PROFESSIONAL PRACTICE REPORTS

by

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Chapter 1

Introduction and Overview

As a Trainee Educational Psychologist (TEP) at the University of Birmingham, a requirement of the Applied Educational and Child Psychology Doctorate programme is a two-year supervised placement within a Local Authority Educational Psychology Service (EPS). During this time, alongside meeting the demands of my role as a TEP, I conducted research which would form the basis of my doctoral Thesis. The Thesis is in two parts. The first volume comprised an original piece of research, using a Realistic Evaluation framework to consider effective practice within Nurture Groups. This second volume includes several smaller studies, presented as four professional practice reports (PPRs), all completed during supervised fieldwork within the employing Local Authority (LA).

1.1 EPS Context

I secured my placement for years 2 and 3 at a LA in a large non-metropolitan county, in the West Midlands, Coalshire[1]. I worked as a TEP in the south area, under the supervision of two experienced Educational Psychologists (EPs), one the Senior EP for the team. During my second year I was the visiting EP for nine settings including; one high school, seven primary schools, and a pre-school speech, language and communication unit. Additionally, in my third year, I was involved in a wide range of statutory work with pre-schoolers, and cover work for our team.

[1] Coalshire will be used as a pseudonym for the employing Local Authority.

Coalshire EPS, until recently, also offered alongside our commitment to training, individual casework and statutory work, a ‘project’ service to schools. Schools could ‘bid’ for additional EP time, at no cost (other than a time commitment) to themselves. Two EPs would then be involved in planning, delivering and reviewing project work. Some examples I was involved with included: establishing a self-maintaining SENCo cluster; supporting the set up and running of a high-school Nurture Group; running parenting workshops alongside family support workers; and an ‘Appreciative Inquiry’ with children as researchers (see PPR 2).

1.2 Overview and rationale for Professional Practice Reports

The University gave direction on structure and broadly on content of the PPRs, I was then able to select cases or projects that aligned with this guidance, tailoring them where necessary to fit with opportunities available within my EPS. The PPRs included in this volume highlight some of the work I have been involved with as a TEP, affording me the opportunity to reflect on this work in depth and detail.

1.3 Professional Practice Report 1

As one of the ‘most vulnerable groups in society’ (DCSF, 2009), Looked After Children (LAC) are a priority for all EPSs. This report provides an analysis of Coalshire LA’s work to raise the educational achievement of children in the Looked After sector. Firstly, what is meant by LAC and Raising Achievement is discussed, and how this relates to national policy and research. Secondly, the relationship between this field and the work of EPs is

explored. Finally, I examine how Coalshire LA strives to raise the educational achievement of this group, with reference to the national context.

This PPR, alongside an Enquiry Based Learning opportunity (where I visited and reported on a local residential Children's home) formed the basis of discussion at University and with Coalshire colleagues about the complex and challenging needs of these frequently marginalised children. As a significant proportion of my casework in Coalshire has been with this population, I found the chance to examine theory and contemplate their needs more fully, informative and highly relevant to practice.

1.4 Professional Practice Report 2

Appreciative Inquiry (AI) originated in the 1980s as a corporate organisational change model in the United States of America (Cooperrider *et al*, 2008). AI shares a similar philosophical basis to that of solution-focused approaches. With its focus on positives, it can help an organisation investigate and build on their strengths (Hammond, 1996). As an educational tool AI is still in its infancy (Lewis, 2010). Its principles, however, have been used in studies relating to pedagogy (Yballe and O'Connor, 2000), student involvement (Morsillo and Fisher, (2007), teacher development (Clarke *et al*, 2006), and professional teams (Van Vuuren and Crous, 2005).

A Coalshire colleague was considering using AI as a methodological framework for her doctoral research, and as part of an EPS 'project', she planned to use AI with a mixed

Year 3 and 4 class, in one of her primary schools. The aim was to use an AI framework to investigate how 'talking and listening' in school could be improved. Whilst the broad focus of 'talking and listening' was donated by the teacher, the rest of the project involved the children, my EP colleague, the teacher and me participating in a genuine inquiry regarding the children's best experiences of talking and listening. Our goal was to develop the children's ideas and dreams into new ways of functioning in the classroom (Lewis, 2010). This PPR describes the AI process, the project, and considers how an AI approach - with children as researchers - aligns well with the right of children to be heard, enshrined in legislation like the Children Act (1989 and 2004), Every Child Matters (DfES, 2004) and Articles 12 and 13 of the UN Convention of Rights (1989). The project was evaluated by the children, using an on-line questionnaire.

1.5 Professional Practice Report 3

My third PPR relates to my final PPR and it aims to consider the evidence-base regarding therapeutic interventions, specifically Cognitive Behavioural Therapy (CBT) in EP practice. Though small when compared to evidence from adult populations, there is now mounting evidence for the effectiveness of CBT with children and young people (Fonagy *et al*, 2005). The evidence regarding the use of CBT with specific populations is also discussed e.g. children or young people with autism. Again, there is growing evidence for the effectiveness of CBT with young people on the Autistic Spectrum (Bauminger, 2002; Fitzpatrick, 2004; Sofronoff *et al*, 2005), albeit often with certain

programme modifications to address the specific needs of this group (Greig and MacKay, 2005; Sze and Wood, 2008).

I chose this focus as the use of therapeutic interventions by EPs is a particular area of interest for me, and it is of particular relevance given the recent coalition Government's mental health strategy where they plan to extend "access to psychological therapies to children and young people...using NICE-approved and 'best evidence'-based therapies" (DoH, 2011, p3). The article concludes that EPs are well positioned and well equipped to deliver CBT, but that strategic and organisational considerations currently mean many EPs are missing Greig's (2007) 'golden opportunity' to use this well evidenced intervention in school settings, and current application of CBT may risk superficiality.

1.6 Professional Practice Report 4

The final PPR provides a case study of a longitudinal, therapeutic intervention, conducted from March 2010 – November 2010 (although consultancy with the school and parents has continued to the present day). The work evolved from involvement in the statutory assessment of the Special Educational Needs of a Y9 pupil, Anna. Anna was returning to my mainstream high school, following a period of prolonged hospitalisation.

Anna has a complex case history, initially presenting with physical symptoms associated with problems with the Urino-genital system, culminating in admission to a local city

hospital due to incontinence and considerable mobility problems. Over a year of significant exploration of organic causes of her condition followed, coupled with extensive school absence. Once this search was exhausted, Anna was eventually admitted to a major city's Children's Hospital in February 2009. At this stage Anna was wheelchair bound, doubly incontinent and significantly low in mood. Anna was initially diagnosed with 'acute conversion disorder and autonomic and secondary depressive symptoms', but following referral to the Psychology department and a Speech and Language team, further assessment established a diagnosis of Autistic Spectrum Disorder (ASD), specifically Asperger Syndrome (AS) in January 2010.

While the impetus for EP involvement was the statutory assessment process of Anna's special educational needs, first contacts with Anna and her mother, and the Consultant Clinical Psychologist (CCP) within the hospital setting Anna had been attending, indicated that Anna would like to do some further work to address her school-based anxiety. This led me to commence therapeutic work with Anna in the school setting, building on work initiated in the clinical setting. This paper seeks to contribute to the evidence-base regarding the use of CBT with girls with AS, as there is minimal research regarding females with AS, especially adolescent females (Beteta, 2008). Indeed, they are described as "*research orphans*" (Bazelon, 2007).

Additionally, the importance of case formulation is considered. Case formulation is seen as central to the successful treatment of complex cases, as it addresses the complex "interplay between multifaceted causative and maintaining factors" (Tarrier, Wells and

Haddock, 1998, pxiii). For Anna, with a complex personal and familial history and the diagnostic classification of AS, this approach provided a robust framework and facilitated collaborative theory building, to ensure that Anna's needs were understood and intervention was appropriately personalised.

1.7 Conclusion

In these PPRs I have sought to make an original contribution to knowledge by exploring relatively under-researched methodological frameworks (e.g. AI) or research areas (e.g. CBT with females with Asperger syndrome), reflecting on and adding to the existing evidence-base. As TEPs we are in a fortunate position where we are encouraged to develop not only our professional practice, but our skills as practitioner-scientists contributing to original knowledge. These PPRs aim to demonstrate theoretically grounded, evidence-based practice and my critical reflections regarding this work. Given the government's increasing call for evidence-based practice and focus on 'what works' (Burton *et al*, 2006), the over-arching narrative, linking Volume 1 and these PPRs, is my on-going interest in what is meant by 'evidence', and how evidence can be used to inform and shape EP practice.

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Chapter 2

An analysis of Coalshire Local Authority's work to raise the educational achievement of children in the Looked After sector, including reference to the relationship between this field and the work of Educational Psychologists.

Abstract

As one of the 'most vulnerable groups in society' (DCSF, 2009), Looked After Children (LAC) are a priority for all EPSs. This chapter provides an analysis of Coalshire[2] LA's work to raise the educational achievement of children in the Looked After sector. What is meant by LAC and Raising Achievement is discussed, and how this relates to national policy and research. The relationship between this field and the work of EPs is explored. The chapter concludes by examining how Coalshire LA strives to raise the educational achievement of this group, with reference to the national context.

2.1 Introduction

> *"The true measure of a community's standing is how well that it attends to its children – their health and safety, their education, and sense of being loved, valued and included in the families and communities into which they are born."*
>
> UNICEF 2007 (in Cameron and Maginn, 2009, p7)

One of the 'most vulnerable groups in society' are children in Local Authority care, described as 'looked after' under the Children Act 1989 (DCSF, 2009b). The statistical

[2] Pseudonym

forecast for this group is bleak. Jackson and Simon (2005) describe how they are far more likely than others to require mental health services, have special needs, misuse drugs or alcohol, end up in prison, become homeless and have children themselves in need of public care. Many children taken into care come from a 'background of family crisis and trauma', with ensuing implications for learning, behaviour and success in school (OFSTED, 2001). Initially, family difficulties will have put these children at risk, but wider systemic failures also contribute to poor outcomes (Jackson and McParlin, 2006).

For too long, responsibility for the disadvantage faced by children in care, was primarily attributed to within-child and familial factors, rather than seen as rooted in systemic failures within education and care systems (Jackson and McParlin, 2006). Jackson and McParlin (2006) argue that poor outcomes for children in care can be "confidently linked to educational failure", with "heavy responsibility" resting with care and education systems (p90).

The 1995 joint report by the Social Services Inspectorate and OFSTED, concluded both the care and education systems were 'failing to promote educational achievement' of children in care (in OFSTED, 2001). Norwich *et al* (2008) describe how poor educational outcomes of this susceptible group have been at the "centre of a policy initiative" since Labour's election in the late nineties (p123; DfES, 2000; Social Exclusion Unit, 2003; DfES, 2007b). Growing concern for and awareness of this vulnerable group has culminated in much Government legislation, which either addresses their needs as part

of a wider agenda for children (The Children Act, 1989 and 2004; DfES, 2004) or specifically focuses on them (e.g. DfES, 2000; DfES, 2007a; DfES, 2007b; Brodie *et al*, 2009).

Firstly, this assignment describes what is meant by Looked After Children and Raising Achievement, and how this relates to national policy and research. Secondly, the relationship between this field and the work of Educational Psychologists is discussed. Finally, it examines how Coalshire Local Authority (LA) strives to raise the educational achievement of this group, with reference to the national context.

2.2 Looked After Children, Raising Achievement and the National Context

2.2.1 A Vulnerable Group

The Children Act (1989) reformed laws relating to children, establishing the idea that children's welfare was paramount and introducing new terminology for children previously known as being 'in care' (Fletcher-Campbell, 1997, p7). It outlined the duty of Local Authorities (LAs) to "safeguard and promote the welfare of children within their area who are in need" (Section 17 (1) (a)). 'Children in need' include children 'looked after' by the LA, more commonly referred to as 'Looked After Children' or LAC. This terminology encompassed all children who are subject to care orders and those 'accommodated' by the LA, including all children for whom the LA has any responsibility (Fletcher-Campbell, 1997, p7). Where a child is subject to a care order, parental

responsibility is shared between parents and the LA. For accommodated children, parents retain primary responsibility, whilst LAs also have responsibilities as 'corporate parents'[3] (OFSTED, 2001).

The terms 'Children in Care' (CIC), 'Children in Public Care' and 'Looked After Children', are transposable and in common usage, with, 'Looked After Children' (LAC) apparently more frequently cited by agencies, researchers and other professionals. Notably, some children and young people in question have expressed 'Children in Care' as the preferred term (Norwich *et al*, 2008). The terms 'Looked After Children' and 'Children in Care' will be used interchangeably throughout this assignment.

At any one time approximately 60,000 children are 'looked after' in England, with around 90,000 passing through the care system in any year (DCSF, 2009c). Nevertheless, relative to the rest of the school system, CIC are a small group, with an uneven distribution (Jackson, 2000). This creates challenges for the system appreciating their needs and "having the capacity to respond to them as children with additional needs" (Norwich *et al*, 2008, p123). Many schools have few or no children in care (Cairns and Stanway, 2004); suggesting many teachers will have little or no experience of working with LAC. Most LAC have experienced a background of either family breakdown, neglect, abuse, rejection or a combination of these (Cairns and Stanway, 2004). All have experienced separation from their families and significant loss (Cairns and Stanway,

[3] The term 'corporate parent' is not without contention, and will be discussed in section 2.2 (Garrett, 2003).

2004, p2), with ensuing implications for emotional well-being and behaviour. However, limited potential contact with LAC, and insufficient training for working with them, means school staff may struggle to meet their individual and complex needs.

2.2.2 Raising Achievement, Corporate Parenting and Government Policy

Educational success can critically impact on life chances of CIC, with its positive impact now well recognised (Jackson and Martin, 1998; Jackson, 2000, p65). However, in terms of educational experience and outcomes, it has long been recognised that LAC are disadvantaged (Jackson and Sachdev, 2001). The educational attainment of LAC was not prioritised until the late nineties, when included in the 'Quality Protects' programme (1998). This programme was a 'central strand' of Government strategy to improve social services for vulnerable children, especially LAC, by ensuring high standards in the management and practices of the care system (Dobson, 1998). The programme was accompanied by an open letter to local Councillors from the Health Secretary, Frank Dobson, outlining and reinforcing the concept of 'corporate parenting', (Dobson, 1998; Bradbury, 2006). Dobson (1998) asserted that councils have a moral as well as legal duty to "provide the kind of loyal support that any good parents would give their children" (p2). The LA should therefore ensure all aspects of a child's life – care, education, health, leisure, friendships, and future planning – are considered (Bradbury, 2006).

The DfEE document (2000a) outlines important aspects of parenting, shown in Table 2.1 below. LAs as corporate parents, like other knowledgeable parents, should prioritise education (Jackson and McParlin, 2006). Crucially, Section 52 of the 2004 Children Act introduced an important amendment to the 1989 Children Act;

> *"The duty of a local authority under subsection (3)(a) to safeguard and promote the welfare of a child looked after by them includes in particular a duty to promote the child's educational achievement."*
>
> Children Act (2004) Section 52

This vital amendment ensures LAs have not only responsibility for meeting children's basic needs like shelter, food and care, but now educational achievement is placed alongside these fundamentals. A more holistic interpretation of 'welfare' is attempted. Encouragingly, Government literature also uses a broader definition of 'Education', encompassing education and personal development of the whole child, not merely educational attainment where only performance in tests and academic assessments are considered (DfEE, 2000a).

Significantly, the 'corporate parent' construct is not without contention (Garrett, 2003). Firstly, applying the terminology of 'parent' to an 'inorganic entity', the LA, could be deemed inappropriate, even a 'retrograde step' given the "redesignation of foster parents to foster carers" (Garrett, 2003, p21). Secondly, as LAs are expected to work in partnership with birth parents, the term could be seen as "marginalising" or "disparaging" (Garrett, 2003). Thirdly, concepts of 'reasonable parenting' and 'good parental care' on which the 'corporate parent' construct is based, are "socially constructed and shift in meaning, both historically and culturally" (Garrett, 2003, p22). Furthermore, Garrett

warns of the dangers of discourse surrounding parenting of LAC. If the impact of mass poverty on families is ignored, if patriarchal relationships are reinforced and if some research remains "rooted in a dominant child-care discourse", we risk "in Foucauldian terms", being trapped "in particular 'regimes of truth' " (2003, p24). However, whilst Garrett's discussion on the 'modernisation' of social care raises some unavoidable quandaries, criticisms and questions around provision for LAC and our conceptualisations of this group and their families, it did not offer alternative practical solutions. Furthermore, the construct of 'corporate parent' could facilitate the process of concerting efforts under an umbrella term, with some shared meaning for most people - parent as carer, provider and advocate.

Other important pieces of legislation have highlighted issues for LAC, including a recent report on improving educational attainment of CIC (DCSF, 2009c). Table 2.1 shows a chronology and brief synopsis of the variety of legislation introduced to improve outcomes for LAC:

Table 2.1: Chronology of Government legislation pertaining to LAC

Legislation/Policy	Key Principles
The Children Act (1989)	Outlined duties that LAs must perform for LAC, primarily the "duty to safeguard and promote the welfare of a looked after child" (Section 22 (3)(a)) and the "duty to maintain a looked after child in other respects apart from the provision of accommodation" (Section 23 (1)(b)).
Quality Protects (1998)	• Introduced by Department of Health to modernise social services practice for vulnerable children • Legislation was accompanied by letter from then Health Secretary, Frank Dobson, reinforcing the principle of 'corporate parenting' (Bradbury, 2006). • The concept of Corporate Parent was introduced so LAs ensured children received a level of support comparable with that provided by a 'good' parent (Norwich *et al*, 2008).

Guidance on the education of children and young people in public care. (DfEE 2000a)	• A guidance document describing aspects of parenting: ▪ Caring about their child's safety, health and education. ▪ Being interested in their friendships and leisure interests. ▪ Maintaining good home–school relationships. ▪ Having continuous knowledge of their children's development. ▪ Knowing their particular talents, achievements, needs and problems. ▪ Listening and talking to their children. ▪ Expressing preferences for schools and appealing against decisions which are perceived detrimental to their child. ▪ Attending parents' evenings and sports days. ▪ Expecting to be consulted and involved if their child has special educational needs. ▪ Acting as advocate for their child. (Bradbury, 2006)
The Children (Leaving Care) Act (2000)	• Places duty on LAs to assess and meet the needs of young people aged 16-17, in care or leaving care, and to keep contact with care leavers until they are 21. • Each young person expected to have an advisor co-ordinating provision and creating a 'pathway plan', mapping the route to independence. (Act revised in December 2009).
The Adoption and Children Act (2002)	• Made further amendments of laws relating to Children, ensuring adoption law was aligned with the relevant provisions of the Children Act 1989 and provides a new right to 'an assessment of needs' for access to adoption support services for adoptive families and others.
A better education for children in care. Social Exclusion Unit (2003)	Identified and discussed the key changes needed to promote better outcomes for LAC: • Greater stability – so that children in care do not have to move home or school so often. • Less time out of school – longer in education – help with school admissions, better access to education with more support to help children in care attend school regularly and stay on after age 16. • Help with schoolwork – more individual support tailored to the child backed by more training for teachers and social workers. • More help from home to support schoolwork – by giving carers better training in children's education. • Improved health and wellbeing – with teachers, social care staff, health workers and carers all working together in the interests of the child.
Every Child Matters (ECM) – Green Paper (2003)	• The Green Paper, Every Child Matters was published alongside the formal response to the report into the death of Victoria Climbié. After a consultation process, the Children Act 2004 became law, and formed the legal underpinning for Every Child Matters, which set out the Government's approach to the well-being of children and young people.

Every Child Matters: The next steps and The Children Act (2004)	• Following consultation surrounding the green paper, the Government published this document and passed the Children Act 2004. This provided the legislative framework for developing 'more effective and accessible services'.
	• The Children Act 2004 is the "legislative spine" for the Every Child Matters Reform Programme and its 5 outcomes. The key mechanisms in the Act for delivering the outcomes are:
	  • A duty to cooperate with other child agencies.
	  • Information databases.
	  • Local Safeguarding Children's Boards
	  • Joint Area Reviews and inspection.

Every Child Matters: Change for Children (DfES, 2004)	• The five principles of the ECM agenda are for children to: 1. be healthy 2. stay safe 3. enjoy and achieve 4. make a positive contribution 5. achieve economic well-being.
Aimhigher (DfBIS, 2004)	• A national programme aiming to widen participation in higher education (HE) by raising HE awareness, aspirations and attainment among young people from under-represented groups like LAC, providing funding and support, visits to university campuses, residential summer schools, master-classes and open days and mentoring schemes.
Statutory guidance on the duty on LAs to promote the educational achievement of looked after children under Section 52 of the Children Act 2004 (2005)	• Sets out essential actions LAs must follow to comply with the duty to promote educational achievement. • Recognises the importance of ensuring that all care placements support the child or young person's educational needs and aspirations, and that the arrangement of care placements should enable existing educational provision is maintained, where this is in the best interests of the child.
The Children's Plan (2007)	• Aimed to strengthen support for all families during the formative early years of their children's lives. Sets out what Government departments are doing to achieve each of its strategic objectives, to secure the health and well-being of children and young people; safeguard the young and vulnerable; and achieve higher standards.
Department for Education and Skills (DfES, 2007a) Supporting looked after learners: a practical guide to school governors.	• As part of the ECM agenda schools are increasingly working with other partners including health and social care services. Effective collaboration between schools and partners means the leadership role of governors in partnership with the head teacher and senior management team is vital – and especially in relation to looked after children. • This publication aimed to help governors ensure that their schools are doing all they can to help children in care fulfil their potential and contribute to school life. (DfES, 2007a)

Care Matters: Transforming the Lives of Children and Young People in Care (2007c) Care Matters: Time for Change (DfES, 2007b)	• White Paper covering Government plans to improve the experience and outcomes for children and young people in care. • Introduced a range of measures attempting to raise educational attainment and enhance prospects for future employment and personal and family fulfilment (DCSF, 2009b)
Children and Young Persons Act (2008)	• Set out legislation to improve outcomes for children and young people who are LAC or at risk of becoming LAC. • Introduced amendments to Children Act 1989, including a new duty on LA to a secure sufficient accommodation for LAC.
One-to-One tuition: Supporting Looked After Children (DCSF, 2008a)	• Provided additional funding for individualised tuition in order to reduce the achievement gap.
Personal Education Allowances for Looked After Children: Statutory Guidance for local authorities (DCSF, 2008b)	• These allowances have been introduced to provide additional, personalised support to CIC who have been identified as at risk of not reaching expected standards of attainment. • Such allowances can be used either for individuals or pooled for a group of CIC where this would result in increased levels of support e.g. 'joint commissioning for a number of LAC with similar learning or development needs'.
Promoting the Health and Wellbeing of Looked After Children: Revised Statutory Guidance (Nov 2009)	• Provides guidance for LAs and their Children's Trust Partners on improving health outcomes for LAC. • Promisingly it includes wider determinants of health and wellbeing
Improving the Educational Attainment of Children in Care (Looked after Children) (DCSF, 2009c)	• The guidance focuses on transforming the educational attainment of LAC, outlining the necessary components for a LA to achieve this. • A key element is the creation of 'virtual school heads' to 'track the schooling of every looked after child and ensure appropriate additional provision is being put in place'. This includes ensuring social workers adequately consider CICs educational needs when deciding placements moves.

2.2.3 Care Matters: Time for Change

Table 2.1 evidences the long-standing rhetoric and will to support; however, meaningful success in promoting outcomes for this group has proved fairly elusive. In June 2007,

the Government published the white paper ‘Care Matters: Time for Change’. This recognised that CIC “are frequently in greater need, but paradoxically less likely to receive the help they require”, emphasising State aspirations for these children “should be no less than each parent would have for their own child” (DfES, 2007b, p3). Care Matters outlined new initiatives to support LAC, including the pledge to introduce a personal education allowance (PEA) for LAC at risk of failing to reach national expected standards of attainment (DCSF, 2008b).

PEAs are intended to help LAs support learning needs of LAC, facilitating access to “additional learning and development activities” (DCSF, 2008). PEAs target those 72% of LAC who fail to meet expected levels (i.e. are not progressing 2 levels across a key stage) (DCSF, 2008). Allowances should be used as a parent would, to help LAC engage in learning and educational experiences (e.g. paying for trips or music lessons), with the implicit aim of raising achievement, since research shows enriching experiences support and encourage learning (DCSF, 2008).

Additionally, the ‘Making Good Progress’ tuition pilot (DfES, 2007c) aimed to focus targeted tuition for pupils at KS2 and KS3 who were not meeting expected levels in English and Mathematics, with funding for 10hrs of targeted individual tuition. LAC were prioritised and made more progress than any other group. This could suggest that lack of opportunity had contributed to lack of progress for LAC, rather than any within-child difficulty, and with appropriate support and interventions LAC can flourish. Following the

pilot, funding is now available to pupils who in KS2, KS3 and (in National Challenge Schools[4]) KS4;

> - entered the key stage behind the expected level and/or
> - are not on trajectory to reach national expectations, or to make two levels of progress and/or
> - are looked-after children who would particularly benefit from this kind of additional support.
>
> (Teachernet, 2009)

Therefore, all LAC are entitled to the PEA and tuition funding. Available money can be used creatively by practitioners working with LAC. Studies have highlighted benefits associated with individual tutoring, and reported positive feedback from social workers regarding the value of additional one-to-one support (DCSF, 2009b). Given this and recognition that early intervention is vital (DfES, 2006), why such support is not available earlier is perplexing.

2.2.4 Virtual School Heads

Low attainment of LAC is thought to result from failures in care and education systems rather than within-child factors (Jackson, 2000). To ensure improvements in LAC's education, one response in 'Care Matters', has been the piloting of 'Virtual School Heads' (VSHs) for LAC in 11 pilot authorities from 2007-09 (DfES, 2007b). The VSH acts as LA co-ordinator and advocate for LAC, to ensure improvements in their

[4] National Challenge Schools are part of a programme by DCSF to ensure that at least 30 per cent of pupils in every maintained secondary school and Academy in England achieves at least five higher grade GCSEs including English and maths by 2011.

education (DCSF, 2009b). LAC attend a range of local schools, with uneven and unpredictable distribution, so some schools go a few years without encountering CIC (Jackson, 2000). The VSH's role is to oversee the education of LAC, improving standards "as if they were head of a single school" (DfES, 2007b, p10). Four of the eleven LAs also piloted private tutoring under a privately funded scheme (DSCF, 2009b). Berridge *et al* conducted an evaluation of the VSH pilot, over an 8 month period (DCSF, 2009b).

Berridge *et al* found similarities in the backgrounds of the VSHs and their general location within education services, but there were some interesting differences, which are listed below (DCSF, 2009b):

- the amount of time allocated to their role, some only part-time;
- positions varied in seniority in the organisational structure, from Tiers 2 to 5;
- the 'virtual school' teams in which they worked varied considerably in size, location and funding;
- VSHs worked differently, prioritising different aspects of their role, although all VSHs placed high emphasis on 'raising the measurable attainment' of LAC, whilst still taking a 'broader view of education'.

Such differences had subtle but pervasive effects on what VSHs achieved. For example, creating successful relationships with local heads was crucial in enabling them to advocate for LAC and avoid exclusions (DCSF, 2009b). Those VSHs who had previously been senior educationalists or heads, and were placed at a higher

organisational level, were able to operate more effectively by exerting particular influence, with the converse position being problematic (DCSF, 2009b).

The main thrust of VSHs' work was strategic, succeeding in many areas, including raising the profile of LAC in schools and notably "the importance given to education by social workers" and the LA in general (DCSF, 2009, p2). However, Berridge *et al* concede that ultimately the impact of the VSH role "on pupils' achievements is the million dollar question" (DCSF, 2009b, p57). Attempting to unpick the precise contribution of VSHs to this outcome is complex. As Berridge *et al* note, LAC's education is a 'multifaceted problem with many potential influences' and any benefits incurred from VSHs are likely to be indirect, thus causal relationships are difficult to prove (DCSF, 2009b, p57). Official statistics inevitably miss subtleties of the impact of different individuals' and agencies' involvement. Evaluation of multi-level interventions is challenging, as establishing causal links is difficult (Brodie *et al*, 2009). VSHs are not alone in the quandary of providing evidence regarding their impact. For EPs too, particularly where work is strategic or indirect, providing accurate evidence of impact is challenging. Nevertheless, providing and developing evidence-based practice should be a central tenet of EPs' role (Frederickson, 2002) and by applying their research skills, this is perhaps an area in which EPs could support other services.

2.2.5 Barriers and Enablers

Numerous barriers and enablers are involved with raising achievement of LAC. Frequency and timing of placement and school moves significantly impacts on LAC

achieving the levels predicted by earlier grades (O'Sullivan and Westerman, 2007, p13). Effective support from adults, encouragement and acknowledgement of CIC's efforts are central to educational success (Harker *et al*, 2004). Whilst flaws in our education and care systems have undoubtedly contributed to poor outcomes for these children, parental rejection, often accompanied by abuse and neglect is also a 'major mediating factor' in restricting life outcomes (Cameron and Maginn, 2008). Cameron and Maginn assert that "good parenting *and* emotional support are key factors in achieving successful emotional, social and academic development" of CIC, and should be provided by carers and residential staff (2008, p1151).

For CIC, education can have an important protective effect, with academic or social achievement in education fostering resilience (Gilligan, 2007). Yet low educational achievement of LAC has been recognised comparatively recently, which may have contributed to the dearth of robust literature regarding the effectiveness of policies regarding LAC (Brodie *et al*, 2009). Whilst numerous services and interventions have been introduced, "evaluations of these are relatively limited" (Brodie *et al*, 2009, p9). However, studies which have evaluated initiatives, suggest assessing the impact on individual outcomes is challenging because:

> "*the heterogeneity of the looked after population, the nature of individual need and difficulties associated with current official outcome measurement*"
>
> (Brodie et al, 2009, p19; see Berridge *et al*, 2008; Harker *et al*, 2004).

The heterogeneity of LAC should not be ignored. The challenge of supporting LAC effectively is ensuring channelling of appropriate, targeted support at multiple levels. Stanley (2006) reports findings of the National Children's Bureau seminar regarding Education of LAC. Table 2.2 shows an outline of what was felt to be working:

Table 2.2: National Children's Bureau Seminar regarding promoting the educational achievement of LAC

What works?	What helps?
Raising the profile	Statutory guidance for LAs
Stability	Reduce number of different placements
Creating a positive learning culture	Recognising achievement, carers support learning, areas to study, continuity and support of school placement
Choice for young people and engaging them in the debate	Listening to the young people involved
Overcoming discrimination	If decisions/actions can't be justified for any child, it is not appropriate to insist that it is acceptable for LAC
Promoting positive achievements	Corporate parenting responsibility of LA

Source: Developed from Lindsey - in Stanley, 2006, p34-35.

However, while practitioners "knew what had to be achieved", "how it could be achieved" highlighted a knowledge and skills deficit (Stanley, 2006, p4). Arguably, EPs could facilitate the narrowing of this gap in knowledge and skills. EPs are part of the wide range of individuals and agencies, who help deliver corporate parenting (DfES, 2000). With their unique positioning and broad skill set, EPs can support LAC indirectly and directly, at multiple levels – individual, family, school, education and care systems.

2.3 Educational Psychologists and LAC

2.3.1 Multi-agency work

Norwich *et al* (2008) describe the scarcity of publications regarding EPs direct or indirect work with LAC, whilst highlighting McParlin's (1996) passionate paper. McParlin, an EP who had himself experienced being in care, sought to raise the profile of CIC amongst EPs, and examined issues impacting on poor educational achievement in this population (McParlin, 1996, p112). Arguably, McParlin's life history and active advocacy, risk contributing to *researcher bias*[5] (Robson, 2002). Nevertheless, McParlin offered rare insight, personal experience of the care system and an EP perspective.

McParlin argued that EPs, with their specific expertise, were well placed to support educational outcomes of LAC, and there existed "historical culpability" in their 'failure to do so to date' (cited in Norwich *et al*, 2008, p126). McParlin's study was conducted before the advent of the ECM agenda and widespread changes in Children's Services, which have made some aspects of his article historic (Norwich *et al*, 2008). However, Norwich *et al* highlight that many of McParlin's ideas for EPs still resonate, such as "educational advocacy, inter-agency working, preventative approaches and early intervention". Indeed, the Working Group (DfEE, 2000b) - which examined the role of EP services, identifying good practice and suggesting future directions - also emphasised these domains. Additionally, there was a call for more direct access by parents,

[5] Researcher bias refers to how elements of the researcher's identity, their assumptions and preconceptions, can affect the choices they make in their research (Robson, 2002).

development of specialisms, more formalised structures around joint assessments, planning and training with social services and health, and crucially recognition that:

> *"Social Services see a key role for educational psychologists in working with a wider cross-section of looked after children"*
>
> (DfEE, 2000b, p8)

Since the DfEE (2000b) report, the ECM legislation represents for EPs the "most significant national strategic development" (DfES, 2006, p9). Farrell ***et al's*** review highlights the impact of LA restructuring, combining educational and social services into children's services (DfES, 2006). There is a renewed emphasis on the importance of multi-agency work, and EPs now occupy a more central location within community contexts, with schools one of a number of settings in which EPs work (DfES, 2006, p9).

EPs collaborate to deliver corporate parenting with a range of other individuals and agencies. The number of other professionals who can be involved includes, but is not limited to:

- elected members
- senior officers and managers of the LEA and social services departments
- representatives of the Health Trust/Authority;
- head teachers and school governors
- social workers, residential social workers and education social workers
- foster carers;
- teachers and learning support assistants
- educational psychologists and education support personnel, including specialist teachers
- Career Advisers/connexions
- Personal Advisers, fostering/family placement managers, and parents.

(DfEE 2000a)

From the child's view, the sheer number of people involved could be overwhelming (DfEE, 2000a), as indeed could be the case for professionals. A significant problem with this number of involved individuals could be dilution of responsibility and accountability. Regarding educational achievement, structures and roles such as VSHs and Designated Teachers, go some way to address this, as they take overarching responsibility for the child's educational achievement and needs. However, as different professionals place different emphasis on the importance of certain factors (e.g. care placement versus educational achievement), and with some social workers and carers not rating educational attainment highly (Jackson, 1994), tensions in decision making are likely. Opportunities exist for EPs to use their knowledge of organisational psychology and communication/negotiation skills to support complex multi-agency meetings, ensure active advocacy of the importance of educational achievement for LAC, and help improve the effectiveness of multi-agency networks and teams, as EPs are "skilled and used to asking important questions" (Dennison *et al*, 2006, p88).

Sloper (2004) argues there is a paucity of evidence regarding the effectiveness of multi-agency working (p571). My own experience of multi-agency teams, suggests simply locating professionals in one team, without sufficient planning for the very different systems and rules of professional groups, can mean teams are co-located but 'multi-agency' in name only - operating more like Atkinson *et al*'s (2002) conceptualisation of 'centre-based delivery' rather than the purported vision of 'co-ordinated delivery'. Since a combined approach to raising achievement of LAC is vital, the amalgamation of services represents an exciting opportunity, not to be missed, for multi-agency working.

However, to ensure effective working, organisations must develop multi-agency services with due regard to systemic challenges and the evidence base e.g. regarding enablers and barriers to co-ordinated working (Sloper, 2004).

Farrell *et al* (2006) also describe how EPs have increasingly contributed to strategic work and capacity building. Indeed they found "very many reported examples of EPs' distinctive contribution to multi-agency work" (DfES, 2006, p44). However, unpicking the direct contribution of EPs here is problematic, as on many occasions at least one other professional group was involved (DfES, 2006). Measuring accurately individuals' contribution to a multi-professional response remains challenging - involvement could be direct or indirect, central or peripheral, subtle or pervasive, and at individual, family and/or system levels. Furthermore, whilst Farrel *et al*'s review is based on qualitative and quantitative data, it still only comprises EPs' and others' reported views on EP contributions. Though such views have value, EPs' views are particularly subject to respondent bias, affecting validity (Robson, 2002). The development of more accurate or objective ways of measuring EPs' impact remains elusive.

2.3.2 EPs as Corporate Parents

Bradbury (2006) sought to illuminate 'What contribution can/should the EP make as a corporate parent?' (2006, p141). Her small scale study involved interviewing 3 EPs with responsibility for CIC, about their work and application of psychological knowledge and skills (Bradbury, 2006). Bradbury herself concedes that the drawing of valid

generalisations is “severely limited by the very small and selective sample size” (2006, p156). Nevertheless, given the relative dearth of literature in this domain, interrogation of findings and some extrapolation is useful. Bradbury (2006, p157) argues that EPs are well placed to;

> *“use their psychological knowledge and skills to work with individual children in care, with the carers and professionals who have a more direct parenting role and in multi-agency teams to facilitate more joined-up care and education for one of the most vulnerable group of children and young people in our modern society.”*

Cameron and Maginn (2009) also strongly advocate for psychologists supporting outcomes for CIC. Arguing that notwithstanding psychologists’ problem-solving and interpersonal skills,

> *“it is the creative application of psychological research and theory which informs decision-making and advice, and which distinguishes the psychologists from others working in the caring professions”.*
>
> (Cameron and Maginn, 2009, p94).

Such ‘creative application’ is underpinned by features shown below:

Table 2.3: Features underpinning EPs’ professional creativity (from Cameron and Maginn, 2009, p94-96)

1. Adoption of an “interactive perspective of the nature of human problems”
2. Use of psychology to uncover “mediating and explanatory variables” and to provide ‘maps’ of the complex interactions that may be affecting problems under investigation
3. Use of psychological research and theory to recommend evidence-based strategies for change
4. Promotion of innovative and creative ways of working to “enable clients to spot potential opportunities for positive change”
5. Work with significant adults to utilise different instruments to “measure outcomes for children, evaluate their practice and provide evidence” of their work

Clearly, EPs support education of LAC in various ways. However, we lack evidence that EPs play a central role (Norwich *et al*, 2008). EPs are perhaps uniquely positioned to apply psychology in home and school settings. Yet, in Brodie *et al*'s scoping study, reviewing the evidence base regarding improving educational outcomes for LAC, there is no direct mention of EPs (2009). There inadequate evidence about complex learning and behavioural needs of many LAC, and the positive and negative impact of recent initiatives (Brodie *et al*, 2009). As applied psychologists, with research experience, EPs have relevant skills to offer, and could be contributing to gaps in the evidence base identified by Brodie *et al* (2009). However, whether their skills are adequately harnessed remains to be seen.

2.4 Local Authority Context

After reviewing the literature, my main aims when investigating Coalshire's work to raise the educational achievement of LAC were to describe the structure of provision for LAC, consider how provision is evaluated, and to discuss how particular challenges were addressed.

2.4.1 Ontological, Epistemological and Methodological considerations

To explore the LA's work, I adopted an interpretive approach, using qualitative research to understand this social phenomena (Wiersma, 1991). Terre-Blanche and Kelly (1999, p123) describe how this tradition assumes:

> *"people's subjective experiences are real and should be taken seriously (ontology), that we can understand others' experiences by interacting with them and listening to what they tell us (epistemology), and that qualitative research techniques are best suited to this task (methodology)"*.

