, therefore, that no significant relationship was found between years of practice and scores for question 17 (X^2=20.383, p=0.06) although the association appeared stronger between years of practice and question 17 scores, as 0.06 was close to the rejection threshold.



Key: bars represent scores for question 17 (blue=agree, green=somewhat agree, grey= somewhat disagree, purple=disagree, yellow=strongly disagree)

Figure 2: A chart representing pattern of responses to question 17

5.3 Educational psychologists' practices in relation to consulting CYP

5.3.1 Stage at which CYP is consulted

The stage at which EP's consulted with CYP tended to be fairly stable across commissioned and statutory work. EPs consulted with CYP most regularly in assessment stage of involvement (statutory assessment stage = 85.7%, commissioned assessment stage=90.5%, see table 4). Slightly more EPs appeared to work most regularly with CYP during the pre-assessment stage for a statutory assessment when compared to a commissioned assessment. EPs appeared to consult with CYP's more regularly during the post-assessment stage than the pre-assessment stage; for example 83.3% indicated they worked lest regularly during commissioned pre-assessment compared to 27.8% at commissioned post-assessment.

Table4: Stages at which children are consulted during statutory and commissioned work

	Percentage of EP's (%)					
Ranking	Statutory Pre-assessment	Commissioned pre-assessment	Statutory assessment	Commissioned assessment	Statutory post-assessment	Commissioned post-assessment
1-most regularly	16.7	11.1	85.7	90.5		
2	5.6	5.6	14.3	9.5	61.1	72.2
3-least regularly	77.8	83.3			38.9	27.8

5.3.2 How regularly to EP's consult with CYP?

EPs responses suggested the majority consulted with 'most' children they worked with (57.1%) with the remaining EP's indicating that they consulted with 'every' child they worked with (see table 5).

Table 5: regularity at which EP's consult with children

Regularity of practice	Percentage of EP's (%)
With every child I work with	42.9
With most children I work with	57.1
From time to time	-
Rarely	-

5.3.3 Methods used to consult with CYP

Verbal methods were given the highest rankings (median = 1.00), with scaling (median = 3.00), Personal Construct Psychology (PCP) (median = 4.50), visuals (median =5.00) and Pupil Involvement Group (PIG) resources (median = 5.00) also ranking in the top 5 positions.

Methods such as letters (median = 9.00), reports (median = 9.00), All About Me worksheets or similar (median = 9.00), another adult (median = 7.50) and smiley faces (median = 6.50) were given relatively lower rankings (see table 6).

Table 6: Methods used to consult with children

percentiles	Letter	Report	Verbal	Smiley faces	Scaling	Visuals	PIG resources	PCP	All about me	Another adult
25	6.00	7.75	1.00	4.75	2.75	3.00	2.00	2.75	5.75	5.00
50	9.00	9.00	1.00	6.50	3.00	5.00	5.00	4.50	9.00	7.50
75	10.25	11.00	1.00	11.00	4.25	6.00	8.50	8.00	11.00	11.00

Some EPs responded to the prompt for 'Other' methods used and reported that they used other methods that were not listed. The number of EPs who mentioned 'other' methods used is indicated in brackets following the method they reported to use; cue cards (1), questionnaires (6), solution focused resources (2), motivational interviewing (1).

90.5% of EPs responded 'yes' to the question of whether they used more than one method with each child they consulted.

5.3.4 Supporting Factors

Written responses to the question '*What factors or tools support you in consulting with children? Please indicate factors or tools that facilitate consultation with children or factors or tools you have found useful in consulting with children?*' were analysed and organised into themes.

- Tools: specific tools and methods for consulting with CYP were mentioned by sixteen out of twenty-two EP's 43 times with many EP's mentioning more than one tool for

consultation. Of the 43 times tools mentioned Personal Construct Psychology was mentioned 8 times (18.6%). Use of visuals were mentioned 7 times (16.3%), Pupil Involvement Group resources 5 times (11.6%), Solution Focused tools 5 times (11.6%), self-reports (questionnaires, checklists etc) 4 times (9.3%) and PCP once (2.3%) (could not be sure if EP was referring to Personal Construct Psychology or Person Centred Planning as used the abbreviation giving no indication of which one they were referring to). A number of other tools were mentioned including drawings, letters and scaling making up the remaining third of responses.

