Chapter 6 - Discussion

6.1 – Introduction:

> ‘One could say, in fact, that no story really has a beginning, and that no story really has an end, as all of the world’s stories are as jumbled as the items in the arboretum, with their details and secrets all heaped together so that the whole story from beginning to end depends on how you look at it’.
>
> (Snicket, 2006, p. 289)

To provide structure and order to the ‘details and secrets all heaped together’ of this thesis, as so beautifully described by Lemony Snicket, the data generated over a further two years of therapy for Heather, Fergus and Angus and 12-24 sessions for Kirsty, Callum and Eilidh will be presented under the headings of the four research questions designed to structure this study and allow the two aims to be explored. These questions will be considered with a mind to oral feedback obtained throughout ongoing therapy reviews (Appendices 3 & 4), in the light of questionnaire data provided and evidence derived from interviews with key informants associated with each of the six children, in line with the principle of mixed method research and triangulation. As this study utilises some of the wealth of material generated through the therapist’s own practice and considers the evolving, dynamic and at times unpredictable nature of decision making, the additional elements of life events, professional issues and changes made to service provision will be considered under Question 3. The findings from Phase Two of this study are layered over those of Phase One, presented in their totality and further analysed in the context of the literature presented in Chapter 2, adding to the robustness of outcomes. Research questions and aims were designed with one clear purpose in mind and the contribution to the field of Looked After Children will be the focus of the final two sections of this chapter.

6.2 - Is it possible to measure and identify the mental health needs of the LAC population using existing scoring instruments?

Phase One of this study concluded that questionnaire material administered at the outset of intervention, appeared to accurately reflect the presenting difficulties of Heather, Fergus and Angus. At the conclusion of Phase Two of this study, screening measures would again appear to accurately reflect the presenting difficulties of Kirsty, Callum and Eilidh at the outset of therapy as orally reported by their carers/parents. There are again some minor disparities in reporting between school, home and oral reports of other professionals but, within reason, difficulties appear to be effectively identified using existing screening measures.

These findings would appear to be consistent with those of Meltzer *et al.* (2000), Mathai *et al*. (2003, 2004), Muris and Maas (2004) and Emerson (2005), all of which describe the effectiveness of the SDQ and PSI as screening measures within the general population. In particular, the work of Meltzer *et al.* (2003), Whyte and Campbell (2008) , Ford *et al.* (2007), Chisholm (1998), Mainemer *et al.* (1998), Jacobson and Miller (1998), Kelly (1992), Harrison *et al.* (2000), Whitley *et al.* (1999) and Heywood (2002) all of which describe the effectiveness of the SDQ, PSI and RADQ as a screening measure within the LAC population.

6.3 - Where there are identifiable problems (as indicated by consensus scores) are Theraplay and Play Therapy useful interventions?

6.3.1 - Theraplay

At the conclusion of Phase One there was little identifiable change recorded in questionnaire data completed for Heather and Fergus following 8 and 18 Theraplay sessions respectively. This appeared to contrast with the oral reporting of Morag, Effie and Dougal, who all noted an increased closeness to the child. This led to the suggestion that Theraplay may support a child to form closer attachment relationships (as orally reported), and in doing so reduces their reliance upon defence strategies. It may be argued that, as defence strategies are deconstructed, carers are no longer kept at arms length by rejecting, attention seeking behaviours, and other more traumatised behaviour characteristics become more evident, as screened for in conventional questionnaires. This would explain the disparity in oral/questionnaire reporting, whilst also going some way to explaining the consistently high questionnaire scores throughout intervention.

Minor changes were seen in the questionnaire scores for Kirsty through the 18 sessions of Theraplay completed by Euan and Duncan, which partly informed the decision to change therapeutic modality. Few changes were seen in Eilidh’s questionnaires during the 12 sessions of Theraplay undertaken and suggested, if anything, that her presentation had worsened. This would appear to contrast with the oral reports of her carers and their description of her overall presentation at the end of intervention. To gain more insight into this dilemma and formulate a possible hypothesis, it proved useful to consider the feedback (at interview), of carers and professionals directly involved in the care of

Heather, Fergus, Kirsty and Eilidh.

Morag reported that she did not find Theraplay a particularly helpful intervention, making reference to the stress of caring for Heather at the time. This would appear to correspond closely with Morag's oral reports at therapy review S.8, later informing the decision to review Theraplay provision for children not in permanent placements.

Effie and Dougal reflected very positively on their experience of Theraplay feeling 'that did work'. Interestingly, they also perceived that the changes they saw in Fergus were accurately reflected in the questionnaire material they completed, when in fact the questionnaire material shows little change or indeed, a worsening in Fergus's presentation.

Euan and Duncan commented 'I think it (Theraplay) has made a big difference'. They reflected on an increased closeness to Kirsty, and the importance of work undertaken with Euan alone. Margaret commented that Kirsty may have been more able to express herself (increasing some of her more challenging behaviour), as she grew closer to Euan and Duncan (following Theraplay).

Elspeth and Campbell appeared to be extremely positive about Theraplay throughout their interview; they reflected on an extensive list of changes in Eilidh's presentation throughout intervention and Maisie commented 'I felt she had made so much progress with Theraplay'. Interestingly, none of these changes or progress were reflected in questionnaire assessments carried out. However, Elspeth went on to comment that she did not feel questionnaire instruments accurately reflected the changes seen in Eilidh, and felt a scale of frequency/severity of behaviour would be more representative.

This would appear to be consistent with the few studies which exist to date, regarding the effectiveness of Theraplay in supporting children to form closer attachment relationships (Makela & Vierikko, 2005; Snipp, 2004). It would also appear to confirm the guidance of the Theraplay Institute that Theraplay is not a ‘trauma based’ intervention, and the suggestion of ‘trauma treatment coming later when life is more secure’ (Jernberg & Booth, 1999, p. 267). It would also appear to be compatible with more recent innovations of the Theraplay Institute as it moves to incorporate more of Dan Hughes’s Dyadic Developmental Psychotherapeutic techniques (2006), to support children in addressing trauma and attachment simultaneously over a significantly longer period of time. These innovations have led to a review of Booth and Jernberg’s original text and the revised addition of the Theraplay Handbook (2010).

Despite these tentative suggestions, the bald fact remains that no or few changes are reported in questionnaire scores for any of these children throughout Theraplay intervention. An alternative view could be that Theraplay is not a useful intervention, or potentially re-traumatises the child accounting for the reported instances of increased questionnaire scoring. This would appear to directly contradict the oral reports collated during therapy reviews and interviews, although the therapist was present in both forums which may potentially impact upon individual reporting. The strong correspondence in reporting, between individuals in interviews undertaken separately, may to some extent mitigate this source of bias, which suggests that an alternative explanation may need to be sought.

One other factor considered at the conclusion to Phase One of this study is the effectiveness of existing screening tools as a measure for change in Theraplay intervention. Snipp (2004) explored the mean SDQ/PSI score for 10 children receiving 12 Theraplay sessions. He reports a deterioration in emotionality and parental distress, no change in peer relationships and an improvement in all other categories. These results mirror some of the findings in this study. However, it must be noted that changes were small (Conduct SDQ 0.8/Total Stress PSI 6.5) and scores as reported in SDQ and PSI remain clinically significant throughout.

Snipp (2004) noted an improvement in the presentation of all 10 children undertaking Marschak Interaction Method (1960) (MIM) video assessment prior to intervention, and following twelve sessions. An improvement was also noted in this study for Fergus, Kirsty and Eilidh in MIM video assessment undertaken prior to the intervention and following 18/12 Theraplay sessions. The MIM does not have a standardised scoring facility at present but, nevertheless, changes observed were used to inform treatment plans. Changes seen in MIM assessment were reflective of oral reports, but not reflected in questionnaire material completed (even those specifically designed to screen for attachment difficulties).

These findings would appear to strengthen the argument that changes were evident in the attachment presentation of Fergus, Kirsty and Eilidh as orally reported, which would support the assertion that Theraplay is indeed a useful intervention. It also draws more sharply into focus the use of questionnaires as outcome measures for this intervention, strengthening the suggestion that they may not be sensitive enough to fully detect the changes facilitated and reported throughout Theraplay.

6.3.2 - Play Therapy

At the conclusion to Phase One of this study, little or no change in presentation was reported in questionnaires completed for Heather, Fergus or Angus following 16, 6 and 24 sessions of Play Therapy respectively. It was suggested that little change would be anticipated, as the introduction of a new adult into their lives would elicit attachment and behavioural patterns screened for within existing measures. These three children progressed through a further two years of Play Therapy and consideration was given to the longer term effects of ongoing therapeutic input. Screening tools continued to be regularly administered by parents/carers and school over this two year period and revealed changes in the presenting behaviour of all three children. Each child showed change in different areas, and the most marked changes were seen for Fergus (it may be worth noting that Fergus ended therapy shortly after this two year period).

Consistent change for all three of these children was reported in the RADQ over the course of Phase Two of the study: Heather showed no attachment disorder or difficulties by session 93, Fergus showed no attachment difficulties by session 71, and Angus showed attachment difficulties rather than disorder by session 80. Consistent change was also reported in the SDQ conduct category, suggesting a decrease in challenging behaviour for all three children (which remained slightly fluctuating in Angus's case). A reduction in SDQ total score is noted for Heather, and to a lesser extent Fergus, suggesting an improvement in overall mental health presentation. This change is not seen for Angus, whose total score increased slightly, suggesting a worsening of his mental health. This may reflect the high level of difficulties he was experiencing at school and home (as subsequently reported).