Arguably, such ontological, epistemological and methodological assumptions fit well with the purpose of this enquiry, my identity as a Coalshire employee and available research instruments. In this instance, I consider the "*reality to be studied consists of people's subjective experiences of the external world*", consequently I have adopted an "*intersubjective or interactional epistemological stance toward that reality*" using methodologies which rely on "*a subjective relationship between researcher and subject*" (Terre-Blanche and Durrheim, 1999, p6). Such methodologies include open-ended interviews with the Education Improvement Advisor (EIA) for LAC and the EP with a LAC Specialism, analysis of policy documentation from the LA, and my own experience of working within the EPS.

There are issues regarding the reliability, validity and ethics of conducting any inquiry, with interpretive approaches posing different problems from positivist positions. Reliability is the degree to which results are repeatable, but in interpretive research there is no assumption of a stable, unchanging reality, and therefore no expectation of finding the same results repeatedly or in different settings (Durrheim and Wassenaar, 1999). Instead of the criterion of reliability, 'dependability' is required, i.e. the "degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did" (Durrheim and Wassenaar, 1999, p64).

The validity of qualitative research is contentious (Robson, 2002). Furthermore, my position in the Authority, increases threats to validity, in terms of *reactivity*[6]*, respondent biases* and *researcher biases* (Lincoln and Guba, 1985, in Robson, 2002, p172). To attempt to address these threats I have used data triangulation (e.g. interviews, documents and observation) and offered member checking (where respondents can check transcripts and interpretations) (Robson, 2002, p174-5).

Arguably, in the interpretive paradigm, reflexivity is necessary for valid interpretation (Potter, 1999, p215). Reflexivity demands awareness of researchers' roles in constructing meaning. Researchers must recognise they are "a part of, rather than apart from the world constructed through research" (Usher, 1996, p35). Reflexivity requires an "acknowledgement of the impossibility of remaining 'outside of' one's subject matter", compelling us to "explore the way in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale and Cromby, 1999, p228). My position within this LA, poses significant difficulties for evaluating critically a provision I am part of, reinforcing the need for reflexivity and potentially compromising the validity of my inquiry. However, as this assignment will be shared with the participants, who occupy a position within the same 'Community of Practice'[7] (Lave and Wenger, 1991), the enquiry potentially has value as a stimulus for reflection.

[6] Reactivity is where the "researcher's presence may interfere in some way with the setting which forms the focus of the study, and in particular with the behaviour of the people involved" (Robson, 2002, p172).
[7] "Communities of practice (CoP) are formed by people who engage in a process of collective learning in a shared domain of human endeavour" (Wenger, 2006). Arguably, those professionals involved in raising the achievement of LAC form a CoP.

There were some ethical challenges inherent in this inquiry. Informed consent was gained orally, however in future I would also gain written consent. Confidentiality of participants remains problematic, as although names are anonymised, protecting identities given role titles and limited numbers of professionals in such roles, means true anonymity is questionable.

2.4.2 Method

As discussed, one method for collecting data was open-ended interviews, allowing respondents the opportunity to respond with 'greater richness and spontaneity' (Oppenheim, 2004, p.81). However, interviews can be 'biased and unreliable' (Oppenheim, 2004). Nevertheless, a broader picture emerges when interviews are used in conjunction with data from other sources. The interviews were conducted in my first term as a trainee EP, while I was still getting to know all the services provided by Coalshire. Consequently, questions posed to interviewees were broad and open, asking for role descriptions, and how they and the LA were involved in raising achievement of LAC. Interviews were not recorded, in line with the wishes of the EIA. Consequently, I scribed responses contemporaneously. This means some nuances and subtleties are lost. Furthermore, cautious interpretation is required, as since interviews were not recorded, there is potential for unwitting bias during transcription of responses.

2.4.3 LA Context

As discussed, LAs have a legal duty to support and guide the education of LAC. Coalshire strives to achieve good outcomes for LAC with varied provision and involvement at different operational levels. The interviews with the EIA and EP revealed much about Coalshire's work to raise LAC's educational achievement. I have selected from the interview data and document analysis three domains to be discussed:

1. **The Structure of Provision within the LA**
    - Context – attainment of LAC in Worcestershire
    - Integrated Service for LAC
    - Role of the EIA
2. **Evaluation of Provision**
    - Evaluation of Care
    - Views of the Children and Young People
3. **Addressing Particular Challenges**
    - Unaccompanied Asylum Seekers
    - Post-16 transitions

2.4.3i The Structure of Provision within the LA

Context

In 2007, a CIC was five times less likely to get five good GCSE passes than other children. Coalshire data shows similarly large disparity between achievement of LAC and other children. Despite significant improvements in attainment of Coalshire LAC from 2008 to 2009, the gap between them and other Coalshire children remains sizable. Tables below show how Coalshire compares with the National Picture (see Appendix I for full report).

Table 2.4: The percentage of LAC achieving Level 4 and above

2008/2009 cohort comprises 22 LAC,14 (64%) male and 8 (36%) female	English		Maths		Science		English and Maths	
	2008	**2009**	**2008**	**2009**	**2008**	**2009**	**2008**	**2009**
Coalshire LAC	48	23	48	32	64	36	36	14
National LAC	46	n/a	44	n/a	60	n/a	n/a	n/a
Coalshire all children	80	80	77	77	89	89	71	71

n/a= Results not yet available

Table 2.5: The percentage of LAC achieving 5 A*-C GCSEs, 5 A*-C GCSEs including English and Maths and 1 A*-G GCSE

2008/2009 cohort comprises 42 LAC,19 (45%) male and 23 (55%) female	% 5 x A*-C		% 5 x A*- C incl. English & Maths		% 1 x A* - G	
	2008	**2009**	**2008**	**2009**	**2008**	**2009**
Coalshire LAC	5	19	2	10	55	60
National LAC*	14	n/a	n/a	n/a	66	n/a
Coalshire All	64	70	48	49	99	n/a

*Figures relate to GCSE only. All other figures include GCSE equivalent qualifications.
n/a= not available

KS2 Coalshire results fit the national picture, but results are lower for KS4. However, to avoid drawing unfairly simplistic conclusions, greater scrutiny is necessary. Firstly, the LAC population is very small in comparison to the overall population of children, so one child's performance impacts greatly on results. Secondly, cohorts won't necessarily reflect a similar ratio of male to female students as the general population, with ratios fluctuating between year groups (e.g. at KS4, 45% male: 57% female, but in KS2, 76%

Male: 24% female). Coalshire results are not always shown by gender, but to avoid contaminating the overall picture, potential differences in performance of males and females should be considered. Thirdly, LAC are “not a homogenous group” (Bradbury, 2006, p7), but it seems their relatively small size, often means clustering of results for analysis. Indeed, within ‘LAC’ exist the sub-group Unaccompanied Assylum Seekers (UAS). Their late entry to British school systems, and potential for limited English language competency on arrival, may also affect results. Finally the proportion of children nationally with a Statement of Special Educational Needs (SEN) is 3%, but for LAC it is 28% (DCSF, 2009d), and in Coalshire this figure rises to 40%. The high number of LAC with SEN is likely to affect their attainment potential (DCSF, 2009b), especially considering the location of 40% of Coalshire LAC at special schools/agency residential placements (15-33%), or PRUs (3-7%).

There are multifarious reasons behind the higher proportion of LAC with a Statement of SEN. Berridge *et al* (DCSF, 2009b, p13) outline some contributory factors:

- *Due to previous experiences (e.g. neglect, abuse, or parental misuse of alcohol or drugs leading to developmental delay) they may be more likely to have SEN*
- *Disabled children may be disproportionately accommodated in LA care*
- *Their increased contact with professionals means LAC may be more likely to be taken through formal assessment processes for a Statement of SEN than their peers*

In my experience, professionals can feel a duty for LAC's additional needs to be outlined legally in a Statement of SEN (DfES, 2001), to ensure children will be adequately protected and not overlooked. Consequently, there can be personal and external pressure towards statutory procedures; where for another child with similar needs it may be deemed these could be met at lower levels of the Code of Practice (see DfES, 2001). Whether or not to pursue a Statement for LAC, can evoke passionate, personal responses. My position encompasses irritation with a system of Statementing that can seem frustratingly bureaucratic and inequitable, and recognition that to obtain additional funding, or simply ensure schools ring-fence delegated funding, Statements are currently necessary.

In Coalshire, LAC are separated into three sub-groups for analysis, with funding implications and monitoring varying according to group, categories are shown below:

Table 2.6: Categories of LAC in and out of county

Group 1	*Coalshire LAC in Coalshire Schools*	Approximately 200 children – taken into care in Coalshire and placed with foster carers in the county.
Group 2	*Coalshire LAC in other LA Schools*	Approximately 85-90 children – taken into care in Coalshire and placed with foster carers out-of-county for different reasons (e.g. to receive access to specialist placement, or live on borders of county, or need to be further from biological family).
Group 3	*Other Local Authority's LAC, placed in Coalshire Schools*	Approximately 150 children –taken into care outside Coalshire.

For Group 3, responsibility for the well-being of these children remains with their original LA, meaning only groups 1 and 2 have access to support from ISL. Indeed, for data analysis purposes, Coalshire only includes Group 1 and 2, so that data is not duplicated in national statistics. However, the EIA still cares for and includes Group 3 children in her outlook and plans, feeling strongly that her role is to advocate for "all LAC", whatever group they come from.

Integrated Service for Looked After Children

Formed in September 2004, from two existing teams, Coalshire LA's designated multi-agency service specifically for CIC is the 'Integrated Service for Looked After Children' (ISL) (Appendix II shows ISL service overview and structure). ISL aims to improve "educational outcomes for LAC and enhance their life chances". Comprised of 47 professionals from wide-ranging backgrounds (including Clinical and Educational Psychologists and Social Workers), it aims for Early Intervention, working with children from pre-school to the first few terms of Year 12. ISL illustrate corporate parenting in practice, and boast no permanent exclusions of LAC in the county, in over 6 years. Labelled "outstanding" by the Joint Area Review (JAR, 2008), my own experience of direct or indirect contact with the team has been similarly positive.

ISL work directly with LAC, their carers, and schools, providing support in various ways (see Appendix II). As most LAC will have "life histories which put them at risk of attachment difficulties" (Bradbury, 2006, p7) training is important to ensure teachers

understand factors affecting some LAC. Part of the role of ISL, and EPs, is providing training to schools, and joint training on ‘Attachment in the Classroom’ has been successfully delivered.

The Education and Improvement Advisor for Looked After Children

The EIA has a background in Educational Psychology and was previously Operational Manager of ISL. Her role is funded through the ‘Care Matters’ agenda. Coalshire LA does not have anyone titled ‘Virtual School Head’. Prior to the piloting of the VSH initiative, the ISL team already conducted similar duties. The ISL Operational Manager is line-managed by the ‘Service Development Manager for Looked After and Adopted Children’ who has the overarching perspective and strategic view for LAC, in a similar way to a VSH. The EIA provides input to this perspective and with the ISL Manager, activates plans.

The EIA was introduced as a type of ‘critical friend’ to work in parallel with ISL, described by a member of ISL as a ‘symbiotic’ relationship. However, despite no explicit 'VSH', the EIA, and Operational Manager for ISL carry out a similar role, working together to promote and improve educational outcomes for LAC by ensuring that tracking and monitoring is achieved and that there is someone directly responsible for their achievement. ISL seeks to operate like a ‘virtual school’, holding data on LAC in the county. Additionally, all Coalshire schools have a ‘Designated Teacher for LAC’, with

statutory responsibility to monitor, track and report progress, and power to influence policy.

From the EIA's perspective, she and the ISL manager are 'Head' of the virtual school. Indeed the EIA's role is partly to make connections and link with VSHs in other LAs, ensuring sharing of good practice, and facilitating discussion of regional out-of-county protocols. The EIA role is strategic, similar to the VSH role (section 2.4). She ensures partners work together, reporting to the Corporate Parenting Board, comprising elected council members. As the term 'VSH' becomes more widely recognised it will be interesting to see how Coalshire responds. The EIA outlined the major areas which critically impact on LAC's success:

1. Stable educational placements
2. Stable and consistent care placements
3. People around the child, understanding their needs and knowing what to do to support those needs

ISL, the EIA, and EPs, support these areas. For example, while difficult decisions regarding placement are being made, educational placement stability must also be prioritised. ISL staff work with foster carers, supporting care placement stability, ensuring effective engagement with schools and that the importance of education is understood. Clinical Psychologists in ISL also work with foster carers, assisting family stability. Placement stability in Coalshire is good, currently falling within the top quartile nationally.

EPs are also directly involved in collecting data at termly multi-professional meetings, informing Coalshire targets for LAC. The EIA described how understanding individual needs is vital and that her role and ISL's is to ensure the right teaching and learning interventions. The EIA argues, *"essentially, everyone needs to be informed, have high expectations and work together*", highlighting the importance of effective multi-agency working.

2.4.3ii Evaluation of Provision

Evaluation of Care

Evaluating care is part of the 'Quality Protects' agenda (DH, 1998). The late nineties brought for the first time, target setting for 'educational outcomes, placement stability, and reducing time out of school' (Jackson and McParlin, 2006). ISL make biannual school visits, monitoring LAC progress, encouraging early intervention and ensuring support plans are appropriate. The EIA described schools are generally very supportive of LAC, partly evidenced by no permanent exclusion of LAC for over 6 years. However, whilst impressive, such data warrants further scrutiny, as this statistic could mask an over-reliance on 'managed moves'.

Public Service Agreements (PSAs) enable Government departments to ensure particular standards are achieved. The 1998 Comprehensive Spending Review introduced PSAs to galvanise public service delivery and impact positively on outcomes (Cabinet Office,

2009). PSAs set out Government's key priority outcomes per spending period (HM Treasury, 2009). Government acknowledged that despite improvements, progress made by lower income children and CIC was "still not nearly good enough" (HMSO, 2007) Two PSAs were introduced to:

1. Raise the educational achievement of all children and young people;
2. Narrow the gap in educational achievement between children from low income and disadvantaged backgrounds and their peers.

PSA 2 focuses on improving the educational achievement of LAC at Key Stages 2 and 4.

National outcome-focussed performance indicators are the only measure by which central government monitors outcomes delivered by LAs (DCLG, 2007), measuring progress towards each PSA. Outcomes for LAC are significantly lower than for children not in LA care (EMIE, 2009). A Government priority is to address this disparity. Targets to improve stability of placements and educational achievement of LAC have been set (EMIE, 2009). National Indicators (NI) are shown below.

Table 2.7: National Indicators and Targets

National Indicators Relating to DCSF strategic objectives:
NI 58 Emotional and behavioural health of children in care (DCSF DSO)
NI 61 Stability of looked after children adopted following an agency decision that the child should be placed for adoption (DCSF DSO)
NI 62 Stability of placements of looked after children: number of moves (DCSF DSO)
NI 63 Stability of placements of looked after children: length of placement (DCSF DSO)

National Indicators Relating to public service agreements:
NI 99 Children in care reaching level 4 in English at Key Stage 2 (PSA 11)
NI 100 Children in care reaching level 4 in Maths at Key Stage 2 (PSA 11)
NI 101 Children in care achieving 5 A*-C GCSEs (or equivalent) at Key Stage 4 including English and Maths (PSA 11)

Source: EMIE (2009)

Views of Children and Young People

An exciting initiative carried out by 'Who Cares: We Care: Children in Care Council', gained views from Coalshire LAC. The survey (July 2009) included 430 LAC aged between 3-17 years. Encouragingly - especially considering that the views of primary school age children are "comparatively neglected" in the literature (Brodie et al, 2009) - 40% of the sample were primary age or below. Survey results are reported below:

Table 2.8: Sample and response data

Age Group	Number of LAC sent questionnaire	% Response in each age range
3-4	37	9
5-11	133	31
12-16	216	50
17	44	10
Total	430	100

Of the cohort, 59%, n=255 resided within Coalshire, 41%, n=175, were placed outside county. A small response rate of 33% [n=143; 21% children out-of-county, n=36; 42% children in Coalshire, n=107] means results must be cautiously interpreted (Robson,

2002). Furthermore, we cannot assume responders and non-responders are similar (Robson, 2002). Indeed, there could be significant differences between responses of respondents and potential responses of non-respondents, especially with a vulnerable group like LAC. Jones (1995) argues, to avoid biased estimates, a response rate of 90% is needed. However, postal surveys typically have low response rates (Robson, 2002), so achieving a 90% threshold would be impractical here.

Encouragingly, most children (99%) identified that they had a trusted confidant. Most children (89%) knew who their Designated Teacher was, but only 59% knew what a Personal Education Plan (PEP) was. PEPs are working tools offering a holistic picture of a child's needs, including placement, heath and education. PEPs must be started before they are 'LAC', or within 14 days (in emergency placement). The PEP needs to be available at the first LAC review, occurring 28 days after a child has been taken into care. PEPs include a chronology of a child's history and educational experience, detailing schools attended and reasons for leaving. Children's views show a need to ensure *all* children know who their Designated Teacher is, and that PEPs are more meaningful.

Children's opinions regarding reviews are noteworthy. Though they reported feeling included, many said reviews were too long, included too many people, representing "a lot of words but little action". "Better communication before and after reviews" was needed. Crucially, some pupils' reported reviews raising feelings of uncertainty prior to

their occurrence and reminded children of their 'difference'. The emotional impact of reviews must not be underestimated. Children's views highlight:

- Good communication between professionals is vital
- There is a need to reduce bureaucracy
- Young people must be central to their reviews, involved and listened to (but not necessarily there for the whole review)
- Agreed actions must happen

Encouragingly, in response to the survey: the EIA will set up 'Designated Teacher Networks' and a training programme; the PEP will be 'refreshed' and its benefits promoted; staff and carers supporting LAC will be directed to proactively involve young people in their PEP planning process.

2.4.3iii Addressing Particular Challenges

Unaccompanied Asylum Seekers

'Unaccompanied Asylum Seekers' (UAS) are a sub-group of LAC with further additional, specific needs. Whilst any age up to 18 years old counts, the EIA reported most are 14-16 years old in Coalshire. There are currently 56 young people in the statutory school age category, although the EIA asserted there are seldom any under 12-14 years old. This sub-group often speaks little or no English, consequently sharing the needs of other pupils with English as an Additional Language. Furthermore, they likely to have experienced multiple traumas - removal from families, loss of family members, other

terrible incidents in their home countries like war, and sometimes horrific experiences when travelling to the UK. The EIA highlighted how another difficulty this group can face is a lack of awareness and sometimes acceptance of cultural differences, from staff working with them. Furthermore, accurately ascertaining ages has proved problematic, with serious implications for inaccurate assessments. It is vital all young people are safe and not placed in situations which can cause risk to themselves or others, especially in children's homes. Accurate age assessing can be facilitated using birth certificates, with universal birth registration now campaigned for by charities like Plan-International[8]. Training, sensitivity and raising awareness of staff is crucial.

Post 16 transitions

Coalshire ISL team primarily support up to KS4, with two terms support around transition into KS5. In Further Education Colleges, Designated Tutors for LAC, fulfil a similar role to Designated Teachers, acting as advocates. Additional support comes from 'Aim Higher', a time-limited Government initiative aimed at vulnerable young people (DfBIS, 2004) The Government targets young people whose parents may not have attended University, aiming to raise pupil aspirations. Notwithstanding some policy assumptions, as lack of University attendance is not necessarily a benchmark of limited aspirations, it does support young people who want to attend University. The EIA works with the link

[8] Universal birth registration helps children gain easier access to education and healthcare, protects against child labour and child marriage, and helps defend against abuse and child trafficking.

professional for Aim Higher, to ensure that LAC are prioritised e.g. for visits to Campuses, and crucially, for accommodation.

2.5 Conclusion

While raising achievement for LAC is vital (DCSF, 2009), measuring educational outcomes of LAC is complex and 'improvements on the ground may not be reflected in LA returns' (Brodie *et al*, 2009). Nevertheless, given the vulnerability of LAC and the protective nature of educational success, it is critical that improving the educational outcomes for LAC remains high on the agenda. Furthermore, the ways LAC are supported can offer effective, general testing of procedures, as "their experiences highlight how robust and inclusive policies and practice really are" (DfEE, 2000a, p3). Bradbury (2006, p146) aptly argues;

> *"Children in public care, like other groups of vulnerable children, show up the cracks in the system because, whereas other children might struggle across, these children fall through".*

Sometimes there can appear an unnecessary dichotomy in the inclusion agenda, where provision for minority groups seems in conflict with provision for all children. The DfEE (2000a) states that *"getting it right for young people in care is about getting it right for all children"*, a message the EIA also stressed. This resonates strongly with Cairns and Stanway's (2004), assertion that it should not be a choice between *"meeting the needs of the majority and risking the social exclusion of LAC, or meeting the needs of LAC and letting down the majority"*. Schools that achieve well with LAC have pastoral systems

that support all children (Stanley, 2006). The goal should be establishing *"an environment and a way of working that will be effective for all children"* (Cairns and Stanway, 2004, p52). EPs can make a distinct contribution to this goal.

The NCB's seminar concluded with five important messages for future work of professionals (Stanley, 2006):

1) *Sharing good practice - around policies and protocols and training needs e.g. how attachment can affect learning*
2) *Child development, especially adolescence – recognising the heterogeneity of LAC e.g. cohort at KS4 very different to KS2*
3) *Dedicated personnel advocating for LAC, with child-centred public services and integrated identification, assessment, planning, monitoring and evaluation*
4) *Evidence – the statistics don't give us the real reasons for differential attainment – the need for more research and evidence based practice*
5) *Attainment and achievement – good news - there is 'more improvement in attainment with the LAC population than for all other children' (Hadley, 2006), however, there is still a long way to go to narrow the gap.*

In typical work in Coalshire, EPs already support the development of these five areas. I would argue Coalshire LA appears progressive and proactive, but there is still room for improvement, particularly with providing evidence based practice and promoting understanding of child development. EPs can and do contribute to these and other areas, but there is still scope for greater harnessing of the unique positioning and broad skill sets of EPs, particularly as new training routes mean EPs are increasingly not only applied psychologists but also researchers.

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Appendix I

Briefing:

Coalshire Looked After Children (LAC) Provisional Results 2008/2009

1. Summary

1.1 Attainment at Key Stage 2 has decreased this year across all subjects. As numbers sitting examinations are small, there is a potentially high % variable.

The 2008/09 cohort for Key Stage 2 (Year 6) comprises 22 LAC – 14 (64%) male and 8 (36%) female. 17 (76%) children were registered at mainstream schools and 5 (24%) at special schools/agency residential placements. It should be noted that the 2008 cohort comprised 22 (88%) at mainstream schools and 3 (12%) at special schools/agency residential placements. In 2009 9 (43%) children had a statement. In 2008 the figure was 28% (7).

1.2 Attainment at Key Stage 4 of both 5 A*-C and 1 A*-G has improved this year. The 2008/09 Key Stage 4 (Year 11) cohort comprises 42 LAC (2008 – 43) 19 (45%) male. There is higher level of females in this cohort than last year. 24 (57%) were registered at mainstream schools (2008 - 58%). The rest of the cohort were registered at special schools/agency residential placements. There are less students with statements this year than last year. 29% (12/42) have a statement (2008 - 42%).

2. Key Stage 2

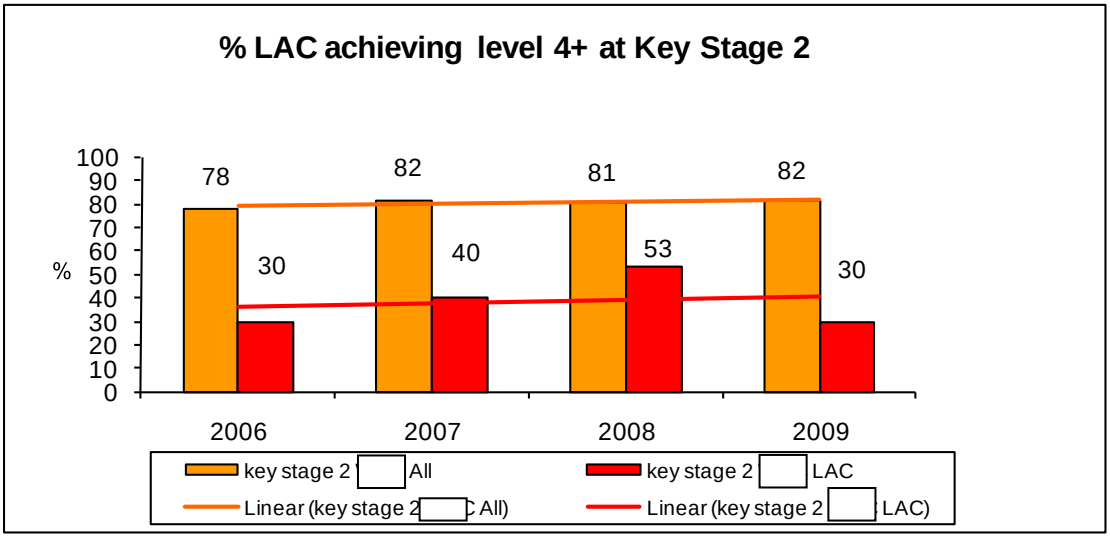
2.1 Percentage of LAC achieving Level 4 and above

- 2009 cohort comprises 22 LAC,14 (64%) male and 8 (36%) female

	English		Maths		Science		English and Maths	
	2008	**2009**	**2008**	**2009**	**2008**	**2009**	**2008**	**2009**
Coalshire. LAC	48	23	48	32	64	36	36	14
National LAC	46	n/a	44	n/a	60	n/a	n/a	n/a
Coalshire. all children	80	80	77	77	89	89	71	71

n/a= Results not yet available

2.2 Trend showing % of LAC achieving level 4 and above 2006 – 2009 (average of English Maths and Science results)



2.3 Progress Levels: Key Stage 1-2, percentage of LAC making two levels progress 2009

	Coalshire LAC	Coalshire All
English	41	78
Reading	50	89
Writing	32	71
Maths	36	78
Science	55	87

3. Key Stage 4

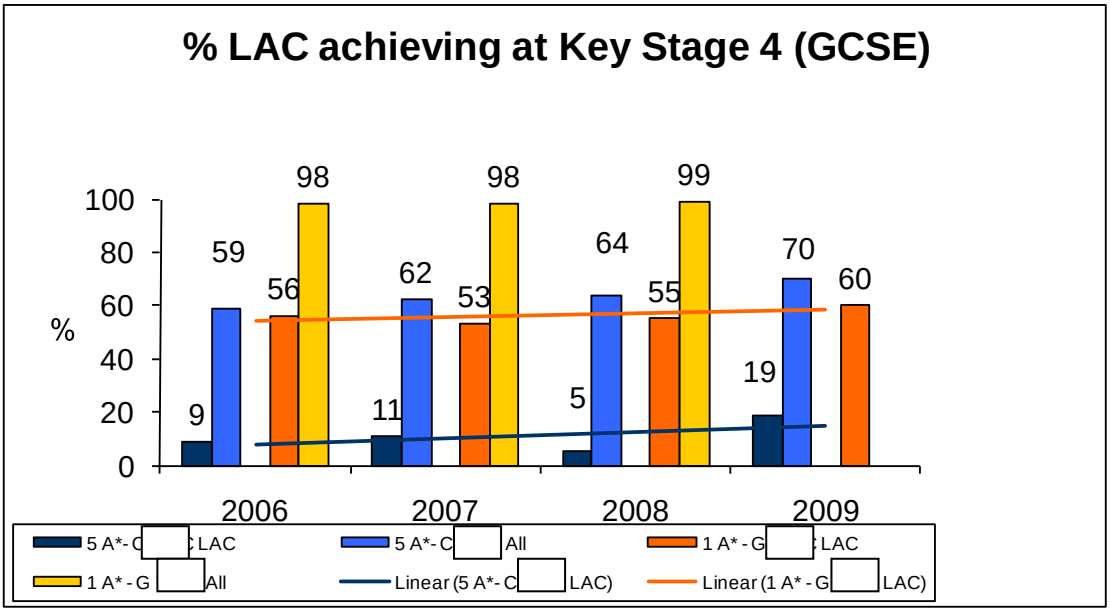
3.1 Results

	% 5 x A*-C		% 5 x A*- C incl. English & Maths		% 1 x A* - G	
	2008	**2009**	**2008**	**2009**	**2008**	**2009**
Coalshire. LAC	5	19	2	10	55	60
National LAC*	14	n/a	n/a	n/a	66	n/a
Coalshire. All	64	70	48	49	99	n/a

*Figures relate to GCSE only. All other figures include GCSE equivalent qualifications.

n/a= not available

3.2 Trend showing Percentage of LAC achieving 5 A*-C and 1 A*-G 2006-2009



Appendix II

ISL SERVICE OVERVIEW AND STRUCTURE

Chapter 3

Children as Researchers: An Appreciative Inquiry with Primary-Aged Children to Improve 'Talking and Listening' Activities in their School

Abstract

Appreciative Inquiry (AI) originated in the 1980s as a corporate organisational change model in the United States of America (Cooperrider *et al*, 2008). AI shares a similar philosophical basis to that of solution-focused approaches. With its focus on positives, it can help an organisation investigate and build on their strengths (Hammond, 1996). As an educational tool AI is still in its infancy (Lewis, 2010). This chapter describes the use of an AI framework to investigate how 'talking and listening' in a Year 3 and 4 class could be improved. This chapter describes the AI process, the project, and considers how an AI approach - with children as researchers - aligns well with the right of children to be heard, enshrined in legislation like the Children Act (1989 and 2004), Every Child Matters (DfES, 2004) and Articles 12 and 13 of the UN Convention of Rights (1989). The project was evaluated by the children, using an on-line questionnaire.

3.1 Introduction

Appreciative Inquiry (AI) originated in the USA in the 1980s, as a corporate organisational change model (Cooperrider *et al*, 2008). AI is a process that strives to create a better future by inquiring into, identifying and further developing the best of an organisation (Coghlan *et al*, 2003). AI shares a similar philosophical basis to that

of solution-focused approaches. With its focus on positives, it can help an organisation investigate and build on its strengths (Hammond, 1996). It has been used to spark positive organisational change in schools (Filleul and Rowland, 2006), but as an educational tool it is still in its infancy (Lewis, 2010). Its principles have been used in a growing number of studies relating to children and young people. Some argue, however, very few have used it as originally intended, with many researchers and practitioners either failing to follow the process adequately or simply not applying "the principles or philosophy authentically" (Lewis, 2010, p2). Furthermore, to date, none has used it *directly* with primary-aged children.

A Coalshire[i] colleague was considering using AI as a framework for her doctoral research. As part of an Educational Psychology Service 'project', she planned to use AI with a mixed Year 3 and 4 class in a primary school in which she worked as an Educational Psychologist. Interested in the process, I asked to be involved. The project aim was to use an AI framework to investigate how 'talking and listening' in their class could be improved. Whilst the broad focus of 'talking and listening' was donated by the teacher, the rest of the project involved the children, my EP colleague, the teacher, teaching assistant (TA) and me participating in a genuine inquiry regarding the children's best experiences of talking and listening. Our goal was to develop the children's ideas and 'dreams' into new ways of functioning in the classroom (Lewis, 2010).

[i] Pseudonym for the Local Authority I work in, and the research was conducted within.

This paper firstly provides a background to AI. Secondly, consideration is given to how an AI approach - with children as researchers - aligns well with the right of children to be heard, enshrined in legislation such as the Children Act (1989 and 2004), Every Child Matters (DfES, 2004) and Articles 12 and 13 of the UN Convention of Rights (1989). Thirdly, the project itself is briefly outlined. Finally, the project was evaluated by the children using an on-line questionnaire - the results are presented and the implications for AI's use with children are discussed. The project *per se* is not the primary focus of this paper, and is summarised very briefly: the empirical work which forms the focus of Section 3.5 is the children's facilitated evaluation of the project.

3.2 Appreciative Inquiry (AI)

3.2.1 Definitions

Appreciative inquiry is described variously as;

> *a "positive model of action research which liberates the creative and constructive potential of organisations and human communities" (Ludema et al, 2006, p155);*
>
> *an exciting philosophy for change (Hammond, 1996, p.3);*
>
> *a group process that inquires into, identifies, and further develops the best of 'what is' in organisations in order to create a better future (Preskill and Catsambas, 2006, p.1);*
>
> *a collaborative search to identify and understand the organization's strengths, its potentials, the greatest opportunities, and people's hopes for the future (Cooperrider et al, 2008, p.151); and*
>
> *less a process and more of a way of being which guides the practitioner (Lewis, Passmore and Cantore, 2008, p.44).*

Thus it has been defined as both a philosophy and/or a process (Lewis, 2010). In essence, it is both:

> *Appreciative Inquiry is a philosophy that incorporates an approach, a process (4-D Cycle of Discovery, Dream, Design, and Destiny) for engaging people at any or all levels to produce effective, positive change (Cooperrider et al, 2008, p.xv).*

3.2.2 Origins

AI evolved in the 1980s from the doctoral studies of David Cooperrider and his supervisor Suresh Srivastva, in a Cleveland Clinic. Whilst using a problem-focused approach to organisational change they realised the negative influence of such emphasis - where 'deficit-based questions lead to deficit-based conversations, in turn leading to deficit-based patterns of action' (Ludema *et al*, 2006, p155). Cooperrider and Srivastva noticed as problems were focused on, more problems emerged, and everyone became discouraged - including the researchers themselves (Ludema and Fry, 2008). They recognised that the type of questions they asked, unexpectedly affected the very "human system they were trying to understand and to help" (Ludema and Fry, 2008, p281). The pair discovered their work was more powerful when they framed their task as *inquiry*, rather than *intervention*, and "focused on everything they could find that appeared to empower and energise the system, everything contributing to excellence and high performance at the clinic" (Ludema and Fry, 2008, p281).

Immediate and dramatic results followed, "relationships improved, cooperation increased and visible commitments by the physicians to change initiatives ensued" (Ludema and Fry, 2008, p281). Ludema and Fry (2008) describe how Cooperrider and Srivastva coined the term 'appreciative inquiry', and published their seminal

article ‘Appreciative Inquiry into Organisational Life’ (Cooperrider and Srivastva, 1987). Cooperrider and Srivastva promulgated *‘a scholarship of the positive*’ (Ludema and Fry, 2008, p281). AI was born.

3.2.3 Underpinning principles

> *“It is based on the assumption that every living system has a hidden and under-utilized core of strengths – its positive core – which, when revealed and tapped, provides a sustainable source of positive energy for both personal and organizational transformation” (Ludema and Fry, 2008, p.282).*

The power of the positive influenced Cooperrider, and he observed its pervasive influence in studies from medicine, sports, behavioural science and anthropology (Coghlan *et al*, 2003): for example, how patients’ symptoms improved if they believed they’d received effective treatment (placebo effect); how teachers’ positive perceptions of students affected students’ performance (Pygmalion studies); and how patients with more positive thoughts recovered from surgery faster (Coghlan *et al*, 2003, p9). Along with others, Cooperrider applied the “theories of social constructionism and the power of image to organisational change”, developing five core principles for the practice of AI; these are shown below (detailed in Appendix III) (Cooperrider and Whitney, 2000; cited in Coghlan *et al*, 2003, p9):

1. *The constructionist principle*
2. *The principle of simultaneity*
3. *The poetic principle*
4. *The anticipatory principle*
5. *The positive principle*

Eight assumptions, the foundation for AI’s processes and methods, are based on these principles and are shown in Table 3.1 below:

Table 3.1: The eight assumptions upon which AI is based (Hammond, 1996, p20-21)

1	*In every society, organization, or group, something works.*
2	*What we focus on becomes our reality.*
3	*Reality is created in the moment, and there are multiple realities.*
4	*The act of asking questions of an organization or group influences the group in some way.*
5	*People have more confidence and comfort to journey to the future (the unknown) when they carry forward parts of the past (the known).*
6	*If we carry parts of the past forward, they should be what is best about the past.*
7	*It is important to value differences.*
8	*The language we use creates our reality.*

The final assumption, that language creates our reality, is a powerful one. As Humberto Maturana says, 'We exist in language...Language is grooming...It creates our bodyhoods' (Maturana, 1985; cited in McAdam and Mirza, 2009, p182). McAdam and Mirza (2009) assert that "through our relationships and the language we use, our identities are created" (p182). In an inspiring AI with marginalised young people in South Africa, McAdam and Mirza show the possibilities an AI approach can open up, when authentically applied. Working with young people whose 'identity stories' had been hitherto steeped in negativism, the results were stirring:

> *"When wondrous worlds are created with young people this offers them opportunities they may never have dreamed of before"*
>
> (McAdam and Mirza, 2009, p182).

3.3 Using AI with Children

3.3.1 Children's Views

Lewis *et al* (2008, p42) describe how AI "meets a deep-seated need in each one of us to be respected, to be listened to and to have the opportunity to shape the

future". McAdam and Mirza, (2009, p182) argue we "have an ethical and moral responsibility to create people in appreciative, growth-giving ways....This is particularly true for children and young people...". Arguably the first step to appreciating others is to listen to them.

The importance of listening to children's views in matters that affect them is finally beginning to gain the momentum it has long deserved (Roller, 1998; Hobbs *et al*, 2000; Lewis and Lindsay, 2000; Clark and Moss, 2001). The 1989 'UN Convention on the Rights of the Child' (UNCRC) (Article 12) stated:

> *"...parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".*

This position was reflected in Government legislature such as the 'Every Child Matters' agenda (DfES, 2004) and the Code of Practice (DfES, 2001a). Fundamentally, children have a right to be heard. Furthermore, it is important to listen to pupils' views so that educational professionals can meet their needs effectively, keep them safe and improve their school experience (DfES, 2001a, 2001b, 2003 and 2004).

3.3.2 Children as Researchers

In the adult world we value the use of research as an advanced learning tool and "whetstone for critical thinking" (Kellett, 2005a p1). Increasingly, "the importance of research in professional and personal development" is acknowledged (Kellett, 2005a p1). Kellett asks, why then "should children not benefit in a similar way?" (2005a, p1).

Rather than research *on* children, research *with* or *by* children offers another way of ensuring children have the opportunity to share their views, and influence the world they operate within. Historically, children have been the 'objects' rather than 'subjects' of research. Kellett (2005b) describes how "the impetus of the UNCRC (1989) brought about change...Children began to be seen as 'subjects' or 'participants' rather than 'objects' and research 'with' children became common practice" (p5). This sea change was "accompanied by a greater emphasis on listening to children, although frequently at a tokenistic level" (Kellett, 2005b, p5).

Kellett (2005b) clearly values children's perspectives and voice, describing how research *by* children sits "within a context of participation and empowerment" (p2). Kellett (2005b) highlights the "original contribution that child researchers can make to our understanding of childhood and children's lives" (p2). Increasingly children are viewed as able to be "competent participants in research" (Farrell, 2005).