- EP skills: Seven EP's mentioned the usefulness of approaches or strategies dependent on the EP's abilities, knowledge and consultation skills, such as ability to establish a rapport, make the CYP feel at ease, adapting resources to meet the needs of the CYP and good listening skills.
- Joint working: references to joint working were made by four out of 22 EP's and the usefulness of involving others, e.g. school staff, in preparing the CYP for meeting EP's and gathering information indirectly on the CYP's views.
- Giving CYP information: three EP's made references to the usefulness of giving relevant information to the CYP to facilitate their participation, such as explaining the role of an EP, explaining what information we hope to gather and providing feedback to CYP.
- Space and place to hear views: an appropriate physical place in which to hear CYP's views was mentioned on a few occasions as were references to creating space for CYP's to express views by invitation, by speaking to the CYP in a respectful manner and by ensuring CYP are not coerced into giving their views.
-

5.3.5 Constraining Factors

Written responses to the question '*What difficulties have you encountered in consulting with children? Please indicate factors that reduce the extent to which you consult with children or prove to be challenging in consulting with children.'*

- Time: lack of time was the predominant theme derived from responses to this question. Twelve of the twenty-two EP's stated time pressures as a challenge to practice in this area.
- CYP engagement: nine EP responses were organised into this theme, linked to the extent to which CYP's were willing to engage with EP's in order to work with them, such as the CYP not wanting to meet with them, being suspicious or anxious of meeting an EP and reluctance to share their views.
- CYP's special educational needs: A number of EP's referred to the challenge of consulting CYP with certain special educational needs; eight EP's stated verbal needs and/or communication skills, two EP's stated CYP with Profound and Moderate Learning Difficulties (PMLD) and two EP's stated CYP with complex needs as challenging.
- CYP's age and stage of development: responses that mentioned the CYP's age and stage of development were organised into this theme, although there is some overlap between this theme and the preceding theme. Responses that made reference to the level of understanding due to age and maturity of CYP were included, with younger children being mentioned most often as challenging to consult with.

- Three responses referred the CYP's level of understanding and /or cognitive abilities. This could either be related to the child's age and stage of development or to the special educational needs of the CYP.
- Three responses made reference to the EP's confidence in consulting with CYP.
- Value placed on the CYP's Voice: seven EP's responses were organised under this theme and many made reference to the value other's placed on the CYP's Voice influencing consultation with children; for example, CYP's not being invited to meetings and schools being reluctant to commission time from EP's to consult with children.
- Place to hear views: this theme overlaps with the 'Space and place to hear views' theme under the preceding section, which gives it further weight in considering factors surrounding consulting with children. Two EP's mentioned difficulties finding an appropriate place for consultation; for example, access to a private space.

6. Discussion

The majority of EPs beliefs on consulting with children were convergent and supportive of this practice. More divergence in responses was found in relation to statements about protecting children. The greatest variance was found in relation to the statement, 'Children need to feel that adults have total control even when they do not'. A stronger agreement with this statement could constrain the practice in consulting with CYP, as suggested by Alderson (2000) and Norwich and Kelly (2006). EP responses would need to be explored in greater depth in order to illuminate possible reasons for why beliefs varied in relation to this question.

EP's tended to consult most regularly with CYP during the assessment stage of case work across both contexts of statutory and school-commissioned work.

The majority of EPs consulted with 'most' children they worked with; reasons for not consulting with every child need to be explored further to check that in the cases in which the CYP is not consulted this course of action is justifiable. A strength of EP practice was that EPs indicated they either consulted with every child or most children they came into contact with.

Verbal methods of consultation ranked most highly as methods used by EPs in consultation. This could highlight the dependence EPs have on verbal methods but it is unclear from the responses whether EPs use verbal methods alongside other modes of communication to support understanding, which could explain the high percentage of EPs who indicated that they used more than one method with each child they worked with.

Some of the themes that emerged from analysis of responses to open-ended questions relating to supporting factors can be linked with the literature. The theme 'Giving CYP information' is in support of Birnbaum's (2015) findings which suggested that children liked to be informed and that this led to decreased worries associated with meeting EP's. It is also linked to Armstrong et al's (1993) findings that lack of information could lead to increased anxiety. Giving CYP more information might help CYP engage to a greater extent in consultation, which may be of relevance as student engagement was identified as a constraint to consultation in responses to the open-ended question on constraints. The theme, 'Space and place' to hear views supports Lundy's (2007) recommendation to provide CYP with opportunities to express their views.