All of those interviewed were very positive about their child's experiences of Play Therapy describing therapy as: 'Something to help her' (Morag), 'a big safety net for all the family' (Ishbel), 'a sort of anchor' (Rhona), 'Helped with inner confusion and divided loyalty' (Effie and Dougal), 'A place to bring unprocessed feelings, to cope a little better on the outside' (Inga), 'A place to think about fear and abuse' (Annabel), 'It [therapy] didn't discard Callum, it completely embraced him, helps them move on' (Lorne), 'He just came on leaps and bounds' (Bonnie), 'she (Eilidh) benefited from another person to listen' (Maisie). Many referred to the importance of the relationship with the therapist, the consistency, containment and space to think or talk that she provided: 'Helped him (Fergus) to know that those bits of himself [worst bits] he could handle – and that he was still a loveable boy' (Inga). 'It was incredible - this was a boy who started to smile, he was able to crack jokes and his humour' (Lorne).

Several of those interviewed made reference to feeling their child needed to 'move on to something else' following Theraplay (Jernberg & Booth, 1999). Interestingly Morag, Blair and Ailsa all found it difficult to comment on the progress of Heather and Angus in therapy due to the external events impacting upon the child (as discussed later in this chapter).

Changes seen in questionnaire material and the perceptions of those interviewed above, would appear to suggest that Play Therapy is indeed a useful intervention. Changes reported in the RADQ would suggest an improvement in the attachment presentation of each child. However, the RADQ is the least researched of all the questionnaires and recently came under fierce criticism by Mercer (2006) who questioned its validity as a screening/outcome tool, and its definition of attachment disorder as reflected in the present debate summarised by O'Connor and Zeanah (2003b). However, the questionnaire was consistently completed by the same four parents/carers at outset (Heather S.40), and completion, suggesting a change in their perception of the child throughout intervention, consistent with those reported orally.

This being the case, these findings support the hypothesis presented at the conclusion to Phase One of this study, that Play Therapy does indeed impact upon a child's attachment presentation. Given what is known of recent research in the field of attachment, what conclusions (if any), can we consider regarding possible mechanisms by which Play Therapy impacts upon a child's attachment presentation?

Schore (2001a) discussed the principle of affect synchrony, by which a child experiences their emotions reflected back to them in a child-leads-parent-follows interaction. Assuming this to be the case, it could be suggested that in the gentle process of reflection, the child presents their emotional state in play, which is observed by the therapist and reflected back to the child ‘the same but not the same’. Thus, the therapist effectively acts as an emotional mirror (Winnicott 1971), giving the child increased insight into their own emotional state, and a language to communicate this, thus increasing their control over their emotions and an ability to ‘read’ the emotions of others, as the therapist has done for them. This process is described by Fonagy (2001) and Howe (2005) as mentalisation, reflective function and mind-mindedness.

The child also learns that their emotions are bearable, and can be tolerated by another, that what threatens to destroy them internally is not only manageable, but at times appropriate when modified through the exploration of trauma (Klein, 1949). Inga described this in terms of an ‘emotional mirror’ providing Fergus with ‘an emotional language’. Iona described therapy as providing ‘connections between his (Angus’s) inner world, and his emotional state’. Rhona referred to therapy as ‘providing a space to talk’ and Esme as a ‘space to think and feel’.

Fosha (2003) and Hughes (2006), explore the impact of disruption in affect synchrony, and the overwhelming feelings of shame and guilt when a child is unable to re-connect with an available care giver. Many times through the process of Play Therapy, a child will disengage from play and the therapist when overwhelmed by thoughts or feelings. It could be suggested that the therapist’s open, supportive availability to re-engage in play and relationship, when the child is ready, could go some way to restoring this balance. When the therapist also applies the core principles of empathy and attunement in session, feelings of shame and guilt, which so often overwhelm children within their new families and relationships, could be addressed.

Esme describes Play Therapy as ‘helping Fergus contain himself a little better outside of therapy’, suggesting that children can also experience increased containment. Bion (1962) described the process of containment as achieved through attunement, reciprocity and empathy, potentially achieved through Play Therapy as described by Siegel (2003):

> ‘The therapeutic process thus enables the therapist to serve in a similar role as an attachment figure: as a part of an interactive relationship, that enables the co-regulation of internal states to eventually lead to more autonomous self-regulation of emotional states within the individuals own mental processes’ (p. 32).

If, as postulated by Trevarthen (1993), affect synchrony is connected to neural development through the stimulus of sight, sound, touch and gesture, then it could be argued that Play Therapy has a direct impact on neural development in synthesising this process through play. As suggested by Archer and Burnell (2003), new neural activity may be stimulated through the process of therapy and Balbernie (2001), reminds us that there is ongoing brain proliferation throughout childhood. Case (2005) describes:

> ‘It is possible for neural pathways to connect where previously there have been none, and it is possible for reflective thinking processes to develop in therapy, but it is a slow and uphill task’ (p. 336).

It must also be borne in mind that a number of other factors will influence children’s attachment relationships, most significantly their relationship with their parents and carers. Both Heather and Fergus had undertaken Theraplay intervention with their carers which, whilst eliciting marked changes in their presentation as recorded by the MIM assessment and oral reports, showed no change in their RADQ score. It is possible that the changes noted coupled with new training/support packages offered to parents/carers, provide a multi-faceted approach to attachment which may account for some of the changes seen over this two year period. This process is described as ‘earned secure attachment’ whereby therapist and carer provide the child with a sense of secure base, thus preventing established defence strategies dominating the child’s relationships, maximising their resilience and allowing the child to internalise a greater sense of self worth and security (Roisman *et al*, 2002; Phelps *et al*, 1998; Crittenden & Claussen, 2000).

Changes were also noted in SDQ conduct for all three children and in total stress (SDQ) for Heather and Fergus. This being the case, Play Therapy intervention would also appear to impact upon a child’s challenging behaviour and overall mental health presentation. Given what is known of the pervasive and lasting implications of trauma on the developing child (Perry, 2007), it could also be suggested that Play Therapy has supported the child in the processes of re-framing trauma, reflecting a more realistic sense of self, which can then be integrated into the child’s conscious mind in a useful way, thus reducing challenging behaviour often associated with complex trauma (Van Der Kolk, 2005).

Through the process of play, the child can experience their perceptions of trauma as distinct and distanced from themselves (Cattanach, 1994; Jennings, 1999). Through the therapeutic alliance, children can be supported to experience this trauma and resultant emotions as bearable (Klein, 1949). They can be supported to explore their sense of self internalised through trauma as ‘separate’ (Winnicott, 1971). Through the process of reflection, the child views their emotions and play, thus facilitating access to their own restorative capacity (Rogers, 1965), in their instinctual drive towards complexity (Siegel, 2003). With a mind to the child’s unconscious, defences are very gently deconstructed through the processes of reflection and play (Barnes, 2007).

If, as postulated, Play Therapy works upon the trauma experienced by each child, a more significant, consistent reduction in scores for SDQ and PSI may be anticipated over this two year period. Fergus, as the only child ending therapy, showed the most significant change in questionnaire scores, but several SDQ categories remain high/very high, and changes noted in PSI scoring are not consistently seen. However, it must also be borne in mind that all three children have experienced significant neglect and abuse in their families of origin. Play Therapy supports children to understand and integrate their trauma in a more useful way, but can never remove these experiences from the child, or fully reverse the physiological impact of trauma. Thus, the changes reported for each child could be argued to be of considerable significance, and that the expectation that they return to a baseline of the ‘average child’ is unrealistic. This again raises the issue of the sensitivity of existing screening tools, and the question of whether change within such a traumatised population can realistically be measured using existing screening tools calibrated within the general child population.

A recent study by Sinclair, Wilson and Gibbs (2005) collected questionnaire data from carers, professionals and children, and then undertook detailed interviews with key professionals for selected children. They found little evidence to suggest therapeutic intervention (of which Play Therapy was one), had any strong impact upon positive outcomes for the child, and concluded that the times at which data is collected may have an impact upon outcome measures. This would appear to be consistent with the earlier suggestion that change is unlikely to be seen in Play Therapy in the short term, and potentially does not take into account the impact of external influences on the LAC child.

6.4 - Is decision making within the Attachment Project a dynamic, evolving process and to what extent is the provision of treatment modalities influenced by child clinical presentation and carer characteristics?

6.4.1 – Dynamic and Evolving Nature of Decision Making

One of the goals at the outset of this study was to consider the decision making process for children in a Project which offers two very distinct therapeutic modalities, within a Team offering a variety of services to Looked After Children. The study has examined how decisions are made, what theory best explains decision making, and what the implications within the therapeutic setting are. Research in the field of clinical decision making is limited, but that which does exist suggests the importance of therapeutic alliance (as described above); clinical skill, training and intuition, informing creative and flexible responses (Patel *et al*., 2001; Leprohon & Patel, 1995; Falzer, 2004; Falvey, 2001; Watts, 1980; Cloitre *et al.*, 2004; Chethik, 2001).

Phase One of this study explored decision making in the context of assessment and therapy reviews regularly undertaken for each child and documented at source. It was concluded that decision making was indeed evolving and dynamic, with resultant changes made to overall service provision, largely informed by child clinical presentation, carer characteristics and external events. Phase Two of this study was designed to explore these factors in greater depth by eliciting the views and perceptions of parents/carers and other professionals.

Without exception, all those interviewed were able to recall therapeutic decisions made in respect of each child. They described the importance of the ‘flexibility’ of the service in responding to the individual needs and circumstances of their child, and the influential role played by child presentation in the decision making process. This suggests that as children move through the therapeutic process their needs change, which raises the question of ongoing assessment.