3.3.3 AI with Children

AI has previously been used in research concerning children and young people, for example;

- regarding student involvement (Morsillo and Fisher, 2007);
- pedagogy (Yballe and O'Connor, 2000);
- enhancing learning in Vancouver schools (Filleul and Rowland, 2006);
- developing teaching practice (Clarke et al, 2006);
- emancipatory work with vulnerable youth in South Africa (McAdam and Mirza, 2009);

- considering best practice within multi-agency working with children with complex needs (Carter, 2006);
- and with High School staff regarding their perceptions of effective teaching, attitudes and traits to motivate students (Calabrese, Goodvin and Niles, 2005).

With the exception of the Vancouver and South African research, the young people themselves appear to have remained ‘objects’ of the research rather than true ‘participants’.

Furthermore, some of the research has adopted a ‘pick-and-choose’ approach to the use of AI, either not using any AI processes, failing to discuss the underlying philosophy of AI, or only utilising segments of the approach (Lewis, 2010). Some researchers are critical of such piecemeal approaches, due to their reductionism and dilution of the process (Rogers and Fraser, 2003; Carter 2006). Given AI’s attempt to ‘overcome tendencies toward reductionist thinking’ (Zandee and Cooperrider, 2008) their criticisms may be valid. On the other hand, others contend a major change programme is not always required and that AI could be as simple as asking “questions at the end of a staff meeting” (Cooperrider *et al*, 2008, p47). Indeed, AI offers great flexibility and scope. For example, “it may be used simply to pose one appreciative question, or it may be used to reframe an entire evaluation process” (Preskill and Catsambas, 2006, p50). Additionally, Micheal (2005) adapted the first Discovery stage of AI to create an interview tool. Moore (2008) argues just asking the right questions has value; “questions and dialogue about strengths, successes, values, hope, and dreams are in themselves transformational" (p. 214).

Kellett (2005b, p30) asserts:

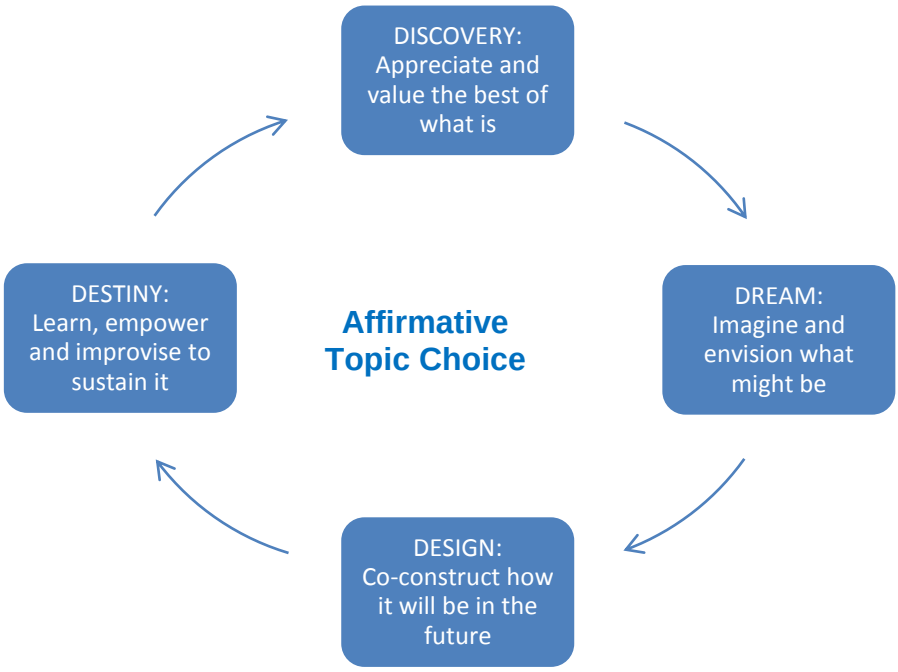
> *"The concept of children as active researchers in their own right is only just beginning to impinge on our consciousness but it is likely to figure prominently in the coming decade. The journey from research on, through research with to research by children is a natural progression accompanying the shifting changes in adult-child power and participation agendas."*

Despite the promise of AI as a powerful tool for transformational change, the development of AI processes within the educational action research literature is very new (Dick, 2006). Its use *with* children is at best 'emergent', and its use *by* children non-existent. The present study pilots its use *by* a class of primary-aged children, to consider the use of AI as a tool for giving children a say in matters that affect them – their learning.

3.4 Appreciative Inquiry in the Classroom

The '4-D cycle' is the most commonly used model for AI and is shown in Figure 1.

Figure 3.1: The 4-D Appreciative Inquiry Cycle



Source: Ludema and Fry (2008)

Ludema and Fry (2008) stress that “AI is a dynamic process” and the “linearity of this diagram should not be mistaken for a 'forced march' agenda that one must follow (Ludema and Fry, 2008, p.284).

The broad area of inquiry, or ‘topic choice’, was ‘talking and listening’. The topic choice was donated by the class teacher[j] as this was already an area for future development with her class. We followed the 4-D cycle with the children, with the addition of some planning and preparation stages by Researcher 1[k]. An outline of the project structure, with details of the different stages are detailed is shown in Appendix IV. Photographs depicting aspects of the process and some of the results at each stage are also shown (Appendix V). Overall, the project took place between July 2010 and March 2011, took approximately 8.5+ hours, and involved 9 sessions - including five planning and preparation meetings (see Appendix IV for details).

In order to evaluate the project I sought to elicit the children’s views of using AI and their involvement with the project. The project has not yet finished, in that the ideas the children came up with are in the process of being implemented by the class. This process is facilitated by the class teacher - whose opinion has also been sought for evaluation purposes. Her responses are shown in Appendix VI, and they are very positive. Despite the continuing nature of the project, as our involvement as researchers had come to the end, the children were asked their views regarding the AI project to date, and the next section presents and discusses their opinions.

[j] Topic choice does not have to come from the teacher, it could be generated by the Head teacher or the class themselves.
[k] Pseudonym for the Researcher who initiated the project, I refer to myself as Researcher 2.

3.5 Evaluating the Project

3.5.1 Questionnaires: Strengths and Limitations

In keeping with the principle of the project – that the children's views were paramount – an on-line questionnaire was used to collect the children's views at the end of the project. A brief questionnaire was also sent to the class teacher and Teaching Assistant (TA); (the class-teacher's response is shown in Appendix VI; – the TA had not sent her response by the time of assignment submission).

The term questionnaire is an umbrella term that can refer to self-administered or postal questionnaires, interview schedules, or simply different sets of questions and scales (Oppenheim, 2004, p.100). Amongst a range of other question types scaling was used to allow us to ascertain what aspects – if any – of the project the children enjoyed. Whilst, the information generated from such questions was useful, caution should be exercised with interpretation. For instance, questionnaires aim to obtain "valid information about the respondents and what they are thinking" or feeling (Robson, 2002, p125). This *internal validity* of the questionnaire can be called into question, if the questions used are incomprehensible or ambiguous (Robson, 2002). I was mindful to keep questions at a developmentally appropriate reading level (though where necessary, children were supported with reading). Additionally, the questions were checked by the class teacher, prior to distribution. Ideally, the questionnaire would have been piloted with a small group of children, but this was not carried out as it was not felt to be a priority within the available time scale.

Internal validity can also be affected if the children do not respond with their true feelings or beliefs (Robson, 2002). It is possible the children felt unable to be really honest, and may have reported more positively than they felt, especially as they were completing the questionnaire in school time (e.g. their answers may have been inhibited in a school context, as they may have been worried they would 'get into trouble' if they gave a negative appraisal). For ethical reasons, and to go some way to address this, informed consent was sought and it was stressed that we wanted the children's honest appraisal and results would be anonymous (see Appendix VII).

A clear advantage of questionnaires is that questions can be standardised to facilitate data analysis. However standardisation relies on respondents understanding questions posed in the same way. The data generated from scaling questions are undoubtedly interesting, but are subjective (what is a '6' for one child may be a '4' for another). Therefore, such information would not necessarily allow generalisability, even with large sample sizes. Generalisability is also affected if sampling is faulty, as *external validity* becomes a problem e.g. the selection process may mean that findings are specific to the group studied (Robson, 2002).

An advantage of using an on-line questionnaire format for this study, was the potential to facilitate data collection from a relatively large number of respondents (Scott and Usher, 2004), quickly and cheaply (Bell, 2001). This would be a clear benefit if, for example, the EPS were to continue using a questionnaire format for eliciting children's views regarding project work, although, given the need for a certain level of literacy, consideration would need to be given to the time and resource implications of

assisting some pupils with questionnaire completion. However, if a familiar adult were to complete this questionnaire with a child, it should take no more than 5-10 minutes to complete, and not all pupils would need support. Considering the possibility of literacy difficulties amongst pupils, it would be inappropriate to expect all pupils to fill in questionnaires unaided. This would be a limitation of using purely postal questionnaires, as respondents would not necessarily have anyone available to answer queries as they filled in the questionnaire. For this study, this was addressed by using an on-line questionnaire, with the class teacher and TA available to answer any questions. I also ensured my contact details were available via the teacher in case the children had any further questions.

Without face-to-face contact, responses to sensitive material can be more easily facilitated (Cohen *et al.,* 2003). Thus a potential advantage of completing the questionnaire on-line is that children may be more likely to share their real feelings. Where children are supported with questionnaire completion due consideration should be given to who supports the pupil, so that they are not inhibited but encouraged to give honest answers.

A potential limitation of a questionnaire format was that it gave the pupils response options which may have literally ‘put words in their mouths’, or they may have felt limited by the donated vocabulary. On the other hand, by providing words, students with a more limited vocabulary may be helped. To ensure pupils could answer more fully if desired, two open ended questions were used - ‘what do you think could have

made the project better' and 'is there anything you didn't like about the project'. Furthermore, a comment box for 'anything else you would like to say' was provided.

3.5.2 Questionnaire Results and Discussion

The class comprised a relatively even mix of Year 3 and 4 pupils. In all 27 pupils started the survey, and 26 (96.3%) completed it. The sample comprised 37% girls and 63% boys. The percentages relating to each score ('1' to '10') are presented in tabular form, following which the general trends are discussed. It should be stressed that due to the nature of data collection (a free on-line survey tool) and resultant data, analysis is arguably superficial and more qualitative in focus, but it is interesting to see what patterns emerge, and what lessons may be worth learning in this under-researched domain.

3.5.2i Pupils' views about the project

On the following page, Table 3.2 presents the pupils' views regarding the project. The results show that 77% of the pupils enjoyed the project (score of 6 or more), with 44.4% giving it a maximum score of 10/10. Nevertheless, a significant minority, 18.5% did not enjoy the project (score of 4 or less). As described above, interviews with the pupils would have allowed us to ascertain in more detail *why* they had or had not enjoyed the project. However, this needs to be balanced with the likelihood that pupils who did not enjoy the project may have felt comfortable to share this information on an anonymous questionnaire, but less so in a face-to-face interview.

Table 3.2: Pupils' views regarding what they thought about the project on a scale of 1 - 10	1 = Lowest score	2	3	4	5	6	7	8	9	10 = Highest score
How much did you enjoy the project?	3.7% (1)	0.0% (0)	3.7% (1)	11.1% (3)	7.4% (2)	14.8% (4)	3.7% (1)	3.7% (1)	7.4% (2)	44.4% (12)
How much were you able to share your best learning stories?	7.4% (2)	7.4% (2)	7.4% (2)	22.2% (6)	14.8% (4)	7.4% (2)	3.7% (1)	14.8% (4)	7.4% (2)	7.4% (2)
How much were you able to share your ideas?	7.4% (2)	7.4% (2)	11.1% (3)	11.1% (3)	14.8% (4)	3.7% (1)	3.7% (1)	7.4% (2)	7.4% (2)	25.9% (7)
How much were you able to share your ideas about talking and listening?	7.4% (2)	3.7% (1)	0.0% (0)	18.5% (5)	14.8% (4)	14.8% (4)	3.7% (1)	7.4% (2)	7.4% (2)	22.2% (6)
How much did you like the ideas your group came up with?	3.7% (1)	0.0% (0)	3.7% (1)	7.4% (2)	7.4% (2)	3.7% (1)	7.4% (2)	11.1% (3)	18.5% (5)	37.0% (10)
How much did you like the ideas other groups came up with?	7.4% (2)	7.4% (2)	3.7% (1)	7.4% (2)	14.8% (4)	3.7% (1)	7.4% (2)	14.8% (4)	3.7% (1)	29.6% (8)
How much did you understand what you had to do?	3.7% (1)	7.4% (2)	3.7% (1)	7.4% (2)	14.8% (4)	3.7% (1)	7.4% (2)	0.0% (0)	18.5% (5)	33.3% (9)
How good was your group at talking with and listening to each other?	3.7% (1)	11.1% (3)	0.0% (0)	7.4% (2)	7.4% (2)	7.4% (2)	7.4% (2)	22.2% (6)	11.1% (3)	22.2% (6)
How much are you looking forward to your ideas happening in school?	3.7% (1)	3.7% (1)	3.7% (1)	7.4% (2)	7.4% (2)	11.1% (3)	0.0% (0)	3.7% (1)	3.7% (1)	55.6% (15)
How confident are you that the action plans you came up with, will help improve talking and listening?	3.7% (1)	0.0% (0)	3.7% (1)	14.8% (4)	3.7% (1)	0.0% (0)	25.9% (7)	14.8% (4)	22.2% (6)	11.1% (3)

I did consider having a ‘comments’ box with each question, where pupils could give reasons for their rating, but felt that this would be too laborious for the pupils to complete for each question, and might take the ‘fun’ out of the novelty of an on-line questionnaire.

It is noteworthy that a large portion of the sample (44.4%) felt they weren’t really able to share their ‘best learning stories’ (score of 4 or less); with a similar percentage (40.7%) saying they were (6 or more). This could suggest, were we to conduct the research again, it would be advisable for us to allocate more time for this part of the AI (the ‘Discovery’ stage). Furthermore, it would be important to ensure pupils had similar time on this within the sessions, rather than more dominant or confident members of the group inadvertently having more time. It is possible, however, that individuals simply felt they were not able to share their stories feeling inhibited in their groups, or simply due to a lack of self-confidence in speaking up, or the influence of other factors. Again, interviews would allow this to be explored. Whilst so many did not feel able to share their best learning stories, most (62.9% scored 5 or more) did feel they were to some extent able to share their ideas generally, or specifically (70.3% scored 5 or more). Pupils were mostly positive about their own or other groups’ ideas, 77.7% gave their own ideas and 59.2% gave others’ ideas, 6 or more. It is perchance unsurprising that the pupils rated their own group’s ideas more highly! Pupils generally felt that they were good at talking with and listening to each other (70.7% scored 6 or more).

Encouragingly, most pupils (62.9% scored 6+) seemed to understand what they had to do, with a minority (22.3% scored 4 or less) not understanding what they had to do. Nevertheless, considering nearly a quarter did not really understand what they had to do, this suggests that our own differentiation of materials was insufficient to facilitate all of the pupils' comprehension and next time resources need to be adapted further or presented differently. Sampling of individual questionnaires suggested that 'understanding what to do' was not necessarily correlated with enjoyment of the project, neither was the students' anticipation of what might happen in the future e.g. one boy rated the project 1/10 for enjoyment, 5/10 for understanding what to do but 10/10 for looking forward to his ideas happening in school. Nevertheless, this is only a superficial examination of the data. I analysed the data using free on-line software ('survey-monkey'). Were I to repeat the project, or use such software again, I would encourage our Service to pay an annual subscription, as this would mean data could be subjected to more sophisticated analysis. For example, it would be possible to test statistically whether there was a significant correlation between 'understanding what to do' and 'how much you enjoyed the project'. It would also be interesting to note trends in the data e.g. with respect to gender.

Most positive, given the purpose of AI as an organisational change based model, is the pupils' anticipation of change and confidence in change occurring; for instance 74.1% gave 'how much are you looking forward to your ideas happening in school?' a score of 6 or more, indeed 55.6% gave this 10/10. Regarding 'how confident are you that the action plans you came up with, will help improve talking and listening?'

74% gave this a rating of 6 or more; however, the distribution of scores was more even with less clustering at the top. I believe this highlights the need for my colleague, the class teacher and me to ensure the pupils' action plans are realised, lest those with little confidence are proved right (22.2% scored 4 or less), and the more trusting and optimistic majority let down.

3.5.2ii What aspects of the project did pupils enjoy?

Table 3.3 below shows pupils' responses to questions regarding what aspects of the project they enjoyed most or least. These questions were included so consideration could be given to whether the AI format itself, or simply working with unfamiliar adults, using computers etc. were prized most highly.

A number of results stand out. Clearly novelty (76.9% gave 6+), working in teams (80% gave 6+), and using the computer (80% gave 6+) were all particularly positive, with most respondents giving these areas a high '10/10' rating. Results for 'having new people come into school' were for the most part positive (65.3% gave 6+), as too were 'using art materials' (69.2%). A notable negative was regarding 'working with people in my class I don't usually work with', as nearly a quarter of respondents gave this '1/10'. Results were spread, however, as a quarter gave it '10/10'. The AI process did allow pupils to choose what type of group they joined, but they did not know who would be in their groups, so it is noteworthy that this clearly mattered to a significant minority. Again, had it been possible, more sophisticated analysis of the data would be interesting here, to ascertain whether there were any patterns e.g. whether this dislike related to friendship groups, or pupils not enjoying working with

pupils with Special Educational Needs (SEN), or girls not enjoying working with boys etc.

Another factor which split opinion was ‘acting things out/role play’. Again a sizable minority (16.7%) gave ‘1/10’ ratings, although for the most part results were positive (48% gave 6+).

It was interesting to note responses to specifically ‘AI’ aspects of the project. For example, for ‘Telling stories about our favourite learning times’ 61.5% of pupils scored 6+, although more gave ‘6’ or ‘7’ than ‘9’ or ‘10’ ratings. ‘Coming up with new ideas about how to improve our learning’ achieved 60% of respondents scoring 6+, ‘Thinking of ways to change my lessons’ was similar (65.4%), and most pupils gave the higher scores for these statements (i.e. ‘9’ or ‘10’). For ‘writing provocative propositions’ 57.6% children gave this a score of 6+, but 30.7% gave it ‘4’ or less. I was not surprised by this result, as this aspect of the process required writing their ideas down, and even with support or differentiation, it was apparent during this part that some of the children were struggling with this. Overall, I think the results suggest that, for the most part, the AI aspects of the process were rated fairly positively, although given how positive ‘using the computer’ came out, perhaps greater use of this tool (e.g. with writing provocative propositions’) would aid general engagement with the process.

Table 3.3: Pupils' views regarding what aspects of the project they enjoyed the most/least on a scale of 1 - 10	1 = lowest score	2	3	4	5	6	7	8	9	10 = highest score
Doing something different	0.0% (0)	3.8% (1)	0.0% (0)	3.8% (1)	15.4% (4)	7.7% (2)	11.5% (3)	0.0% (0)	0.0% (0)	57.7% (15)
Having new people come into school	3.8% (1)	3.8% (1)	7.7% (2)	7.7% (2)	11.5% (3)	7.7% (2)	3.8% (1)	11.5% (3)	7.7% (2)	34.6% (9)
Working with people in my class I don't usually work with	24.0% (6)	0.0% (0)	8.0% (2)	8.0% (2)	12.0% (3)	4.0% (1)	0.0% (0)	20.0% (5)	0.0% (0)	24.0% (6)
Working in teams	0.0% (0)	0.0% (0)	0.0% (0)	4.0% (1)	16.0% (4)	12.0% (3)	0.0% (0)	8.0% (2)	12.0% (3)	48.0% (12)
Telling stories about our favourite learning times	7.7% (2)	7.7% (2)	7.7% (2)	3.8% (1)	11.5% (3)	19.2% (5)	15.4% (4)	7.7% (2)	3.8% (1)	15.4% (4)
Coming up with new ideas about how to improve our learning	4.0% (1)	4.0% (1)	12.0% (3)	16.0% (4)	4.0% (1)	4.0% (1)	16.0% (4)	0.0% (0)	16.0% (4)	24.0% (6)
Thinking of ways to change my lessons	3.8% (1)	3.8% (1)	0.0% (0)	15.4% (4)	11.5% (3)	7.7% (2)	3.8% (1)	7.7% (2)	15.4% (4)	30.8% (8)
Using the computer	8.0% (2)	0.0% (0)	4.0% (1)	4.0% (1)	4.0% (1)	4.0% (1)	4.0% (1)	8.0% (2)	4.0% (1)	60.0% (15)
Using art materials	7.7% (2)	7.7% (2)	0.0% (0)	3.8% (1)	11.5% (3)	3.8% (1)	7.7% (2)	15.4% (4)	19.2% (5)	23.1% (6)
Writing provocative propositions	7.7% (2)	3.8% (1)	7.7% (2)	11.5% (3)	11.5% (3)	3.8% (1)	7.7% (2)	3.8% (1)	19.2% (5)	23.1% (6)
Acting things out/role play	16.7% (4)	0.0% (0)	4.2% (1)	0.0% (0)	12.5% (3)	4.2% (1)	8.3% (2)	4.2% (1)	16.7% (4)	33.3% (8)

3.5.3 Implications for Future Research

On reflection I feel I should have also given the pupils the option of scoring aspects of the project '0' and this was an oversight on my part. This would have allowed pupils to give a 'neutral' response when reporting a '5' – rather than this being in the negative half of the scale. I also think that, whilst generally positive, a significant minority of pupils did not enjoy particular aspects of the project, and were we to use AI again, I would wish to adapt aspects of the process (e.g. using the computers for 'provocative propositions' or bringing some 'child friendly' exemplars for the 'Design' section) and perhaps allocating more time to certain phases (e.g. 'Dream' and 'Destiny' stages) so the pupils had more time to rehearse or make their models (as most of the stages were covered in 1 – 1.5 hour slots).

When asking students to evaluate a course, Norum (2001) used AI questions of a 'solution-focused'[12] nature. Were I to repeat this project, I would have framed some of the questions in this way e.g. 'if you had a magic wand and could make the project as good as it could be, what would you see...what would be different?'.

Nevertheless, the pupils were able to give their own ideas for how to improve the project next time, responding to 'what do you think could have made the project better?'. Many did not report improvement suggestions (41%), but the majority offered the following suggestions: a number of pupils - as I did - noted the need for more time ("more time", "a lot more time", "more time to do the project", "more time to discuss ideas"); some felt more group work would help ("working more with other

[12] Stems from 'Solution focused brief therapy' (SFBT) where there is a focus on the client's preferred future.

groups", "working more in a team"); some wanted more options ("more choice", "coming up with more ideas", "more ideas", "more computer", "talking and writing"); some had creative ideas ("make a theatre", "food", "sing more"); and some wanted "for people to think carefully". I think the respondent who said "bit more fun" highlights that if we were to carry out an AI project with children again, this should be high on the agenda. I think videoing the 'dream' stage and acting out the provocative propositions, rather than writing them, could be possible adaptations to serve this purpose.

Another question on which the pupils were invited to comment was 'is there anything you didn't like about the project?'. Most students responded to this question (74%, n = 19). Positively, the majority (n = 12) commented "no", with one pupil emphasising "N O spells no"! Others gave the following comments: "people being rude"; "when R1 and R2 went"; "the map"; "some ideas" and "a few of my ideas"; "songs"; "talking"; "the writing". Finally, a few of the pupils made polite comments in the last box – "thank you very much"; "it was very nice thank you I enjoyed it very much"; "thank you for teaching me provocative propositions"; and "thank you for the questionnaire".

Opie (2004) describes how the use of questionnaires is not 'problem free' and perhaps the most significant limitation has been highlighted by Bell (2001, p11):

> *"Can provide answers to the questions What Where? When? and How?, but it is not so easy to find out Why? Causal relationships can rarely if ever be proved by a questionnaire. The main emphasis is on fact-finding."*

Opie (2004) argues that questionnaires are still a 'useful procedure', if one accepts this limitation. For this research, a detailed interview with every pupil would no doubt

answer more 'Why?' questions, but this improved knowledge needs to be counterbalanced by the time and resource implications of collecting and analysing such information.

In the context of this research, using on-line questionnaires appeared effective and 'fit for purpose', but results can only ever suggest areas for future research, rather than answer more fully our queries regarding the pupils' actual views and ideas about the AI process. The finding that 53.8% of the pupils 'would recommend a project like this to other children', 3.8% 'wouldn't', and 42.3% 'might' recommend it, suggests that there is some further work to do with adapting or presenting the AI process in a way that increases engagement and is capable of contributing to a more emphatically positive response.

3.6 Conclusion

Teachers and children bring wide ranging ideas that can "provide a powerful basis for developing understanding of the complexities of classroom practice" (Clarke *et al*, 2006, p407). Research which has previously used AI to examine young people's learning has proved helpful (see Carnell, 2005). In this project, the potential benefits of AI have not been realised as fully as they might have been, had more time been available for planning and execution. Nevertheless, it has proved a valuable tool for exploring the children's ideas around how to improve 'talking and listening' in their lessons. The majority of children responded positively to the AI process, and with some amendments to our execution of the process, I would like to think that all of the children would have responded positively.

Inherent in AI research are 'transformative possibilities' (Johnston, 2008). A meta-case analysis of the use of AI suggests that cases where research has showed transformational outcomes (35% of studies), only occurs where there is "(a) a focus on changing how people think instead of what people do" and "(b) a focus on supporting self-organising change processes that flow from new ideas" (Bushe and Kassam, 2005, p161). This suggests that for future AI projects it would be important to look beyond simply changing actions, and also ensure a focus on how to help sustain ideas that emerge from any process. Certainly, I am mindful that we need to follow up this project with the class teacher, and see whether further support is needed.

True transformational possibilities have yet to be realised with this project, but as a pilot for considering future use of AI with children, I think it has proved positive. Given the right of children to have their voice heard on matters affecting them (UNCRC, 1989), I think an interesting direction would be a project where there was no donation of a theme, but rather the children themselves decided on what they would like to inquire about appreciatively.

> *An important premise of appreciative inquiry is that high quality inquiry depends on the presence of all participants in full voice*
>
> *(Zandee and Cooperrider, 2008, p.191)*

I think it would take time for us as researchers to gain the trust and confidence of all the pupils so that they could truly participate in "full voice". I observed that for some children with Special Educational Needs (SEN) or English as an Additional Language (EAL) their engagement in some of the AI activities and their ability to contribute fully

to some tasks was limited. I do not think this means that AI is unsuitable for use with such pupils, but time and resources need to be given to adapting or differentiating aspects of the process/tasks, to ensure such children are fully included. We did differentiate to an extent (e.g. for one Bengali pupil, I contacted the EAL department for support and ideas) and children were supported when needed, but there was certainly scope for improvement, though time pressures were the main restrictor here affecting planning, preparation and meeting time.

Lewis (2010) in her critical review of the literature regarding AI argues there are nine points that should be considered when using AI authentically in educational research:

Table 3.4: Key Points towards Authentic AI

1	*AI projects must be inclusive, involving as many different stakeholders as possible from within the target organisation, including managers.*
2	*Participants should self-select topics in latter two stages of AI, based on personal interests.*
3	*AI processes can be flexibly employed in teams and schools, but must be underpinned by an understanding of AI's strengths-based solution-focused philosophy in the spirit of a genuine inquiry to use the term AI authentically.*
4	*The term AI should be reserved for organisational change projects not diluted by using it in reference to positively framed questioning or positively story-telling.*
5	*The Discovery stage of AI, which involves positive story-telling, is powerful in changing relationships but not sufficient on its own to transform an organisation.*
6	*Participants must be allowed and encouraged to take the initiative, making things happen for themselves. Those leading AI initiatives should act as facilitators (or trainers of facilitators) in this process.*
7	*AI has the potential to transform pedagogy, if children, young people and teachers participate together in a genuine inquiry about their best experiences of teaching and learning, developing their ideas and dreams into new ways of functioning together in the classroom each year. Educational Psychologists could facilitate this and provide training for others to conduct AI within schools.*

8	*Genuine, evidence-based 'ability-spotting' (see McAdam and Mirza) helps to build confidence and has the potential to transform relationships (for teachers and colleagues, as well as children and young people).*
9	*Authentic AI focuses upon a personal engagement in a process of inquiry within a human system, and is not an individual task. EPs could have a direct contribution in facilitating AI with their knowledge and expertise about human systems.*
10	*Professional teams (including EP and multi-agency teams) could use AI to develop their vision, ethical codes and ways of working, derived from their collective beliefs.*

Source: Lewis (2010, p10 and p16)

Although there were a number of ways this project could have been improved – not least ensuring that there was enough time dedicated to the different stages – mindful of Lewis' (2010) 'key points' I do believe this was an 'authentic' appreciative inquiry. Carter (2006) asserts the success of AI is dependent upon the understanding and philosophical orientation of the researchers. Arguably, my EP colleague's and my understanding of AI is sound, and our philosophical orientation aligns well with its principles. Nevertheless, this project highlighted the need to ensure enough time is allocated to the process, with regards to planning, delivery, and the implementation of actions, so that all children can participate with 'full voice' and the use of AI avoids superficiality, and is indeed truly transformational. Carrying out this project has highlighted numerous areas that can now be reflected on, learnt from and built upon in future applications of AI in Coalshire. The promise of AI is tantalising but perhaps the best course of action is to follow Carter's (2006, p61) sage advice:

> *"Fall in love with it as a way of (re)framing your research, see yourself as 'one expert among many'; but keep your eyes open and maintain a critical stance".*

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APPENDIX III

Cooperrider and Whitney, 2000: five core principles for the practice of Appreciative Inquiry

1. *Constructivist Principle.* Related to the notion that multiple realities exist based on perceptions and shared understandings, this principle suggests that what is known about an organization and the organization's actual destiny are interwoven.

2. *Principle of Simultaneity:* Because reality is an evolving social construction,it is possible through inquiry to influence the reality an organization creates for itself. Inquiry and change are simultaneous and "inquiry is intervention." Thus, the nature of the inquiry itself is critically important where the very first questions we ask set the stage for what people discover and learn and the way they co-construct their future.

3. *Poetic Principle.* Because reality is a human construction, an organization is like an open book in which its story is being co-authored continually by its members and those who interact with them. Consequently, members are free to choose which part of the story to study or inquire about—its problems and needs, or its moments of creativity or joy, or both.

4. *Anticipatory Principle.* This principle postulates that the image an organization has of its future guides that organization's current behavior. Thus, an organization's positive images of its future will anticipate, or lead to, positive actions.

5. *Positive Principle.* This principle arose from extensive experience with Appreciative Inquiry. Early Appreciative Inquiry practitioners found that the more positive the questions they asked were, the more engaged and excited participants were and the more successful and longer lasting the change effort was. This is in large part because human beings and organizations want to turn toward positive images that give them energy and nourish happiness.

(Source: Cooperrider and Whitney, 2000; cited in Coghlan *et al*, 2003, p9):

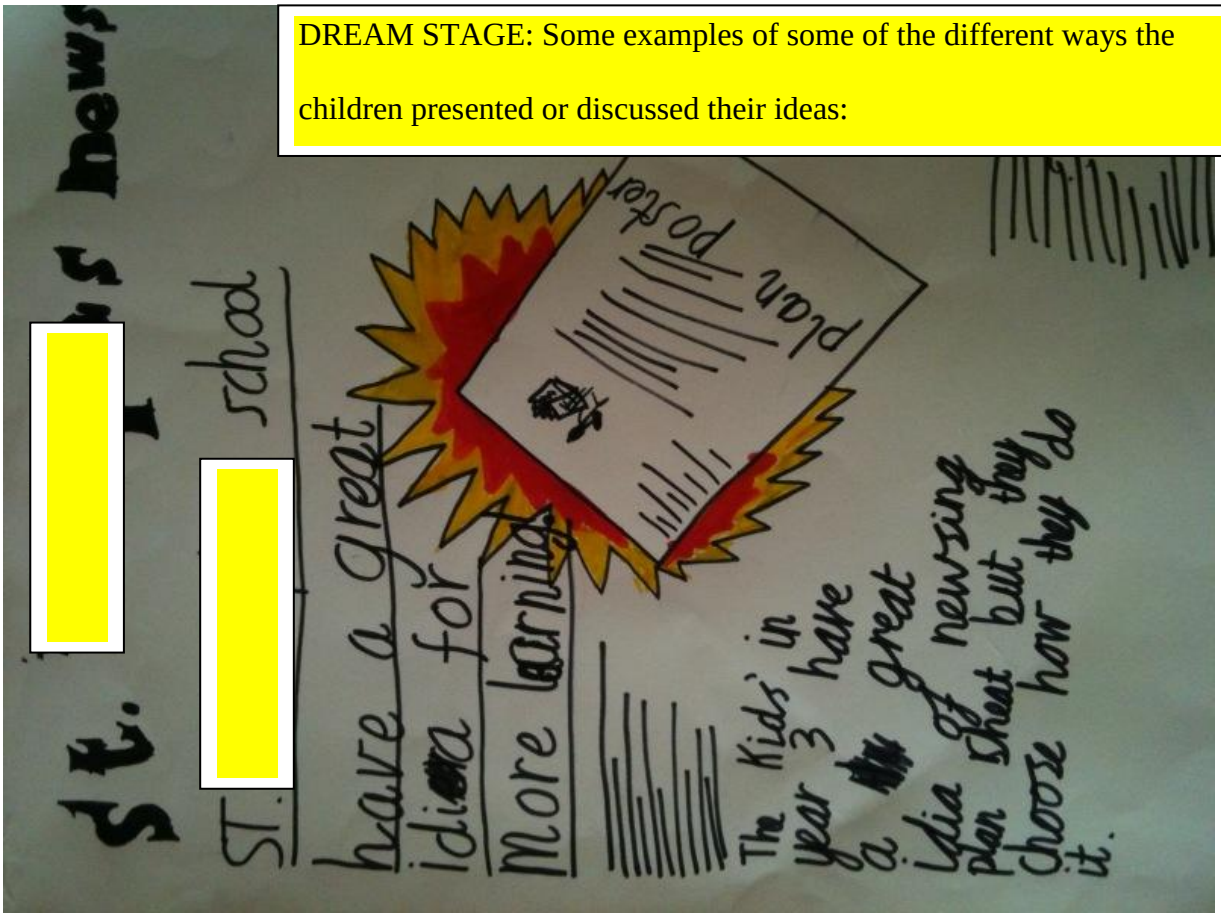
APPENDIX IV: OUTLINE/STRUCTURE OF THE PROJECT

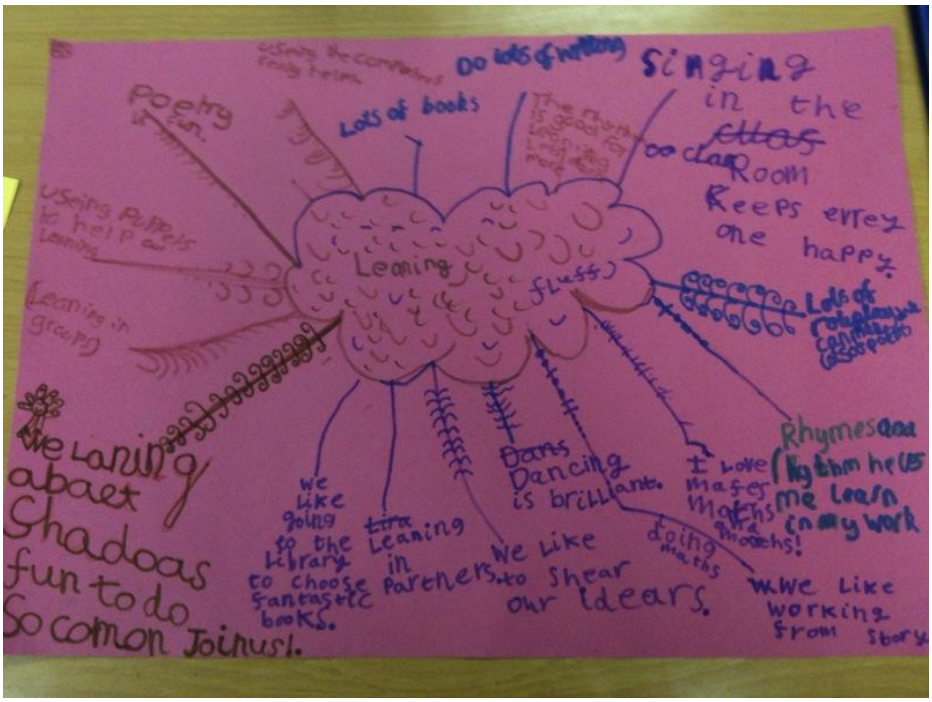
Aspect	Content	Who's involved?	Time taken
1. *Planning and preparation*	Initial meeting with class teacher to gauge interest	Class teacher, Researcher 1	1 hour
2. *Planning and preparation*	Whole staff meeting to brief them about the project and promote awareness and interest in AI	Whole staff, Researcher 1	1 hour
3. *Planning and preparation*	Initial planning meeting and discussion with class teacher: • Identified theme/topic choice. • Decided on a having a 'planning group' of children. • Discussion on how to get representative mix of 8-10 pupils.	Class teacher, Researcher 1	1 hour
4. *Planning and preparation*	Pupil planning group meeting: • Three groups of 3-4 pupils, supported by an adult, wrote questions to frame the inquiry. • Questions would then provide useful prompts for the class at the Discovery stage where they would be discussing their best times relating to talking and listening. For example, the groups came up with questions like *"what is the most exciting learning you've ever done in school....did it have any talking and listening in it?"*	Class teacher, Researcher 1 and 2, and representative group of pupils	1 hour
5. *Discovery*	• With teacher guidance, children were paired up with someone they knew least well. • Children asked each other about their 'best ever times learning at school' (using question prompts generated by pupil planning group). • In groups of 4-6, children listened to the best bits of each other's stories, whilst the adult supporting the group made notes of the main emergent themes. • Groups then decided on the strongest themes and story examples to feedback to the whole class. • Whole class feedback of stories and themes for each group.	Class teacher and TA, Researcher 1 and 2, whole class	1 hour
6. *Dream*	• In the same groups as the Discovery stage, adults reminded/prompted reminding of the stories and themes that were talked about last time in the groups.	Class teacher and TA, Researcher 1	1.5 hours