A significant barrier to consultation, as identified by a theme that emerged from analysis of responses to the question regarding constraints, was that of a lack of time to consult with children. This could be linked to the theme, 'Value placed on the CYP's voice' as schools who place a greater value on consultation CYP may be more willing to commission an EP to involve CYP in this way. Other barriers included the challenge of enabling the views of younger children and those with needs which impacted on their ability to understand and communicate. Norwich and Kelly (2006) also found school staff perceived it as more challenging to consult with children with these needs, but stressed the importance of finding alternative and adapted methods to communicate with these CYP.

6.1 Limitations

The descriptive nature of this study limits what can be learned from the meanings participants attribute to consulting with children and reasons underlying their beliefs and practices. Grimes and Schulz (2002) described good descriptive studies as those that report on the five 'W' questions- who, what, why, when and where. This study produced a description of what EP's beliefs and practices were, however, the description could have been extended to include more description on why tools were chosen, in what contexts and for whom; for example, some tools may have been chosen over others due to consideration of the CYP's needs, developmental stage and age.

Grimes and Schulz (2002) also suggested that descriptive studies should have a clear, specific and reproducible case definition for the phenomenon being studied. The definition for consultation with children derived from the literature could have been shared with participants to ensure that there was a shared understanding of what the questions related to and so that if

the study was reproduced, one could ensure that consultation with children was defined by participants using the same criteria. This would increase the validity of comparisons made.

As a random sample of participants was not taken, findings can't be statistically generalised to the EP population as a whole. The study could be replicated, however, to see if the same results would be obtained with other EP's. In this way, a theory of EP's beliefs and practices on consulting with CYP can be developed; an approach described by Yin (2009) as analytical generalisation.

There were some methodological limitations to my study which pose a threat to the validity of some of my findings. Some terms used in the questionnaire could have been more clearly and explicitly defined and shared with the respondents to avoid the assumption that the researcher and participants would attribute the same meaning to phenomenon; for example, EP comments on the questionnaire suggested that the term 'pre-assessment' had different meanings for different EP's. Furthermore, EPs may not have conceptualised the terms 'consulting children', 'consultation with children' and the 'Child's Voice' in the same way, threatening the validity of the researcher's interpretations of responses to items on the questionnaire. Some EP's commented on the ambiguity of some of the statements on beliefs about children and that some of the statements would have been less ambiguous if split into two parts; for example, the statement 'To consult young children is to confuse and worry them. Adults should care for children by not passing responsibility onto them'. Some statements were omitted from analysis to address this issue. The statements were derived from Alderson (2000) and had been intended for focus group discussion so perhaps needed to be adapted further for use in a questionnaire.

6.2 Future directions

Future directions for research in this area was summarised with the following bullet points:

- Exploring why certain tools or methods are used and for whom they are appropriate for.
- Exploring how methods and tools are adapted for children of varying ages and developmental stages, with varying needs.
- A more in depth examination of the beliefs of EP's, to illuminate possible constraining beliefs professionals may hold.
- Further refinement of questionnaires used to gather information from professionals on this topic.
- A consideration of the role of age and developmental stage of CYP and how this might influence beliefs and practices in consulting with children.

7. Conclusion

The practice of consulting with children has relevance for EPs as it can help to bring about positive change for the CYP we work with and can ensure that the rights of the child are honoured. The profile of the child's voice has been raised both internationally and nationally with implications for all professionals involved in making decisions in the best interests of CYP. The study findings suggest that on this local level, EP's beliefs would mostly support consultation with children and that most CYP are consulted with. The study highlights a number of constraining factors, linked to the perceived capabilities of some CYP to express their views, but also to the wider context in which EPs work. Further exploratory research in this area is needed to capture the complexity of this phenomenon.

Words: 6235

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Appendix: Information and consent form followed by questionnaire used to gather information

Project on consulting with children

Dear Colleague,

I am conducting a small-scale piece of research into Educational psychologist's practices in consulting with children.

The questionnaire that follows will be used to explore this under-researched area. Please can I invite you to spend a short time in its completion?

If you are willing to be involved, please complete the questionnaire and return it to me by April 30th.

The questionnaire will take around 15 minutes to complete. You do not need to write your name and all data will be anonymised so you will not be able to be identified or traced from your responses.

I will use this information to produce a written assignment, which will be submitted as part of my doctoral course. After this, I would happy to discuss my findings with you.

You are under no obligation to participate in this piece of work and you have the right to withdraw from the study at any time.

If you wish to discuss any aspects of the study then please do not hesitate to contact me.

I very much hope you will be able to participate. May I thank you, in advance, for your valuable co-operation.