Most of those interviewed recounted similar decisions for each child:

- assessment
- type of therapy/and support
- changes in venue, time, frequency and duration of therapy

The greatest disparity was most evident in terms of:

1. Professional Responsibility:

- Decision to refer Kirsty for ADHD assessment – Margaret
- Therapeutic ending for Callum – Annabel
- Ongoing support for adopters and referral to local services – Bonnie and Lorne

2. Closeness to child:

- Decision to work with Kirsty and Euan alone – Euan and Duncan
- Decision to offer assessment – Elspeth and Campbell

3. Active involvement in regular therapy reviews:

- Decision to offer Fergus soft play materials – Inga.

This suggests that those interviewed showed the greatest disparity in recall in relation to role and closeness to child, with the strongest correlation found amongst those who attended regular therapy reviews.

Decisions recalled for each child by interviewees were then compared with decisions recorded at regular therapy reviews (Appendices 3 & 4). There was close correspondence between decisions recounted at interview and facts recorded at therapy reviews. The most notable disparity existed around decisions made at emotionally laden and stressful times i.e. placement crisis (Fergus) and diagnosis/medication (Angus). These decisions often carried the greatest meaning for those interviewed, left the most lasting impression, and showed the greatest divergence of perception. This was perhaps to be expected, given the facts already established regarding the release of cortisol at times of stress, and published evidence of the impact of cortisol upon memory (Perry, 2007).

It potentially becomes important for the therapist not only to bear in mind the impact that stress will have upon their own decision making process, emphasising the need for good clinical supervision and accurate record keeping in accordance with social judgement theory, but also to recognise when the system around them is stressed. This would suggest an added responsibility upon the therapist not only to provide an insight into the inner world of the child and contain the stress of the system, but also to maintain clear boundaries according to the therapeutic needs of the child in decision making.

Decisions were made in response to circumstances and events directly affecting the child and, at times, professionals did not agree. Iona did not agree with the decision to change the time and day of Angus's therapy, but acknowledged the therapist's reasoning for this and her own issues in working with Blair and Ailsa. This again highlights the importance of communication, as this decision was discussed in the context of a therapy review which Iona was unable to attend due to mounting work pressures. Angus's professional network potentially showed the greatest conflict and splitting, but was also the network which showed the most chaotic communication (Iona). Callum's professional network openly reported the conflict which existed in multi-agency systemic decision making; this was regularly discussed and acknowledged. Interestingly, therapeutic decision making showed significantly more containment as reflected in the interviews of Annabel, Lorne and Bonnie. This would appear to suggest a containing role played by the therapist in providing communication and information, thus reducing potential splits within the system in relation to therapeutic decisions made.

One of the emerging themes from interviews was the willingness of parents to allow changes in approach or content to the process on the advice of the therapist, even where they had some apprehension that such changes could result in a deterioration of the situation. Their trust in the therapist, built up over their engagement with her in the process, allowed them to take these risks and on each occasion they acknowledged that their earlier fears had proved to be unfounded, so their confidence in working with the therapist increased. At the same time it was evident that the therapist, as she became more aware of the parent's capacity, was tailoring her decisions to take account of this alongside the best interests of the child.

All those interviewed felt that the therapist, in consultation with the parents/carer and child, was most influential in making therapeutic decisions. For example, Rhona initially commented that Heather's views were not influential, but her perception changed as she considered each individual decision in more depth. This suggests that the therapist made short cuts in her decision making process in line with the principles of heuristics, and based on her knowledge of each child and the expertise/experience of all those involved in the care of the child. Most people reported feeling consulted by the therapist (mainly at therapy reviews); that their views were taken into account, and that they had trust/respect for the therapist in making these decisions. It could be argued that the therapist was regularly challenged through open discussion and accountability to the professional network and ongoing supervision, which would accord with social cognitive theory. The view of decisions made rarely changed, and most people agreed with the decisions, in line with some of the principles of social judgement theory.

6.4.2 – Child Presentation and Carer Characteristics

Interestingly, interviewees showed the greatest degree of agreement when considering child clinical presentation, but most also reflected upon carer characteristics, especially in the light of decisions to offer support to the family. All of those interviewed were able to reflect upon their child at the outset of therapy, and changes seen (even when much of their child's behaviour remains challenging). Most parents/carers were also able to reflect upon the benefits to them of receiving support from the service, and several spoke of their relief at the decision to offer ongoing support/flexibility especially around times of stress, (i.e. significant life events or external influences).

Respondents suggested that decisions were made largely in response to child clinical presentation, strengthening the suggested need for ongoing assessment throughout therapy. Carer characteristics were considered prior to offering therapeutic intervention, and also interplay with child presentation and life events as reported through the PSI. For parents and professionals, the impact of life events on the child was highly significant and they saw these as key factors in precipitating a review of the process and further decision making. They also made reference to the role of therapist as decision maker at such times, and flexibility was valued in the context of the perceived worth of therapeutic intervention to the child.

Therefore, it can be concluded that decision making over the provision of treatment modalities was influenced by child clinical presentation, carer characteristic and life events. These combined to inform ongoing assessment, and due to the subjective, interactive nature of each factor, it is impossible to quantify them separately. It is also clear to see that decision making within the Project was indeed a dynamic and evolving process that proceeded throughout intervention: firstly, as children and their families were assessed for appropriate treatment modalities; secondly, throughout Theraplay; thirdly, at the completion of Theraplay and possible transition to longer term therapeutic intervention; fourthly, on an ongoing basis throughout longer term Play Therapy intervention; and finally in the context of broader service provision as described at the end of Phase One of this study.

It could be argued that creative and dynamic thinking is an important way of facilitating the evolving needs of children. In no way should the essence of therapy be changed or diluted. To do so would be to compromise the effectiveness to the child but equally, to remain fixed and rigid in a therapeutic support that may conflict with the evolving needs of the child, could potentially be every bit as limiting.

Barnes (2007) has explored the need for evolving decision making in the context of integrative work with children in long-term placements and concludes:

> ‘It is useful to be able to draw on a variety of resources that allow different emphasis in order to further a child’s journey to making sense and building functional relationships’ (Barnes, 2007, p. 49).

6.4.3 – External Life Events

Life events were thought to have a significant impact on the child due to the re-traumatising nature of loss and the level of historical trauma each child had experienced. Carers were conscious that the questionnaires they completed did not give them opportunity to comment on the role and significance of life events in the process. During the interviews, respondents were given the opportunity to consider and reflect upon their child's experiences over their two years or 12-24 sessions of therapy, and factors emerged specific to individual children as well as more general themes. As these themes are explored what (if any) further insight can be gained into factors affecting the LAC child, the resultant decision making process and impact upon questionnaire scoring?

Placement Crisis (Fergus): All those interviewed commented upon the profound impact which the threat to Fergus's placement had. As discussed earlier, people's perceptions of events are often affected by stress and, in this particular example, those interviewed show quite divergent views. The threat to Fergus's placement had a direct impact upon his therapeutic provision in two quite different ways. Firstly, his therapist made the decision to refer internally to the forensic psychologist Stuart, thus increasing the therapeutic team and secondly, to strip the room of all hard objects at a time when Fergus was struggling to contain his sexualised and often aggressive feelings. Stuart offered support at school, Inga continued to offer support to Effie and Dougal whilst Fergus's therapist worked with him in a safe contained environment. Effie and Dougal very powerfully claimed him at a time of reduced contact, (Tarn had temporarily refused further contact and Rory was in a Young Offenders Institute), and fought to keep him in placement with them. The resultant changes in Fergus's presentation were significant, his placement stabilised and therapy ended shortly after.

As the only additional variable at this powerful time of change, Stuart's role was perceived by Effie, Dougal and Esme to be quite significant. This contrasts with the frustrations felt by the established therapeutic team at Stuart's lack of liaison and communication, in a system which clearly valued regular reviews. There is no doubt that Stuart played a significant role in stabilising a very difficult situation; however, the reports of those interviewed would appear to suggest that the most lasting effects upon Fergus have been his perception of his place within his family, and the changes to his internal working model.

Additional children in placement (Heather, Fergus and Angus): Effie, Dougal, Blair and Ailsa all considered offering permanent homes to another child over this subsequent two year period of therapy. Esme commented upon Effie and Dougal's decision not to adopt a little girl but instead chose to focus upon the considerable needs of both Fergus and Scott. Blair and Ailsa sought the advice of the therapeutic team in their desire to offer a permanent home to another child. Iona commented upon her mixed feelings; that Angus might benefit from a sibling relationship conflicting with his needs within the placement, and the possible relationship dynamics between Blair and Ailsa. Angus's therapist remained consistently opposed to another child in placement, given his considerable needs, the lack of a stable period without any external events, and the concerns raised around the attachment relationships within the home.

Child Protection (Angus): Blair, Ailsa, Iona and Janet all made reference to the allegations made by Angus, the delays and poor practice surrounding the investigation of these allegations. Angus was deeply affected by the alleged assault which impacted upon his faith and belief in adults to keep him safe, to listen or believe and triggered a return to more traumatised presentation. Angus enacted the rage and fear he felt in therapy, projecting his feelings of despair and deceit into his therapist, leading to the decision to modulate play materials available.

Diagnosis and Medication (Angus): Blair, Ailsa and Iona all made reference to the important role they felt diagnosis and medication had made to Angus. Iona described the importance of ‘frameworks’ and the ‘protective’ nature of diagnosis. School initially reacted very favourably to medication but his situation within class quickly deteriorated again. Despite some initial concerns regarding the impact which medication may have upon Angus’s access to his internal world, little change was noted therapeutically.