	• Children started to think and dream (in pairs initially) about ideas for how their stories and themes could happen even more in their learning – make notes on large paper. • Each group decides on what they are most excited about that is realistic, and linked to the topic choice. • Groups decide on how they would like to creatively present their chosen idea to the class and practice/prepare e.g. one group presented their idea as a newscast, one group made up a song. • Show and tell to the class, and four themes/ideas were identified by the class	and 2, whole class	
7. Preparation	• Class teacher asked children to choose which idea they would like to follow up, and placed children in groups accordingly.	Class teacher whole class	0.5 hour
8. Design	• Researcher 1 explains what 'provocative propositions' are i.e. statements which describe what the dreams would look like when operating successfully • Groups make 'provocative propositions' • Groups share their provocative propositions with the class, and class comment on these appreciatively e.g., what they like about other groups' provocative propositions and any suggestions they have for further improvements – revisions made where appropriate.	Class teacher and TA, Researcher 1 and 2, whole class	1 hour
9. Destiny	• The groups start working on the provocative propositions, and create an action plan regarding what needs to happen in the future so that these are realised. For example, one group opted to improve talking and listening activities by inviting visitors to come in to school to be interviewed by the children about their jobs. This group's action plan involved writing the invitation letter and planning out the questions they would ask.	Class teacher and TA, Researcher 1 and 2, whole class	1.5 hours
10. Destiny continued	• Class teacher, TA and class continue to work towards realising the class' dreams.	Class teacher and TA, whole class	On-going

APPENDIX V: CHILDREN'S WORK EXEMPLARS

DREAM STAGE: Some examples of some of the different ways the children presented or discussed their ideas:

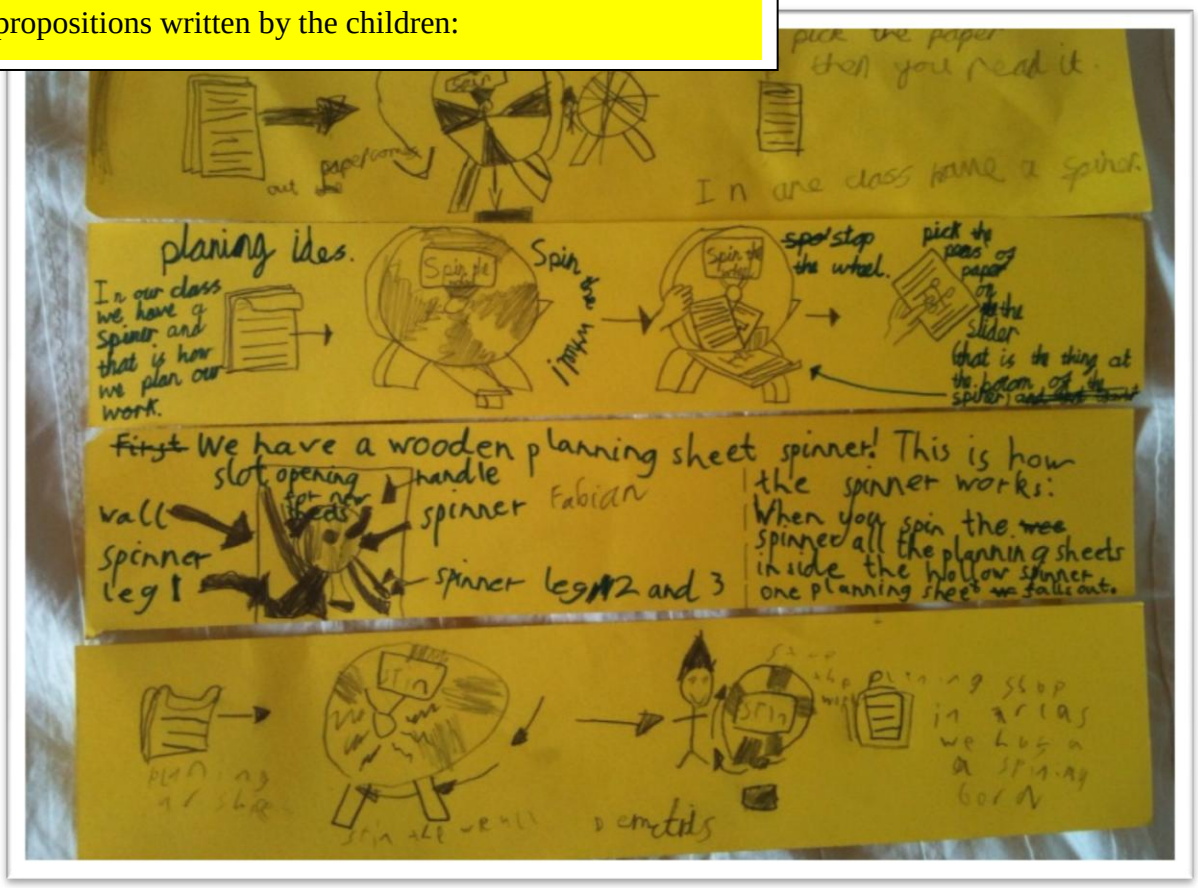


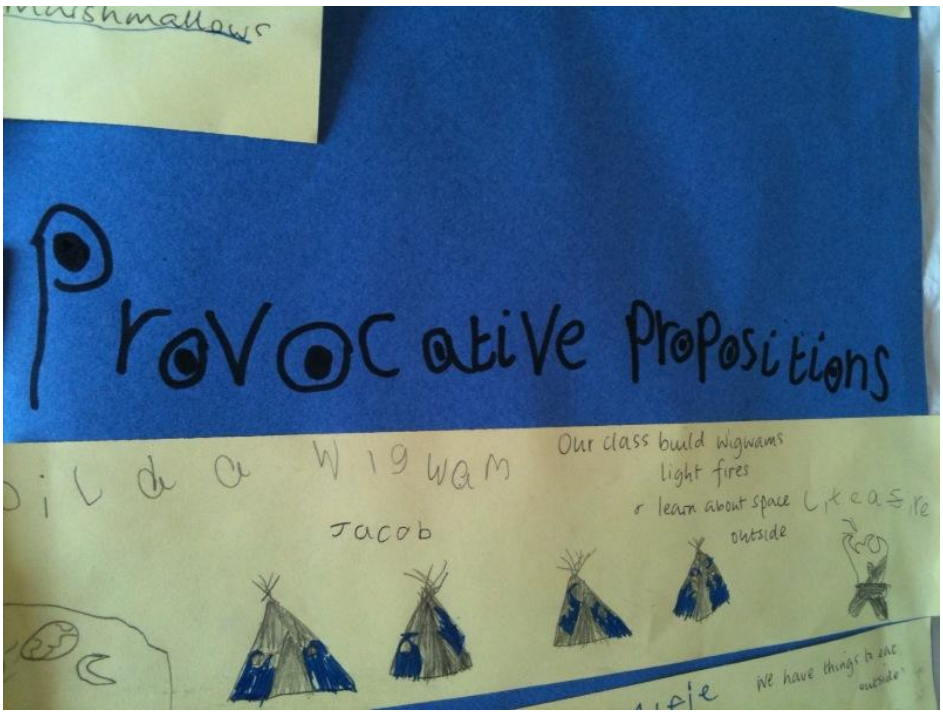


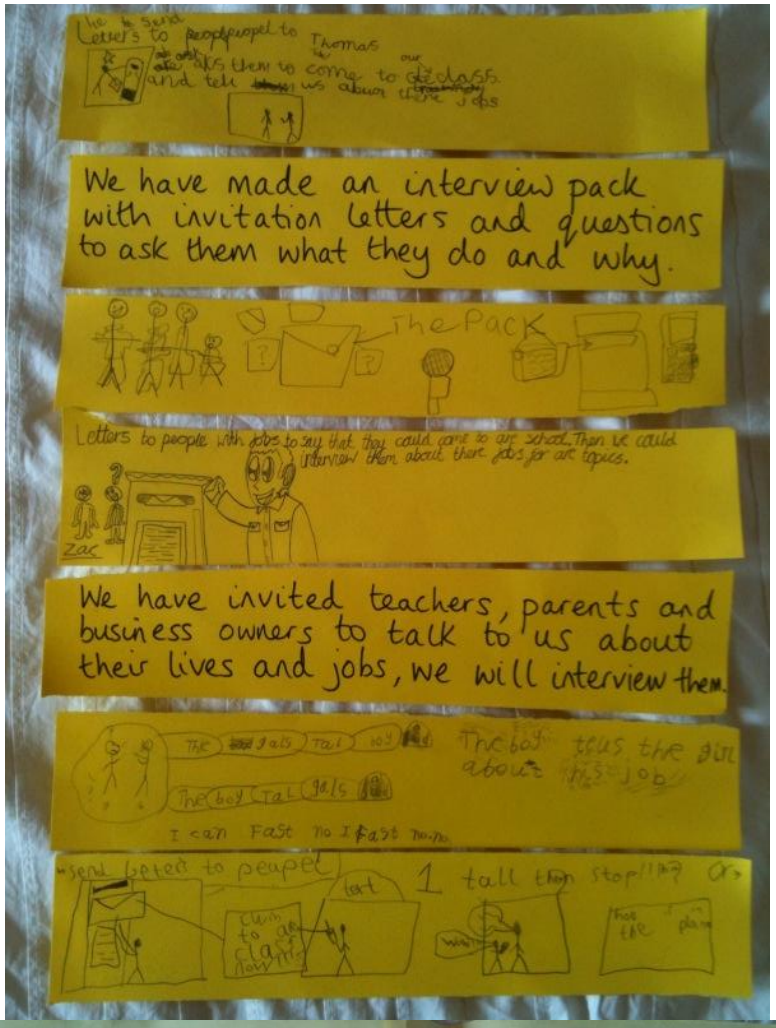

Slot to put papers in.
Spin
Slot for a paper to fall out.
Big write
R.E
Maths
Art
Date
Name
Title
Method.

DESIGN STAGE: Some examples of provocative

propositions written by the children:

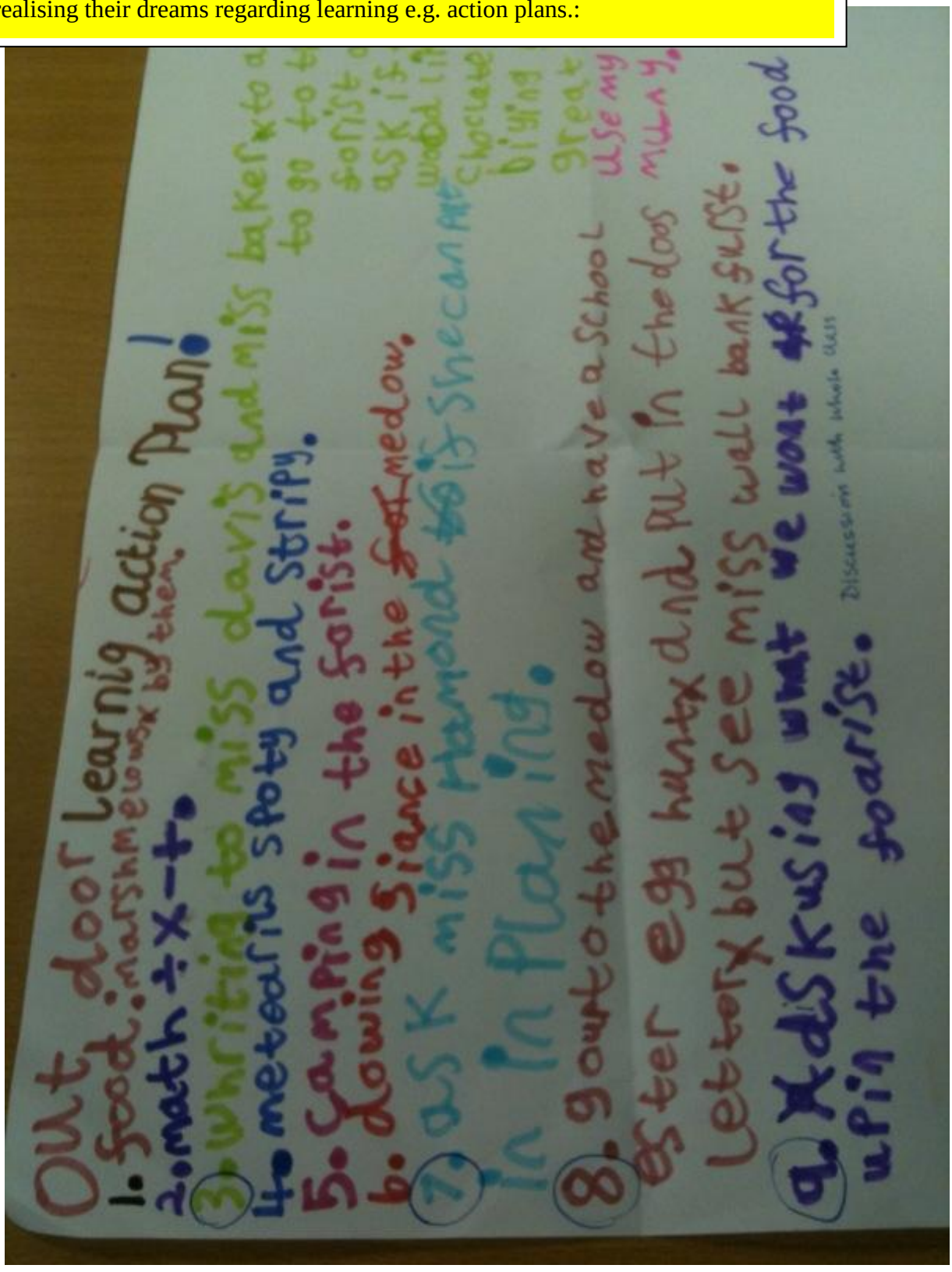





We have made an interview pack with invitation letters and questions to ask them what they do and why.
ThePack
Letters to people with jobs to say that they could come to our school. Then we could interview them about their jobs for our topics.
Zac
We have invited teachers, parents and business owners to talk to us about their lives and jobs, we will interview them.


We Can Create a List of Out door Learning
Ideas
Provocative Propositions
Have a carneng down time for if yo have hurt sumwon
Francesco

DESTINY STAGE: Some examples of the work produced by the children towards realising their dreams regarding learning e.g. action plans.:



THE AI DISPLAY BOARD IN THE CLASS:

APPENDIX VI: Class teacher's Feedback

Is the inquiry leading to real changes in the classroom?
Yes, much more confident to allow for child led activities and to allow them to to plan how and what they want to learn

What have you appreciated/liked about AI with the whole class?
The opportunity to try something different, with a real focus on learning and ways each child wants to learn

What are the benefits as you see it?
Children involved in their learning.
Children aware of how they want to learn
I'm a more confident practitioner, in myself

What does it bring that's new i.e. that you haven't already done with the class in other ways?
Not sure that it's brought about anything new, but it has given me different way of looking at things and the opportunity/time [to explore these]

What are the risks/difficulties?
No risks or difficulties from my point of view. Time could have been an issue but felt it was an important development so tried to give it as much time as necessary. Other difficulties could have been 'letting go' and allowing children to take complete control, even though I knew what I wanted out of it, but recognise the best way for children to learn is to be in charge of their own learning and for me to act more as a facilitator.

How could the process be improved if we did it again next year?
Ideally needs to start in the Summer term so ideas can be implemented sooner i.e. Autumn term

Have other members of staff been interested in what has been happening in your class?
Yes, have shared AI in staff meetings and looking at applying for a Leading Aspect in it, and will be sharing it with new staff in September.

Would you be interested in helping others to do an AI with their classes (e.g. in other schools)?
I'm more than happy to share my experiences with others.

Any other comments regarding the project?
Children have really enjoyed it and benefited from it, helping them to recognise how they learn and the importance of their ideas and suggestions, alongside our own school's use of AfL (Assessment for Learning) and BLP (Building Learning Power)

Has been a fantastic use of time and CPD for myself and thank you for the opportunity!

APPENDIX VII: Copy of e mail sent to class teacher to describe informed consent

(she then read this aloud to the class, prior to their completion of the questionnaire).

Dear ..... (Classteacher)
>
> Please find the link to the survey I've made for the children to complete.
> Please could you have a look at it and let me know if there is
> anything you would like me to add/amend?
>
> Copy and paste the HTML code below to add your Web Link to any webpage:
> http://www.surveymonkey.com/s/278JYCN
> Alternatively, the children can just type this link in and it takes
> them there anyway.
>
> If it's good to go, then the link needs to be pasted onto your school
> website so the children can complete it. Can you please give each
> child a number (eg 1-28 in the register), and this is the 'code' they
> have to fill in. This is so that if they want to withdraw their data
> at a later point they can.
>
> Please can you explain to them about informed consent! - If you read
> the following to them this should be ok:
>
> - Oonagh Davies and Anna Lewis are seeking your permission to get your
> views about the research they completed with the class (the
> Appreciative Inquiry, talking and listening project) - give them some
> prompts to check they remember!
> - we would like you to complete a very quick questionnaire for us
> (shouldn't take more than 5-15 minutes to complete depending on
> reading ability - so some may want support to complete)
> - the information they give us will be kept confidential (private) and
> anonymous (no one can tell who said what)
> - the data they give us will be private too (e.g. they can give their
> honest opinion) and if they don't want to fill in the questionnaire
> they don't have to
> - if they complete the questionnaire, then change their mind and want
> to remove their data, they can (and Mrs ..... classteacher, will let me know the code number to remove)
>
> Many thanks
>
> Oonagh

Chapter 4

Can Cognitive Behaviour Therapy be a therapeutic intervention of choice for educational psychologists working in community settings with children and young people who have Autistic Spectrum diagnoses?

Abstract

This chapter considers the use of therapeutic interventions, specifically Cognitive Behavioural Therapy (CBT) in educational psychology practice. The chapter outlines the national policy context surrounding child and adolescent mental health. The potential strengths and challenges of a CBT approach are discussed, along with the use of CBT with specific groups of children. The chapter concludes that educational psychologists (EPs) are well positioned and well equipped to deliver CBT, but that strategic and organisational considerations currently mean many EPs are missing Greig's (2007) 'golden opportunity' to use this well evidenced intervention in school settings.

Chapter 4 and Chapter 5 are interrelated. In Chapter 5, a case example of a teenage girl with Asperger syndrome is used in order further to discuss CBT, demonstrate and consider assessment methods and tools, and illustrate the importance of case formulation.

4.1 Introduction

4.1.1 Background

Young people's mental health has significant implications for their social development, educational achievement, and future health and social outcomes (Department of Children Schools and Families, DCSF, 2007, Kuh *et al*, 1997). The British Association for Counselling and Psychotherapy (BACP, 2009) asserts that early, easy access to therapeutic interventions in schools can "prevent mental health problems in children developing or becoming more serious" (p1). Despite its importance, the mental health agenda for young people, and the potential contribution of schools, has only relatively recently been supported by a legislative impetus (Department for Education and Skills, DfES, 2004; DCSF, 2007). Furthermore, in schools the application of national guidance about promoting mental health is still severely limited, particularly in secondary schools (Office for Standards in Education, Ofsted, 2005a). Schools do, however, have an important role to play in mental health work (Merriman, 2009). Table 4.1 below provides a chronological overview of publications by the UK Government:

Table 4.1: Key publications produced by the UK Government relating to mental health promotion for children and young people (CYP)

Publication	Key Details
'Together we stand: The commissioning, role and management of child and adolescent mental health services' (National Health Service (NHS) Health Advisory Service, 1995)	The Health Advisory Service (HAS) developed and published a framework for tiered support which continues to be used in structuring the organisation of multi-agency mental health services (see Table 4.2 below).

'National Service Framework for Mental Health' (Department of Health, DoH, 1999)	Outlined long term strategies for improving care in this area, and acknowledged mental health had not been given the priority status it requires given the prevalence of mental distress. However, framework focused on adults of working age and only referred to children and young people (CYP) who are about to become adults, or whose parents are experiencing mental health difficulties.
'Promoting children's mental health in early years and school settings' (Department for Education and Employment, DfEE, 2001).	This document explains to schools that they are in a strong position to influence their pupils' mental health as they are able to conduct preventative work, identify and intervene with problems at an early stage, reach more children than specialised mental health services, and support and maintain the progress of children in a way which mental health professionals who only have contact with a child in relation to a specific problem and for a specific period of time cannot.
Every Child Matters Green Paper (Department for Education and Skills, DfES, 2004).	Being mentally and emotionally healthy is a key part of 'Be Healthy,' one of the five key outcomes.
'National Service Framework (NSF) for the mental health and psychological well-being of children and young people' (DoH, 2004)	This framework forms Standard 9 of the NSF for Children, Young People and Maternity Services. The report indicates that while approximately 10% of children aged between five and 15 have a diagnosable mental health disorder, there are a similar number of children and young people who have less serious mental health problems, but would also benefit from additional support. The report emphasises that all agencies who work with children and young people (including those within education, social care, primary health care and the voluntary sector) have a responsibility to promote their mental health and well-being, and provide additional support.
'Healthy Minds: Promoting emotional health and well-being in schools' (Ofsted, 2005b).	This report begins to evaluate the role played by schools in promoting the emotional well-being of pupils. It identifies opportunities for positive work within the curriculum, culture, policies, and initiatives of schools. Significant areas for development are also highlighted, including the need to train staff, to identify pupils experiencing difficulties, to improve behaviour policies and to work with outside agencies.
The Social and Emotional Aspects of Learning (SEAL) programme (Primary National Strategy, 2005; Secondary National Strategy, 2007).	A curriculum resource designed to help schools develop children's social, emotional and behavioural skills.
The National Healthy Schools Programme (DoH and DfES, 2005).	The programme offers support and guidance to Primary Care Trusts, LAs and their schools to support them in promoting the link between good health, behaviour and achievement.
'Promoting children's social and emotional wellbeing in primary education' (National Institute for Clinical Excellence, NICE, 2008, commissioned by the DoH).	Recommendations represent an holistic approach, with an emphasis on the development of supportive and secure environments, and an ethos that avoids blame; the importance of working in partnership with children, ensuring that they can express their views and opinions is also emphasised.

National Child and Adolescent Mental Health Service Review (DCSF and DoH, 2008).	The CAMHS review creates a vision that everybody will recognise their role in promoting mental health and psychological well-being, and will understand their role and responsibilities, and the roles and responsibilities of others, and will have the skills and competencies required to fulfil their role.
'Targeted Mental Health in Schools Project - Using the evidence to inform your approach: a practical guide for head teachers and commissioners' (DCSF) (2008)	Aimed at supporting the development of innovative models of therapeutic and holistic mental health support in schools for children and young people aged five to 13 at risk of, and/or experiencing, mental health problems, and their families (discussed and illustrated below).
'Promoting children's social and emotional wellbeing in secondary education', (NICE, 2009, commissioned by the DoH).	Follows on from NICE (2008a), and made a number of recommendations relating to (a) establishments having access to the specialist skills, advice and support they require; (b) practitioners should have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing; (c) establishments should provide a safe environment which nurtures and encourages young people's sense of self-worth, reduces the threat of bullying and violence and promotes positive behaviour; and (d) social and emotional skills education should be tailored to the developmental needs of young people.
'No health without mental health: a cross-government mental health outcomes strategy for people of all ages' (DoH, 2011a)	This strategy sets out 'six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality services. It supports the Government's aim of achieving parity of esteem between physical and mental health. The interconnections between mental health, housing, employment, and the criminal justice system are stressed'.
'Talking Therapies: A four-year plan of action' (DoH, 2011b)	This plan accompanies the cross-government mental health strategy, *No health without mental health*. It outlines how the Government's commitment to expanding access to psychological therapies will be achieved in the four years from April 2011. The aim is to develop talking therapies services that offer treatments for depression and anxiety disorders approved by the NICE across England by March 2015, and involves the initiation of a stand-alone programme to extend access to psychological therapies to children and young people, building on learning from the 'Improving Access to Psychological Therapies' programme and using NICE-approved and 'best evidence'-based therapies where NICE guidelines are pending.

(Sources: Merriman, 2009, p62-63; DoH, 2011a and 2011b)

As shown, 'Together We Stand' (HAS, 1995), offered a review of and strategic framework for the organisation and management of CAMHS, and introduced a tiered

model of intervention (Partridge and Richardson, 2010). EPs were viewed as working at Tier 2 (see Table 4.2 below):

Table 4.2: Framework for tiered support in mental health services

Level	Purpose	Delivered by
Tier 1	Services provided by people who in the normal course of their professional lives have an effect on children's mental health. A primary level of emotional and behavioural advice, intervention and support, and early identification of mental health problems.	• GPs • Health visitors • School nurses • Social workers • Teachers • Juvenile justice workers • Voluntary agencies • Social services
Tier 2	A service provided by specialist individual professionals relating to workers in primary care and offering training, consultation, outreach and assessment. An integral part of 'specialist CAMHS' or 'CAMHS proper' and is where individual CAMHS professionals practice their individual skills as part of the multidisciplinary CAMHS.	• Child and Adolescent Mental Health workers • Clinical child psychologists • Paediatricians (especially community) • **Educational psychologists** • Child & adolescent psychiatrists • Child and adolescent psychotherapists • Community nurses/nurse specialists • Family therapists
Tier 3	A specialist multi-disciplinary service for more severe, complex or persistent disorders. Includes teams within a 'specialist' or 'core' CAMHS, with a team structure and approach targeted at particular problems (e.g. an eating disorders team or an attentional problems team).	• Child & adolescent psychiatrists • Clinical child psychologists • Nurses (community or in-patient) • Child psychotherapists • Occupational therapists • Speech and language therapists • Art, music and drama therapists • Family therapists
Tier 4	Essential tertiary level services such as day and inpatient units, highly specialised out-patient teams and in-patient units, complex interventions.	

(Sources: DfES and DoH, 2004; Richardson *et al*, 2010)

A key innovation, which saw the collaboration of hitherto unhelpfully disparate organisations/Government departments, was the Targeted Mental Health in Schools programme (TaMHS) (DCSF, 2008). TaMHS evolved from the HAS (1995) model:

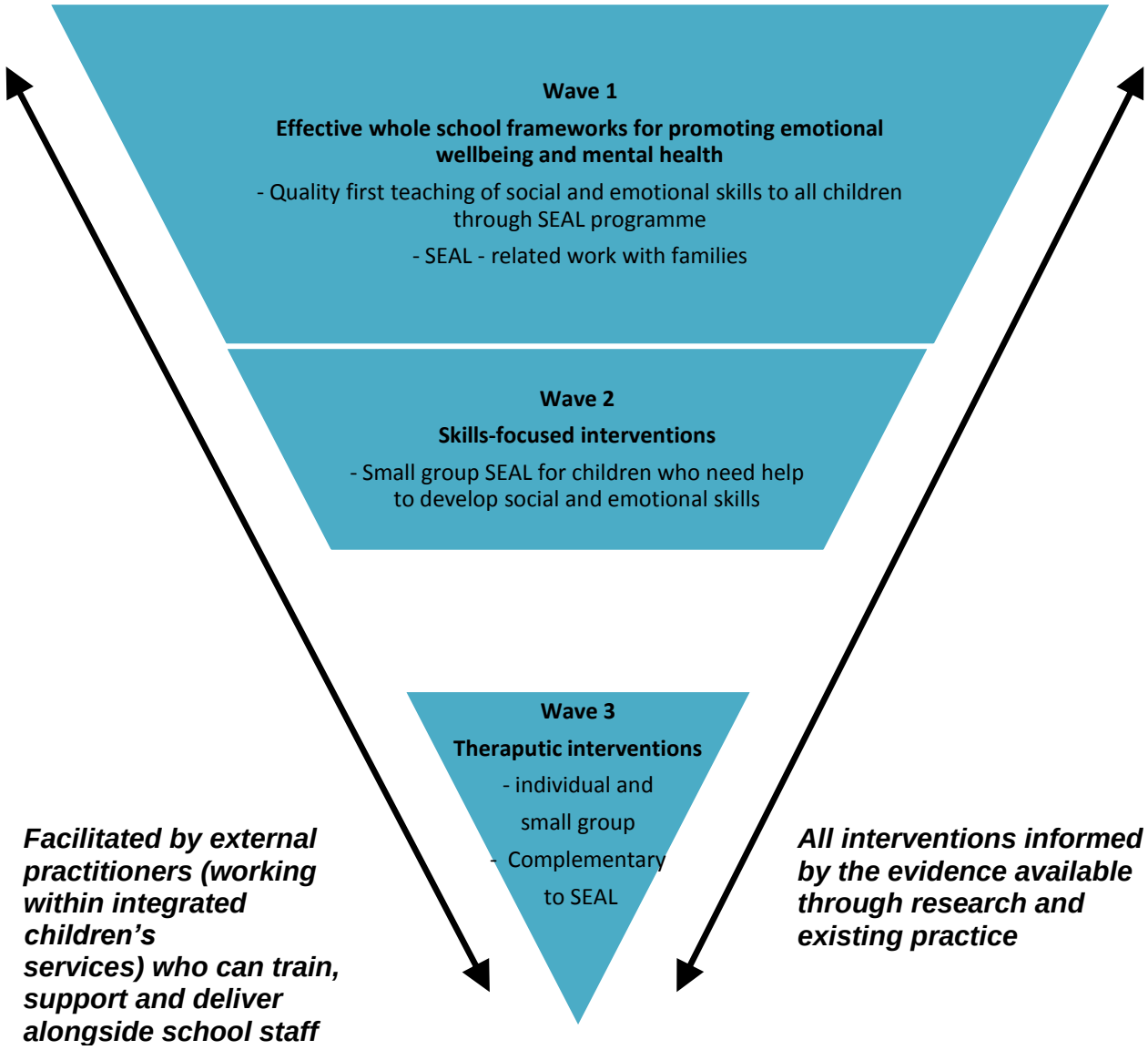
indeed the tiered model is where the TaMHS universal, targeted and more specialist intervention pyramid is grounded. The TaMHS three-year pathfinder project involved collaborative working between Health and Education departments and the voluntary sector, to develop in schools innovative evidence-based models of therapeutic and holistic mental health support for children and young people, aged 5-13 years, at risk of, and/or experiencing, mental health problems, and their families (DCSF, 2008). The two core aims of the TaMHS project were (DfES, 2008, p4):

- *strategic integration of all agencies involved in delivering child and adolescent mental health services (including schools) with the goal of collaborative work and flexible, responsive and effective early intervention; and*
- *delivering evidence-based mental health interventions.*

The model for TaMHS is shown in Figure 4.1 below.

Arguably, both the working model and core aims of TaMHS sit comfortably with the role of EPs, as EPs are already often part of multi-agency teams involved in CAMHS (DfEE, 2000), already work in schools and already proffer evidence-based interventions (Farrell *et al*, 2006; Turner *et al*, 2010). Furthermore, given the model of working for TaMHS, EPs are in the relatively distinctive position of being able to offer support to children, families and schools within all three waves of intervention. Certainly, in the HAS (1995) model, the expected role of EPs is clearly stated, and the role of EPs in providing therapeutic work is also noted by the National CAMHS Review (DoH/DCSF, 2008). Moreover, by "CAMHS" I refer to the comprehensive CAMH strategy, and the emphasis that CAMH is "*everybody's business*", which was reiterated in the National CAMHS Review (DoH/DCSF, 2008).

Figure 4.1: The TaMHS model (DfES, 2008, p5)



Currently however, in many Local Authorities, EP time is not allocated to providing individual therapeutic interventions directly (Boyle and Lauchlan, 2009). This is despite the recommendation of the national review of educational psychology in England and Wales that there should be expansion into areas such as group and individual therapy (Farrell *et al*, 2006). Boyle and Lauchlan (2009) assert that EPs are the 'natural providers' of in-school counselling and intervention, and the

profession risks becoming obsolete if it continues to move away from this type of individual working.

4.1.2 Aims of the study

This chapter aims to review the literature relating to the use of therapeutic interventions by EPs, and to focus specifically on Cognitive Behavioural Therapy (CBT), so relevant strengths and limitations can be identified. A case example is detailed in Chapter 5, to promote reflection on and reflexivity in my own practice. The case involved longitudinal work with a teenage girl, Anna[13], who had been experiencing high levels of anxiety, significant psychosomatic symptoms and had been recently diagnosed with concurrent 'Asperger syndrome' (described in Section 4.4). Other topics emerging from and relating to this particular case study will also be discussed, including the following; Asperger syndrome in girls (Section 4.4.1), the importance of case formulation (Chapter 5, Section 5.3), systemic working and embedding CBT training in Educational Psychology practice (Section 4.5).

4.2 Methodology: Cognitive Behavioural Therapy (CBT)

4.2.1 Origins of CBT

The 'empirical foundations' of CBT originate in the early part of the 20th Century (Hawton *et al*, 1989a). Firstly, Hawton *et al* (1989a) describe how the early work on animal learning by Pavlov and other Russian physiologists contributed the 'classical conditioning paradigm', and our understanding that emotional responses such as fear

[13] Due to confidentiality requirements and the need for protection of the client's identity (HPC, 2009), the client will be referred to as 'Anna' throughout Chapters 4 and 5.

could be conditioned (p1). Secondly, Skinner and others (e.g. Thorndike, Tolman and Guthrie) contributed to the identifying principle of 'operant conditioning', where it was recognised that if a specific behaviour is "followed by a particular event and the behaviour increases in frequency, then the behaviour is said to be reinforced" (Hawton *et al*, 1989a, p2). Hawton *et al* (1989) describe how the development of these two paradigms and their integration were "invaluable in the evolution of behaviour therapy" (p3).

Developments in the 1950s, such as Dollard and Miller's (1950) work which explicated the impact of cultural influences within a behavioural framework, demonstrated the "broader explanatory power of behavioural theory, and laid the foundations for subsequent cognitive-behavioural formulations which incorporated findings from cognitive and social psychology research" (Hawton *et al*, 1989a, p4). Additionally, Wolpe's (1958) research on 'experimental neuroses' in cats[14] led to the development of the procedure of 'systematic desensitization' and concept of 'reciprocal inhibition'. Whilst Wolpe's work has been surpassed by the understanding that exposure *in vivo* is the most effective way to bring about reductions in conditioned anxiety, and neither graded exposure "nor the use of reciprocal inhibitors" are necessary, nevertheless, his work has been "a major influence on the practice of behaviour therapy" (Hawton *et al*, 1989a, p5). Indeed, Hawton *et al* (1989a) describe how Rachman (1977, 1978a, 1978b and 1979), who had worked with Wolpe, was "instrumental in the development of aversion therapy, behavioural

[14] Hawton *et al* (1989a) describe how Wolpe proposed that fear reduction could generally be accomplished by the "simultaneous presentation of anxiety-provoking stimuli and stimuli evoking a response antagonistic to anxiety (the reciprocal inhibitor), provided that the antagonistic response was the stronger of the two" (p5). He later extended this work to humans e.g. using the reciprocal inhibitor of progressive relaxation.

medicine and the behavioural treatment of obsessional disorders" (p5). Rachman and others' work that also used behavioural approaches to fear reduction, became influential partially because their "effectiveness was systematically investigated in controlled trials" (Hawton *et al*, 1989a, p6). An evidence-based approach, integral to behavioural psychology, was emerging.

The 1960s saw behavioural treatments expanded to be use with a wider range of problems and saw the application of operant approaches (e.g. applied behaviour analysis) to clinical work involving adults and children with moderate and severe learning difficulties (Hawton *et al*, 1989a). Researchers realised that Skinner's 'reinforcers' may be different for different people, and that what might work for one person would not necessarily work for another e.g. eating alone may act as a positive or negative reinforcement depending on the individual's preference (Hawton *et al*, 1989). Ayllon and Azrin's (1968) work introduced the system of a 'token economy', where tokens were used as 'reinforcers' to be exchanged for various privileges, although Hall and Baker's (1986) more recent work highlighted that social reinforcers (e.g. praise and attention) may be as (if not more) effective than tokens in fostering desirable behaviour.

The 1970s saw the "full emergence of behaviour therapy", with new techniques developed and experimentally validated (Hawton *et al*, 1989a, p8). Additionally, the influence of 'cognition' was increasingly realised: Lang, Rachman and others highlighted that psychological problems might best be conceptualised in terms of "loosely linked response systems" such as behavioural, cognitive/affective, and

physiological systems (Hawton *et al*, 1989a, p9). Furthermore, some practitioners became increasingly discontent with rigid behavioural approaches, and there was growing recognition that there were some patients who did not respond even to competently delivered behaviour therapy (Hawton *et al*, 1989a). Consequently, there was mounting evidence and acceptance of the involvement and influence of cognitive factors (Hawton *et al*, 1989a). Certainly, Meichenbaum's (1975) cognitive approach of *self-instructional training* showed that behaviour change could be achieved by changing patients' negative or maladaptive self instruction to more adaptive self-talk (Hawton *et al*, 1989a). Hawton *et al* (1989a) explain how Beck's (1970, 1976) more "sophisticated cognitive therapy" was "adopted much more slowly, but has now become the most important of the cognitive approaches" (p11).

Bailey (2001) describes how in the 1980s the merging of behaviour therapy (BT) and cognitive therapy (CT) into cognitive behaviour therapy (CBT) occurred in both Europe and North America, particularly in response to the successful treatment of panic disorder by UK and USA practitioners. CBT now "dominates clinical research and practice" (Rachman, 1996, p1). The merger was not without challenge, but essentially the "behavioural emphasis on empiricism" was absorbed into CT, alongside the search for "increasingly dependable methods of measurement" (Rachman, 1996, p8). Certainly, considerable emphasis is placed on the empirical validation of treatment in a cognitive-behavioural approach (Hawton *et al*, 1989, p11). In turn CT began "supplying content" to BT in the form of cognitive concepts (Rachman, 1996, p8). For example, whilst obsessions would have been understood by a behavioural therapist - in a similar way to a cognitive therapist - as 'unwanted,

intrusive thoughts', the precise content of these unwanted thoughts was not deemed important, but with the influence of CT the content of thoughts becomes "intensely interesting" (Rachman, 1996, p9).

4.2.2 What is CBT?

A cognitive-behavioural approach considers cognition to be a real entity, influencing one's feelings and behaviours (Marshall and Turnball, 1996). The foundation of CBT lies in the discoveries of Ellis (1973) and Beck *et al* (1979, 1985, and 1990), that psychological distress and maladaptive behaviour, caused by erroneous thinking, could be reduced by therapy which altered cognitive processes (Greig, 2007). Beck coined the term 'Cognitive Therapy' in 1976, and introduced the idea that the knowledge base of cognitive psychology[15] could be useful in the clinical setting. The 'behavioural' part of CBT stems from the idea that by doing something differently, our perception can be changed, and that a behavioural change may lead to a change in thinking. Whilst Beck's early books did stress the importance of a cognitive-behavioural approach, the *cognitive* component had greater emphasis (Greig, 2007).

In essence, Beck proposed that in conditions such as depression, negative thinking originated in attitudes (*assumptions*) laid down in childhood and beyond, and whilst in some situations these assumptions could be helpful and guide behaviour, in others they may lead to an unhelpful interpretation of an event, and the production of *negative automatic thoughts* (NATs) (Hawton *et al*, 1989a). For example, an assumption such as 'To be worthwhile I must be successful' might "motivate

[15] 'Cognitive', from the Latin term, 'Cognoscere', means 'to come to know', so cognitive psychology is the study of how we learn or get to know things.

considerable positive activity", but would render the individual vulnerable to certain events, like failing an exam, where such an event might be interpreted as a major loss, and lead to the production of NATS such as 'I am worthless' or 'I am a failure as a person' (Hawton *et al*, 1989a). Such negative thoughts would lower mood, and create a vicious circle where further NATs might occur, thus maintaining the depression (Hawton *et al*, 1989a).