Yours sincerely, Janet Anyika

☐ Yes, I wish to participate in this study

☐ No, I do not wish to participate in this study

Questionnaire: Consulting with children

Section A

Please tick next to the response that applies to you

Are you a Trainee Educational psychologist or a fully qualified Educational psychologist?

Trainee Educational psychologist	
Educational psychologist	

How many years have you been practicing in this profession? (Please include year (s) of training- this applies to both TEP's and EP's)

1-5	
6-14	
15-24	
25+	

Section B

The following section of the questionnaire asks questions about beliefs you have about consulting with children. Please answer the questions to the best of your ability and be as truthful as possible. There are no right or wrong answers. Circle the numbers to indicate whether you:

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6

	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
1. Children, like adults have the right to be consulted and to express their views	1	2	3	4	5	6
2. To consult children is part of the duty of care we have towards them. Part of responsible adult care is to be willing to explain to children and be accountable to them	1	2	3	4	5	6
3. To consult children is to respect them	1	2	3	4	5	6

4. We can give more effective care if we use information from children	1	2	3	4	5	6
5. Talking together while making decisions can help to prevent misunderstandings or disagreements, and children becoming anxious or resisting help	1	2	3	4	5	6
6. Children who feel respected are more likely to respect others	1	2	3	4	5	6
7. Children are more committed to decisions when they have been agreed with them	1	2	3	4	5	6
8. It is educational to consult with children as they will learn important skills from the process, such as expressing their ideas, decision-making and to know how to question and disagree politely	1	2	3	4	5	6
9. Children have the right to be protected by adults and to rely on them, it is wrong to encourage them to question adults views	1	2	3	4	5	6
10. The child's best interests are paramount and only adults understand these	1	2	3	4	5	6
11. Children's views are unreliable and so therefore, can't be fairly represented	1	2	3	4	5	6
12. To consult young children is to confuse and worry them. Adults should care for children by not passing responsibility on to them	1	2	3	4	5	6
13. Young children do not have clear sensible views to express	1	2	3	4	5	6
14. If children and adults disagree, children must realise that adults know best	1	2	3	4	5	6

15. It is unfair to parents if professionals teach children to expect to be consulted	1	2	3	4	5	6
16. Pretending to consult children risks raising false expectations, children will then be disappointed	1	2	3	4	5	6
17. Children need to feel that adults have total control- even if we do not	1	2	3	4	5	6
18. Children can't make informed decisions because they haven't developed the thinking skills to do this	1	2	3	4	5	6
19. Children will become responsible adults if they are set firm examples of responsible adult control	1	2	3	4	5	6

Section C

Please tick next to the response (s) that apply to you

At what stage (s) do you tend to consult with children as part of **commissioned** work? Please rank the following stages from 1 to 3 (1 = consult with children most regularly during this stage, 3 = consult with children least regularly during this stage)

Pre-assessment (before you begin to gather information for assessment purposes)	
Assessment (at the stage in which you are gathering information as part of an assessment)	
Post-assessment (after you have finished your assessment)	

At what stage (s) do you tend to consult with children as part of **statutory** work for EHC's? Please rank the following stages from 1 to 3 (1 = consult with children most regularly during this stage, 3 = consult with children least regularly during this stage)

Pre-assessment (before you begin to gather information for assessment	

purposes)	
Assessment (at the stage in which you are gathering information as part of an assessment)	
Post-assessment (after you have finished your assessment)	

How regularly do you consult with children? Tick one of the statements that applies to you most

With every child I work with	
With most children I work with	
From time to time	
Rarely	

What methods do you use to consult with children? Please indicate which methods you use and how regularly by ranking the methods you use (1 = I use this method most regularly, with increasing number indicating decreasing use)

Letter	
Report	
Verbal discussion with child	
Smiley faces	
Scaling questions	
Visuals	
Pupil Involvement Group resources	
Personal Construct Psychology	
All About Me worksheet or similar	
Ask another adult to consult with the child on my behalf (e.g. SENCO, teacher, parent)	

Other (Please specify):

_____

_____

Do you regularly use **more** than one of the above methods for **each** child you work with?

Yes	
No	

What difficulties have you encountered in consulting with children? Please indicate factors that reduce the extent to which you consult with children or prove to be challenging in consulting with children.

_____
_____
_____
_____

What factors support you in consulting with children? Please indicate factors that facilitate consultation with children or factors you have found useful in consulting with children.

_____
_____
_____
_____

Any other comments?_____
_____
_____

Many thanks for your participation