Assessment and Therapy (Kirsty): Margaret commented upon the decision of the therapist to refer Kirsty for an ADHD assessment based on her respect for Euan and Duncan. She commented upon the therapist’s reservations coupled with her own ‘hunch’ that diagnosis was not appropriate. Margaret commented upon the need for ongoing reviews, whilst Euan and Duncan continued to express concerns that Kirsty might be suffering from some additional, as yet undiagnosed condition.

Ill Health (Fergus): Inga and Esme both made reference to the ill health experienced by Effie and Dougal which is likely to have been anxiety inducing for the whole family, triggering renewed fear of loss and rejection for Fergus; thus increasing insecure behaviour patterns.

Discrimination (Kirsty): Duncan made several references to his fears that Kirsty would be treated differently, and his pain when peer relationships showed up her naivety and poor engagement skills. Kirsty's therapist has reflected with Euan and Duncan on the discrimination they have faced, and their need to recognise their own experiences in their desire to protect Kirsty.

Respite (Heather and Eilidh): Both Rhona and Ishbel commented upon the importance of Heather receiving respite due to the burden of care placed upon Rhona, and the impact upon her relationship with Aidan. They expressed concern at respite being provided by a carer; the consequences for Heather's fragile attachment relationships, sense of self and emerging identity. Both expressed their relief that respite eventually came from within the family, as Heather's relationship with her cousin Flora grew and, as a natural progression, she was invited to stay over.

Campbell and Elspeth also described their need for respite, which was provided informally by family members, and one weekend a month with another carer. Thought and consideration was given to ensuring that Eilidh always received care from the same family. Discussion at the outset of one Theraplay session centred on respite and Eilidh's understanding of shared care in the context of her growing attachment relationships with Campbell and Elspeth.

Death (Heather, Angus and Callum): Heather, Angus and Callum all experienced the death of someone within their extended foster families during the time they were placed with them or after they had moved. The bereavement was noted to have impacted upon each child differently, and changes in child presentation were noted in therapy sessions. What is perhaps most interesting is the very distinct way in which each bereavement was addressed by parents/carers.

Rhona sought the advice of the therapist and told Heather about the circumstances of Ross's death two days before therapy, giving her a chance to internalise the news before seeing her therapist. Heather was very reluctant to attend therapy and asked Rhona to explain that she did not want to talk about Ross; but themes of anger, sadness and confusion escalated in her play over the coming weeks. In agreement with Rhona, Aidan and Ishbel during a therapy review (S.70), the frequency of therapy was increased to allow Heather the opportunity to process her feelings not only in relation to Ross's death, but also all the unresolved rejection and envy she felt in relation to her foster placement.

Blair and Ailsa contacted Angus's therapist and Iona after every bereavement, asking advice about speaking to Angus, saying good-bye and reassuring him especially around his fear that Blair would die. Angus brought his fears around death and loss into session, and also his fantasy thinking that he was somehow responsible.

Ina insisted that Callum should not be told about the death of her brother-in-law and persisted in her belief that the children knew nothing; despite the level of distress in the family, his disappearance and the regular visits of his daughter to the family home. The resultant themes of confusion, despair and deception were noted in Callum's play impacting upon his already fragile trust in the adult world.

Each child was profoundly affected by the bereavements, not just the direct loss but the layers of loss experienced and the triggers for other more complex internalised responses, such as envy and rejection (Fahlberg, 1991; Jewett, 1984). Much of the early work of Murray-Parks (1997), Bowlby (1973) and Kubler-Ross (1970) consider bereavement and loss in terms of stages of grief and resolution, with those who did not 'recover' described as experiencing 'pathological grief'. More recent research looks at loss in terms of integration and adaptation (Walter, 2005), which would appear particularly pertinent for the LAC child who has experienced loss on so many levels and for whom the concept of resolution is deeply flawed (Verrier, 1993).

The strongest mitigating factors in managing the children's distress were open communication and an available/responsive adult to contain and think with the child (Worden, 1996; White & Epston, 1990). As described earlier, children will react to trauma in a variety of ways, and death is a highly re-traumatising event. Therefore, it was to be expected that there would be an increase in challenging, insecure and distressed behaviours (of the type screened for in conventional outcome measures). This distress was recognised by Rhona, Blair and Ailsa, who all sought advice for managing this appropriately, but Callum's distress was further escalated by Ina's limited ability to understand his behaviour and relate this to the inner confusion he was experiencing.

Birth Family (Fergus and Heather): At the conclusion of Phase One of this study the impact of birth family, ‘sideways contact’ and divided loyalties upon Fergus was clearly evidenced (Schofield & Beek, 2005; Verrier 1993; Cairns, 2002). These difficulties escalated throughout Phase Two of this study to the point where Effie and Dougal powerfully claimed Fergus, taking legal advice to prevent his removal from their family, contact with Rory and Tarn was temporarily suspended and Fergus was able to explore this confusion therapeutically. At the time this study concluded, Heather’s desire to have renewed contact with her siblings was growing and the resultant impact was clearly described in questionnaire material completed.

Extreme Fear (Heather and Kirsty): As described earlier, exposure to chronic, persistent trauma leads to a rise in production of cortisol and can, over time, lead to a change in the body’s homeostasis (Perry, 2007). Cortisol prepares the body for fight, flight or freeze responses and thus a constantly elevated level of cortisol leaves the LAC child on edge. It is therefore not at all uncommon for traumatised children to present as highly or disproportionately anxious and predisposed to certain anxiety disorders. Rhona commented upon Heather’s disproportionate responses to fairly innocuous risks and her preoccupation with danger (S.91). Euan and Duncan commented upon Kirsty’s extreme reaction to medical or emergency staff and Father Christmas, suggesting exposure to previous trauma.

The impact of these events for each child has been clearly described, as has the thought and reflection that has gone into supporting both the children and their families. In some instances the events have impacted directly on the therapeutic decision making process, and in others indirectly through discussion with family or other professionals in the network/Team. One of the problems for any therapist is not being made aware of events such as contact or respite taking place. Difficulties arise when the significance of such events is not fully understood or apparent to the professional network and, most commonly, to the family. There are clear implications for the emotional well-being of the child and the need for appropriate strategies in working together to support events in a planned way that is less likely to trigger a child's defences and lead them into a spiral of fear.

Life events are also thought to have impacted upon questionnaire scoring as re-traumatising events elicit behavioural responses and parental distress screened for in these measures. If Play Therapy, as postulated, works on the trauma and attachment of the child, would we not expect to see a reduction in the impact of potentially re-traumatising events throughout therapy? Play Therapy could be described as working on the 'internal scaffolding' of the child. As this scaffolding strengthens throughout therapeutic intervention and is protected in increasingly supportive family environments and therapeutic decision making, the child potentially becomes less vulnerable to the impact of life events, and scores would be anticipated to reduce as seen (to an extent) for Heather, Fergus and Angus.

However, as described earlier, it is perhaps unrealistic to expect a greater degree of reduction in oscillation within such a traumatised population, especially using screening tools calibrated against the ‘average child’. The securely attached child grows with an expectation that stress will be managed for them by a consistent, safe caregiver and their cortisol levels remain low, (Gunnar & Donzella, 2002; Gunnar *et al.*, 1996; Nachmias *et al.*, 1996; Essex *et al*., 2002). However, it could be argued that any one of the above life events would have an impact upon all children, and even the most securely attached of children would show a definable response.

Most of the children within this study experienced multiple re-traumatising life events throughout therapeutic intervention and, despite the postulation that Play Therapy may go some way in restoring the body’s homeostasis; it is perhaps unrealistic to expect a return to baseline calm. It could be suggested that given all these children had to contend with as they settled into families and worked on attachment and trauma, whilst also being repeatedly exposed to multiple re-traumatising life events, an even greater response in questionnaire scoring than that seen would have been elicited, but for the operation of a ‘ceiling effect’.

This argument would support the claim that Play Therapy is a useful intervention, given how well each child did ultimately manage these traumas, and consultation offered to carers/parents/professionals allowed the child to be supported in a consistent manner by all those working with them, (Siegel, 2003; Burr, 1973; Freeman *et al.*, 1997). The oscillation in questionnaire scoring could be seen as a very natural response to re-traumatising events, and with time both Heather and Fergus showed slightly reduced responses, suggesting that Play Therapy/support to the network went some way towards addressing attachment difficulties, giving weight to the idea of ‘earned secure attachment’ (Roisman *et al.*, 2002; Phelps *et al.*, 1998; Crittenden, 2000). This also potentially supports the earlier suggestion of interviewees that a life events scale would be welcomed to allow any potential changes seen to be viewed within the context of external re-traumatising life events.

6.4.4 – Therapeutic decision making and the Professional Network

The therapeutic decision making process gave rise to a number of unexpected issues, which emerged in the responses of the professionals interviewed and spontaneously highlights some of the ways in which researcher bias was managed as described in Chapter 3.

Therapy Reviews: All professionals involved in the care of these six children consistently commented upon the importance of regular therapy reviews and communication, which would appear to be in line with Lord Laming’s (2003) recommendations following the inquiry into the death of Victoria Climbie. The children’s social workers often commented upon the ‘space’ to think and the input into their own decision making processes: Ishbel described professional isolation once a child is adopted; Skye described the importance of joining with other agencies. Both Margaret and Janet made reference to having access to the child’s network when needed in their roles as psychiatrist/manager. Iona described the importance of regular reviews and the chaos reflected in the system when effective communication cannot be established. Both Inga and Annabel reflected their in-depth knowledge of the child’s therapy and system through their own work, regular liaison with the therapist and discussion at therapy reviews.