Within the cognitive paradigm, the experiences people have are considered to lead to the development of beliefs which then influence their interpretation of the world around them (Turnbull, 1996). In essence, the theoretical foundation for CBT is that psychological or behavioural difficulties such as depression or anxiety result from cognitive deficiencies and distortions (White, 2004). As people experience life differently, some develop irrational, unhelpful ways of thinking of events, others or themselves, leading to distress (Turnbull, 1996). CBT has been defined as:

> "...*a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behaviour, by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions"* (Beck *et al*., 1993, p27).

Hawton *et al* (1989a) describe how Lang's (1970) ideas of "three relatively independent response systems had laid the foundations for the acceptance of cognitive notions within the behavioural approach" (p10). CBT is often characterised by the relationship between these different response systems e.g. behavioural, cognitive, affective and physiological. Westbrook *et al* (2007) outline what they consider the six core principles on which a CBT model is based (p4-6), with the notion of 'interacting systems' forming one core principle (see Figure 4.2 below):

- ***The cognitive principle:*** *people's emotional reactions and behaviours are strongly influenced by cognitions (i.e. their thoughts, beliefs and personal or situational interpretations – the meaning they give to the events in their lives). Thus by helping people change their cognitions, we might be able to help them change the way they feel*

- ***The behavioural principle:*** *behaviour (what people do) is crucial in maintaining or changing psychological states.*

- ***The 'continuum' principle:*** *CBT takes a biopsychosocial rather than medical approach to mental health problems, where difficulties are seen as arising from exaggerated or extreme versions of normal processes, rather than qualitatively different from, and inexplicable by, normal states and processes. Related to this is the belief that psychological problems can happen to anyone and that CBT theory applies to therapists as much as to clients.*

- ***The 'here and now' principle:*** *In contrast to traditional psychodynamic therapy, with a focus on the 'root causes' of a problem (i.e. the developmental processes, hidden motivations and unconscious conflicts), CBT focuses on what is happening in the present, and is primarily concerned with the processes currently maintaining the problem, rather than the processes that might have led to its development many years ago (although these may form part of CBT formulation, discussed in Chapter 5).*

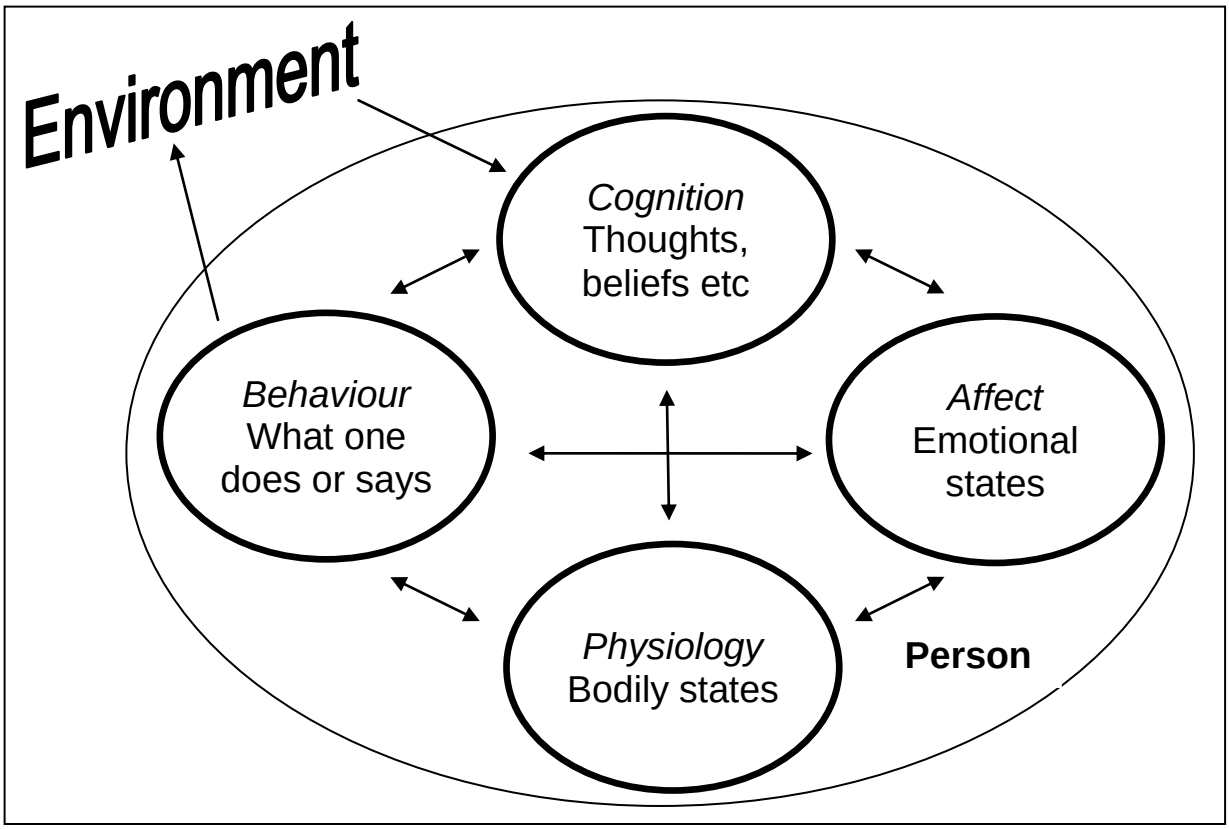
- ***The 'interacting systems' principle:*** *Problems should be considered as resulting from the interactions (complex feedback processes) between various 'systems' within the person and in their environment*[16] (see Figure 4.2 below).

- ***The empirical principle:*** *Theories and treatments should be evaluated as rigorously as possible, based on scientific evidence rather than just clinical anecdote.*

Crucially, the 'interacting systems' model (Figure 4.2) is not a linear, or a one-directional process stemming from thoughts; rather factors are interactive and interlinking (Graham, 2005). Consequently, there is a range of possible routes of causation and remediation which can stem from any of the areas e.g. behaviour, feelings/emotions or thoughts (Greig, 2007), and indeed environment (e.g. in a cognitive-behavioural approach which adopted a family-systems model of therapy).

[16] Environment should be understood in the broadest sense where physical, social, family, cultural and economic environment are all considered (e.g. see Bronfenbrenner's (2005) bioecological framework).

Figure 4.2 Interacting systems



Source: Westbrook *et al* (2007, p6) based on the 'hot cross bun' model by Padesky and Greenberger (1995)

Thus CBT is based on the assumption that behaviour results from specific factors in the external environment as well as internal cognitive processes (Goldfried and Davison, 1994).

The recognition of the importance of environmental factors is crucial. Without consideration of environmental factors, there is a danger of locating problems within individuals, rather than looking at systemic influences such as poverty and access to services (Rait *et al,* 2010), and individuals may have little power to alter their environments (Moloney and Kelly, 2004). As problems such as poverty are harder to

change, and often outside the control of the individual, one of the criticisms of CBT could be that by targeting the individual, a therapist is not changing a negative situation, but rather is just helping an individual to 'cope'. Arguably, CBT should not necessarily be used where environmental factors outside one's control, rather than erroneous thinking, contribute substantively to someone's distress, as in the case, for example, of a child who experiences sustained maltreatment from their primary carers. Nevertheless, the judicious use of CBT may strengthen an individual's capacity to cope with enduring adversities, with reduced levels of distress. Furthermore, Dummett (2010) argues that when "working with children, young people, their families and wider systems (e.g. a support network), therapy should incorporate interpersonal, family and systemic factors, together with developmental and attachment issues and phenomena more commonly expressed through other psychotherapeutic modalities" (p23). Dummett (2010) calls for further, formal evaluation of this greater systemic focus in CBT but asserts that there "is growing clinical experience that systemic cognitive–behavioural formulation can lead to systemic-process working on an individual, parent–child, family or wider-system basis" (p23).

4.2.3 Cognitive-Behavioural Assessment

Greig (2007) discusses how in CBT the beliefs and consequences (e.g. resulting behaviour or feelings) surrounding a situation are examined, with a focus on the *"cognitive processes that intervene between the antecedents and the behaviour, and then on the feelings and behaviours that arise from these cognitions"* (p21). Kirk (1996) details the principles and process of cognitive-behavioural assessment, which

are summarised in tabular form in Appendix VIII. The goals of cognitive-behavioural assessment include: agreement of an initial formulation of the target problems between therapist and client; the therapist to have elicited sufficiently detailed information about factors maintaining the problem to be able to design and present a treatment plan; the therapist to have begun to educate the client about the psychological model; and a comprehensive and dynamic risk assessment should be carried out (Kirk, 1996).

Cognitive-behavioural assessment is underpinned by two core principles. Firstly, that the ways in which an individual behaves are determined by immediate situations, and the individual's interpretation of them, with an emphasis on specific problems rather than global entities (Kirk, 1996). Secondly, that assessment is a dynamic and on-going process e.g. initial formulations are likely to be supplemented by additional information (Kirk, 1996). Another core element of cognitive-behavioural assessment is the characteristics of the therapist. Those characteristics of therapists that are considered to be important in other forms of therapy e.g. an empathetic understanding (Rogers, 1961), are "likely to be just as relevant in cognitive-behavioural treatment" (Kirk, 1996, p13). The client needs to feel safe, so it is crucial a warm and trusting atmosphere is created, and the therapist demonstrates commitment to helping the client overcome their difficulties (Kirk, 1996).

The process of cognitive-behavioural assessment involves the therapist educating the client about the CB approach: For example, the 'self-help' and collaborative nature of therapy is discussed, as too are the practical components such as the

treatment structure and need for ‘homework’ tasks (Kirk, 1996). Additionally, the “general educational role” of the assessment is to help the client focus on “internal and external variables which may not have been seen as relevant to the problem” (Kirk, 1996, p14). A crucial part of teaching the client about the psychological model is drawing attention to these variables and how they relate to the problem (Kirk, 1996). It is important that the therapist’s and client’s expectations of treatment are similar, as if they are not, the client may decide not to pursue treatment (Kirk, 1996).

The ‘Behavioural Interview’ is a key approach to assessment and is how the therapist might approach the identification of the key components of thinking, feeling and behaviour (Kirk, 1996). The Behavioural Interview involves a number of stages, and along with other modes of assessment, it is detailed in tabular form in Appendix VIII. Key aspects include the therapist eliciting details of the problem and its development, ascertaining what contextual and modulating variables are in operation, identifying maintaining factors, and questioning the client about coping resources, other assets/strengths, and their beliefs about the problem (Kirk, 1996). A principle aim is to discover how the problem is currently maintained, in what way it is interfering with client’s life, and whether the problem is serving any useful purpose for client (Kirk, 1996). For example, Kirk (1996) describes how having built up a picture of conditions under which the problem is most likely to occur, the next step is to look at what is maintaining (in the long or short-term) the problem behaviour. Situational cues, behavioural cues, cognitive factors, affective states, interpersonal and physiological factors are all considered (Kirk, 1996, p22). Questions like ‘what are the (especially immediate) consequences of the problem behaviour’? and ‘what changes might be

made in any of these to produce changes in the problem behaviour?' are examined. Notably, 'avoidance' is often the 'most potent' maintaining factor (Kirk, 1996).

At the initial Behavioural Interview, it may not always be possible for the client readily to identify the relevant thoughts, or to focus on them at the necessary level of specificity (Kirk, 1996). This may be because thoughts were not attended to at the time, or when the client is calm "thoughts are discounted as ridiculous and exaggerated" (Kirk, 1996, p29). Consequently, a client may need some training before she/he can confidently identify negative thoughts, and a therapist would also need gently to "persist in questioning until appropriate cognitions are elicited" (Clark, 1996, p67). Clark (1996) provides a useful rule for therapists to ask themselves: 'Would I be as anxious as my patient if I had this thought and believed it?' (p67). If the answer is 'no', the elicited thought is likely to be 'inaccurate' or require 'further elaboration' (Clark, 1996, p67). There are a number of techniques used to help clients identify NATs, with the most common, a "detailed discussion of a recent emotional experience" (Clark, 1996, p67).

The application of the experimental method to problems of individual clients is central to cognitive-behavioural assessment and treatment (Kirk, 1996). Kirk (1996) stresses how "a formulation is used to make predictions about the effects of particular interventions and these are then tested out in treatment" (p17). Therapy with a client can be seen as a 'single-case experiment', with much of treatment revolving "around measures taken both during treatment sessions, and between sessions" (Kirk, 1996,

p17. There are a number of advantages with this approach to assessment and treatment:

- *direct recording allows a more accurate description of problem e.g. with regards to frequency and intensity;*
- *measurements allow the modification of treatment where necessary;*
- *measurements can be used to give the client consistent and accurate information about their progress;*
- *and measurements allow the therapist to establish whether the treatment has been delivered as intended (e.g. allows for effective evaluation).*

(Kirk, 1996, p17)

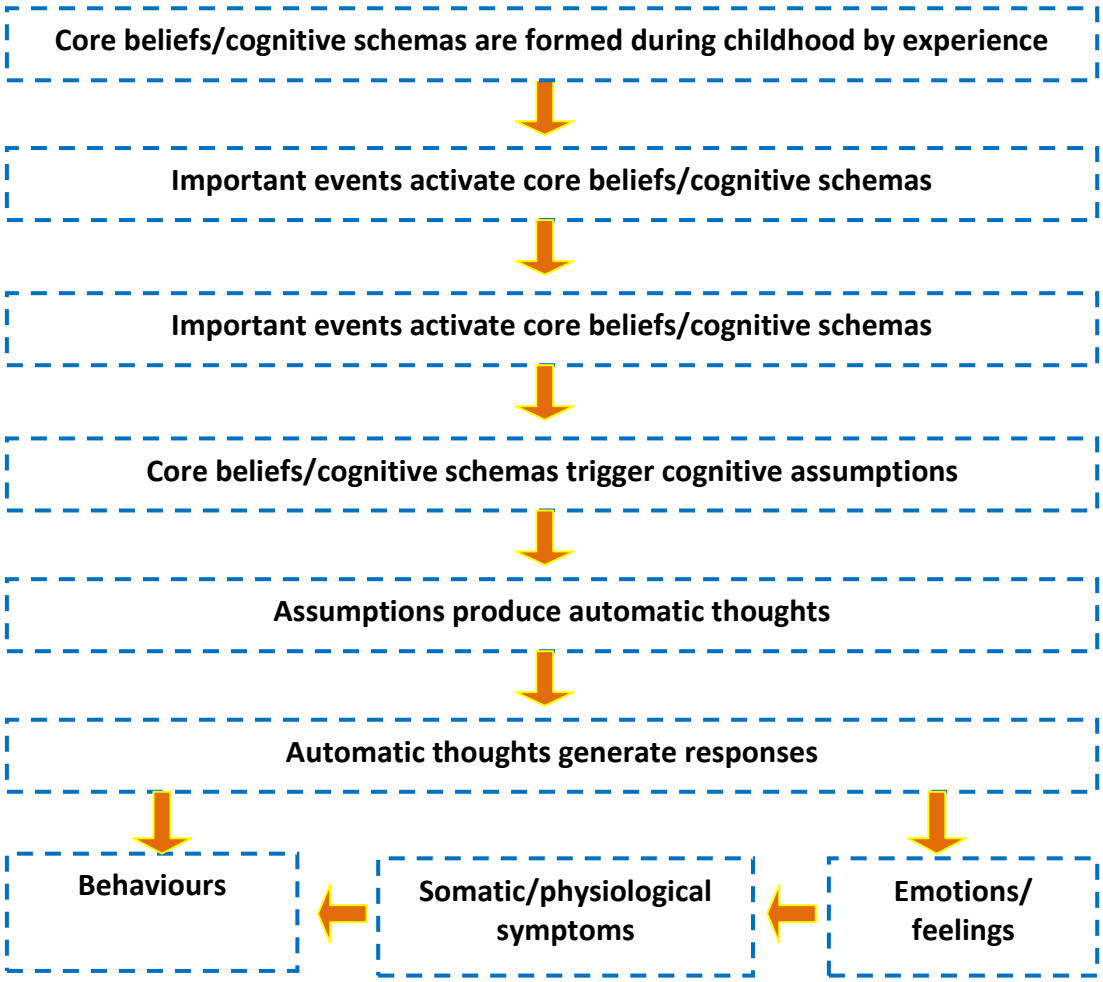
4.2.4 CBT with children and young people

Stallard (2005) provides a useful framework, developed for work with children and young people, to describe the key explanatory elements of a cognitive-behavioural approach (see Figure 4.3 below); application of this framework with Anna is described in Chapter 5. Figure 4.3 shows clearly the major premise of CBT, that feelings, actions, and some physical sensations are the products of thoughts. Whilst the CBT process is adapted and applied in a variety of ways, it typically comprises:

1. *assessment of the problem;*
2. *affective education: to illustrate the connection between deficiencies and distortions of thinking, affect, and behaviour;*
3. *cognitive restructuring: to challenge dysfunctional thinking in a logical way, and implement more healthy ways of thinking;*
4. *stress or anxiety management;*
5. *self-reflection: to improve insight into thoughts; and*
6. *practice of the principles learnt in everyday situations.*

(Attwood, 2003)

Figure 4.3: Key explanatory elements in a cognitive-behavioural approach (Stallard, 2002 and 2005)



Similarly to use with adults, Kendall (1993) describes how:

> *"...cognitive–behavioural strategies with children and adolescents use enactive, performance-based procedures as well as cognitive interventions to produce changes in thinking, feeling and behaviour." (p. 235)*

In order to reach this goal, however, adaptations to the therapeutic process must be made so that the approach is 'developmentally orientated' (Kendall, 2011) and so that the differing social position and agency of children and young people is acknowledged. With regard to developmental perspectives, practitioners using CBT with children have adapted it variously: For example, giving clear, simple instructions

and using familiar activities and events (Stallard, 2005), pacing the content and speed of therapy at an appropriate level (Bailey, 2001), and being mindful of younger children's developmental level with regard to metacognition and labelling feelings (Bailey, 2001; Stallard, 2005). Indeed, for younger children, the therapist may be more active and use a "higher proportion of behavioural to cognitive techniques" (Bailey, 2001, p225).

Stallard (2005) addresses more fully the 'cognitive capacity debate' regarding the age at which children are able to participate in CBT. He describes how some argue that children younger than 12 years old have not yet acquired the necessary cognitive skills to possess the "necessary conceptual platform to engage in CBT" (Stallard, 2005, p105). In order to participate in the CBT process, children do need to be able to 'monitor affective states', 'reflect on automatic thoughts', 'distinguish between and understand the link between thoughts and feelings', and 'engage in thought appraisal and cognitive restructuring' and there is evidence to suggest that for some young children each of these tasks would pose a significant challenge (Stallard, 2005, p105). Nevertheless, Stallard (2005) goes on to argue that these core skills can be "addressed and taught as part of the intervention" (p105). Furthermore, with regard to cognitive restructuring, whilst a more 'problem-specific approach' may be necessary for younger children - as they may be "unable to recognise overarching rules or generalise their strategies to other situations" - this problem-based, present focus is not necessarily a 'problem' and may even be 'attractive' to children (Stallard, 2005, p106). Adaptations to CBT may also include training in social skills and inter-personal

problem-solving, as opposed to a focus only on correcting maladaptive and dysfunctional distortions of thinking (as would be the case with adults) (Bailey, 2001).

Therapists should be 'developmentally sensitive' rather than simply 'age – sensitive'. Stallard (2005) argues "the issue is not about whether young children possess the necessary cognitive or conceptual skills but instead whether CBT has been modified and provided in a developmentally appropriate way for a child to access" (p105). For adolescents too, perhaps even more so, there is a need to be 'developmentally orientated' (Kendall, 2011). Treatment should take into account the "critical developmental tasks and milestones relevant to a particular adolescent's presenting problems (e.g. pubertal development, cognitive development, the development of behavioural autonomy and social perspective-taking)" (p430). For example, for an adolescent who presents with poor anger management or high levels of risk-taking (i.e. 'inappropriately low levels of behavioural self-control') and concurrent "moderate levels of parent-adolescent conflict", the therapist may consider "the former more developmentally atypical than the latter" and therefore focus on self-control difficulties in treatment (p430). Adaptations when using CBT with adolescents are crucial, especially since this transitional developmental period is characterised by "more biological, psychological, and social role changes than any other stage of life except infancy" (Kendall, 2011, p431). Positively, in a recent review of the literature regarding CBT interventions with adolescents, "roughly 86% of the reviewed empirical articles mentioned developmental issues in the design and evaluation of the treatments" (Kendall, 2011, p432)

A further challenge for the use of CBT with children and young people, is with regard to the “inherent power inequalities involved in any relationship between adult and child” or young person (Davie *et al*, 1996, p137). Furthermore, children and adolescents’ development into adulthood is influenced by many systems:

- *the **microsystem** (immediate environment in which they are operating e.g. family, classroom, school, clubs etc);*
- *the **mesosystem** (two mircosystems interacting, e.g. home and school);*
- *the **exosystem** (an environment in which the child is only indirectly involved, but it affects them regardless e.g. parents’ workplace);*
- *the **macrosystem** (larger cultural context);*
- *and the **chronosystem** (time and the sociohistorical conditions and time since life events)*

(Bronfennbrenner and Morris, 2006).

Adults themselves at times can feel that they have little or no power in one or many of these systems. Children and young people can sometimes actually be ‘powerless’ in all of these systems.

The power dynamics between CYP and adults, can mean that CYP can become disadvantaged (e.g. during the behavioural interview), but steps can be taken to overcome this, partially at least, if the interviewer matches “their methods of questioning to the cognitive skills and emotional development of the child” (Davie *et al*, 1996, p68). In this way, being ‘developmentally sensitive’ is again important. Nevertheless, it takes more than just adapting therapeutic methods to begin to address the power inequalities at play. Firstly, the referral process itself is problematic. Whilst adults will more often have elected to be referred to a therapist and want to engage in therapeutic work, it is very unlikely that CYP will have chosen to meet with a therapist. Though therapists on meeting CYP can ensure developmentally appropriate ‘informed consent’ is sought (Robson, 2002), the initial

meeting will more than likely not have been of the CYP's choosing. Furthermore, even once therapy has commenced, given the power dynamics at play, how much power and agency does the child or adolescent have for contributing authentically to or challenging formulation, planning homework sessions, for changing their therapist or even stopping therapy altogether? Particularly with regards to formulation development - which should be "collaborative and not imposed" (Tarrier, 2006, p5) - given the inherently imbalanced nature of power in adult relationships with CYP, it is crucial that CYP who have been recommended for CBT, and are thus arguably even more vulnerable than their non-referred peers, are 'empowered' by the therapist to choose to collaborate - or not - in the therapeutic process.

4.3 Evidence-base for CBT

There is now an established, robust evidence-base for a range of psychological therapies (Fonagy *et al*, 2005; MacKay, 2007). The evidence-base for the use of CBT with adults has developed over the last 30 years, and is now endorsed by the National Institute for Health and Clinical Excellence (NICE) (Gilbert, 2009). Indeed, CBT is recommended by NICE (2008b) for the treatment of depression, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and anxiety. Some argue CBT has an "impressive research base" (Gaudiano, 2008), but closer scrutiny of the evidence-base reveals that whilst *quantity of research* is not necessarily a problem, *the nature of the evidence* sought and utilised may well be. For example, Parker and Fletcher (2007) highlight the problem of using solely outcome-focused evaluation research, as is the case with Randomised Controlled Trials (RCTs). Such research 'obscures' the "identification of true treatment validity"

of CBT, as this level 1 evidence-base (see Table 4.3 below) has often been "inappropriately constructed and analysed" (Parker and Fletcher, 2007, p352). Parker and Fletcher (2007) argue that "outcome research should move away from testing treatments as if they have universal application for heterogeneous disorder categories" (p352).

Pugh (2010) raises similar criticisms of RCTs in dictating patterns of research and provision, arguing they are "overused in establishing intervention efficacy" (p392). RCTs are based on the assumption that psychopathology is "malleable and can be easily altered by administering a brief intervention" (Pugh, 2010, p392). Pugh (2010) also highlights a tendency to categorise clinical populations using labels like 'anxiety' and 'depression' which neglects unique personality factors which affect an "individual's receptivity to psychological intervention"; this tendency also overlooks the considerable heterogeneity of clinical samples and the variability of intervention delivery, both of which "violate assumptions upon which a RCT is based", especially where clinical samples do not share very specific symptoms (p392). Consequently, the "superiority of CBT...may well be able to be demonstrated across defined rather than universal circumstances", but the specificity of CBT for conditions like depression has yet to be demonstrated (Parker and Fletcher, 2007, p352). Illuminative case-studies, or programme-theory evaluation models (e.g. Realistic Evaluation – see Table 2.1 in Volume 1 of this thesis) would facilitate greater understanding of what aspects of CBT might work, for whom, and in what circumstances (Pawson and Tilley, 1997).

Whilst there are now many[17] studies of the use of CBT with adults, there have been comparatively few studies of its use with children (Bailey, 2001); indeed its use with CYP is far more limited (Dunsmuir and Iyadurai, 2007). Professionals working under the direction of the Child and Adolescent Mental Health Services Evidence Based Practice Unit (EBPU), in collaboration with other organisations like the British Psychological Society (BPS), developed a booklet whose aim was to inform mental health practitioners working with young people of the most current research findings in this domain (Wolpert *et al*, 2006). Building on previous guidance (Fonagy *et al* , 2005), considering relevant NICE guidelines and Cochrane reviews, and examining recent research, the booklet aimed to provide an accessible précis of the evidence-base; summarising strengths and highlighting limitations of different interventions, and eliciting implications for practice (Wolpert *et al*, 2006). Standard criteria were used to rate each statement from the evidence and contingent practice implication (Shekelle *et al*, 2000; Wolpert *et al*, 2006). These criteria were utilised for evaluating the evidence-base for a range of treatments for children and adolescents with mental health concerns, and are shown in Table 4.3:

Table 4.3: Categories of evidence with ensuing implications for practice

Categories of Evidence	
1a	Evidence from meta-analysis of randomised controlled trials
1b	Evidence from at least one randomised controlled trial
2a	Evidence from at least one controlled study without randomisation
2b	Evidence from at least one other type of quasi-experimental study
3	Evidence from descriptive studies such as comparative studies, correlation studies and case-control studies

[17] Gaudiano (2008) cites “325 clinical trials of CBT for various clinical populations” and there have been “16 separate meta-analyses of CBT studies” (p5).

4	Evidence from expert committee reports or opinions, or from clinical experience of a respected authority, or both.
Strength of Practice Implications	
A	Directly based on category 1 evidence
B	Directly based on category 2 evidence, or extrapolated from category 1 evidence
C	Directly based on category 3 evidence or extrapolated from category 2 evidence
D	Directly based on category 4 evidence or extrapolated from category 3 evidence

Source: from Shekelle *et al* (2000), in Wolpert *et al* (2006)

Advice which follows these criteria is therefore that the most robust evidence to guide practice is from meta-analysis of RCTs. However, like Pugh (2010), Wolpert *et al* (2006) recognise the inappropriateness and crudity of a "wholesale application of findings" from RCTs to "all individuals with similar problems in a 'one size fits all' policy" (p5), and stress the need for a sensitive decision-making process which weighs a range of factors (e.g. the young person's characteristics, their family and social circumstances, contextual factors, likely costs, risks and benefits etc.). Furthermore, they highlight how limitations and gaps in the evidence base (e.g. how over-simplicity of diagnostic labels masks phenomenological complexity, and the dearth of knowledge regarding application with minority groups), mean conclusions should be cautious, and there remains a need for an interplay between professional experience and systematic research (Wolpert *et al*, 2006, p6). Additionally, though short-term gains are being demonstrated, the "evidence for medium and long-term effectiveness of CBT with CYP is lacking" (Dunsmuir and Iyadurai, 2007, p16). So too

is evidence for its use with externalising conditions such as ADHD (Dunsmuir and Iyadurai, 2007).

Dunsmuir and Iyadurai (2007) concur with Wolpert *et al*'s (2006) cautions, adding that because research with CYP has focused primarily on "groups defined by diagnostic classifications, whereas children and families tend to be referred because of a range of complex, multi-faceted difficulties....this complexity means that any attempt to 'prescribe' intervention on the basis of diagnosis or presenting problem is likely to be over-simplistic" (p16). There is, however, a growing body of research to suggest that where there is a specific, clearly defined difficulty, as is the case with anxiety, CBT may well be effective (Dunsmuir and Iyadurai, 2007).

Despite the caveats mentioned above, the existent evidence-base supports CBT being consistently recommended as an appropriate intervention for a range of difficulties in childhood, including disturbances of conduct, anxiety disorders, post-traumatic stress disorder, depression, *bulimia nervosa*, recurrent abdominal pain and other physical symptoms with no known cause, coping with painful procedures and chronic physical illness and disease (Wolpert *et al,* 2006). However, CBT is not the only intervention suggested for many of these conditions, and in some circumstances (e.g. for disturbances of conduct in adolescents), there is only weak evidence for the effectiveness of 'stand-alone' CBT. In this circumstance a combined approach is called for, where some form of family therapy is also included (Wolpert *et al*, 2006). Dunsmuir and Iyadurai (2007) also argue "systemic work with schools or families may be more appropriate than individually delivered CBT" (p16).

The need for a systemic, combined approach is also clear from Maxwell *et al*'s (2008) review on supporting children's emotional wellbeing and mental health in England, which found that in schools:

> *"sustained broad-based mental health promotion programmes combined with more targeted behavioural and cognitive-behavioural therapy (CBT) for those children with identifiable emotional wellbeing and mental health needs, offer evidence of a demonstrably effective approach" (p272).*

The flexibility of approach that CBT affords makes it an invaluable tool for EPs who work across a range of levels, as CBT can be applied at the individual, group and family, and other systemic levels (Greig, 2007). Greig (2007) argues that CBT "appears set to become an integral part of the educational psychologist's repertoire" (p19), and calls for EPs to seize the 'golden opportunity' of incorporating therapeutic work into their practice. The literature does indicate an increasing interest in therapeutic work in schools (Squires, 2001a), EPs are increasingly using such approaches in their practice (Greig and MacKay, 2005; Rait *et al*, 2010) and the call by EPs for more therapeutic work by EPs is loud and clear (see DECP 2007, Educational and Child Psychology 'Therapy' edition). Nevertheless, Greig and Mackay (2005) as practicing EPs in Scotland, arguably have more freedom than their English-based peers, as in Scotland EP practice is arguably less constrained by dated rhetoric and the structural demands derived from statutory responsibility. Perhaps therefore, the real obstacle to overcome is not whether the evidence-base is robust enough, or how to ensure EPs have the competencies to deliver CBT interventions (Squires and Dunsmuir, 2011), but rather whether in an already challenging political and local authority financial context, weighed down by the professional norms EPs have themselves constructed to maximise the impact of their

limited combined human resources, opportunities to show the benefits outweigh the perceived costs of EPs carrying out this type of work, can be limited.

Regardless of potential barriers, the identification and management of the psychological well-being of children and young people *is* "everybody's business", and has legislative support (DfES, 2001; Rait *et al*, 2010). Schools are a major "*therapeutic environment*" (Rait *et al*, 2010, p105). EPs have a core remit for work with the mainstream school population (Greig, 2007), but as EPs' focus tends to be on pupils with special educational needs, one area for assertive exploration could be the use of therapeutic interventions with children with low incidence disabilities. For example, the effectiveness of CBT for those with Asperger syndrome is now increasingly documented (Greig, 2007) but there remains a dearth of evidence regarding the use of CBT with specific groups of children. The following sections will explore Asperger syndrome (AS), AS and girls, and the use of CBT with this population.

4.4 Asperger Syndrome

Autism is a developmental disorder[18], with a neurological basis and strong hereditary component (Tantum and Girgis, 2009; Baron-Cohen *et al*, 2009). It is estimated to have a prevalence rate of 100 per 10,000 (1%) in the UK; however a recent study of school-based populations suggests that due to undiagnosed/unknown cases,

[18] It should be stressed that the language associated with autism i.e. "disorder", can itself be disabling. Many argue that those on the autistic spectrum should be viewed as "different" rather than "disordered" – this has parallels to many people's views about, and views within, the deaf community. Baron-Cohen (2002) questions whether Asperger Syndrome is a difference or a disability; however Beteta (2008) highlights that though 'difference' may be more socially acceptable, it lacks the entitlements and protection that 'disability' entails.

prevalence may be slightly higher, at 157 per 10,000 (Baron-Cohen *et al*, 2009). Whilst causal factors are still not fully understood, autism is characterised by social interaction and communication difficulties, repetitive behaviours and restricted interests (Hill and Frith, 2003).

Autism is a disorder of non-verbal communication, with ensuing social impairments including restricted empathy, self-awareness and executive function[19] (Tantum and Girgis, 2009). Difficulties with empathy involve two issues - firstly at the cognitive level, difficulties with theory of mind, and secondly at the social level, difficulties responding appropriately to people's cues e.g. distress (Baron-Cohen, 2009). Frith (1989) and Happé (1996) argue that people with autism have weak 'central coherence', meaning reduced ability to extract the most relevant information from an input, in order to get the 'whole picture'. This over-attention and attendance to details, and focus on the minutiae, is a possible contributor to the sensory sensitivity many people with autism experience, as they may focus on seemingly extraneous detail e.g. the hum of a projector, or other background noise. This focus on details can of course be a strength rather than difficulty, with research showing proficiency in tasks requiring a focus on specific details (Shah and Frith, 1993).

There is enormous variability in the impact of difficulties on the everyday life of people with Autism. Diagnosis itself may only be considered necessary when difficulties interfere with normal functioning. The clinical picture of autism varies in severity, is modified by numerous factors (e.g. ability, temperament), changes over

[19] Executive function is "the ability to plan and organise tasks, monitor one's own performance, inhibit inappropriate responses, utilize feedback, and suppress distracting stimuli" (McAfee, 2002, p338).

the course of development and within individuals, and is often associated with other disorders (Hill and Frith, 2003). Consequently, there is now consensus that there is a spectrum of autistic disorders, spanning all degrees of severity, and all levels of intelligence and language ability (Hill and Frith, 2003). Within this very broad spectrum of disorders sits the sub-group of Asperger Syndrome (AS) (Attwood *et al*, 2006).

This "special sub-group" of people with AS differ diagnostically from their autistic counterparts because of 'normal' language and cognitive development (Hill and Frith, 2003, p281). Many researchers interchange the terms AS and High Functioning Autism (HFA) (Beteta, 2008). Currently, there is much debate around whether HFA and AS can be clearly differentiated (Connor, 2000), and significant changes to diagnostic criteria are rumoured to be in the pipeline (Scott, 2010).

4.4.1 Asperger Syndrome and Girls

In addition to the existing controversies surrounding the diagnostic criteria for AS, further complexities arise with identification and diagnosis in girls. There is minimal research regarding females with Asperger syndrome (Beteta, 2008). Indeed, they are described as "*research orphans*" by Ami Klin, the director of Yale's autism programme (Bazelon, 2007). The research that is available suggests that females with AS may present themselves differently than males (Jennings, 2005). Table 4.4 shows Nichols' (2009) summary of emerging literature that addresses sex differences in autism, and how girls with autism differ from neurotypical girls:

Table 4.4: Sex differences in autism

1	*As a group, males with ASD score higher than girls with ASD on intellectual assessments (this might support the idea that higher functioning girls are not being diagnosed and included in these calculations.*
2	*The play of boys with ASD has been found to be more repetitive and restricted in range.*
3	*As assessed on diagnostic instruments for autism, the communicative abilities of girls with ASD have been observed to be stronger (e.g. pointing, gaze following).*
4	*Boys and girls with ASD may experience different developmental trajectories related to social difficulties, with boys demonstrating more difficulties earlier in life, and girls expressing greater impairment in early adolescence.*
5	*Boys with ASD may tend to engage in disruptive behaviour to gain objects, while girls with ASD may tend to engage in disruptive behaviour to get attention.*
6	*Girls with ASD may be better able to focus and may be less distractible than boys with ASD.*
7	*Young girls with ASD have been found to appear more anxious and depressed than boys with ASD.*
8	*Parents may overestimate the social difficulties or impairments of their daughters because they have (and society has) greater expectations for how girls should behave in the social and communicative domains.*

Source: Nichols (2009)

Table 4.4 highlights how there may be significant diagnostic bias surrounding identification of females with autism (Nichols *et al*, 2008). Questions remain about the relative ratio of prevalence of autism in females and males, with any figure likely to represent an underestimation, as diagnostic criteria are certainly biased (Faherty, 2002). Table 4.5, shown below, highlights how many of these pitfalls of diagnosis could be avoided:

Table 4.5: Suggestions for assessing females with possible ASDs

1	*Referral for further evaluation if scores are close to, but do not meet cut-off, on an autism screening measure.*
2	*Comparison of a girl's social and communicative abilities to what is considered normative for females of her age and cognitive ability.*
3	*Careful examination of social and communicative difficulties in the absence of significant disruptive behaviour.*
4	*Avoid comparison of a girl's set of symptoms to prototypical male presentation.*
5	*Consideration of how a girl may perform in a simple social setting where she only has to interact with one other person versus how she may perform in an unstructured, real-world environment with peers.*
6	*Understanding a girl's social network and taking into account whether she has a "mother hen" friend who has supported her in the social world (which may have masked her social deficits).*
7	*Consideration that deficits in girls may become more apparent over time, particularly in early adolescence.*

Source: Nichols (2009) from Koenig and Tsatsanis (2005), and Nichols *et al* (2008)

There appears to be a consensus that current diagnostic criteria are male-biased, and it is not surprising that females are harder to identify as they may be better able to compensate for or mask their difficulties, superficially mimicking social behaviour, and having more 'normal' or typical restricted interests that are harder to spot e.g. soap operas or animals (Scott, 2010). The relative lack of research attention for girls on the autistic spectrum, and the fact that our understanding of autism generally is still evolving, means conclusions should be tentative and revised in light of new information.

4.4.2 CBT and Asperger Syndrome

By its nature CBT depends upon a set of cognitive skills which not all clients will possess, thus restricting its possible use to those children or young people at, or exceeding this threshold. CBT has been suggested for some people on the autistic spectrum, particularly those with AS, as they "tend to be high functioning, have high verbal IQs and are receptive to factual and logical thinking" (White, 2004, p6; Attwood, 2003; Hare and Paine, 1997). There is growing evidence for the effectiveness of CBT with young people on the Autistic Spectrum (Bauminger, 2002; Fitzpatrick, 2004; Sofronoff *et al*, 2005), albeit often with certain programme modifications to address the specific needs of this group (Greig and MacKay, 2005; Sze and Wood, 2008). Additionally, as noted in Section 4.2.4, when used with children, CBT is adapted to meet the developmental level of the child. For example, sessions may be shorter, more visual methods used for assessment and teaching, and theming of materials to suit children's interest (Attwood, 2003; Drinkwater and Stewart, 2003; and White, 2004). As discussed, Anna, the teenager girl whose case is presented in Chapter 5, received a diagnosis of Asperger syndrome in adolescence. Following consideration of the possible impact of Asperger syndrome and advice from the Clinical Psychologist as to what had worked well in her sessions with Anna, the following approaches were incorporated into work with Anna:

- *greater use of visual information when presenting ideas or formulations to Anna; and*
- *use of clear, short sentences, with regular checking of understanding.*

Notably, the STEER report (Succinct and Timely Evaluated Evidence Review) (2004) regarding the use of CBT with children on the autistic spectrum, suggested that reliable conclusions about the effectiveness or otherwise of CBT with children with

ASD, have yet to be drawn (White, 2004). Although there was some evidence that CBT is a "feasible treatment option in high-functioning children with ASD" (p5), a more recent small scale study on the efficacy of a Cognitive-Behavioural (CB) treatment programme for anxious youth with ASD showed reduced anxiety for three of the four subjects (White *et al*, 2009). However, as treatment was supplemented with parent education and group social skills training, the direct impact of the CB aspect of the intervention is hard to extricate.