Compromised professional practice: Morag, Effie, Dougal, Elspeth and Campbell all made reference to their frustrations around delays and struggles in having the needs of their children recognised by the professional network. Morag spoke of her frustration at the perceived inactivity and unresponsiveness of agencies. Effie, Dougal, Elspeth and Campbell described the impact of the regular change in social workers on the child, disrupted assessment/recognition of need and referral to appropriate agencies for support. However, Dougal concluded that, when the case was allocated within the Project, ‘the situation was so swiftly caught for Fergus.’

Those working with Callum spoke of their frustration at the lack of strong social work lead and the resultant delays to assessment and adoption. Annabel described the planning process as ‘shambolic’ and described the impact of this practice upon Callum and Mhairi. Janet made reference to her concern at the way Angus’s child protection allegation was addressed, the anxiety caused by the number of social workers working with him and delays in approaching his therapist for consultation.

Interdisciplinary Working: Margaret made reference to the tension between the medical and therapeutic models. She described her perception of initial wariness towards her, and the process by which she had become more integrated into the Team. It was perhaps unrealistic to expect that tensions would not exist within such a diverse team, and it should be noted that in coming from a social work/therapeutic background, the children’s therapist will be more strongly aligned to the therapeutic model. This also has implications for joint working, as the experience and training of staff is likely to impact upon their perception and expectations of those working around them. Furniss (1991) also describes some of the conflicts often acted out between professionals working with very traumatised children and stressed systems. It is perhaps in recognising, acknowledging and communicating some of these differences that the real strength of interdisciplinary working can be found.

Personal Issues: Lorne in her description of Coll's treatment of May, and the resultant feelings she attributed to Callum regarding this 'betrayal', suggested that she might herself experience some personal issues in relation to these events. Hopkins (1992) comments:

> 'There is a long tradition of psychoanalytic literature on direct work with children. This acknowledges the way that the workers' own unmet needs of childhood interplay with the needs of the child and confuse the helping processes. (p. 148)

He goes on to describe the importance of supervision and personal therapy in recognising these needs and distinguishing 'self' from child in work undertaken.

Therapeutic History: Previous experiences of therapy and agencies can strongly impact upon people's perceptions as described by Euan and Duncan. Ishbel on the other hand made reference to her positive experiences of the Project and Play Therapy which informed her initial thinking on starting work with Heather's therapist. It is important to understand these perceptions in starting work, to support families and professionals to engage.

LAC Services: Ishbel and Maisie commented upon their experience of seeking support for LAC children and the significant divergence in services available through different local authorities. This is likely to have impacted upon their positive perception of support offered to Heather/Eilidh and comments regarding the importance of services dedicated to LAC children. Services dedicated to the mental health provision of Looked After Children can become deeply specialised in the support they offer, understanding of the internal world and the impact of trauma/attachment; as reflected in the comments and understanding of those interviewed.

Consultation: Esme, Ishbel, Janet, Skye, Lorne, Bonnie and Maisie all made reference to the professional support they received in working with the Project. Commenting upon how it has impacted upon their understanding of the child and the therapeutic process, and how it has informed their own practice and their work with children.

Ryan (2004) in her work with Delroy comments:-

> “Child therapists have a key role, enhanced by their specialist training and clinical supervision, in helping carers and professionals who are working closely with these children to understand and respond appropriately to children’s difficult and distorted attachment patterns and interactions” (p. 84).

This would suggest a fairly significant role for mental health services in informing the knowledge and practice of the professional network, which again strengthens the argument for specialist teams dedicated to LAC children (Ford *et al*., 2007; Richardson & Lelliott, 2003).

The importance of effective interagency and interdisciplinary communication is clear, as are the implication for the system and decision making when this is compromised. Acknowledging the strengths and the impact of difference between disciplines can potentially facilitate clearer and more effective communication, bypassing professional mistrust and mitigating some of the effects of researcher bias. When working with such a troubled client group, professionals acknowledge their own personal and professional needs, and those interviewed, commented upon the peer learning they had achieved through engagement with highly specialised LAC services. Thus successfully achieving the recommendation of the 1999 Children in Mind Audit Commission Report 'Health authorities and trusts should establish more consistent provision of specialist CAMHS and should link their activities with those of other agencies'.

6.4.5 – Therapeutic Decision Making and Service Provision

At the end of Phase One of this study, eight substantive changes were made to service provision according to the changing needs of children and their families. Initial assessments were expanded to gain greater insight into attachment relationships, especially for children in short term-placements, and carers were offered additional support/training. Kirsty, Callum and Eilidh all entered the Project after these changes were made and additional support/training extended to those already within the Project. The questionnaire data generated, and the comments of all those interviewed are now discussed in an attempt to consider the impact which these changes may have had to service delivery.

Questionnaires: There were some changes noted in Kirsty's presentation over the first twenty four sessions of therapy which, in the main, corresponded with the oral reports of Euan and Duncan. However, there were limited changes in data for Callum and Eilidh during this period and, if anything, their presentation worsened as reported through questionnaires administered. As discussed previously, little change would be anticipated for Callum at this stage of Play Therapy, but greater changes might have been anticipated for Eilidh following twelve Theraplay sessions, especially in the light of the MIM video assessments undertaken. This would appear to suggest that the changes made to service provision had little positive impact upon the three children subsequently entering the service, which directly contrast with the oral reports of those interviewed, as presented below.

Assessment and Permanence: Euan, Duncan, Elspeth and Campbell all commented upon the assessment process and felt that it adequately prepared them for Theraplay. They commented upon feeling informed and consulted; as well as feeling that service provision was appropriate for their child. Euan and Duncan made reference to their naivety at the outset and the deflating impact that assessment had upon them 'you'd (Kirsty's therapist) already prepared us, I mean it's not until you actually internalise it and start working through it that you realise'. This would appear to suggest that through the changes made in the assessment process, families were supported to think realistically about their child, their own needs and to make an informed decision regarding therapeutic support offered. These findings mirror the recommendations of Lindaman (1999) in the Theraplay Handbook, who emphasises the importance of rigorous assessment prior to Theraplay intervention for fostered and adopted children.

Following the new assessment format, it was agreed not to offer Theraplay to Callum (Appendix 4) as he was not in a permanent placement, and a number of carer characteristics had come to light which, when combined, contra-indicated its use. This decision would appear to reflect some of Virginia Ryan's (2004) comments on her work with 'Delroy'. She describes the 'limitations of Delroy's foster carer' and the impact of therapy upon children within short-term placements potentially 'stretching their resources further, and not extending their fragile and fraught attachment relationships' (p. 85). Callum was instead offered Play Therapy, and Ina was also offered support in thinking about Callum's needs. Ina was not interviewed for this study but instead Annabel, as therapist to Ina and co-worker within the Project, was asked for her views regarding assessment. Annabel commented that she agreed with the therapist's decision not to offer Theraplay, based mainly on Ina's presentation and the lack of permanence for Callum.

Annabel (as the other therapist within the Project) comments upon the decision to change service provision being based upon the experiences of both practitioners within the Project, and her increased confidence in the revised process, 'the level of commitment that the carers and I have towards one another must make it feel safer for the child'.

Support: Lindaman (1999) describes adoptive and foster parents' need for 'more support, understanding, reassurance and guidance than almost any other group of parents' due to the level of challenge presented by LAC children. Morag, Rhona, Effie, Dougal, Blair, Ailsa, Euan, Duncan, Elspeth and Campbell all made reference to the support they have received from the Project, with many commenting on the significant role they feel this played in their interactions/understanding of their children, and their own emotional wellbeing. For example Euan commented 'but I know sometimes when we've had a really bad time I speak to you (Kirsty's therapist) and you've been able to talk me through and I sort of then stand back'.

Morag, Rhona, Effie, Dougal, Euan, Duncan, Elspeth and Campbell all questioned their ability to continue caring for Heather, Fergus, Kirsty and Eilidh had they not received the support they did from the Project. For example, Elspeth and Campbell commented 'If she hadn't had therapy we wouldn't have been able to manage her anymore because it's helped us to understand Eilidh's needs'.

Effie, Dougal, Blair, Ailsa and Ina all received additional support from colleagues within the LAC Team, Inga, Iona and Annabel, respectively, who acted as therapists to the carer/system and protected the therapeutic role/space of Play Therapy. Margaret also provided psychiatric input for Angus and Kirsty, and Iona was consulted in the assessment process for Callum and Eilidh.

Effie and Dougal made repeated reference to the support they received from Inga. Inga in turn commented on some of her frustrations in working with Effie and Dougal, but also the significant changes she had seen in them over this time. Annabel made similar reference to her work with Ina, describing the impact they had on one another. Blair and Ailsa commented upon support offered, especially in the light of Angus's diagnosis and resultant medication 'it's the support not only what he gets, but we get, which helps you get through'. Blair, Ailsa and Iona also individually recognised some of the circumstances and conflicts which have impact upon access to this support.

Training: Those professionals who attended training as part of a group, prior to the changes made in service, (Esme, Janet, and Bonnie) described finding the training useful in refreshing their knowledge of Theraplay and attachment, but presented as quite vague regarding the details. Training is now undertaken individually during the assessment process and carers, parents and professionals who have undertaken training since these changes, appear more aware of principles discussed, especially in relation to their individual children. Lorne described her surprise at attending training 'just for me' during the assessment process, and feeling this allowed her 'insight into the work you (therapist) will be doing'. These comments would appear to support the research of Dumaret *et al* (1997), who conclude the need for appropriate training and support to foster carers to prevent placements from breaking down.

Iona, as training co-ordinator within the LAC Team, spoke about the Project's practical approach to training and the positive evaluations received. Annabel spoke about the importance of being able to share training with more people directly involved in the care of the child, ‘I think it has helped, particularly foster carers have a real confidence in what they’re doing’.

The impact of changes made to service provision can be most clearly seen in the positive attitude towards support, training and assessment of those interviewed. In addition, their comments clearly demonstrate a capacity to internalise the support offered, reflected in their learning, knowledge and interaction with the child:

> “I’ve watched them (Campbell and Elspeth) develop as carers through the work you’ve done with them, and I think they have developed a real understanding of the children and their emotions” (Maisie).

Thus, it could be argued that despite no clear, consistent changes being reported in questionnaire data for Kirsty Callum and Eilidh over the first 12/24 sessions of therapy, there was in fact a significant impact upon each child, their family and the professional network as a result of changes made to service provision. This again potentially highlights the disparity in oral and questionnaire reporting, especially in the early stages of therapy. The comments of those interviewed in relation to Heather, Fergus and Angus, strengthened the argument that changes made in service provision were also beneficial to those already receiving a service with several able to clearly delineate the additional support they had received.

At the conclusion to Phase One and now Phase Two of this study, it has been argued that decision making within the Project is evolving and dynamic. In evaluating the impact of change and the process of decision making within the Project, comes strength in looking ahead to meet the evolving therapeutic needs of LAC children and their families.

6.5 – What is the validity and usefulness of outcome measures when considering the effectiveness of therapy?

Phase One of this study concluded that there were few changes in questionnaire material over the first 24 sessions of therapy for Heather, Fergus and Angus; however, this appeared to contrast with changes reported orally at therapy reviews. In Phase Two, further consideration was given to the disparity between oral and questionnaire reporting, and those interviewed were asked for their opinions. Consideration was also given to questionnaires as more longer term outcome measures, when therapy for Heather, Fergus and Angus continued over a further two year period.

Many of those interviewed felt that the questionnaires were repetitive and asked similar questions. Morag, Effie, Dougal and Elspeth all made comments regarding their role as foster carers, feeling some more personal questions were not appropriate to them (as caring is their job), or that they did not have the knowledge of the child as an infant to answer other questions. Rhona, Effie, Dougal, Euan and Duncan all spoke about the opportunity to reflect upon the child as they completed questionnaire material. Effie and Dougal spoke of the progress they felt they had seen in Fergus as they completed questionnaires. Euan and Duncan commented that at times they did not agree, so they talked about their differences, compromised and gave Kirsty a score in the middle.

As described earlier, once scored, questionnaire material is used to inform discussion and promote thinking around the internal/external presentation of the child during therapy reviews. Margaret, Iona and Annabel (all professionals within the Team), also commented upon the role of questionnaire material in informing discussion. This suggests that, despite some potential limitations of questionnaires in summative assessment, they can play a very important role in formative assessment, thus providing a more qualitative use for traditionally quantitative measures.

Blair, Ailsa, Euan, Duncan and Elspeth all stated that they did not feel questionnaires were reflective of changes they felt they had seen in their children, commenting:

- Their child may fall between categories
- Their child may present differently at different times
- Oral reporting allowed more scope for accurate reflection of change
- Questions may have two parts but there is no place to answer parts differently
- Having to report behaviour even if it is minimal or reduced

Most of those interviewed reported that they would welcome changes in questionnaire format commenting:

- One longer questionnaire incorporating all the questions would be useful;
- Frequency and severity scales for behaviour would allow for greater reflection of change, the behaviour may still be present but be less severe or frequent which respondents did not feel was fully accounted for in present questionnaire format;

- Life events’ scale would be most welcome; feeling the impact of life events was often not accounted for in reporting and yet had significant effects upon the child;
- Space for comments would allow questionnaires to be more individualised and reflective of the child.

These comments would appear to be fairly consistent with what was seen in Phase One of this study, where oral reports of change were often more positive than those of questionnaire data. They also give additional insight into the suggested hypothesis that present questionnaires may not be sensitive enough to serve as outcome measures for the LAC population and, as asked above, is it really realistic to expect this highly traumatised group of children to be able to reach a baseline standardised against the whole child population?

Recent work by Alter and Oppenheimer at Princeton University (sited by Bennet, 2010) found that when a personal questionnaire is presented in a less legible font, people tend to answer it less honestly than if it were written in a more legible font. The implications of questionnaire and font design for the accuracy of respondents’ answers is still a developing field of study. While future questionnaires will be devised in a way that incorporates the learning from this work in the field of cognitive fluency, this factor alone is not considered sufficient to account for the discrepancies between questionnaire and oral accounts of child presentation and change.

Although changes were noted in the questionnaire data for Heather, Fergus and Angus over their subsequent two years of therapy, even Fergus, who showed the most significant changes, still reported high/very high in several categories for the SDQ. Few changes were noted for Kirsty, Callum and Eilidh in their first 12-24 sessions of therapy. However, without exception, all those interviewed were able to identify significant changes in the presentation of all six children, again suggesting a disparity between oral and questionnaire reporting.

One explanation for this may be a ceiling effect, as suggested by the evidence gathered in both Phase One and Phase Two of this study. That is to say behaviour changes, but not to the extent which would warrant a different response in questionnaire categories. The greatest disparity in longer term reporting appears to be in the SDQ, as parents reported struggling to quantify their child's behaviour whilst perceiving their relationship with the child to have changed (PSI, RADQ). However, most of those interviewed also commented upon the impact that external life events had upon the child and their family, accounting for some of the variation in reporting, which is not presently facilitated in conventional questionnaire formats.

It is interesting to compare these findings with those of Peterson and Moran (1995), who undertook a study of infant-mother relationship within the home, and their relation to the Q-sort Measure. They found strong correlation in several categories between what was observed and what was reported in questionnaire format. However, they found in some scales 'the agreement between mothers score and observers score was very low' (p. 125). They suggest that this may in part be related to 'aspects of naturalistic interactions'

(p. 128), which, prompted changes in how behaviour was scored or categorised. Whilst these authors address the issue of inter-observer reliability, it could be argued that their findings are also relevant to this study due to the disparity in oral reporting of observed behaviour and questionnaire reporting.

Little research presently exists, looking at the use of these questionnaires specifically within the LAC population, and that which does exist largely addresses the issue of effectiveness as screening measures rather than outcome measures. Those professionals interviewed for this study were mixed in their view of the use of questionnaires. Margaret reflected that they could be useful tools in the diagnosis of certain medical conditions and felt that they were reflective of change. Annabel described her experience of the disparity between oral reporting and questionnaire material ‘sometimes you wouldn’t believe this is the same child you’ve been discussing with the carer’. Iona described questionnaires as a useful component of the practitioner’s ‘tool kit’ but also commented that they ‘were not designed with children who have been so deeply traumatised’, ‘I’m not sure that they are precise enough to make good outcome indicators’ and ‘we need to rethink what we consider appropriate measurable outcomes’.

6.6 – Wellbeing of the Looked After Child

The final section of this discussion explores factors which were found to affect all six children studied, and are thought to have potential implications for the wellbeing of the LAC population as a whole.

6.6.1 - Placement Stability

‘The prevalence of childhood mental disorders tended to decrease with the length of time in their current placement’ (Meltzer et al., 2003, p. 14).

One of the original goals in setting up a service dedicated to the needs of Looked After Children, was that of placement stability shown within surveys carried out by Sinclair, Wilson and Gibbs (2005) and Lowe and Murch (2002) to be the most likely indicator of a positive outcome for LAC children. However, as described in the introduction, national statistics continue to convey a bleak picture for placement breakdown and emotional well-being of the LAC child. One national newspaper recently carried the headline ‘How our angelic adoptive daughter turned into Little Miss Evil’, containing the story of an adoptive family who struggled to understand the needs of their child or receive appropriate support for her.

Schaefer and Kaduson (2006) suggest that, despite a very divergent research base, the most positive outcomes were noted when parents/carers received a service, suggesting that positive outcomes for children are directly related to the support offered to families. Ryan and Silky (1996), Condon and Corkindale (1997) and Thompson (1995) suggest that quality (rather than quantity), creativity and flexibility of support, were found to enhance psychological well being and feelings of control.

Much of the support offered within the Project is modelled on the work of Schofield and Beek (2005), Golding (2008), Jernberg and Booth (1999), Burr (1973) and Hughes (2006) in facilitating attachment relationships within new families. As described earlier, the Project aims to support parents/carers as their child settles into their home and family, through the use of consultation and, at times, accompanied by direct therapeutic support. Howe (2005) cites the work of Schofield and Beek (2005) as ‘providing in fascinating detail, how foster carers provide a secure base and promote reflective capacity, self-esteem and autonomy for children whose pre-placement histories were ones of neglect, hurt and rejection’ (Howe, 2005, p. 235).

In order to effectively ‘hold’ adoptive/foster families, support has to be as evolving, dynamic, creative, flexible, unpredictable and varied as the families themselves. Support in this Project is tailored according to their individual needs:

- Daily phone contact when needed
- Support - individual, couples, family and group
- Therapeutic support - individual, family and group input
- Training – new training packages devised with creative, visual, theoretical and practical input at an understandable level in attachment, play and defence
- Liaison, training, support and advocacy within the education setting
- Training, consultation and support to social workers, link workers, police and other professionals
- Work with extended family and friends
- Home visits and therapy
- Financial advice

All six of the children within this study are currently in settled permanent families; five were at serious risk of disruption during therapeutic input, and therapeutic input has now ended for all six children. Morag, Effie, Dougal, Euan, Duncan, Hamish, Thora, Elspeth and Campbell all comment that they do not think they would have been able to continue offering a home to Heather, Fergus, Kirsty, Callum and Eilidh, if it had not been for the input of the Project/Team. As described earlier, interviews undertaken reveal the insight parents and carers now have regarding the emotional well being of their children. This coupled with their positive perceptions of therapeutic input and perceived impact upon the child, strengthens the suggestion that this holistic package enhances the likelihood of positive placement outcomes. In considering the previous experiences and needs of each child, a placement breakdown would have been devastating. Not only is this work widely acknowledged by children and their families, it is also increasingly recognised within the broader professional arena including commendation by judicial representatives on final adoption hearings and an award to the Team.