Cooper (2009) conducted a systematic review of the evidence–base addressing the question 'how effective is CBT in reducing anxiety in school-aged children and young people with ASD?'. Cooper (2009) discussed the six studies which met the inclusion criteria, noting that all "reported positive effects of CBT in reducing anxiety". There were significant concerns, however, with regard to methodology adopted, as no studies employed an "active control group" comparison (p1) and extraneous factors (e.g. such as concurrent interventions like 'buddy systems') could also have affected results.

The use of CBT with young people with Asperger syndrome may appear a promising domain, but further work is required for its effectiveness to be evaluated adequately, and to identify which specific aspects of therapy are helpful (Anderson and Morris, 2006). Moreover, as cognitive inflexibility in people with Asperger syndrome is an "impairment or deficit rather than a distortion brought about by circumstance" (Greig, 2007), this will significantly affect the therapeutic approach taken. Additionally, other therapeutic interventions, and methodologies with a broader focus (e.g. on work with parents) may prove to be valuable avenues for exploration (Vismara and Rogers,

2009). Chapter 5 seeks to contribute to the evidence-base regarding the use of CBT with female teenagers with AS by presenting a case-study of its use by this researcher.

4.5 Conclusion

CBT is now the most commonly prescribed 'talking therapy' in the UK (Cooper, 2009), and has "emerged as a dominant paradigm in psychotherapy" (Gilbert, 2009, p400). Gilbert (2009) describes how the National Institute for Health and Clinical Excellence (NICE) has endorsed CBT because of a mounting research base, amassed over the past three decades. CBT also appears to be the Coalition Government's therapy of choice for their new strategy 'No health without mental health', and related 'Talking Therapies: A four-year plan of action' (DoH 2011a and 2011b). At a time when the government wants to see *"an improvement in the mental health of all children and young people"* (Standard 9, DoH and DfES, 2004), CBT offers one evidence-based possibility.

The evidence-base for CBT, and its widespread use, is not without contention (see Section 4.3). Gilbert (2009) highlights specific controversies: for example, the disputes surrounding the 'values' of methodologies such as Randomised Controlled Trials (RCTs), and those who incorrectly interpret NICE guidelines as supporting the "superiority of CBT over all other interventions" (Gilbert, 2009, p400). Certainly, CBT is not a panacea for all mental health problems. Nor should CBT negate a systemic, biopsychosocial route to improving mental health in favour of a purely individualised

approach (as discussed in Section 4.2.2 and 4.3, and this will also be explored further in Chapter 5). As Gilbert (2009) asserts, 'CBT is a model for therapy....not a service delivery model' (p403). CBT, however, does offer a valuable approach for tackling difficulties such as depression and anxiety, and there is evidence that to this end it is as effective as medication, and "better at preventing relapse" (DoH, 2011b).

The current political climate (DoH and DCSF, 2008; DoH, 2011a and 2011b) indeed offers Greig's (2007) 'golden opportunity' for Educational Psychologists to assert ourselves as professionals able to implement successful therapeutic work with children and young people. Yet, as discussed in Section 4.1.1, EP time is infrequently allocated to the direct provision of individual therapeutic interventions (Boyle and Lauchlan, 2009). Could we be 'missing the boat'? Encouragingly, Squires and Dunsmuir (2011) do highlight a variety of studies reporting "positive outcomes for children seen in school settings by EPs using CBT" (Bernstein *et al*, 2005; Gregor, 2005; Greig, 2007; Humphrey and Brooks, 2006; McNamara, 1998; Squires, 2001a, 2001b, 2002, 2006) (p118). Cooper (2009) highlights a number of studies where positive effects of using CBT have been demonstrated for reducing anxiety in school-aged children and young people with ASD: for example, Ooi *et al*, (2008), Reaven, *et al*, (2009), Sze and Wood (2008), White *et al* (2009), Wood *et al* (2009a) and Wood *et al* (2009b). Cooper (2009) does raise, however, some of the significant methodological limitations of these studies and that any conclusions should be tentative.

Atkinson *et al*'s (2011) national review of the use of therapeutic interventions by EPs found that 63.5% of respondents *had* used CBT in the last 2 years. Notably 'limitations to Service time allocation model' and 'Service capacity' were the biggest barriers to the use of therapeutic interventions by EPs (Atkinson *et al*, 2011, p10). Now schools' are increasingly the commissioners of EPSs work, it will be interesting to see whether, given the range of government guidance on improving mental health provision in schools and early years settings (see Table 4.1), schools will choose to delegate limited school resources to the commissioning of therapeutic interventions for their pupils by EPs. If EPs are commissioned to engage more often in therapeutic work, then 'access to training' will be a key enabling factor (Atkinson *et al*, 2011). Furthermore, in their "ethnographic" research, Squires and Dunsmuir (2011) highlight some of the 'facilitators and barriers' to embedding CBT training in EP practice (in light of the new three-year doctoral training programme): for example, effective supervision and the receptiveness and flexibility of the placement EPS were seen as key facilitators, whilst perceived professional boundaries and limited EP time were viewed as potential barriers. Squires and Dunsmuir (2011) conclude;

> *"Overall, there are strong indications of commitment from TEPs and Services to embed CBT as part of the applied psychology practised in schools. Increasingly EPs are key players in supporting the use of CBT with children with social, emotional and behavioural difficulties and contributing to the improvement of their mental health. This work may well be in the form of direct therapeutic work, but there is also an important role in offering consultation, training and supervision as part of a multiprofessional team"* (p130).

Moreover, they contend that in light of the National CAMHS review (DoH and DfES, 2008), with schools' increasing role as commissioners of Services to support children and young people with identified mental health needs, "there is therefore a need for

psychological services to develop competence, experience and capacity and to develop flexible service structures that will support this growing demand" (p130).

I would argue, CBT can indeed be a therapeutic intervention of choice for EPs working in community settings with children and young people generally, and specifically for CYP who have Autistic Spectrum diagnoses. Additionally, EPs can also make a valuable contribution to the still comparatively embryonic research base regarding the use of therapeutic interventions such as CBT with CYP. Moreover, as discussed, Westbrook *et al* (2007) highlight a core principle of CBT is that it should take a biopsychosocial rather than medical approach to mental health problems, where children's difficulties are perceived on a continuum rather than as "qualitatively different from, and inexplicable by, normal states and processes" (p4). A biopsychosocial approach is a core principle of EP practice, and in this way it would appear that the use of CBT by EPs is a natural progression.

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APPENDIX VIII: Overview of Cognitive-Behavioural Assessment

(Adapted from: Kirk, 1996, p13-51)

Goals of cognitive-behavioural assessment	1. Therapist and client agree an initial formulation of the target problems 2. Therapist has elicited sufficiently detailed information about factors maintaining the problem to be able to design and present a treatment plan 3. Therapist begins to educate the client about the psychological model 4. A risk assessment is carried out e.g. regarding suicidal intent, possibility of abuse. Allows emergency factors to be assessed.
Core principles	• The ways in which an individual behaves are determined by immediate situations, and the individual's interpretation of them, with an emphasis on specific problems rather than global entities. • Dynamic and on-going process e.g. initial formulations are likely to be supplemented by additional information.
Characteristics of therapists	With all therapy, a therapist needs to make the client feel safe (so they can disclose information that may be of a sensitive or distressing nature).The therapist needs to create a warm and trusting atmosphere, with no risk of censure. The therapist needs to be empathetic and clearly committed to helping the client overcome their difficulties.

PROCESS	**Educating the client about the CB approach**	• Client should be informed that a CBT approach is largely 'self-help', with the therapist aiming to help the client develop skills to overcome current problems and similar problems in future. • Therapist emphasises role of 'homework', and that the major part of therapy takes place in everyday life, with the client applying what has been discussed in CBT sessions. • Collaborative nature of the therapeutic relationship is discussed, and patient is expected to participate actively by collecting information, giving feedback on the effectiveness of techniques and making suggestions about new strategies. • Information about treatment structure is shared e.g. how many sessions, length and location of sessions. • General educational role of the assessment is to help client focus on internal and external variables which may not have been seen as relevant to the problem: Client is asked about situations, physiological states, cognitions, interpersonal factors, and overt behaviour, and about how each of these groups of variables relates to the problem. Drawing attention to these functional relationships is part of teaching the client about the psychological model. This helps to increase agreement between therapist and client's expectations of treatment, as if they remain dissimilar; the client may decide not to pursue treatment.
	Functions of assessment	• As the therapist helps clarify and differentiate between problems, so the difficulties are frequently reduced to manageable proportions, and the client begins to believe that change is possible. • The assessment empathises the possibility of change by helping the client think of what might be achieved, and sets reasonable limits on what might be achieved (e.g. it is unreasonable for a client with agoraphobia to aim never to experience unpleasant emotions, but is should be possible to go to a supermarket in comfort). • Allows client to see that variations in intensity of distress are predictable in terms of internal and external events (i.e. not 'fate'). Additionally, if variations are predictable, they may also be controllable e.g. help client see functional relationships between symptoms and events. • Therapist offers non-judgemental sympathy and concern about client's problems and distress (offers relief to client, especially if they have felt embarrassed, guilt, shame or hopeless).

	Modes of assessment **Behavioural Interview (major part)** *– see Kirk (1996, p20-42) for further detail.* *Behavioural Analysis stage - major part of interview*	When assessing problems it is useful to differentiate between four different classes of response – behavioural, physiological, cognitive and emotional. It is useful to assess a problem in multiple ways, to allow a more accurate picture of change following treatment e.g. a client may change behaviourally but still feel distressed and experience physiological changes in fearful situations: **STAGES OF BEHAVIOURAL INTERVIEW:** • Brief description of problems: ○ "Dr... wrote me about the problems you would like help with.. but I do not have a lot of detail... I would like you to tell me briefly how *you* see the problem(s) just now". ○ If client is finding it difficult to describe their problems, prompting questions can be used e.g. "Can you describe to me what happened last time you were upset? When was that? What was the first thing you noticed? In what way has your life changed since you developed these problems? What does the problem prevent you from doing? What have you had to give up because of the problem?" ○ Therapist communicates caring concern and summarises and paraphrases what has been said, to obtain feedback on accuracy of their interpretation. ○ Considering, what is the person doing, overtly or covertly, that he/she would like to change? • Development of problems: ○ Precipitants/onset - What are the precipitants (situational, internal, mental) for the problem behaviour, and in what settings does the problem occur? ○ Time course ○ Predisposing factors • Detailed description of the problem behaviour (internal and external events, and overt behaviours are discussed): ○ Behavioural ○ Cognitive ○ Affective ○ Physiological *What? When? Where? How often? With whom? How distressing? How disruptive?* • Contexts and modulating variables: Abnormal behaviour has been learned, and such behaviours are triggered by external or internal cues which have become associated with the problem behaviour. Information regarding contextual triggers is important as treatment plans often include manipulation of the contexts in which problems occur. Crucially, it is a client's interpretation of the cues that is important. ○ Situational, behavioural, cognitive, affective, interpersonal, physiological all considered.

	Aim here is to discover how the problem is currently maintained, in what way it is interfering with client's life, and whether the problem is serving any useful purpose for client. **Other modes of assessment** (used in conjunction with behavioural interview) (see p16 for detail)	• Maintaining factors: Having built up a picture of conditions under which the problem is most likely to occur, next step is to look at what is maintaining (in the long or short-term) the problem behaviour. ○ Situational, behavioural, cognitive, affective, interpersonal, physiological. ○ What are the (especially immediate) consequences of the problem behaviour? ○ What changes might be made in any of these to produce changes in the problem behaviour? ○ Avoidance (often the most potent maintaining factor). • Questioning regarding coping resources and other assets/strengths. • Psychiatric and medical history. • Previous treatment: response, current medication. • Beliefs about problem: the client is unlikely to engage in treatment if the approach the therapist offers in not congruent with their beliefs about the nature of the problem. • Engagement. • Mood/mental state. • Psychosocial situation: family, psychosexual relationships, accommodation, occupation, social relationships, hobbies/interests. ☐ Self-monitoring. ☐ Self-report (e.g. questionnaires, global rating scales). ☐ Information from other people (e.g. monitoring by key people, interviews with key individuals). ☐ Direct observation of behaviour in clinical settings (e.g. role play, behaviour tests). ☐ Behavioural by—products. ☐ Physiological measures.
	Measure-ment in assessment and treatment	• Application of the experimental method to problems of individual clients is central to a CBT approach. A formulation is used to make predictions about the effects of particular interventions and these are then tested out in treatment. Therapy with a client can be seen as a single-case experiment, and treatment revolves around measures taken both during treatment sessions, and between sessions. Direct recording allows a more accurate description of problem e.g. with regards to frequency and intensity. • Measurement allows modification of treatment where necessary, gives client feedback with regard to progress, and allows therapist to establish whether the treatment has been delivered as intended.

Chapter 5

A casework example of the application of Cognitive Behavioural Therapy case formulation with a teenage girl with a diagnosis of Asperger syndrome.

Abstract

This final chapter presents a case study of a longitudinal, therapeutic intervention, conducted from March 2010 – November 2010 (where consultancy with the school and parents has continued to the present day, October 2011). The work evolved from my involvement in the statutory assessment of the Special Educational Needs of a Y9 pupil, 'Anna'[20]. Anna was returning to a mainstream high school in the Local Authority in which I was employed as a Trainee Educational Psychologist (TEP), following a period of prolonged hospitalisation. While the impetus for Educational Psychologist (EP) involvement was the statutory assessment process, first contacts with Anna, her mother, and the Consultant Clinical Psychologist (CCP) within the hospital setting Anna had been attending, indicated that Anna would like to do engage in further work to address her school-based anxiety. This led me to commence therapeutic work with Anna in school, building on work initiated in the clinical setting.

This Chapter relates to Chapter 4, where Cognitive Behavioural Therapy (CBT) in educational psychology (EP) practice, the national policy context surrounding mental health and the potential strengths and challenges of a CBT approach were

[20] The pseudonym 'Anna' has been used throughout to preserve the anonymity of the client.

discussed, along with how CBT can be used with specific groups e.g. young people with Asperger syndrome. This chapter provides a case example, within which I explore the use of CBT with young people, consider assessment tools, and illustrate the importance of case formulation. Additionally, this chapter seeks to contribute to the evidence base regarding the use of CBT with girls with AS, because, as described in Chapter 4, there is minimal research regarding females with AS, especially adolescent females (Beteta, 2008). Indeed, they are described as "*research orphans*" (Bazelon, 2007). The chapter concludes that formulation and intervention which takes into account young people's social context may prove more effective than casework with a purely individual focus, and that EPs' position of being able to work with school, family and child could facilitate this development to practice.

5.1 Background and referral

Due to confidentiality requirements and the need for protection of the client's identity (HPC, 2009), the client will be referred to as 'Anna' throughout this report. Anna and her parents have all given prior written, informed and freely given consent for the write up of this case study (see Appendix IX for anonymised example). Anna's father also proof read the report, to provide comment on the family's perception of Anna's situation. This case study is based upon work completed with Anna, from March to November 2010, and makes reference to my continued, indirect involvement with Anna to the current day (October, 2011).

A number of sources of information - consultations with Anna's parents, discussion with the CCP who had been working with Anna, and documentary evidence from the hospital Anna attended – were used to derive the following case résumé: Anna is the eldest child of a couple who have been divorced for over ten years, and now have new partners. Anna lives with her mother, her mother's new husband, and Anna's two younger sisters (aged 10 and 12 years), with whom she reportedly has fairly typical sibling relationships. Anna regularly sees her father, and the relationship between him and her mother appears cooperative, mutually supportive and amicable, and they work well together to ensure Anna's complex needs are met.

Anna is 15 years old, and attends a large high school in a small city. I was initially asked to be involved in working with Anna, as a Statutory Assessment was being sought by her high school. This Statutory Assessment of Anna's Special Educational Needs was being pursued to support her reintegration into school following a prolonged period as an in-patient at a large city hospital. I began working with Anna in the latter half of Year 9. Anna was finding transition into Key Stage 4 challenging. In Year 10, She attended college on a Tuesday and Thursday (doing a Hair and Beauty Course), and was in school on the remaining three days.

Whilst Anna reported having looked forward to attending secondary school, transition was problematic. In the February of Year 7 Anna began to present with physical symptoms associated with problems with the Urino-genital system, leading to incontinence and mobility problems, and culminating in admission to the local city hospital. Over the next year significant exploration of organic causes of her condition

followed, coupled with extensive school absence (with some periods of successful schooling at a Medical Education Unit, and patchy high school attendance). Once the medical examinations were exhausted, a process which in itself lasted nearly a year, Anna was eventually admitted to a major city's Children's Hospital[21] in February 2009. At this stage Anna was wheelchair bound, doubly incontinent and significantly low in mood.

On Anna's admission to City Hospital she was initially assessed by a consultant child and adolescent psychiatrist; as no organic cause of her difficulties had been found, professionals wanted to establish whether she had a pervasive developmental disorder. Anna was initially diagnosed with *'acute conversion disorder*[22] *and autonomic and secondary depressive symptoms'.* Further observations of Anna in the hospital and hospital school were carried out by hospital staff (including a Psychiatrist, Clinical Psychologist and Speech and Language Therapist), and in April 2009, Anna was referred to the City Hospital's Psychology Department for 'help with rehabilitation' (in particular managing difficult emotions). In the Autumn of 2009, Anna was referred to a Language Unit, a multidisciplinary assessment and treatment facility for children and young people whose cases are complex and difficult to diagnose. Her referral to their Speech and Language team reflected her observed difficulties expressing how she felt. Throughout her time on the hospital ward Anna

[21] The term 'City Hospital' will be used as a pseudonym for the large City Hospital which Anna attended

[22] The International Classification of Diseases (ICD-10, World Health Organisation, WHO, 2003) describes how the term "conversion" is widely applied to some of these disorders, and implies that the unpleasant affect, engendered by the problems and conflicts that the individual cannot solve, is somehow transformed into the symptoms (p123). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 2000) classifies conversion disorder as a somatoform disorder (p485) (i.e. 'a mental disorder characterized by physical symptoms') while the ICD-10 classifies it as a dissociative disorder (F44, p122-129) (i.e. a 'condition that involves disruptions or breakdowns of memory, awareness, identity and/or perception').

made remarkably positive progress both physically and emotionally. Indeed, Anna reportedly made a full recovery from her physical difficulties. However, the multi-agency assessment initiated by the Language Unit established a diagnosis of Autistic Spectrum Disorder (ASD), specifically Asperger Syndrome (AS)[23] in January 2010. It is currently hypothesised by the professional team at City Hospital and myself, that transition to Secondary school triggered acute anxiety, and that Anna's physical symptoms had a psychological aetiology. This will be explored further in Section 5.3.

Anna's father described to me how the news that she had a diagnosis of Asperger syndrome Anna was explained to her, recalling how he and her mother were told by Anna herself, on the telephone, and that Anna was upset. Hearing the news of Anna's condition was challenging for her parents on a number of fronts: that they had not be told previously, so had not been able to prepare for how to help Anna with this news, and in learning to *"accept that our 'perfect' daughter, might after all have a problem that we couldn't ignore or cure"* (father's words).

In March 2010, I began working with Anna in order to facilitate her gradual transition back from the Hospital School to the high school. First contacts with Anna, her mother, and the CCP at City Hospital had indicated that Anna would like to engage in further work to address her school-based anxiety. Consequently, I also offered to continue to deliver, in the school setting, CBT work with which Anna had been engaging with the CCP, and this was agreed in consultation with Anna, her parents and the CCP. I shadowed two appointments with the CCP and Anna in the clinic

[23] Asperger syndrome is an autism spectrum disorder that is characterized by significant difficulties in social interaction, alongside restricted and repetitive patterns of behaviour and interests, DSM-IV (2000, 299.00, p75).

setting, in order to meet with Anna, and to discuss with Anna and the CCP what had been working well, so I could tailor my planning accordingly.

5.2 Bioecological perspective

In Chapter 4 I considered the lack of power and agency children and young people (CYP) experience, relative to adults. In the cognitive-behavioural therapeutic process, where a facilitated, 'self-help' approach is adopted, with the client as practitioner-scientist, such inequality could prove problematic; for example, if the child or young person was not empowered to contribute fully to the process and/or if wider systemic issues, over which the child may have little or no control, are largely responsible for maintenance of the 'problem' behaviour. One core principle of CBT is that of systems interacting (Figure 4.2) (Westbrook *et al*, 2007). Gilbert (2006) argues that it is "now recognised that most psychological difficulties emerge from non-linear, complex interactions that involve genes, physiological systems and social relationships", and consequently a biopsychosocial approach to formulation can be helpful. Moreover, with regards to intervention, because factors are interactive and interlinking (Graham, 2005), there is a range of possible routes of remediation which can stem from any of the areas involved (e.g. behaviour, feelings/emotions or thoughts, and indeed environment). Dummett (2006) highlights the "extensive evidence-base" for efficacious child and adolescent mental health interventions that address "systemic factors in general and particularly for the efficacy of systemic interventions in augmenting benefits of individual CBT in this age range" (p180).

Dummett (2006) proposes the use of a theoretically-derived (from Beck *et al,* 1979; Rachman, 1978; and Williams, 2001) *systemic cognitive-behavioural formulation* template, which alongside the traditional 'four systems' (cognitive, affective, behavioural and physiological) integrates "other important (particularly interpersonal) perspectives such as attachment, family, wider systems, cultural, developmental factors, intrinsic difficulties and biological factors into therapy" (p179). This develops and broadens the 'environment perspective (see Figure 4.2) to incorporate factors which may "open up new ways of working and allows the therapist and client(s) together to tailor interventions to suit the child or young person in their family and wider-system context" (Dummett, 2006, p180). For this case study, although Dummett's (2006) systemic cognitive-behavioural formulation template was not used[24], a broad bioecological perspective was adopted, where Anna's needs were not seen in isolation but rather as a product of the interaction between different aspects (or levels) of the environment (see Bronfenbrenner and Morris, 2006).

I recognised the importance of working directly with Anna, and addressing problems or coordinating support at the microsystem and mesosystem levels. For example, in addition to direct work with Anna, I also liaised with:

- her parents;
- school staff (the SENCo, Anna's Teaching Assistant and the school's Family Support Worker);
- SEN services;
- the local Complex Communication Difficulties team (which includes specialist teachers for autism);
- City Hospital professionals, which included the CCP, Psychiatrist and SaLT who were involved in her care;

[24] On reflection, and were I to undertake this case work again, I would use Dummett's (2006) template. Even if I were not able to conduct family systems work *per se*, I would expect it would still prove a useful template for structuring formulation and sharing information.

- and local Tier 3 and 4 CAMHS professionals i.e. the psychiatrist, the therapeutic social worker and the CBT accredited psychiatric nurse (who I would be 'handing over' to).

Systemic work posed a number of challenges: Firstly, in addition to time with Anna, and follow up with her parents and the school, there were significant time implications of coordinating support between so many professionals, in two different Local Authority Areas. Secondly, communication with other agencies proved difficult at times, and the evidence which informed Anna's diagnosis of AS, was not available despite written permission from both parents, and numerous e-mail and telephone requests, and a further telephone conversation with the City Hospital Psychiatrist[25]. Thirdly, and linking with this lack of information sharing, whilst reports were forthcoming, it was not possible to gain access to the Clinical Psychologist's formulation: a regrettable omission, since this necessarily restricted the extent to which her formulation and her post hoc evaluation and revision of this could form a basis for my own formulation, so strengthening prospects of therapeutic continuity at this important transition period. Finally, despite written and telephone communication with the local CAMHS team, asking for us to coordinate work and plan transition (as after two school terms of work, my supervisor directed me – due to EP Service time constraints - to scale down my involvement, and 'hand over' Anna's case), her case was not picked up by CAMHS until a 3 months later, despite a self-evident need for continuing therapeutic work. Nevertheless, the above difficulties I faced were not exceptional, as the challenges of multi-agency work involving Health and Education professionals - especially with regards to 'communication' - are well documented

[25] The psychiatrist said she was "surprised that I wanted this information", as EPs don't normally want to have this level of detail. She tried to assure me that the diagnosis was 'multi-professional', although details remained fairly opaque, and it was not possible to elicit all the information I wanted.

(Atkinson *et al*, 2002; Milbourne *et al*, 2003), and are commonly commented upon by practitioners within my own work setting.

Whilst there are some difficulties associated with ensuring interventions address systemic issues and multi-agency working, the benefits of such an approach are likely to outweigh any limitations. In a controlled trial of CBT or CBT plus family management (FAM) for the treatment of childhood anxiety, "self-report measures and clinician ratings indicated added benefits from CBT+ FAM treatment" (Barrett *et al*, 1996, p333).

5.3 Case Formulation

5.3.1 Definition and purpose of formulation

Case formulation or case conceptualisation, is a key component of cognitive-behavioural therapy (Kuyken *et al*, 2008). Case formulation can have subtly different definitions, and can mean different things depending upon which type of therapeutic intervention is adopted (Johnstone and Dallos, 2006). However, Johnstone and Dallos (2006) state that the common components of a formulation provide a hypothesis about a person's difficulties, drawn from psychological theory. Many also emphasise the collaborative nature of formulation (Tarrier and Calam, 2002; Kuyken *et al,* 2008). This contrasts with the omission of the client's role and viewpoint in developing the formulation, which has been noted in a number of cases (Johnstone and Dallos, 2006). The purpose of a formulation has been variously described as;

> *"1. relates all the client's complaints to one another, 2. explains why the individual developed these difficulties, and 3. provides predictions concerning the client's behaviour given any stimulus"*
>
> (Meyer and Turkat, 1979, p261, cited in Johnstone and Dallos, 2006, p5).

> *"To provide an accurate overview and explanation of the patient's problems that is open to verification through hypothesis testing, and to arrive collaboratively with the patient at a useful understanding of their problem that is meaningful to them....The case formulation is then used to inform treatment or intervention by identifying key targets for change"*
>
> (Tarrier and Calam, 2002, p312).

Formulation is a prerequisite for any intervention, and in the case of CBT, involves working to create a shared understanding of the onset and maintenance of an individual's presenting problems (Stallard, 2005, p27). Described as '*the heart of evidence-based practice*' in case conceptualisation, presenting problems are described and theory is used to make explanatory inferences, in a way that informs intervention (Kuyken *et al*, 2005, p1188). This role in guiding intervention is critical, as case conceptualisation "provides the explicit, shared, working hypothesis that is used to direct and inform the specific content of the intervention" (Stallard, 2005, p27).

A case formulation allows a flexible conception of a client's unique profile of strengths and difficulties "irrespective of their diagnostic classification" (Tarrier and Calam, 2002, p323). Such a personalised approach means that targeted treatment, specific to the individual's needs, can emerge from the formulation (Tarrier and Calam, 2002). Case formulation is seen as central to successful treatment, as it addresses the complex "interplay between multifaceted causative and maintaining factors" (Tarrier, Wells and Haddock, 1998, pxiii). For Anna, with a complex personal and familial history and the diagnostic classification of AS, this approach provided a robust

framework and facilitated collaborative theory building, to ensure that Anna's needs were understood and intervention was appropriately personalised. The formulation process described below, was dynamic and subject to change, with the information presented in the following sections representing the final formulation discussed with Anna and her mother in June 2010 and again in September 2010, and amended in light of their feedback.

5.3.2 Approach to formulation

The process of CBT formulation is sometimes shorthanded to 'The 5 Ps', outlined as follows (Johnstone and Dallos, 2006, p21):

- ***Presenting issues:*** *what are the problems?*
- ***Precipitating factors:*** *what triggers the problems?*
- ***Perpetuating factors:*** *what keeps the problems going?*
- ***Predisposing factors:*** *what led to the problems starting?*
- ***Protective factors:*** *what are the person's strengths?*

Anna's case is considered in relation to each of these domains (Sections 5.4.2-5.4.7), with assessment results and a contingent case formulation presented utilising Stallard's (2005) framework (see Figure 5.2)[26]. EPs work "according to a scientist-practitioner model" (Dunsmuir and Iyadurai, 2007, p18). Consequently, this approach to formulation is compatible with long-established principles of accepted practice for EP assessment and intervention e.g. illustrated in the Division of Educational and Child Psychology's (DECP, 2002) *Framework for Psychological Assessment and Intervention.* The framework involves the investigation of hypotheses that build on

[26] Though on reflection, as described in Section 5.2, were I to conduct similar case work again, I would instead utilise Dummett's (2006) systemic cognitive-behavioural formulation template.

psychological research (Frederickson *et al*, 1991). Furthermore, such a framework recognises that psychological assessment:

- *is embedded in a context;*
- *should take place in a climate sensitive to ethical practice, equality of opportunity, politics and values; and*
- *is viewed as being an intervention in itself, inextricably linked to any subsequent formal intervention"*

(DECP, 2002, p26).

5.3.3 Cognitive-Behavioural Assessment

5.3.3i Ethical Considerations

Ethical considerations should form part of all psychological assessment and intervention (DECP, 2002). As discussed, there are inherent power imbalances between children and adults (Davie *et al*, 1996), and "most young people and some parents are vulnerable in their dealings with professionals because of relative lack of professional knowledge and, in some cases, lack of skills and resources" (DECP, 2002, p5). Consequently, EPs have "a responsibility to redress the potential power imbalance by involving clients fully in decision-making", and "should endeavour to make sure that they obtain informed consent and establish a climate of open communication" (DECP, 2002, p5). To meet this end, in all my interactions, I endeavoured to ensure informed consent was elicited from Anna. At the start of working with Anna, I wrote to her and her parents separately to seek informed consent (see Appendix IX for copy of consent letter). All three gave their informed consent. Furthermore, Anna was also reminded during our sessions that her participation was voluntary, and that she could leave or stop our meetings at any

time, should she wish. Anna never exercised this right, and indeed, in my clinical judgement, never appeared reluctant to engage, because she was there through choice rather than coercion, I felt this impacted positively on the therapeutic relationship. Additionally, as collaboration between client and therapist is a crucial component of case formulation (Tarrier, 2006), Anna's full cooperation was essential for this end, as well as on ethical grounds.

5.3.3ii Assessment of Risk

Risk assessment is a method of "calculating the relative value and likelihood of different possible outcomes" (Glancy and Chaimowitz, 2005). Risk assessment and management are both important issues in clinical practice (Glancy and Chaimowitz, 2005), but both bring their own challenges (Subotsky, 2003, p319). For example, there can be "conflicting obligations" between "confidentiality v. safety, or in 'ethical' terms, autonomy v. beneficence; medication – too much or too little; diagnosis – entitlement or stigma; the child's interests v. the parent's" (Subotsky, 2003, p319). Furthermore, the context is also complex, as there are "multi-disciplinary and multi-agency issues" (Subotsky, 2003, p319). Risk assessment for children and young people differs from that used for adults, and a wider range of issues need to be included e.g. the risk of harm to self, to others (including staff), from others, and from the system itself either by 'omission or commission' (Subotsky, 2003). Faced with such complexity it is important that organisations have systemic policy development and "interagency agreements to promote coordination" (Subotsky, 2003, p319).

Risk assessment should be a dynamic and on-going process, as 'risk' itself can change over time (Williams, 2005). Risk assessment involves the consideration of 'the likelihood of something bad happening', with risk management the attempt to "reduce the risks of adverse events occurring by systematically assessing, reviewing and then seeking ways to prevent their reoccurrence" (Subotsky, 2003, p319). Risk assessment was carried out in May 2010, when 'vulnerability to exploitation, self-neglect, self-harm, child protection, aggression and suicide risk' were all actively considered using a Clinical Psychology Service Child and Family Speciality, Case Formulation proforma (Hall, 2010). Questions from the BECK Youth Inventory were used to prompt discussion e.g. items such as, 'I feel empty inside' and 'I think my life will be bad', correlate well with measures of 'hopelessness'; a key cognitive predictor of suicide (Padesky, 2004). Anna was also asked if "*there was anything that had happened to her that she wished hadn't*", as an open question. I ensured I discussed the risk assessment results with my supervisor, and kept a record of results. On reflection, I consider that I should have formally assessed risk more frequently than I did, but I did carry out informal risk assessment and ongoing risk management, as I always followed up any concerns I had promptly and systematically. For example, in one session, Anna was distressed (tearful and angry; her TA had reported her throwing chairs in frustration), so, with Anna's consent, I shared this information with my supervisor, parents, school and CAMHS professionals, in order to plan intervention and thus any risk to Anna and others was managed appropriately. The reliability, however, of risk assessment and management is contentious, and this will be discussed in Section 5.4.1v.

In addition to information garnered from consultation with Anna and her parents (March – June 2010), and reports from other involved agencies, a number of assessments were carried out to elicit information for the formulation and to provide a baseline for later comparison and these are shown in Table 5.1:

Table 5.1: Assessment tools/screening questionnaires used with Anna

Test	Author	Other information
Strengths and Difficulties Questionnaire	Goodman (1997)	Self, parental and teacher reports
Children's Automatic Thoughts Scale	Schniering and Rapee (2002)	Self report
BECK Youth Inventory 2nd Edition	Beck *et al* (2005)	Self report
Screen for Child Anxiety Related Disorders (SCARED)	Birmaher *et al* (1997)	Self and parental report
Beck Anxiety Inventory (BAI)	Beck and Steer (1990)	Self report

These tools were selected from a wide range of possible assessment tools/screening questionnaires, on the basis of their relevance for this case, ease of application, the relevance of standardisation populations, and their validity; these are discussed further in the following sections.

5.3.3iii Strengths and Difficulties Questionnaire (SDQ)

The SDQ allows a focus on a child's strengths as well as difficulties, and is a brief behavioural screening questionnaire for 3-16 year olds (Goodman, 1997), which has been adapted for use with adolescent populations (Goodman *et al*, 1998). The adolescent, parent and teacher are each independently asked 25 questions, which consider five areas:

1. *emotional symptoms*
2. *conduct problems*
3. *hyperactivity/inattention*
4. *peer relationship problems*
5. *prosocial behaviour*

In addition, an impact supplement[27] allows the parent or teacher to consider whether the young person has a problem, and if so, enquire further about 'chronicity, distress, social impairment, and burden to others', providing useful additional information for clinicians and researchers with an interest in psychiatric cases (Goodman, 1999).

I selected this questionnaire for the standardisation sample populations' relevance and size (Meltzer *et al*, 2000). It also allows some consideration and triangulation of results from Anna, her parents and her teacher (see Table 5.2 below). It was also a measure I already used with other pupils at Anna's school, and consequently her teachers were familiar with it. It is easy to administer and score, which helps encourage staff to use it as a pre- and post-measure for their work with pupils. Moreover, the SDQ is one of the main measures recommended by CAMHS Outcome Research Consortium (CORC, 2007).

Table 5.2: Anna, her mother's and her teacher's scores on the SDQ May 2010

	Anna's Report	**Mother's Report**	**SENCo's Report**
Overall stress	Very High (23)	Very High (24)	Close to average (9)
Emotional distress	Slightly raised (5)	Very high (9)	Very high (6)
Behavioural difficulties	Very high (6)	High (4)	Close to average (0)

[27] The impact supplement is also available for 11-16 year olds to complete.

Hyperactivity and attentional difficulties	Very high (8)	Slightly raised (6)	Close to average (1)
Difficulties getting along with other young people	High (4)	Very high (5)	Close to average (2)
Kind and helpful behaviour	Very low (4)	Very low (4)	Slightly low (5)
Score for the impact of any difficulties on the young person's life	Not completed by Anna	Very high (7)	High (2)

The scores highlight some differences between Anna's mother's perception of Anna's difficulties and the SENCo's. Such differences could be due to a number of factors. For example, Anna's difficulties may be more apparent in the home context, her mother knows her better than the SENCo, her mother may have an exaggerated view of Anna's difficulties. On the basis of the evidence I collected, my view is that both Anna's mother and the SENCo share the view that Anna's difficulties are having a 'very high' or 'high' impact on her life, and that she is clearly experiencing 'emotional distress', and this is what is important. I think that as the SENCo sees Anna as 'having friends' and not exhibiting clear 'behavioural difficulties' in the sense that her behaviour in class is not disruptive, or particularly externalising, this might explain the other differences in the scores. As Anna's social difficulties are more apparent to her mother and in the home context, this would also explain the differences. As Nichols (2009, described in Chapter 4, Table 4.3) stated, it is important to understand "*a girl's social network and taking into account whether she has a "mother hen" friend who has supported her in the social world*" as this may have masked her social deficits. As Anna has a male friend in school who takes this role, her difficulties may be less apparent to the SENCo, as she is not 'friendless', and therefore perhaps not as much of a concern as other children the SENCo works

with who have no social network. Relative to the SENCo's experience of pupils, Anna's difficulties are less severe, whereas relative to her mother's experience (Anna has two sisters) her difficulties are more apparent. Anna's self-reported difficulties are broadly in line with her mother's views, although it is interesting from Anna's perspective it is 'behavioural' or 'hyperactivity and attentional difficulties', rather than 'emotional distress', that are of primary concern. These different calibrations of 'emotional distress' suggest the need for further exploration during the therapeutic process.

5.3.3iv Children's Automatic Thoughts Scale (CATS)

CATS is a "developmentally sensitive measure of cognitions associated with childhood internalising and externalising disorders" (Micco and Ehrenreich, 2009, p532). CATS comprises "a self-report measure designed to assess a wide range of negative self-statements in children and adolescents" and considers automatic thoughts on physical threat, social threat, personal failure and hostility (Schniering and Rapee, 2002, p1091). This tool was chosen as it assists in the assessment of a range of 'negative automatic thoughts'[28] (Schniering and Rapee, 2002), and has been shown to be highly sensitive to treatment change, has good convergent validity with related anxiety and depressions scales, and shows internal consistency and criterion validity (Schniering and Lyneham, 2007; Micco and Ehrenreich, 2009).

[28] Negative Automatic Thoughts or 'NATS' are the negative thoughts people may think about themselves, the world, or the future. They are automatic, distorted, unhelpful, plausible and involuntary (RU-OK, 2002). They may pop into a person's mind when they are experiencing some kind of emotional distress (Beck, 1976).