The creativity of this service reflects the scale of the needs of these children, and the need for high level response to their families. The Children's Act '95 and the amendments to the Adoption Act published in 2008, reiterate the departmental responsibility to child and family. The Project and Team have proactively sought to raise awareness of the mental health needs of LAC children and promote close links with other agencies. Children are now routinely referred to the Project/Team and informal contact between workers ensures a quick, early response. This can reduce anxiety so often experienced by families in waiting for services, and stabilise placements, as described by Morag, Effie, Dougal, Campbell and Elspeth, whilst also reducing the amount of input ultimately needed.

6.6.2 - School

The poor educational attainment of LAC children is well documented both nationally and at local authority level. Recent statistics published by the Social Care Institute for Excellence suggest that 37% of LAC children (who responded to the survey), had been excluded from school, and of those 51% felt that they would have done better at school if they had been given more support. Sinclair, Wilson and Gibbs (2005) suggest that second only to placement stability, the greatest stabilising factor for LAC children was reported to be the involvement of an educational psychologist and Lowe and Murch (2002), Phillips and McWilliams (1996) and Selwyn and Quinton (2004), report a close correlation between placement stability and positive outcomes at school.

Morag consistently reported that Heather was managing well at school and achieving academically. However, towards the end of her time in placement with Morag, school also started to note an increase in her anxious, attention seeking behaviours (S.24). No difficulties were reported as Heather moved across into her new school and, despite a personality clash with one of her teachers, no behavioural concerns were raised. This suggests that Heather's behavioural difficulties in class escalated at a time of significant stress.

Fergus's school consistently raised concerns regarding his challenging and low level sexualised behaviour (Appendix 3). However, Fergus's sexualised challenging behaviour escalated significantly following the birth of his younger brother and exposure to pornography. School reported a significant risk to female members of staff and other children, and had to resort to teaching Fergus in isolation, supervised by a male member of staff. Following their concerns that Fergus would not manage secondary transfer, even into an emotional and behavioural unit (EBD,) consideration was given to residential support.

Angus was originally placed within a mainstream school and quickly provided with one-to-one LSA (Learning Support Assistant) provision. The school reported difficulties prior to Angus being referred to Play Therapy, and both reviews and interviews are dominated by discussions around Angus's wellbeing in this provision. Issues largely centred on Angus's challenging behaviour, resistance to learning and difficulties with his peer group. The level of Angus's trauma often led him to feel tricked or persecuted, which would lead him to retaliate by lashing out. Despite repeated attempts to support school, this behaviour was often seen as defiant and naughty, with behavioural measures implemented, causing a downward spiral in behaviour.

As Kirsty moved to be with her new family, she entered local mainstream school where she has received support from the same LSA (Skye) for the past four years. Kirsty was held back a year in an attempt to support her learning, and over the past year school have noticed a significant decline in her ability to access learning. As she progresses through therapy, it is felt that some of her learning difficulties may be becoming more evident as she no longer employs the same defences to promote 'invisibility' in class.

Callum was also classified as globally delayed, but was reported to have made significant progress in learning through his placement with Ina. One of the greatest difficulties for

Callum was his outbursts in class; he would struggle to understand what he was asked to do, feeling tricked or attacked and, as with Angus, this would trigger a fight, flight or freeze response and Callum would lash out. As there was no one-to-one provision for Callum in class, teaching staff had few resources to manage him and the resultant punitive actions were potentially very damaging. Callum moved school for one term prior to being placed with his adoptive family, which caused a lot of conflict within the system, but this meant he moved away from informal contact with his birth family. His new class teacher had an autistic son and had significantly more personal resources for managing Callum's behaviour, helping him to feel good about himself and promote his learning.

Eilidh was assessed as having significant learning difficulties and had been in an appropriate school provision for some time. Few difficulties were reported with school during the time Eilidh was in Theraplay and they noted positive changes in her presentation over this 12 session period. However, when Eilidh moved to the bigger, less contained secondary provision, Elspeth and Campbell started to note a decline again in her behaviour at home and school started to report Eilidh as bullying some of the other children.

The impact of early trauma is very pervasive, and children may potentially react differently to events they perceive as threatening. In the example of Angus and Callum, they lashed out at those around them; Fergus used inappropriate language, touching and sly bullying to express his distress; Kirsty withdrew into herself projecting an image of a happy, pretty little girl providing an air of invisibility; Eilidh when threatened and fearful of change, managed her distress by making herself strong and bullying those she perceived as vulnerable; Heather reacted by trying to elicit the attention of those around her, seeking for her needs to be met, her distress to be managed and calmed. All of these behaviours have at their root fear and distress, but when presented in a busy class of thirty, with discipline to be maintained, the wellbeing of all the children to be protected, targets to be reached and mounting professional pressures, a major problem emerges.

Schools have the primary purpose of facilitating learning and are therefore designed and organised with this end in mind. Strategies for encouraging, boundarying and sanctioning children are often very prescribed and behavioural in nature, i.e. merits which can be earned and taken away. Children who have been socialised in a world of right and wrong, also learn to feel appropriate guilt when they do something wrong. This child will potentially grow up in a world where things are removed as a sanction but, where there is a secure attachment, this does not alter the fact that they are loved and lovable, which in turn supports them to internalise their own sense of self worth (secure attachment). On the other hand, the LAC child is socialised in a world where truth changes all the time and how you react is not about what is right, but what will keep you safe. For the LAC child, therefore, when something as ‘simple’ as a merit is taken away this gives rise to feelings of deceit and confusion, leaving the child feeling tricked and scared, which in turn can spiral them into uncontainable feelings of shame, loss and rage. (Hughes, 2006; Geddes, 2006; Cairns & Stanway, 2004).

Given the disparity between conventional educational structures and the needs of the

Looked After Child, how can these two very different worlds come together in a way which makes learning accessible, and reduces potential risk to all children within the classroom setting? If we return to the concepts of containment and affect regulation, LAC children do not have the same resources for internal containment seen within other children. For this reason they will require support to remain contained (especially in a big classroom setting), until those around them can work on their internal world enough to put in place an internalised scaffolding of containment, which can take a long time. When containment cannot be accessed internally, it follows that this containment may need to be accessed externally in the form of one-to-one Learning Support Assistants (LSA).

However, LSA support requires a statement of educational needs, completed by an educational psychologist and has resource implications (Sinclair, Wilson & Gibbs, 2005). At a time of constricted budgets, limited access to educational psychology and a directive to limit the number of statemented children, these resources are increasingly scarce. LSA positions are often unqualified and poorly paid, with limited access to training. If, as described above, the LAC child becomes distressed, they will require those close to them to have an understanding of their internal working model to appropriately calm and contain them (Gilligan 2001). At present LSAs often report feeling overwhelmed and scared of the LAC child, with schools increasingly resorting to excluding children, as reflected in national statistics. Placements within mainstream provisions are threatened, leading to an increased number of children in specialist educational provisions such as EBD, residential or off site alternatives, which is also reflected in the high national statistics.

If there is any hope that these statistics for LAC children are to improve, significant changes may be required. These changes are likely to have resource implications, not only in educational psychology but also the provision of appropriate LSA support. This then in turn has implications for the recruitment, training, role and pay of an LSA supporting a highly traumatised LAC child. Change may also need to be considered at a policy level as schools consider facilitating the needs of the LAC child in a way which is supportive of learning whilst limiting their shame responses.

The question could then be asked about the suitability of mainstream provision for LAC children. When considered in the context of Heather, who is achieving well and requires no additional support, or Kirsty and Callum who now receive support, and despite their limitations in learning and peer relationships are integrated well into the classroom settings, this model clearly can work. Fergus, Angus and Eilidh are all now in specialist school provision and, despite their limitations, are all thought to be appropriately placed. This highlights the importance of considering each child individually. No solution will ever be applicable to all LAC children, due to the diversity of trauma they experience and the operation of a range of mitigating factors at the time.

Perhaps an alternative question becomes how LAC children access support in school. At present all LAC children in England and Wales must have a Personal Education Plan (PEP) which assesses their educational needs and is discussed in a multi-agency setting. However, this does not automatically entitle the LAC child to support and they go through the same assessment process as all other children, with the limitations described above. Often by the time the LAC child is assessed, if indeed they are assessed, the difficulties in class are already well established or they have moved placement. The question then becomes do LAC children need automatic or priority assessment in accessing appropriate support? As described above, this would have major resource implications but may potentially offer more positive outcomes in the longer term.

One of the other factors which influenced the children's presentation in class was the impact of external events, for example Heather's family finding, Fergus's birth family. These events impact upon the well being of the child and the results are global (as described earlier). This would appear to strengthen the argument for regular therapy reviews and close inter-agency working in an attempt to more appropriately manage external events and provide a consistent response to the child.

6.6.3 – Relationships

All six children experienced difficulties in forming close, meaningful relationships within their new families, which forms the basic referral criteria for children entering the Project, and much of the subsequent thinking for this study. However, all six children also experienced difficulties within their peer and sibling relationships. As described earlier, much of our capacity to form meaningful relationships is held within our ability to understand our own internal state and 'read' the internal state of 'the other' in a process described as 'Mind-Mindedness', Howe (2005). When a child has limited experience of their own internal state, then they are unlikely to be able to comprehend the impact they have on others, and in turn are unlikely to be able to react to others according to their needs. The result is either a child who is reported to be quite isolated and favour the company of adults, the child who lashes out and attacks peers, or the child who haphazardly and inappropriately approaches their peer group in a desperate desire for inclusion (Geddes, 2006).

Research clearly shows the impact of a new child entering a family upon the parents' relationship, be it a birth child or an adopted child (Wilson, Sinclair & Gibbs 2000; Stritof, 2010). Considering the needs of most LAC children, their difficulties in forming relationships and their frequent attacking behaviour towards their primary care giver, it is perhaps little wonder that parental relationships can experience significant stress in the adoption/permanence process. Rhona and Ishbel both commented upon the impact which Heather's placement had upon Aidan, both in his relationship with Rhona and his emerging relationship with Heather. Aidan was able to acknowledge some of his own difficulties and although now much closer to Heather, (Ishbel) there are some residual concerns regarding how Aidan will cope when Heather reaches adolescence (Rhona).

Despite this raft of difficulties and challenges to their relationship, several of those interviewed also inferred a deep warmth towards their child. This would appear to be quite a common response to the LAC child and would suggest that there is some mitigating capacity to draw people's affection (Gilligan, 2000). The holistic package offered by the Project/Team is orally reported to have had a profound impact on each child's ability to form meaningful relationships at home and elsewhere, thus strengthening the argument for the provision of a mental health service dedicated to the needs of LAC children.

6.6.4 - Contact

Research published to date would appear to suggest the importance of ongoing contact with the birth family to promote a child's identity, reduce fantasy thinking and promote emotional well-being (Cleaver, 2000; Shaw, 1998). As Heather settled into her adoptive family, her desire to have contact with her siblings grew. Heather was supported to act out her inner fantasies in relation to her siblings in therapy, helping her to appropriately connect with the rage and anger she felt at being scapegoated. In doing so, Heather was supported to de-construct her idealised view of her birth family and recognise her fantasies/fears (Fahlberg, 1991). Heather's birth parents were supported by Jean to acknowledge the impact of their actions upon Heather and explain these circumstances appropriately to their other children. In doing so the family was supported to relate to Heather differently, and Heather was able to relate more realistically to them. The ability of the birth family to recognise and facilitate change was the greatest mitigating factor in allowing contact between siblings to proceed (Neil & Howe, 2004).

Conversely, Tarn consistently struggled to let go (even when offered support by Inga), in a way which would allow Fergus to settle in his new family, and contact was rife, with inappropriate messages of control, causing significant difficulties within the home. The loss of a birth child has huge ramifications for any parent, but for those experiencing mental health difficulties who themselves have experienced trauma and loss in childhood, the results are quite devastating. Where parents are so overwhelmed by their own needs that they struggle to demonstrate any capacity for change, or struggle to separate in their own mind from the child, they will have few available resources to support their child in forming new relationships with others (Howe & Steele, 2004). Thus, the onus to protect the child falls upon the professionals responsible for their care, and difficult decisions regarding the level of contact were made in an attempt to contain Tarn. When properly supervised and managed, contact was finally re-established between the boys and subsequently with Tarn; Fergus was much stronger emotionally, and now sees himself very firmly as Effie and Dougal's child, allowing him to enjoy the time he spends with his Mum and brother (Schofield & Beek, 2005).

Callum’s extended family would regularly turn up unannounced at school, causing extreme distress and traumatised response, despite Lorne’s repeated requests for them to keep away. There were significant delays in moving Callum which resulted in prolonged distress and may have accounted at least in part for some of his more difficult behaviour in class. Kirsty is not aware of the letterbox contact she has with her parents, but with time will be supported to look at the material kept for her. Duncan was able to consider the anger he feels towards Kirsty’s family, but acknowledged the importance of keeping this link. Neither Angus nor Eilidh have contact with their birth parents but both have contact with their siblings, which despite being quite positive at the time, often have emotional ramifications for both. These observations are reflected in the research of Farmer *et al.* (2004) and Quinton *et al.* (1998) who both report that children often desire more contact, even when this is detrimental to them.

One of the consistent themes for several of the children was the way in which birth parents were supported to facilitate and maintain contact, even when they were not directly involved. This would appear to suggest a significant role for post-adoption services and Social Services, in supporting parents to think about the emotional well-being of their child. There is no doubt that contact can support a child in their relationships when this is appropriately assessed and managed (Schofield & Beek, 2005). However, this must also be viewed in relation to parental capacity (Farmer *et al.*, 2004; Quinton *et al.*, 1998; Sinclair, 2005). At a time when social workers are under significant legal pressure to promote contact with birth families; perhaps the legal obligation of parents to accept appropriate support and assessment in meeting their children's needs through contact also requires consideration.

> 'The contrast between families who can be supportive to a particular child with help from the social worker, adopter or carer and contact involving high risk birth families who are not properly supported or monitored, shows that we need to think flexibly about both potential benefit and harm for the child'.
>
> (Schofield & Beek, 2005, p. 348).

6.6.5 - LAC Complexity

All six children were accommodated following chronic neglect and suspected abuse. What in fact became apparent through 12-24 sessions or 2 years of work was the extent of abuse experienced by each of these children in their birth families and, for some, in foster placements. This would appear to be fairly reflective of the experiences of other members of the LAC Team, and not only highlights the trauma experienced by the LAC child, but again suggests the importance of specialist provision to support this level of need.

It also highlights the necessity for close interagency working, in an attempt to support families and provide consistent care-giving to the child. Therapy reviews take on a new role not only in providing a forum to share information, but also in providing opportunities to reflect and think about the child’s complex needs. The contexts in which LAC children find themselves, as we have seen, rarely remain static for long, and as life events unfold so do their varied repertoire of defence mechanisms. Workers and families need space to consider, to anticipate, to manage, to understand, to speculate, to feel and to grieve. As more is known and understood of the prolific impact of attachment and trauma on the developing child, so this knowledge is being increasingly applied to the practical care of the LAC child. The responsibility upon the mental health profession to act as guide and interpreter grows, and in doing so the system begins to come together in their approach to these very fragile, frightened children. The idea and concept of therapy reviews as a ‘safety net’, as described by Ishbel, would appear to take on a new and deeper meaning in the context of this level of complexity.

The need for ongoing assessment, open reflective supervision and dynamic decision making, also takes on a new meaning for this very complex population. The idea that the LAC child’s needs will remain static throughout therapeutic intervention, no longer appears realistic and although therapist/modality may remain consistent, much creative thinking will be required in responding to child, family and professionals. As the knowledge, skill, experience and understanding of professionals working with these children grows, so does the challenge to appropriately meet their needs throughout their different developmental stages. It is in recognising and responding to these developmental needs that the Project has evolved. Modalities are different and there is value in each. It could be argued the skill then becomes identifying, and matching need in accordance with the therapeutic modalities available.

In answering the original question identified, both Theraplay and Play Therapy would appear to be useful interventions in addressing these children's highly complex needs. Their approach and application is different. However, in the context of a Project offering services to children assessed as having attachment related difficulties, Heather, Fergus, Angus, Kirsty, Callum and Eilidh have benefited from both, in assessing and meeting their evolving needs. The exact mechanism of decision making is as complex and unique as each child, and the systems which surround them. However, there are processes (clearly delineated throughout) of accountability, application, knowledge, skill and experience in relation to the decisions made for each child.

The impact of this work upon workers must also be acknowledged as the level of complex need, trauma and distress being contained within this Team is huge. Good, appropriate clinical and managerial supervision are essential, but therapeutic support to workers is not provided and is at the discretion of individual disciplines/practitioners. The Team is sensitively managed and receives significant support, funding and respect from Children's Services. Practitioners are skilled and experienced, but as external pressures mount so do the pressures upon time and availability.

6.7 – Concluding Comments

In the busy working week there is rarely time to stop, reflect and think, especially with such a complex group of children. The phone rings, time for session, notes and records to maintain, a carer who needs ten minutes, a social worker calling from court, your opinion, your thoughts, your time, a quick reaction, questionnaires to score, a report to write, a letter to support a carer, meetings, training, consultation. Even in the quiet space of supervision the clock is ticking and there is so much to consider, who to discuss, who can wait till next time, who has never been discussed, what is it about some children that they push themselves so deeply into you and others, your supervisor may never know you hold in mind. In the midst of this you provide a space to think not only for yourself but for others, you juggle the parts of your conscious thinking and finally, you stop.

When you stop you begin to realise how much you have learnt and the impact of this learning on your practice. When you stop, you begin to wonder, and in wondering you begin to read and amass information. What does this information mean and how is it relevant to the children you work with? You look at their therapy, you ascertain the views of those that surround them, how are they functioning, why do they behave in the way they do, what is the impact of the work you undertake?

In this chapter these threads of thinking are pulled together, what has been read and understood is applied in the context of the outcomes (or perceived outcomes) of therapy. Hypotheses are generated and tested against what is already known, to be further explored in subsequent research. To be a practitioner undertaking research, is to explore these ideas from the inside out, it is an unusual and privileged position which can yield extremely rich qualitative data. It is also a position of trust as those involved place their faith in the therapist to support them, work with their child and use their experiences to support the understanding of others. As the Project has developed and evolved so it will continue.

In the final chapter consideration will be given to summarising the findings from this present study, the impact of these findings on theoretical understanding, on professional development and future service delivery within a Project which has consistently proved itself to be creative and evolving.