There are some limitations to the use of this tool, as in comparison to the population for whom it has been developed (7-14 years old) Anna was in the upper end of this population at time of testing (14 years 6 months), making the validity of the test less robust.

An additional reason for the use of this assessment was that at the end of her work with Anna, the CCP had assessed Anna using this tool. I used the information gathered to assist with my construction of Anna's formulation. I also reassessed Anna in May 2010 and found the following change of scores (Table 5.3):

Table 5.3: Anna's scores on the CATS prior to work starting and in May 2010

Scale	Scores from Clinical Psychologist, February 2010	Scores in May 2010
Physical Threat	5	0
Social Threat	23	7
Personal Failure	8	8
Hostile Intent	21	20
Total Score	*57*	*35*

The scores indicate a reduction in all but the 'Personal Failure' domain, with negligible change on the 'Hostile Intent' scale and a notable reduction in perceived 'Social Threat'. I shared the results with Anna, and such improvements were very encouraging for both her and me.

5.3.3v BECK Youth Inventory 2nd Edition (BECK YI)

The BECK YI contains five scales to assess the nature of a young person's depression, anxiety, anger, disruptive behaviour and self-concept (Beck *et al*, 2005). They measure the stress a young person may experience in association with mental health difficulties. The scales involve statements about thoughts, feeling, or behaviours associated with emotional and social difficulties in adolescence. I selected this tool as it can be used pre- and post-intervention to examine outcomes, and to track progress, and as it focuses on the child's experience rather than observer ratings. It is designed for use with children and adolescents (aged 7-18). It has a USA national standardisation sample, stratified by ethnicity and socio-economic status, so these variations needs to be factored in to any consideration of use with UK children and young people. The BECK YI gives a useful breadth of assessment (see Table 5.4), and in Anna's case also contributed to the risk assessment (Section 5.3.3ii) and prompted discussion with Anna e.g. regarding her response to Question 44 which states "I wish I were dead".

Table 5.4: Anna's scores on the BECK YI May 2010

Scale	Score	Clinical range
BSCI-Y Self Concept	32	Much lower than average
BAI-Y Anxiety	49	Average range
BDI-Y Depression	54	Average range
BANI-Y Anger	60	Mildly/moderately elevated
BDBI-Y Disruptive Behaviour	65	Moderately elevated

The results indicated that Anna's self-perception of her competency, potency and positive self-worth (self-concept) needed developing. It also suggested to me that

rather than ‘anxiety’ necessarily being a key area for us to work on, ‘anger’ (including perceptions of mistreatment, negative thoughts about others, feelings of anger and physiological arousal) also required addressing.

5.3.3vi Screen for Child Anxiety Related Disorders (SCARED)

As ‘anxiety’ had been highlighted by staff working with Anna at City Hospital and at her high school, further assessment of anxiety was undertaken. SCARED is a self-report questionnaire that measures symptoms of DSM IV linked anxiety disorders in children (Muris *et al*, 1998). SCARED allows comparison between Anna and her mother’s perceptions of her difficulties (as does the SDQ). SCARED is also reported to demonstrate good internal consistency, test-retest reliability, discriminative validity (both between anxiety and other disorders, and within anxiety disorders), and moderate parent-child agreement (Birmaher *et al*, 1997). It is also a reliable and valid instrument by which to screen childhood anxiety difficulties (Birmaher *et al*, 1999). Anna and her mother’s scores for Anna are reported in Table 5.5 below:

Table 5.5: Anna’s scores and her mother’s reported scores for Anna on SCARED May 2010

For specific questions...	Anna’s scores	Mother’s scores for Anna	Anna/Parental scores highlight concern?
Panic disorder or significant somatic symptoms may be indicated by score of 7+	3	4	No
Generalised anxiety disorder may be indicated by 9+	11	13	Yes

Significant school avoidance may be indicated by 3+	4	6	Yes
Separation Anxiety Disorder may be indicated by 5+	0	3	No
A social anxiety disorder may be indicated by 8+	7	14	Part
Total Score (where 25+ suggests presence of an anxiety disorder)	25	40	Yes

On the SCARED assessment scale, there were some clear discrepancies between Anna's self-perception and her mother's perception. These were particularly with regard to items concerning sociability and thus informed the possibility that a social anxiety disorder may be indicated. For example, Anna's mother would describe Anna as 'shy' "very or often true" but Anna did not ("not true" or "hardly ever true"). However Anna did report as "very or often true", finding it hard to talk to people she doesn't know well, and reported being a worrier. This discrepancy may be because Anna's mother does not see Anna in the school context, where she has familiar peers and friends around her. A Teaching Assistant who worked closely with Anna reported how she is very chatty in lessons with certain girls and with familiar groups, and that she does not come across as 'shy'. In contrast, Anna's mother sees her being shy with unfamiliar people. Overall, I found the measure useful in terms of reinforcing/confirming the idea that Anna may be experiencing some school-based anxiety, and for offering us a way of measuring progress in this domain.

5.3.3vii Beck Anxiety Inventory (BAI)

The BAI is a well accepted self-report measure of anxiety in adolescents, describing emotional, physiological, and cognitive symptoms of anxiety (Beck and Steer, 1990).

It allows a current focus on the physical effects of anxiety It has been used in peer-reviewed studies with younger adolescents aged 12 and older, although it was designed for use with 17-80 year olds (Kashani *et al*, 1990). The BAI has good reliability and validity for adolescents in Anna's age range (Grant, 2007). To inform formulation, in addition to the BECK YI, I also used the BAI with Anna in May 2010 in order to explore whether there were any physical sensations affecting Anna. I note below those symptoms that Anna reported had mildly or moderately impacted upon her, she reported no effects under 'severely – I could barely stand it' (see Table 5.6 below):

Table 5.6: BAI scores for Anna, May 2010

Symptom	**Mildly** 'it did not bother me much'	**Moderately** 'it was very unpleasant but I could stand it'
Feeling hot	X	
Unable to relax		X
Fear of the worst happening		X
Heart pounding or racing	X	
Nervous		X
Hands trembling	X	
Fear of losing control	X	
Scared	X	
Face flushed	X	

Arguably such scores, especially when considered against her CATS scores, do highlight that Anna is likely to be experiencing some significant, uncomfortable physical symptoms and negative automatic thoughts which might benefit from a CBT approach to intervention.

5.3.3viii Personal Construct Psychology (PCP)

PCP was used to gain insight into Anna's sense of self and how she construes the world around her (Kelly, 1955; Moran, 2008). A key postulate of Kelly's (1955) PCP stipulates "a person's processes are psychologically channelized by the ways in which he anticipates events" (p32). This argues an individual's experiences are determined by the way he or she predicts events in their world, based on previous learning from similar experiences (Shilvock, 2010). Another key principle of PCP is Kelly's (1955) philosophical position of 'constructive alternativism' (Shilvock, 2010). This epistemological stance proposes one's experience can be changed, by changing the way one construes it (Burnham, 2008). Thus the fundamental principles of CBT and PCP are well aligned; for example in CBT "the ways in which an individual behaves are determined by immediate situations, and the individual's interpretation of them" (Kirk, 1996, p13), and excessive emotional reactions and self-defeating behaviour can be reduced "by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions" (Beck *et al*, 1993, p27).

PCP was selected because of its parallels with the core principles of CBT and because it provides a useful structure for exploring individuals' subjective versions of reality (Beaver, 1996; Shilvock, 2010). Anna was asked to imagine the kind of person she would and would not want to be like, and to answer prompts about this person (adapted from Moran, 2008; Fransella and Dalton, 1990). Anna elected not to draw a sketch of the person, but preferred to write her responses, which are summarised in Table 5.7 below:

Table 5.7: Anna's responses to 'Ideal' and 'Non-Ideal Self' prompts (from Moran, 2008)

Prompts	Responses to Non-Ideal Self	Responses to Ideal Self
What **kind of person** is she? What is she like? Could you tell me 3 things about what kind of person she is?	'Unrespectful' Stuck up Nasty/think you're better than everybody else	Takes care of looks/hygiene Kind/respectful Lots of friends/popular
This person goes to school every day with a **bag**. What kind of things would a person like her take with them?	Would have cigarettes, a phone and make up in their bag	Would have books, a phone and make up in their bag
It is this person's **birthday**. What would this person like for their birthday present?	Would want money for their birthday	Would want money and a party for their birthday
What is this person like **at home with their family**?	Wouldn't be home much Too good/cool for them	Spend a couple of hours with them Go out or on laptop sometimes
Everyone has something that they are **afraid** of. What would be the biggest fear of a person like this?	Spiders Hair going curly at school No make up *[from conversation with Anna, I suspect these are all Anna's fears too]*	No friends! Insects
How did this person come to be like this? Were they always like this or **did they change** somehow to become like this? What happened to them?	Changed in high school Needs to be popular to have friends Doesn't care about education	Always been like this
What do you think might happen to this person **in the future**?	Probably still be popular Very stuck up?! Good job? *[when questioned about this point..."probably, most of them people do get good jobs"]*	Good family Good job Easy life Good money

As the use of PCP was limited, there are questions concerning the validity and reliability of this approach. I considered, however, that the assessment data collected helped my understanding of Anna and informed the CBT formulation. Importantly, it also helped as a rapport building exercise. I think Anna showed a fairly limited capability to engage in this abstract task, possibly a characteristic of the Asperger syndrome, but this apparent lack of engagement could also be explained by a lack of motivation or interest in the activity. My interpretation of the information gathered, and from further discussion with Anna, suggests that Anna wants to be with her family, but sometimes struggles with her relationships, in particular with her sisters, her mum, and with her dad's girlfriend. I wondered whether the "changed in high school" aspect for how the 'non-ideal' self came to be that way, could indicate Anna's awareness of this transition being a significant challenge for her too, in particular due to the changing nature of social relationships and school context/nature.

5.4 Formulation development

5.4.1 Additional background information

Consultation with Anna, her parents and the CCP, suggested that when Anna initially returned to the high school in Year 8, she felt she was bullied and accused by peers of "faking it" to get time off school. She worried constantly about having to return to school and was often distressed. Anna's perception was that people did not understand what she was going through and thought she was doing it on purpose.

Scores in May 2010 on the CATS (see Table 5.3) indicate a significant reduction since initial testing by the CCP[29], in Anna's perceptions/belief regarding social threat (e.g. how others perceive her); however there was almost no improvement in her views regarding the hostile intent of others (e.g. having the right to take revenge on people if they deserve it and not letting people get away with picking on her). Similarly, in their large sample of 'anxious youth' Schneiring and Lyneham (2007) also found, following treatment, no reduction in hostility beliefs, despite reductions in 'threat' and 'failure beliefs'. This more hostile perception of others and retaliatory response set, coupled with her anxiety at school, may affect Anna's relationships with her friends and peers, and is an area in which she might benefit from further work. However, Anna could identify a number of people with whom she was friends, and I observed her to have a close, mutually supportive friendship with a boy in her year. Furthermore Anna's allocated TA has also described her as having a few other girls in her classes, with whom she engaged well. However, Speech and Language Therapy (SaLT) reports highlighted that Anna may be vulnerable in the presence of more streetwise young people, as she finds it difficult to identify processes such as persuasion or bluffing. On a more optimistic note her father indicated she had recently been attending parties, and was making some progress with her social engagement.

5.4.2 Presenting issues: what are the problems?

A key problem for Anna was anxiety, particularly around school (see Tables 5.2-5.7). To those who did not know Anna, she could sometimes present as a fairly 'typical

[29] No date was available for when the CATS assessment was completed by the CCP.

sulky teenager', often appearing to be in a mood. The nature of Anna's difficulties meant that she could sometimes misinterpret the intentions of others. When Anna was stressed she found it difficult to listen and process instructions. Pragmatic language impairments are often related to AS (NAS, 2010) and the Speech and Language therapist reported that Anna had difficulties with abstract language, using language appropriately in social situations, and interpreting correctly the meaning of what is being said.

Anna's communication levels were greatly affected by her mood. When in a low mood she was fairly uncommunicative and it was difficult to engage with her or elicit her views; she would often respond *"don't know"* or *"I'm tired"*. It may well be that on such occasions, such responses constituted her learned, instant response to tasks involving a cognitive demand and that sometimes she could be 'thinking' herself tired. Anna's attitude and approach to learning was demonstrably affected by her anxiety levels. When she felt stressed she struggled to attend school, or attended and struggled to work. For example, during exam times at school, with lots of disruption to Anna's timetable, she reported increased anxiety and frequently went home ill. This stress could be reduced or alleviated with appropriate support e.g. planning ahead, teaching assistant time to help the process change. However, Anna had made very significant progress, following diagnostic uncertainty around her symptoms, over a year of hospitalisation, and contingent impact on her relationships with family and friends, she had managed to have relatively good school attendance over the period from March 2010 – November 2010, despite her continuing reluctance to go and anxiety when attending.

The CCP described how for Anna, anxiety is caused by her assumption that others are judging her and thinking she is faking illness. This anxiety was expressed through social withdrawal and physical deterioration leading to mobility problems. Furthermore, anger (usually caused by social interactional difficulties), was expressed in explosions of temper and some aggressive behaviour, although this occurred almost entirely within the family and towards her sisters. There had been only one report of this type of outburst in school; Anna felt like destroying a room, but controlled her behaviour. Latterly, (October, 2010) at the school, Anna's anxiety was primarily expressed through social withdrawal and difficulty talking to people or communicating her worries; phrases like "*I'm tired*" or "*I'm bored*", may also sometimes be used as defence against underlying anxiety.

To conclude, the key presenting issues for Anna were:

- physical symptoms, or the reporting of physical symptoms, at times of psychological distress;
- low mood;
- school-based anxiety and worrying about school (with ensuing impact at home (Anna described how *"when I'm at school it has an effect on me at home"*); and
- social withdrawal when anxious;
- and self-reports of depression.

5.4.3 Predisposing factors: what led to the problems starting?

Information gathered from consultation with Anna's mother, father and the CP, suggested that transition to secondary school may have initially precipitated problems with anxiety. Whilst it is possible Anna had always experienced some anxiety with change and social situations, and/or with aspects of her school

experience, the radical change of environment that occurred with transition from her smaller, friendly, well-structured, predictable and nurturing primary environment to the far less predictable, large, complex, socially intimidating nature of her secondary high school is likely to have been the most significant factor in triggering Anna's problems, and the level at which they were manifest. Notably, discussions with primary school staff have revealed they do not remember any concerns with Anna in that setting, and were surprised by the diagnosis of AS. However, it could be that as environmental factors at school and at home were very constant, predictable and routine during Anna's primary years (according to parental reports), it was not until Anna experienced a significant transition that her problems were manifest. Additionally, as described in Chapter 4, Table 4.3, Nichols (2009) highlights in relation to AS that "deficits in girls may become more apparent over time, particularly in early adolescence".

Anna's age is likely to be an important contributory factor in accounting for the later manifestation of any difficulties. Adolescence is a "high-risk period for the onset of psychopathology" (Walker, 2002). It is possible her difficulties were precipitated by the onset of puberty, as research implicates this as pertinent in activating biogenetic risks of mental health disorders (Walker, 2002). Additionally, research reports that girls and boys on the autistic spectrum "experience different developmental trajectories related to social difficulties", so the expression of girls' difficulties may not occur until early adolescence (Nichols, 2009, p1). Furthermore, Jennings (2005) argues that girls with autism may find puberty and menstruation overwhelming, as their chronological age does not reflect their psychological age (p592). Anna,

however, described how *"she hates it when people say it's because of my periods...it [the difficulties] started before"*. This is supported by her father's reported chronology of events which indicated the difficulties started before Anna's periods. However, I wondered if Anna's difficulties were linked to the onset of adolescence, and perhaps the fear of growing up and not being able to cope:

> ***Oonagh:*** *"Why did you like primary school so much?"*
> ***Anna:*** *"because you didn't have to worry about things.....mum would sort worries out"*

Girls are described as 'worrying about school performance' more than boys (West and Sweeting, 2003).

Anna struggled to understand what might have led to the problems starting, and has difficulties remembering accurately the period when she was physically ill, and hospitalised. However, as part of constructing a 'Life Journey[30]' with Anna, the CCP elicited something of Anna's earlier history from her own perspective: Anna reportedly remembered that she had not wanted to attend nursery but had settled into primary school and had managed well. There was one episode of bullying in Year 2 which was resolved by Anna's mother and school. From an early age Anna experienced recurrent urinary tract infections and had had multiple hospital appointments, investigations and some time off school.

Anna reported that she had looked forward to attending secondary school and had initially found the work manageable. However, she remembered having a lot of

[30] The therapist facilitates the client in constructing a narrative or pictorial account of the timeline of events that have occurred, and this may include the client's thoughts, feelings and behaviours in relation to any significant events.

homework, forgetting to do it, worrying about doing it and not handing it in for which she got detention. Anna's father described how he and her mother had begun noticing problems when Anna started Year 7 e.g. she started "complaining of tummy aches", and "worrying about homework".

It is reported that continued having infections and became water incontinent. Her father described how:

> *"She was having some minor wetting of her underwear and we remember having to buy more underwear and Anna was sitting on a towel to prevent further accidents. She had no sensation of when she needed to pee and was very frustrated. We remember her wetting her underwear on almost a half hourly basis".*

Anna remembered being educated in a hospital school unit for a while. In Year 8 she was "sent back" to her High School. On her return she felt she was bullied and accused by peers of "faking it" to get time off school. She worried constantly about having to return to school and was often distressed. Anna's father reported how:

> *"...school were not willing for Anna to return to the school environment due to the risk of wetting which they would have difficulty dealing with and Anna was very embarrassed about her condition, how she would explain it to her friends, they would make fun of her pads which she was worried others could see through her clothes, what would happen if she had an accident in the classroom ('accidents' were very frequent at this time and Anna was filling incontinence pads during the daytime of one every 30-45mins). They did though send work home but Anna could not hold her concentration long enough to successfully apply herself to the work".*

Towards the end of 2008 there was a further decline in Anna's physical state: she reported having "flu", started having memory problems and mobility problems and became wheelchair-bound. Over the Christmas period that year she became 'depressed and suicidal'. The local CAMH services became involved and she was

put on anti-depressants. Anna reported to the CCP that she had thought that people did not understand what she was going through and that she "*was doing it on purpose*".

Possible organic causes of Anna's physical symptoms were examined by medical professionals from the local and City Hospital from February 2008 -2009, and Anna was in and out of hospital over this period. Anna's parents had an appointment with the consultant at the local hospital in mid-January 2009. The consultant told parents that *"he was nearing the end of all the physical tests he could do, to prove that there was nothing physically wrong with Anna, and that the root cause of Anna's condition was psychological"*. Indeed, Anna had a full MRI scan in late January 2009 which finally confirmed no physical problems were causing her symptoms.

My hypothesis is that her and her parents' worrying about physical symptoms, anxieties about attending school and her peers' reactions, the onset of adolescence, and Anna's feeling that no one understood what she was going through, are all likely to be significant predisposing factors. Given the extreme nature of Anna's difficulties, however, it is likely that there are further predisposing factors that have not yet been identified.

5.4.4 Precipitating factors: what triggered the problems?

From her own accounts, it appeared that Anna found new situations or change difficult. In a busy high school where numerous transitions occur every day, the ever changing, unpredictable environment around her triggered her anxiety. Furthermore,

she did not enjoy school, and experienced this environment, in which she perceived herself as "*different*" and others as "*treating her differently*" hard work. For the TA who now works with Anna, there was a delicate balance to be struck between giving Anna the support she needs, both academically and socially, whilst not evoking further anxiety by Anna feeling she is 'standing out' or being singled out in some way. Additionally, as social communication was problematic, when Anna had difficulties at home (e.g. fights with her sisters or mother) she got anxious and angry but did not know how to process or deal with the complexities of these familial relationships, lacking coping strategies. She then brought an elevated level of anxiety into the school situation.

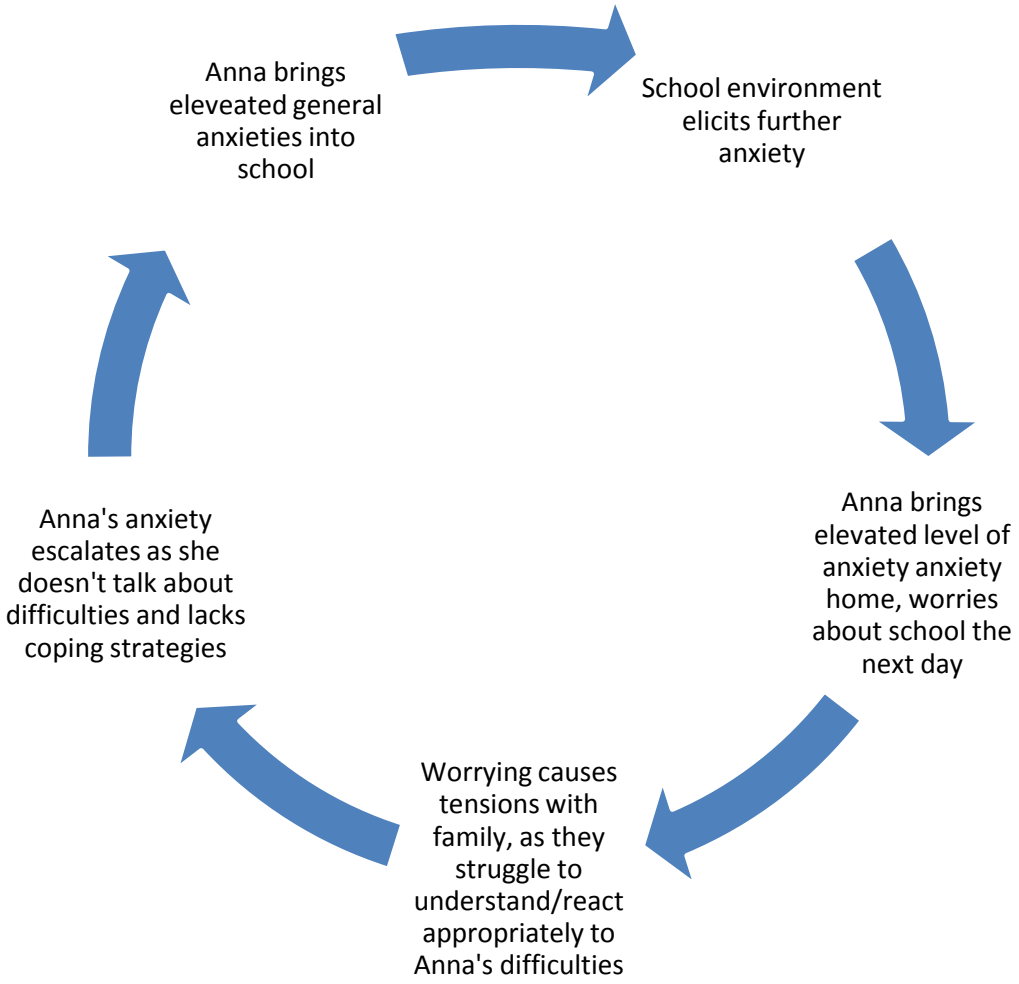
5.4.5 Perpetuating factors: what keeps the problems going?

I believe there may be a circular causation occurring where this school-based anxiety interplays with complexities in the home environment, both triggering the problem behaviours of school/work avoidance, negative attitude ("I'm bored"/"I'm tired") and physical symptoms (see Figure 5.1 below).

I also hypothesised that Anna's difficulties with both the semantic and pragmatic aspects of language – as evidenced by the SaLT assessment (January 2010) could mean she struggled to follow what was being said, sometimes misinterpreting meaning, with ensuing impact on her relationships. Aside from difficulties stemming from the AS, I believed another significant factor in the perpetuation of Anna's difficulties had been how the initial diagnosis was handled. Her mother reported confusion, from both Anna and herself, around what caused the initial deterioration in

Anna's physical condition and made it so severe. From Anna's mother's point of view, "*if I can't understand it, how do I know how to avoid it happening again?".* She felt she was *"walking on eggshells"*, so that Anna would not become ill again. The anxiety of the adults around Anna was likely to exacerbate Anna's worries. Parenting during adolescence can be difficult for many families (Pickhardt, 2011). Teasing apart whether behaviour and moods are due to 'autism, adolescence or both' is a common experience of many families with children with AS (Nichols *et al*, 2008), and clearly complicates an already challenging developmental period.

Figure 5.1: Proposed interplay between anxiety at home and school



Consultation with Anna's mother revealed she had always struggled to understand and accept the AS diagnosis. She wrestled with why they did not see any problems before *"... as a mum.. you would know.... doesn't make sense".* Consultation with Anna and her father suggested that prior to Anna becoming ill Anna's relationship with her mum "was complicated". Anna may have felt her mum did not understand her. During the diagnostic process, Anna's mother reported that the Speech and Language Therapist (SaLT), who discussed the diagnosis with Anna, and later her parents, suggested that Anna's mother also had some AS type traits. This had led to Anna often saying to her mother, *"you understand mum"* or *"you're like me"*. So when her mother did not understand, or when Anna felt she did not, problems were exacerbated. Furthermore, Anna's mother's negative reaction to the suggestion she also had AS, meant that she may have rejected the diagnosis in its entirety, believing that, if the SaLT could make her 'fit the diagnosis', "they could make anyone". Anna's mother did not accept that she was on the autistic spectrum. Significant investigation of the diagnosis and consultation with the psychiatrist and SALT who were involved, highlighted that Anna's diagnosis was, however, part of the thorough, multi-disciplinary assessment. Multi-disciplinary assessments are recommended by the Royal College of Psychiatrists (2003) in the National Autism Plan for Children (NAPC), itself part of the National Initiative for Autism: Screening and Assessment (NIASA).

As Anna's mother struggled to accept Anna's AS diagnosis, her behaviour with Anna at home varied too, from supportive to frustrated (especially when Anna avoided school; as noted above, her mother also worried she may inadvertently make Anna ill

again). I wondered whether she blamed herself for Anna's 'illness', not believing the AS diagnosis and its corollaries. Anna's mother's frustration was understandable; she has three teenage daughters and works almost full time, which in itself posed challenges. Additionally, with Anna, she felt she *"doesn't get anything back"* so did not know whether or not she was meeting Anna's needs. This caused frustration and meant that, when her patience was exhausted, she shouted, increasing Anna's anxiety and lack of social connectedness and meaning that the vicious circle was maintained. Anna showed good insight into what was going on:

> *"Me and my mum had an argument the other day...I wasn't talking... I understand why.....she's trying....but it's not changing anything....my step-dad gets angry because my mum's getting stressed and it's because of me".*

Ronen (1998) argues that "the relationship between children and their social systems cannot be overempahsised, the environment both affecting and being affected by the child's behaviour" (p3). Whilst Anna and her mum were apparently close, and her mother very supportive, in my judgement Anna was greatly affected by the dynamics of their relationship. Indeed, a key hypothesis was that the fluctuations in Anna and her mother's relationship, which were often dictated by Anna's mother's own emotional well-being and/or relational situation (i.e. the status of Anna's mother's relationship with her partner, or her own mother), appeared to be one of the key predictors of Anna's own emotional well-being (as shown in Figure 5.1 on p201). From a family systems perspective, with regards to 'boundaries', Dallos and Draper (2005) highlight how family members can "range from being too close (overinvolved or enmeshed) to too distant (disengaged, detached, and overrigid) with each other" (p39). My hypothesis was that enmeshment could be seen in the ways in which Anna

and her mother related (Dallos and Draper, 2005), and the assessment evidence suggested that enmeshment was an important perpetuating factor for Anna's difficulties. For example, Anna was often too involved in her mother's feelings and thoughts, frequently discussing her mother's moods and worrying about her mother's feelings. Furthermore, analysis of Anna's reported emotions and observed behaviours in relation/comparison to home events also suggested enmeshment was a key component, and important perpetuating factor (e.g. Anna's behaviour difficulties in school often escalated around times where there were problems at home). Dallos and Draper (2004) highlight how the three related factors "comprising expressed emotion – high levels of criticism, emotional involvement and lack of emotional warmth – have all been seen as likely to promote relapse following hospitalisation and recovery" (p213). Dallos and Draper (2005) describe how the "level of expressed emotion in the family environment of a person who has suffered from a serious mental disturbance, is significantly related to the likelihood that they will subsequently relapse" (p213). Considering the entanglement between Anna and her mother's well-being - and as discussed in Section 5.2 the recognition that systemic CBT approaches may be more beneficial than those with a purely individual level focus - this again highlights the need for intervention which addresses such complexity at multiple levels.

A further difficulty for Anna and her mother's relationship appeared to be the time they had spent apart. As Anna was away for a year, her mother noted that she found it difficult to reconnect to Anna, feeling that, as a result of the AS diagnosis, Anna was no longer the 'daughter she knew'. Moreover, Anna's difficulties with social

communication were likely to mean that she found being at home, and coping with the normal complexities of family life, very tiring and sometimes sought solitude. Anna described how:

> *"Before I went on the ward I was alright at home...I spent a year and a half on the ward....now I don't want to be at home all the time".*

I viewed Anna's feelings in this regard as developmentally appropriate, considering her age, and sustained period away from home. Ronen (1998) suggests the major developmental task of middle adolescence is individuation from the family and moving toward independence; to meet this end appropriate cognitive intervention might include problem-solving skills and self-control. Furthermore, Anna's parents themselves may benefit from support, as they had been coping with the stress of caring for a child with a chronic illness, "the difficulties of which are well recognised" (Ronen, 1998, p391).

I considered that Anna felt quite alone and misunderstood. Whilst she did not crave social situations – *"I know it sounds really bad....I hate people....I want to be on my own"* - I consider she would not necessarily have felt this way if she were better equipped to deal with the complexities of relationships, and if those around her were better equipped to deal with her needs. Consultation and the PCP activity suggested Anna did want friends (Table 5.7). Anna did not like feeling different, *"if you were in an ASD* school...*they'd treat you normal...here [at the high school] they make me feel completely different"*. Anna had liked being on the ward, as there were other people there who were like her/understood: for example, her male "best friend" outside

school, was someone from the ward, also on the Autism Spectrum. This desire not to seem different, and fit in, also meant difficulties were perpetuated, as Anna did not easily seek help, or accept support in class.

A further significant perpetuating factor could be Anna's recourse to physical symptoms as the only way she had been able safely to express her difficulties/get people to understand her difficulties. Griffin and Christie (2008) highlight how "difficulty expressing emotional distress verbally is widely thought to underlie the presentation of physical symptoms which cannot be explained in medical terms" i.e. psychosomatic symptoms (p531). Perhaps then, for Anna, somatisation of stress had formed a powerful means of communicating her distress: *"I'm anxious"*.

My hypotheses were that in addition to the enmeshment between Anna and her mother, Anna was not really happy at school, as her current school environment lacked many aspects Anna needed (e.g. predictability, nurture, small-group work, adults with training in working with pupils on the Autistic Spectrum), it is possible that at times 'illness' has enabled her to avoid or escape a situation in which she was unhappy. Anna lacked incentive for her to keep attending the high school, as 'positive' behaviours (attending school and coping) were not positively reinforced, because she did not want to be there, whereas previously 'negative' behaviours or physical symptoms, were negatively reinforced, by enabling her to avoid or escape this distress-evoking environment and attend a setting better attuned to her needs.

5.4.6 Protective factors: what are the person's strengths?

Whitfield and Davidson (2007) contend that in CBT "it is important not to simply look at the pathology, at what is wrong, but to also look at what is right" (p68). Anna exhibited a wide variety of strengths; she was highly ICT literate (social networking sites occupied much of her free time); she was creative, enjoying art and the hair and beauty course she attended; she was very interested in fashion and always looked well presented; she was friendly to familiar adults and showed good eye contact; she had a good sense of humour and presented in a 'warm' and cooperative way. Additionally, she claimed to want the situation to improve/change (although I found some resistance to CBT homework tasks, or engaging in aspects of the CBT process). Anna had friends in school. Her parents were a very important protective resource. Despite the difficulties in her relationship with her mother, there appeared a desire on both their parts for this relationship to work better. Whilst Anna had difficulties getting on with her father's new partner (which she sometimes raised in therapeutic sessions), she also enjoyed a very close relationship with her father. Her father had also attended training about AS and showed good understanding of how to support Anna.

Despite their divorce, Anna's parents appeared to communicate well, and offered a united front for supporting her and coping with challenging behaviours (e.g. if I e mailed Anna's father, he would share this with her mother, and if I spoke to Anna's mother, she would let Anna's father know of any developments). Given the importance of social relationships among family members e.g. they are the best predictors of children's behavioural outcomes (Feldman, Stiffman and Jung, 1987),

they can afford a key sphere of protective influences, which may "prevent further deterioration and has implications for prognosis and response to treatment" (Carr, 2005, p52). Indeed, Hetherington *et al* (1993) stress the importance of parental co-operation following divorce. The advantage of such an amicable relationship between her divorced parents should not be underestimated. Whitfield and Davidson (2007) suggest asking whether the situation "would....have been worse if some factors had not been present" in order to identify protective factors (p68). If Anna's parents' relationship was acrimonious it is likely this would have compounded her difficulties in a number of ways e.g. it would cause Anna additional stress and anxiety, it would make transition time between parents' houses more difficult, it would increase tension in the family and impact on hers and her sisters' relationships, and it would mean that information sharing and communication between agencies and parents would be far more challenging.

5.4.7 Provisional conceptualisation/initial diagnostic impression

In the course of my own work with Anna she initially reported being happy at home; latterly, it emerged Anna was experiencing some difficulties at home. It was clear that whilst she had a close bond with her mother, whom Anna described as "great" at "helping her" and "saying the right thing", Anna appeared greatly affected by the dynamics of their relationship. For example, when Anna had recently been chastised for using the 'phone into the early hours, she reported:

> "*...when my mum shouts at me...I don't talk to her...when I haven't talked to my mum for a long period of time... I don't want to talk to anyone and I go into depression...sort of...I've been depressed before... I don't know if it's the same... I was on tablets."*

Anna accrued a large bill for her use of the 'phone. She used it secretly, when her mother had gone to bed and this situation (not being truthful with her mother, and the significant financial cost of the bill), had caused numerous arguments between Anna and her mother. Anna discussed this with me in our sessions, as too did her parents, and I considered it had an impact in school, as Anna reported and demonstrated a low mood during this time.

As noted in Section 5.4.4, there may be a type of circular causality occurring (shown in Figure 5.1 on p201). Whilst Anna and her mother had a loving relationship, there were complexities within this relationship, described previously (see Section 5.4.5), which appeared to affect Anna at home and school - especially in terms of understanding and processing the diagnosis of AS, and its implications for Anna.

Stallard (2005) describes how formulation development can be a powerful way of helping a child and their parents understand the impact of past events, and to explain why current difficulties are occurring and how they are maintained (p39). More complex formulations specify in greater detail "important events or experiences and their relationship with particular beliefs or assumptions" (Stallard, 2005, p39). The link with parental behaviour and specific core beliefs can be included in the formulation (Stallard, 2005). I found sharing Figure 5.1 and the diagram of the formulation (Figure 5.2 on p211) with Anna's mother a constructive step: whilst the material was clearly emotionally challenging, she responded that *"it makes more sense"*.

Figure 5.2 overleaf shows a schematic representation of the formulation of problems and maintaining contingencies for Anna, based on the information presented in Sections 5.3 and 5.4.

5.5 Discussion

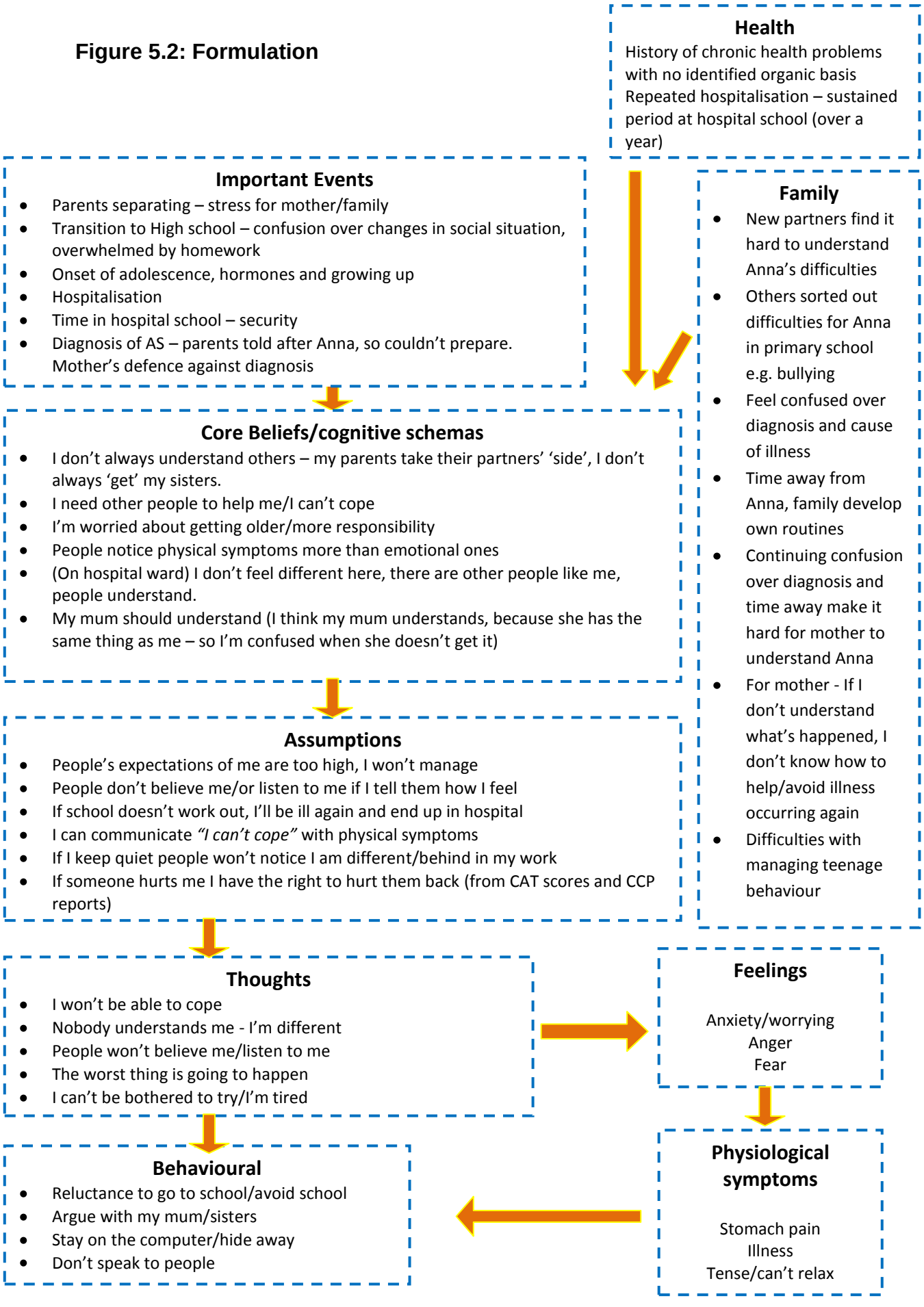
5.5.1 Critique of formulation

The formulation outlined in Figure 5.2 below represented the latest (December, 2010), most thorough conceptualisation of Anna's situation. Persons (1989) proposes five tests of a formulation arguing that it should:

> *1. try to account for each problem/symptom in the light of the case formulation;*
> *2. try to account for current (including new) precipitants of problems;*
> *3. make predictions/retrodictions about how the client is likely to behave, feel, think, or have behaved, felt, thought, in specific circumstances;*
> *4. check whether the client feels that the formulation "fits" them; and*
> *5. evaluate treatment success/failure; this may not always be due to the accuracy/inaccuracy of the formulation, but there is at least a strong possibility that it is.*

On reaching this final formulation, towards the end of my work with Anna (June 2010, for the purposes of this report, but further amended in September 2010 in the context of my continuing professional practice), I went through Persons' (1989) steps, and concluded (albeit intuitively) that the information 'fitted', not least with Anna and her mother, but from my perspective it also tied problem dimensions together and was coherent. Furthermore, Anna's father read through the details of my formulation and commented: *"Oonagh's synopsis of her work and findings with Anna are accurate".*

Figure 5.2: Formulation



Whilst Anna's father's comments are encouraging, an independent critique of the formulation process I adopted is essential, not least in order to control for risks of confirmatory bias (Nickerson, 1998).

5.5.1i Using CBT as a Trainee Educational Psychologist

My position as a novice in using CBT, and the fact Anna's case represented my first attempt at using a structured cognitive-behavioural approach to assessment, formulation and intervention, doubtless had the potential to affect the reliability and accuracy of cognitive-behavioural assessment, interpretations of the evidence, and subsequent case-formulation. Whilst inexperience was unavoidable, in endeavours to contain these risks, ensure safe practice and maximise my own professional learning, I did ensure I sought regular CBT-focused supervision with an experienced and skilled CBT practitioner. Squires and Dunsmuir (2011) report a number of facilitators and barriers TEPs face when trying to embed CBT training in practice, with 'supervision' being a key facilitator (and its absence, a significant barrier). Certainly, supervision is essential for the development of CBT skills (Armstrong and Freeston, 2006). Similarly to Squires and Dunsmuir's (2011) TEP respondents, I found regular, high quality supervision by an experienced supervisor important for enabling safe and ethical practice, helping guide problem formulation and skill development, and crucial when "dilemmas were presented" (p126).

5.5.1ii Multi-agency working

Squires and Dunsmuir (2011) report how TEPs found multi-systemic working "important, yet complex and challenging at times" (p127), while 'professional territory' was an important theme influencing TEPs' capacity to embed CBT practice. The challenge I found with regard to multi-agency working, was specifically with the sharing of case formulations and the sharing of diagnostic information more generally. For example, Kuyken (2006) discusses how "competent CBT practitioners would normally have a set of hypotheses, a diagram or a written formulation as part of their case and supervision notes, which guides their intervention" (p21). Anna had been seeing the CCP in City Hospital during her year of hospitalisation, but despite my attempts to see or discuss the case formulation for Anna, this was not forthcoming. I did send a copy of my formulation to the CCP, but did not receive feedback. I would imagine, however, that someone in the CCP's position, with what is likely to be a heavy case load, perhaps simply did not have time to liaise with other professionals. As discussed in Section 5.2, similar difficulties were found with trying to ascertain detailed information regarding the bases for the diagnosis of Asperger syndrome.

Additional to the challenges of sharing information, was the difficulty of consistent interpretation of the evidence. For example, Kuyken (2006) argues that "it is reasonable to suppose that two practitioners asked to make inferences about the same case using the same theory and same case formulation framework should construct similar formulations...on the other hand, given the complexity of this task and the intrinsic role of heuristics in formulation it may be too much to expect any

level of consistency" (p21). Reliability in case formulation is complex, with reliability between CBT practitioners fairly good when it comes to analysis of the descriptive elements of a case, but less reliable when it comes to the inferential component of case formulation e.g. in "identifying hypothesised underlying cognitive mechanisms" (Kuyken, 2006, p22). Whether or not consistency could be achieved, co-construction or discussion with another involved professional (in addition to supervision), would surely have been useful in increasing the inter-rater reliability of my case formulation for Anna. Kuyken (2006) highlights studies where the lack of inter-rater reliability between CBT practitioners continued despite greater alignment in methodology. He suggests, however, that there is "preliminary evidence that systematic frameworks...enhance the reliability of practitioners' formulations on the more readily interpretable cognitive and behavioural mechanisms" (Kuyken, 2006, p23). In future, I will ensure that I continue to use a systematic and structured framework such as Dummett's (2006) systemic cognitive-behavioural formulation template. If there were other involved professionals, I would be more assertive in advocating the need for information sharing and reciprocal formulation critique.

5.5.1iii Differential diagnosis

A further problem with regards to accuracy of case formulation arose because detailed diagnostic information was difficult to elicit from other professionals. Specifically, because Anna did not present in home, school or individual interview contexts as being clearly on the autistic spectrum in the judgement of those who worked with or interacted with her within these community settings, there remained a

level of uncertainty regarding the validity of a diagnosis of Asperger syndrome. Indeed this was a recurrent theme in supervision sessions. In addition to the wider repercussions of such a classification (see National Autistic Society, 2011), a neurodevelopmental difficulty such as Asperger syndrome would have implications for all aspects of CBT from assessment and formulation, to the structure of sessions, affective education, and with regards the nature of the therapeutic relationship itself (Anderson and Morris, 2006). This diagnostic uncertainty did affect my confidence in the accuracy of the case formulation. Appendix X shows a comparison of the diagnostic criteria for Asperger syndrome (ICD-10, World Health Organisation, WHO, 2003, F84.5) which I have completed with regards to my knowledge of Anna. Moreover, I have added to this some of the difficulties Nichols (2009) identifies with regard to sex differences and assessment of ASD in girls (discussed in Section 4.4.1).

Appendix X shows that whilst Anna's presentation, to my mind, does not entirely 'fit' the ICD-10 (WHO, 2003) diagnostic criteria, when her presentation is not compared to prototypical male presentation, and where consideration is given to Nichols' (2009) reported 'sex differences in autism' and 'suggestions for assessing females with possible ASDs', there are some indicators of ASD. Whether or not AS is a correct diagnostic classification for Anna's difficulties, my interpretation is that currently Anna and her father have found this categorisation helpful in providing an explanatory framework for problems such as her difficulty with developing appropriate peer relationships, managing change, and restricted interests (i.e. level of internet use), and in helping to shape interventions at the family level e.g. her father has ensured

that Anna has far more predictability and structure at weekends when she stays with him, and she and he both report that she finds this beneficial.

CBT can successfully be used for clients who exhibit 'medically unexplained symptoms' (MUS) (Brown, 2006), as did Anna. The purpose of cognitive-behavioural formulation of MUS is to "understand the range of physiological, emotional, behavioural, cognitive, and social processes involved in the creation and maintenance of an individual's symptoms, distress and disability" (Brown, 2006, p267). In this way, I would argue that formulation for MUS or for a client with AS may not be substantially different, and that what is needed is for formulation to be personalised, dynamic, on-going and to be amended in light of new information e.g. response to intervention. As questions do persist regarding the accuracy of the diagnosis of AS, I am currently (November 2011) exploring this with the CAMHS Nurse Practitioner who is now working with Anna.

5.5.1iv Nature of the evidence used

The reliability of the case formulation was affected not only by my questioning skills but the nature of assessment tools used. For example, with regards to assessment tools, self-reported data could be questioned for their reliability. For example, Yu (2011) describes how some researchers question the accuracy of self-reported data for numerous reasons e.g. because human memory is fallible (Schacter, 1999), or because subjects tend to report what they think the researcher expects to see or the more positive aspects of their own abilities, knowledge, belief or opinion (Cook and

Campbell, 1979). Chan (2009), however, contends that the 'bad reputation' of self-reported data is nothing more than "urban legend" (p313). Moreover, for this study, a number of the self-report measures used (e.g. SCARED, SDQ) also included a parent and/or teacher report too, which alongside the range of measures used (see Section 5.3.3) facilitated triangulation of results to provide a more valid and rigorous account of Anna's difficulties, albeit with triangulation posing its own challenges (Robson, 2002). The British Association of Behavioural and Cognitive Psychotherapies require that, for accreditation as a cognitive-behavioural therapist, three cases should be "closely supervised using live (in-vivo, video, audio) assessment" (BABCP, 2011, p12). In future work, in line with this criterion, and subject to each client's informed consent, I would hope to video or audio record our sessions so that greater reflection regarding the nature of the questioning or assessment tools used - and the child or young person's responses to them - could then occur in supervision.

5.5.1v Reliability of risk assessment

As discussed in Section 5.3.3ii risk assessment is a dynamic process. The reliability of risk assessment is contentious and complex, and Bailey (2002) describes how "risk escalates when there is failed multi-agency risk assessment and management, which includes failure to respond to reported episodes....poor record-keeping and communication, and taking a cross-sectional rather than long-term view of the young person and his or her behaviour" (p98). I attempted to make a comprehensive assessment of risk towards the start of work with Anna, outlined in Section 5.3.3ii, but the methods I adopted were not standardised approaches, and the reliability and

validity of this risk assessment is questionable. 'Formal' risk assessment only occurred on one occasion, and whilst I did seek and weigh information re: risks of harm during every session (e.g. by ensuring I noted and responded to any indicators of distress), I did not formalise this process. I found it interesting that in Stallard's (2005) clinician's guide to 'using CBT with children and young people' I found no explicit reference to risk assessment or management, despite a discussion about risky behaviour e.g. deliberate self-harm. Furthermore, the DECP's (2002) Professional Practice Guidelines have only one fairly broad reference to risk, with the example presented apparently more concerned with the risk was to the EPs themselves rather than the child:

> *"Educational psychologists...should be particularly sensitive to the potential risks that may be incurred in their work with young people, parents and others. For example, in addition to educational psychologists not using their position of power over a child in any way that might be construed as abusive, they should be aware of situations where accusations of this nature might arise (e.g. work with adolescents in residential establishments) and take appropriate action to avoid the possibility of the situation arising"*
>
> (p11).

Subotsky (2003) outlines how it is important that a number of risk variables are considered e.g. the risk of harm to self, to others (including staff), from others, and from the system itself, either by 'omission or commission'.

5.5.1vi Ethical considerations

Numerous ethical challenges arose in this work. For example, I considered sharing of the formulation with Anna a crucial component of the process, as many researchers emphasise the collaborative nature of formulation (Tarrier and Calam, 2002; Kuyken *et al,* 2008), insisting it should be "collaborative and not imposed" (Tarrier, 2006, p5).

On reflection, however, the level of detail in the formulation I shared with Anna (Figure 5.2) may have posed a barrier to her understanding. Given her age, reported difficulties (e.g. the SALT described how Anna "would probably follow rather than contribute ideas"), and the power differential inherent in our roles, I am concerned that she was not fully able to contribute to and/or challenge my interpretations. I did strive to redress potential power imbalances by involving Anna in decision-making and ensuring I secured her informed consent (DECP, 2002, p5), but in future I would also further simplify the formulation to be shared with the child or young person.

A further challenge arose with the sharing of the formulation with Anna's mother. I am mindful that in order to preserve my good working relationship with Anna's parents, I was possibly less transparent and/or 'critical' in reporting my views about the complex nature of the relationship between Anna and her mother. In future, I would aim to discuss this quandary further in CBT supervision. I did, however, share both the formulation (Figure 5.2) and the circular causality diagram with Anna's mother (Figure 5.1), who reported to find these helpful in coming to an understanding of some of the causal mechanisms underpinning Anna's difficulties - as described previously Anna's mother commented that *"it makes more sense".*

5.5.1vi Dynamic formulation and systemic working

The aim of formulation is to "arrive collaboratively with the patient (*sic*.) at a useful understanding of their problem that is meaningful to them" (Tarrier and Calam, 2002, p312). Formulations are also dynamic and as such "can never be totally correct" (Stallard, 2005). Whilst case formulation can never be 'totally correct' it can at least

be useful and meaningful to the client (in this case, Anna) The case conceptualisation developed over time, taking into consideration information which surfaced gradually from sessions with Anna, and on-going consultations with her mother and father. Kuyken *et al* (2008) argue that the validity and reliability of case formulation is improved if it is allowed to develop and "evolve over time in the context of new information and client responses to therapy interventions" (p762). The formulation process with Anna was dynamic and evolving. Specifically, as a more detailed developmental history emerged from consultation with Anna's parents, and as rapport was built with Anna and her family, it became apparent that individual work with Anna needed to be supported by, or perhaps superseded by work which involved Anna and her family, particularly her mother (as previously discussed). I discussed this with Anna and her parents, and with their support made a referral to the local CAMHS team, so that some form of therapeutic intervention at the family level could be initiated. Due to my own Service constraints, I was not in the position to offer this myself. Once the referral was processed, work undertaken between Anna and me was shared with relevant professionals within the CAMHS team.

A further challenge was in assessing Anna's 'readiness to change'. Prochaska *et al* (2002) provide a useful framework – 'The Stages of Change Model' - for considering a client's readiness for active participation in therapy, which Stallard (2005) has adapted for working with children. On reflection I think Anna was at the 'contemplation' stage where she had 'begun to identify some potential areas that she would like to change, but appeared unsure about the possibility that this could be achieved' (Stallard, 2005, p12). Anna's readiness to change, however, was further

complicated by the systemic aetiology of Anna's difficulties i.e. that a number of her problems did not arise from 'erroneous thinking' *per se* but from the effects of difficulties at the family and school level. I consider it is crucial that systemic difficulties are addressed prior to or alongside any further individual-focused CBT, so that Stallard's (2005) warning is heeded:

> *"...pursuing child-focused CBT without addressing the wider systemic influences runs the danger of colluding with the dysfunctional family system and pathologising the child" (p23).*

Given the need for further work at the family and school levels, if a systemic CBT model is to be followed, it will be crucial not only to address at what stage Anna is at regarding Prochaska *et al*'s (2002) model, but at what stage are the family and school systems.

5.5.2 Post-intervention outcomes from assessment measures

Alongside more qualitative data (e.g. feedback from Anna's parents and school staff, comment in case notes) I evaluated the work I had completed with Anna by repeating a number of the initial assessments in September 2010, so that progress could be considered, Tables 5.8-5.11 show the results:

Table 5.8: Anna and her mother's scores on the SDQ May 2010, compared with September 2010 (in red)

	Anna's Report	Difference	Mother's Report	Difference
Overall stress	Very High (23) Close to average (14)	-9	Very High (24) Very High (27)	+3
Emotional distress	Slightly raised (5) Close to average (4)	-1	Very high (9) Very high (8)	-1
Behavioural difficulties	Very high (6) Close to average (3)	-3	High (4) Very high (7)	+3

Hyperactivity and attentional difficulties	Very high (8) Close to average (5)	-3	Slightly raised (6) Slightly raised (6)	0
Difficulties getting along with other young people	High (4) Close to average (2)	-2	Very high (5) Very high (6)	+1
Kind and helpful behaviour	Very low (4) Very low (3)	-1	Very low (4) Very low (1)	-3

Table 5.8 shows Anna viewed that her difficulties had reduced over the period we were working, but that such results were not reflected in her mother's scores for Anna. It is possible that Anna over-emphasised improvements, or that she perceived improvements which her mother had not. Other responses to questions on the SDQ are shown in the table below:

Table 5.9: Anna and her mother's responses to follow-up questions from the SDQ

Question to child/parent	Anna's response	Mother's response
Since coming to the clinic (i.e. to see Oonagh), are your/your child's problems: Responses: Much worse, a bit worse, about the same, a bit better, much better.	"much better"	"a bit better"
'Has coming to the sessions been helpful in other ways e.g. providing information or making the problems more bearable?' Responses: Not at all, only a little, quite a lot, a great deal.	"quite a lot"	"quite a lot"
Over the last month, have you/has your child had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people? Responses: No, Yes –minor difficulties, Yes-definite difficulties, Yes- severe difficulties.	"Yes - definite difficulties"	"Yes - minor difficulties"
Do the difficulties upset or distress you/your child? Responses: Not at all, only a little, quite a lot, a great deal.	"quite a lot"	"only a little"
Do the difficulties interfere with your/your child's everyday life in the following areas? Home life: Friendships: Classroom learning: Leisure activity: Responses: Not at all, only a little, quite a lot, a great deal.	 "quite a lot" "not at all" "quite a lot" "not at all"	 "only a little" "only a little" "quite a lot" "quite a lot"

Do your difficulties make it harder for those around you (family, friends, teachers etc.)?	"only a little"	n/a
Do the difficulties put a burden on you or the family as a whole?	n/a	"quite a lot"

I think the trends suggest that whilst progress had been made, there remained a need to continue support for Anna and her family so that further reductions in problem dimensions can be achieved.

I also evaluated progress using the BECK YI and BAI; results are described below:

Table 5.10: Anna's scores on the BECK YI May 2010 compared with Sept 2010

Scale	Clinical range and score May 2010	Clinical range and score September 2010	Change (black desirable change, red undesirable)
BSCI-Y Self Concept	Much lower than average (32)	Much lower than average (35)	+3
BAI-Y Anxiety	Average range (49)	Average range (43)	-6
BDI-Y Depression	Average range (54)	Average range (55)	+1
BANI-Y Anger	Mildly/moderately elevated (60)	Average (53)	-6
BDBI-Y Disruptive Behaviour	Moderately elevated (65)	Average (48)	-17

The results show nearly all trends are in a positive direction, with slight improvements in Anna's self-concept, decreased anxiety, depression slightly higher (increased by 1 point, but still in average range), reduced anger and disruptive behaviour. Anna had recently started in Year 10 when these results were obtained, and had been nervous at the prospect of transition.

The results on the BAI in September 2010 reveal a mixed picture (see Table 5.11 below). Whilst some physical symptoms had disappeared or reduced in severity, new symptoms had emerged e.g. wobbliness in legs or shaking. Nonetheless, all symptoms were rated in the 'Mild' range rather than the 'Moderate' range, and again none was in the 'Severe' range.

Table 5.11: BAI scores for Anna, May 2010 and September 2010 (in red)

Symptom	**Not at all**	**Mildly** 'it did not bother me much'	**Moderately** 'it was very unpleasant but I could stand it'
Feeling hot		X **X**	
Wobbliness in legs	X	**X**	
Unable to relax	**X**		X
Fear of the worst happening	**X**		X
Dizzy or lightheaded	X	**X**	
Heart pounding or racing		X **X**	
Unsteady	X	**X**	
Nervous		**X**	X
Hands trembling	**X**	X	
Shaking	X	**X**	
Fear of losing control	**X**	X	
Scared	**X**	X	
Faint	X	**X**	
Face flushed		X **X**	

In my view, results from SCARED (Table 5.11 below), may be more reliable than those from the BECK YI, as I considered that, though Anna had certainly made improvements over the time we spent together in attending school, many other her difficulties were still affecting her. It is interesting to note the slight reductions in her mother's perception of Anna's difficulties, using this scale, in contrast with the SDQ results.

Table 5.12: Anna's scores and mother's reported scores for Anna on SCARED May 2010 and September 2010 (in red)

For specific questions...	Anna's scores	Mother's scores for Anna	Anna/Parental scores highlight concern?
Panic disorder or significant somatic symptoms may be indicated by score of 7+	3 **5**	4 **0**	No **No**
Generalised anxiety disorder may be indicated by 9+	11 **11**	13 **13**	Yes **Yes**
Significant school avoidance may be indicated by 3+	4 **6**	6 **8**	Yes **Yes**
Separation Anxiety Disorder may be indicated by 5+	0 **0**	3 **2**	No **No**
A social anxiety disorder may be indicated by 8+	7 **6**	14 **12**	Part **Part**
Total Score (where 25+ suggests presence of an anxiety disorder)	25 **28**	40 **35**	Yes **Yes**

5.6 Conclusion

Future directions

Anna made measurable improvements during the time we worked together, both in terms of scores on assessment tools like the BECK YI, increased school attendance (reported by mother and school SENCo), and reported positive effects from Anna and her family. Furthermore, her father commented:

> *"Oonagh worked tirelessly with Anna, ourselves, School, Health professionals and other agencies to help ensure that the network around Anna provided an environment that fostered continued and consistent communication and support. I am quite sure that without Oonagh's efforts our daughter's health and future would not be as secure as it is today".*

Nevertheless, at the start of Year 10 Anna began to express her anxiety more strongly, was very tearful and reported to her mother and the TA she was feeling ill. Consequently I planned a multi-agency meeting for October 2010 to help address this by joint problem-solving and developing a plan where a number of organisations would be involved in supporting both Anna and her family, as family support is a crucial protective factor (Carr, 2006). I judged that Anna was now better able to express her anxiety with her family and familiar adults, through talking, crying and externalising emotions, rather than the previous circumstances where psychological distress had been communicated through physical symptoms. In November 2010, I began to wind up my involvement with Anna, primarily due to service constraints, as I was no longer able to dedicate the weekly session or planning time to Anna, and recognised that work with Anna needed to be on-going and therefore provided by professionals with the capacity and remit to meet her needs in the long-term e.g. local CAMHS team.

Need for systemic interventions

Interventions need address underlying causative and maintaining processes (Dummett, 2006). I consider that whilst the initial purpose of my involvement was to help Anna in her transition back into school, case formulation had led me to view that the most significant causative and maintaining factors affecting Anna were her familial relationships and home rather than the school context. Dummett (2006) highlights the "*extensive evidence base... for the efficacy of child and adolescent mental health interventions addressing systemic factors in general and particularly for*

the efficacy of systemic interventions in augmenting benefits of individual CBT" (p180). Furthermore, systemic approaches can help incorporate the influence of environmental factors on a young person, as a significant criticism of CBT can be its focus on the internal world of the individual rather than the individual in context (Rait *et al,* 2010). Parental involvement in applied CBT programmes leads to, perhaps unsurprisingly, better outcomes for children than those involving only the young person (Greig, 2007). Consequently, systemic cognitive behavioural therapy with Anna and her family is likely to produce more positive and perhaps more sustainable change. Dummett (2006) describes a systemic cognitive-behavioural formulation template and process that aims to incorporate a range of perspectives (e.g. attachment, family, wider systems, developmental factors, intrinsic difficulties and biological factors), yet is simple enough to "derive collaboratively and leads to a distinct clinical process for working with individuals, families and wider support systems" (p179). For Anna, such a therapeutic process would allow complexity of her situation to be encompassed, whilst offering a comprehensive route forward, where key areas such as family *and* school can both be considered and addressed.

Role of the EP

Positive feedback from the school and Anna's family gave me confidence that there *is* a significant role for EPs to play in the delivery of therapeutic interventions such as CBT, and in helping coordinate and problem-solve for families and schools. However, current role restrictions and models of service delivery mean therapeutic work with families is not currently offered by my employing EP Service. Many authors argue

that EPs should be more involved in individual casework, and therapeutic interventions in particular (Jensen *et al*, 2002; Greig, 2007; MacKay, 2007; Boyle and Luchlan, 2009; Gersch, 2009). MacKay (2007) argues that EPs are "a key therapeutic resource for young people, especially in educational contexts such as schools" (p16). They argue that our distinctive positioning and work with schools, families and young people, could lend itself well to the application of Dummett's (2006) systemic CBT within the range of core services which EPs offer. With the news that the Government is looking to unite health, education and social care contributions under a single SEN assessment process (DfE, 2011), with stronger group advocacy perhaps EPs could offer therapeutic work which also bridged these currently unnecessarily and unhelpfully disparate domains.

In Anna's case, I concluded that support for not only the young person, but for their family is crucial. Consultations with Anna's parents highlighted that they considered that whilst Anna had received the support she needed on the hospital ward, on her return from the ward, other than what I had been able to offer (e.g. regular telephone consultations, e mail communications, coordination of the work of involved professionals, and sign-posting to parent workshops), there had been very little support for them as parents. Furthermore, I am aware that the support I was able to offer significantly exceeded what I would typically be able to offer as a qualified EP.

A specific hypothesis that underpinned the work with Anna was that using CBT collaboratively with a young person, within an educational setting (*cf.* the previous hospital setting), would allow greater specificity and a more comprehensive, systemic

formulation of her needs. Furthermore, I anticipated through this recourse to a dynamic 'assessment through intervention' paradigm, the 'statementing' process would be better informed. The use of a cognitive-behavioural approach provided an invaluable framework for formulation, intervention, and the psychological advice for the Statementing process.

Final thoughts

There is evidence that CBT is more effective when targeted at the milder end of the spectrum of psychological difficulties such as anxiety and depression (Rait *et al*, 2010). Stallard (2005) cautions against using child-focused CBT on occasions where there are multiple problem presentations and/or the systemic context in which the problem presents is itself contributing significantly to the onset or maintenance of a child's presenting problems (p23). The formulation process has highlighted the complexity of Anna's situation e.g. with regard to diagnostic uncertainty and Anna's complex family system. Anna clearly has complex needs, which are likely to require considerable on-going therapeutic support throughout adolescence, and whilst CBT has provided an invaluable framework for conceptualisation of Anna's difficulties and in guiding intervention direction, it has not proved sufficient. I believe that there is a pressing need for Dummett's (2006) 'distinct systemic therapy' with Anna and her family, because Anna is coping with challenge and complexity in both her internal and external world.

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APPENDIX IX: Consent Letters sent to Anna and her parents.

ANNA'S LETTER

4.5.2010

Home (mother's) address and COALSHIRE LOGO

Dear Anna

It was good to meet you recently. I thought it might be helpful for me to outline who I am, why I have been asked to do some work with you and what I hope we can achieve by working together.

My background

I am a Trainee Educational Psychologist (EP). I used to be a Secondary school Science teacher but am retraining as a Psychologist. I am in my second year of training and work part time as an EP, and part time doing research at the University. Educational Psychologists try to understand how students think and learn, feel and behave. This is so we can work with a student, their teachers and/or their parents, to try to make a situation better.

Why I'm here

The school, J (CCP) and I feel that it would be good for me to carry on the work you have been doing with J (CCP) using Cognitive Behavioural Therapy (CBT), so that together we can find a way for you to feel more comfortable in school. I am planning to use something called a "Cognitive Behavioural Approach" with you, and to continue the work you have been doing with J (CCP). As you may already know CBT is a way of working together, to think about the ways everyone's thoughts, feelings and behaviour are connected. It's a way of learning and practising new ways of thinking and behaving to make life easier for you and others. I want us to work out how some small changes, might help you feel a bit happier in and out of school. I understand that some things that happen in school sometimes make you feel anxious or angry. My goal for our work together would be to help you feel happier and more relaxed.

What I'd like us to do

In a similar way to the work you've already done with J (CCP), the work I plan to do with you will involve us talking about your thoughts, feelings and behaviour, and using some worksheets to structure our chats. In fact, as you are so good with the computer, I would probably like to complete these worksheets on the computer where possible. What do you think about this? I will probably ask you to do some 'homework' tasks (was that a groan I heard?!). These are nothing like normal homework, I promise. They are a bit like doing an 'experiment', but you do the experiment on yourself and use the people around you. Some of the time, we could do these 'experiments' in school.

In the sessions, you can talk to me in confidence (I won't tell other people what you tell me without your permission – unless what you tell me means I am worried about your

safety or another person's). However, I will have to discuss what you tell me with my supervisor, but they will also keep this information confidential. I hope that some of the information you tell me, you will be happy for me to share with other adults who work with you, and your parents – as this information will help them understand you better and be able to support you better in school and at home.

We're in this together....

I would like you to think that we're in this together. I want you to know that if you don't want to do the work with me, you can stop anytime and you won't be in trouble. We won't even start the work, unless **you** want to. However, what I'm hoping is that the work we do together will make you feel a bit happier about some of the things that might be causing you to worry.

If you do decide to go ahead, I was thinking of coming to your session with J (CCP) next week, on the 12th May. So you could meet me again, and I could meet J (CCP). Then, you and I could sit down to work out when we could do the sessions. I work on a Monday, Tuesday or a Wednesday, and can be flexible about the time. Perhaps we could work together during a lesson you don't like as much?!

How does this all sound to you? I know there's a lot of information here. Please ask me any questions you want and I'll try and answer them.

If you want to give your permission for us to get started, please sign below.

Yours Sincerely

.....	.....
Oonagh Riordan Trainee Educational Psychologist	Supervisor Educational Psychologist

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At this stage....

- ○ I do want to work with Oonagh
- ○ I do not want to work with Oonagh
- ○ I would like more information

Other comments:

Signed: ……. Anna X

COALSHIRE LOGO

Coalshire address

Phone number

A similar letter was also sent to Anna's father

4.5.2010

Parent address

Dear Mrs X

Following on from our phone conversation this evening, I wanted to take this opportunity to further introduce myself and outline my plan for potential work with Anna. As you know I am HIGH SCHOOL's Educational Psychologist (EP). I am currently half way through the Educational Psychology doctoral training which is necessary in order to become a qualified EP. I have enclosed information about the role of the EP, should you or Anna wish to know more about my role.

As you know, I have been approached by HIGH SCHOOL to support the school with Statutory Assessment. When you, Anna and I met on the 30th March 2010, to discuss this process, you mentioned that Anna often feels anxiety and sometimes anger in school. We briefly discussed Cognitive Behavioural Therapy then, and I was going to investigate what support we could get for Anna. Coincidentally, as part of my training, I am required to carry out a piece of therapeutic case work. Due to this requirement, I am in the unusual position of being able to offer Anna a series of approximately eight or nine one-to-one sessions, using a Cognitive Behavioural Approach. I mentioned on the phone that part of the University requirement is to write up this case-work for an assignment. I would like to also write up the work I do, for possible publication in a research journal. However, all names would of course be completely anonymised and confidential.

I want to work with Anna to try to identify what triggers and maintains her anxiety/anger, and to see if we can work together to make some adjustments in her thinking so that the same triggers are less intense and her anxiety/anger is reduced. Working with Anna, subject to her, yours and Mr X's (father's) consent, I will try to identify what unhelpful thoughts Anna is having. As you know, by helping a young person to understand how their thoughts, feelings and behaviours are related, and by helping them recognise unhelpful thinking, they can learn to react more appropriately to a situation, and counter any negative thoughts they have with more rational and useful strategies. I should stress, that Anna will also identify entirely appropriate thoughts, but these can also be very helpful in informing interventions for the school to carry out e.g. stress around exam situations. You mentioned on the phone that you would also like more information about CBT and its use with young people with Asperger syndrome. Part of my assignment will be researching this, and I am very happy to share the information I find with you.

In order for the work to be successful, it is very important for Anna to be supported by school and home with the work we do. She will have regular 'homework' tasks, which are hopefully more like 'behavioural experiments' than homework. I will try my best to keep you updated with an overview of our sessions and the 'homework', so that you know how you can help her best at home. The evidence base tells us strategies that only focus on individual children, and do not take home and school situations into account, have limited success. I would want to ensure that you are also involved with the work I do with Anna (e.g. in encouraging her with her 'homework' tasks) and will try and ensure regular

communication with you. Likewise, if there is anything you need to discuss with me, please don't hesitate to get in contact.

As a trainee, I would have regular supervision regarding my work with Anna. In the unlikely event that Anna requires even more specialised support than I am able to offer, I will of course inform you, the school and my supervisor. I would also pass on the information I have gathered from my sessions with Anna. However, from speaking to you and J (CCP) about Anna, I am confident that my sessions and continued school support, should be sufficient in meeting Anna's needs. Subject to everyone's agreement, and subject to my initial meeting with Anna indicating that this is the appropriate way forward for Anna, I can begin working with Anna on either a Monday, Tuesday or Wednesday and will discuss with Anna and the school what works best for timings. I will plan to work with her for approximately 8-9 sessions, bringing us to the end of this academic year. I would also meet her for a few follow up sessions at the start of next year.

In order to proceed, I would want to gain Anna's and your specific, informed consent for this work to occur (see below). This is in addition to the consent you have already given for Anna to be seen by an Educational Psychologist. Please do not feel under any obligation for me to proceed with this work. If you or Anna are not happy for me to carry out this CBT intervention, I will still carry out the necessary work for the Statutory Assessment, and end my involvement there.

Yours Sincerely

.....	.....
Oonagh Riordan	Supervisor
Trainee Educational Psychologist	Educational Psychologist

Consent:

- ○ I understand the information that has been presented and know where to seek clarification should I need it. I am happy for Anna to work with Oonagh, using a Cognitive Behavioural Approach. I am able to support Anna with any 'homework' tasks, and generally with the work she completes with Oonagh. I give permission for work to be written up for assignment purposes, and possibly published, as long as it is completely anonymised and data is kept confidential.
- ○ I would rather Anna did not undertake work of the above nature with Oonagh.

Other comments:

Signed: …….. Mrs J
Date:

APPENDIX X: Anna's difficulties compared with diagnostic criteria for Asperger syndrome ICD-10 (WHO, 2003)

ICD-10 (WHO, 2003) F84.5 Asperger syndrome

- **A.** A lack of any clinically significant general delay in spoken or receptive language or cognitive development. **YES** Diagnosis requires that single words should have developed by two years of age or earlier and that communicative phrases be used by three years of age or earlier. **YES** Self-help skills, adaptive behaviour and curiosity about the environment during the first three years should be at a level consistent with normal intellectual development. **YES** However, motor milestones may be somewhat delayed and motor clumsiness is usual (although not a necessary diagnostic feature). **NO** Isolated special skills, often related to abnormal preoccupations, are common, but are not required for diagnosis.
- **B.** Qualitative abnormalities in reciprocal social interaction (criteria as for autism) **– see ``````` below**
- **C.** An unusually intense circumscribed interest or restricted, repetitive, and stereotyped patterns of behaviour, interests and activities (criteria as for autism; however it would be less usual for these to include either motor mannerisms or preoccupations with part- objects or non-functional elements of play materials). **YES – internet usage/time spent on computer**
- **D.** The disorder is not attributable to the other varieties of pervasive developmental disorder; schizotypal disorder (F21); simple schizophrenia (F20.6); reactive and disinhibited attachment disorder of childhood (F94.1 and .2); obsessional personality disorder (F60.5); obsessive-compulsive disorder (F42).

B. Qualitative impairment in reciprocal social interaction	(3 out of 5)	**C. Restricted repetitive and stereotyped patterns of behaviour, interests and activities**	(2 out of 6)
Failure to use eye gaze, body posture, facial expression and gesture to regulate interaction adequately;	Yes, in part – good eye contact at times but sometimes stares. Limited range of gestures (but broadly in line with peer group).	An encompassing preoccupation with stereotyped and restricted patterns of interest;	Yes, in part – use of social-networking sites (although, again, this may at times be in line with her peers)
A failure to develop (in a manner appropriate to mental age, and despite ample opportunity) peer relationships that involve a mutual sharing of interests, activities and emotions;	Yes, in part. Has difficulties in her peer context e.g. with regard to problem solving where there are conflicts. Again, however, this could be broadly in line with typically developing peers.	Specific attachments to unusual objects;	Not observed

Rarely seeking and using other people for comfort and affection at times of stress or distress and/or offering comfort and affection to others when they are showing distress or unhappiness;	Yes/in part – although difficulties seeking comfort and affection may be due to systemic factors e.g. maternal responsiveness or availability of skilled adults. She does offer comfort to others and show concern.	Apparently compulsive adherence to specific, non-functional routines and rituals;	Not observed or reported.
A lack of shared enjoyment in terms of vicarious pleasures in other people's happiness and/or a spontaneous seeking to share their own enjoyment through joint involvement with others;	No	Stereotyped and repetitive motor mannerisms that involve either hand/finger flapping or twisting or complex whole body movements;	No
A lack of socio-emotional reciprocity, as shown by an impaired or deviant response to communicative behaviours.	Not apparent.	Preoccupation with part-objects or non-functional elements of play materials (such as odour, the feel of their surface, or the noise/vibration that they generate);	Not apparent
		Distress over changes in small, non-functional details of their environment.	Some distress over functional details e.g. room changes. Not noticed distress over small, non-functional details.

Sex differences in autism	
9 As a group, males with ASD score higher than girls with ASD on intellectual assessments (this might support the idea that higher functioning girls are not being diagnosed and included in these calculations.	Lower scores on curriculum and SaLT assessments
10 The play of boys with ASD has been found to be more repetitive and restricted in range.	
11 As assessed on diagnostic instruments for autism, the communicative abilities of girls with ASD have been observed to be stronger (e.g. pointing, gaze following).	Anna's communicative ability appears stronger (SaLT reports indicate difficulties)
12 Boys and girls with ASD may experience different developmental trajectories related to social difficulties, with boys demonstrating more difficulties earlier in life, and girls expressing greater impairment in early adolescence.	Yes – greater impairment in adolescence
13 Boys with ASD may tend to engage in disruptive behaviour to gain objects, while girls with ASD may tend to engage in disruptive behaviour to get attention.	Some indicators that disruptive behaviour (e.g. angry episodes, refusing to go to school) could be related to gaining attention from mother.
14 Girls with ASD may be better able to focus and may be less distractible than boys with ASD.	Yes, better focus than expected if AS
15 Young girls with ASD have been found to appear more anxious and depressed than boys with ASD.	Very apparent distress.
16 Parents may overestimate the social difficulties or impairments of their daughters because they have (and society has) greater expectations for how girls should behave in the social and communicative domains.	Anna has two sisters for comparison, and I do not think that her parents do overestimate Anna's social difficulties.

Suggestions for assessing females with possible ASDs	
8 Referral for further evaluation if scores are close to, but do not meet cut-off, on an autism screening measure. 9 Avoid comparison of a girl's set of symptoms to prototypical male presentation.	Whilst Anna's presentation, to my mind, does not 'fit' the above diagnostic criteria, when her presentation is not compared to male presentation, there are more indicators of ASD.
10 Comparison of a girl's social and communicative abilities to what is considered normative for females of her age and cognitive ability.	SaLT report indicates that Anna does have difficulties in this domain, when compared to peers.
11 Careful examination of social and communicative difficulties in the absence of significant disruptive behaviour.	Social and communicative difficulties with regard to expressing her emotions and feelings.
12 Consideration of how a girl may perform in a simple social setting where she only has to interact with one other person versus how she may perform in an unstructured, real-world environment with peers.	I have only observed her in 1:1 settings – TA reports of being ok in lesson, but Anna felt that the TA "doesn't understand her difficulties". Moreover, as her difficulties are less apparent in a 1:1 setting, I may be seeing 'optimum' performance.
13 Understanding a girl's social network and taking into account whether she has a "mother hen" friend who has supported her in the social world (which may have masked her social deficits).	Makes friends with isolated males. As she presents well groomed etc other girls do make friends with her. But she appears not to be able to cope with the complexity of teenage girls relationships e.g. lacks problem solving skills when she fell out with Hair and Beauty course peers.
14 Consideration that deficits in girls may become more apparent over time, particularly in early adolescence.	Onset of difficulties gradual but peaked in adolescence.