Chapter 1 – Introduction

Prologue

The three orphans huddled together, shivering in cold and fear, as Captain Sham sailed the boat by himself. They didn't dare do anything but hope. Their feelings for Aunt Josephine were all a-tumble in their minds. The Baudelaires had not really enjoyed most of their time with her – not because she cooked horrible cold meals or chose presents for them that they did not like, or always corrected the children's grammar, but because she was so afraid of everything that she made it impossible to really enjoy anything at all. And the worst of it was that Aunt Josephine's fear had made her a bad guardian. A guardian is supposed to stay with children and keep them safe, but Aunt Josephine had run away at the first sign of danger. A guardian is supposed to help children in times of trouble, but Aunt Josephine practically had to be dragged out of Curdles Cave when they needed her. A guardian is supposed to protect children from danger, but Aunt Josephine had offered the orphans to Captain Sham in exchange for her own safety. But, despite all of Aunt Josephine's faults, the orphans still cared about her. She had taught them many things, even if many of them were boring. She had provided a home, even if it was cold and unable to withstand hurricanes, and the children knew that Aunt Josephine, like the Baudelaires themselves, had experienced some terrible things in her life. So, as their guardian faded from view and the lights of Damocles Dock approached closer and closer, Violet, Klaus and Sunny did not think 'Josephine Schmosephine' they thought 'We hope Aunt Josephine is safe' (Snicket, 2001b, p.193-195).

In the opening pages of Lemony Snicket's The Bad Beginning: Book The First in *A Series of Unfortunate Events* we find the three children orphaned, following a terrible fire which destroys their home and kills their parents. Throughout the remainder of the thirteen books the children are sent to a variety of different guardians, pursued throughout by the ruthless Count Olaf (in many different disguises!) who is determined to steal the children's fortune. Although entirely fictional in nature and often quite dark humoured, the books show just how powerless the children are, as they are passed from place to place and person to person. Adults struggle to hear children when their lives are at risk, when they are not receiving proper care, or when they are being moved with little reason, discussion or preparation.

Sadly these 'entirely fictional events' begin to sound all too familiar and the internal confusion so eloquently described is the reality for many Looked After Children (LAC). Many of these children, for one reason or another, are unlikely ever return to their families of origin but will instead live the remainder of their childhood in foster or adoptive homes and more often than not will struggle with the same concepts of loyalty, identity and trauma.

Unlike the Baudelaire orphans, most LAC children do not experience early childhood in secure, stable or consistently loving homes and often lack the resilience or basic building blocks to form later meaningful relationships. They carry with them the legacy of insecure attachment patterns; they search for validation and approval, which they struggle to accept when it does finally come in the form of a secure, permanent placement. It is

little wonder then that such children face inordinate strain and that practitioners struggle to provide solutions to address some of these persisting difficulties.

1.1 – Background to the Study

This research explores one aspect of the search for effective models of intervention to support Looked After Children in placements that are under stress or at risk of collapse. The context for this research is a busy English inner city mental health service for Looked After Children and Young People, and the work within that service of a therapist working as part of a multidisciplinary team.

This study has two aims. Firstly, to explore the impact of the use of Theraplay and Play Therapy when supporting Looked After Children assessed as experiencing attachment-related difficulties, using a number of techniques to evaluate the child's presentation prior to, throughout and at the end of intervention. Secondly, to explore the therapeutic decision making process which is the responsibility of the therapist alone, to consider how decisions are made when several therapeutic modalities are available through Project and Team, and to explore the process of decision making to determine whether it is dynamic and evolving or otherwise characterized.

The purposes of this study are four-fold:

- To provide a contribution to the understanding and impact of Theraplay, an emerging model of intervention, on the use of which little research has been done in the UK.

- To explore the process of Play Therapy for Looked After Children against a background of scant substantive research in this field.
- To provide insight into factors influencing the therapeutic decision making process and its effects, in order to inform subsequent therapeutic interventions.
- To explore the approaches used by the therapist within the context of current knowledge and understanding of therapeutic decision making techniques.

Over the past fifty years, there has been a proliferation of research undertaken in the fields of attachment and trauma, providing a strong body of evidence enhancing the understanding of the internal world of the LAC child. However, despite a strong anecdotal base to suggest the effectiveness of therapeutic interventions with this child population, scant research exists to support this thinking. In this current political climate, there is a strong drive towards evidence-based practice and measurable outcomes. тhere is, however, growing recognition amongst clinicians that screening tools, presently used to measure and monitor the effectiveness of therapeutic intervention, may not be as effective with this client group for four reasons.

Firstly, given what is increasingly known of the effects of complex trauma and attachment, it is argued that these measures may not be sensitive enough to measure the changes in a child's emotional and behavioural presentation. This derives in part from the extreme degree of difficulty and damage with which these children present (i.e. tier 3 and 4 mental health provision), which is significantly elevated beyond the mental health features found within the general child population. One consequence of the degree of

emotional trauma presented by this group is the difficulty in accurately calibrating screening tools to provide a meaningful comparison across the general population.

Secondly, the different screening tools used by therapists with this group measure different presenting behavioural and relational interactions suggestive of a variety of possible diagnostic categorisation. What these tools are unable to address is the ceiling effect that, once a high score is gained for any of the screenable difficulties, significant change is required to alter the diagnostic categorisation, which therefore compromises the capacity to effectively monitor progress for these children and the value of therapeutic intervention.

Thirdly, given the political drive and the clinical necessity of effective screening measures, it could be argued that tools that do not deliver adequate evidence of outcome in this particularly vulnerable clinical population are destined not only to underreport changes achieved therapeutically, but also to further disadvantage these children who may be denied appropriate support if services are not felt to be cost effective.

Fourthly, such resource-intensive interventions may find it hard to continue or expand without an adequate evidence base of their performance and effectiveness, despite the fact that therapeutic intervention is widely acknowledged to have the potential to prevent costly placement breakdown.

A recent Mental Health Conference for England (July 2008) was entirely devoted to this

issue, focusing on the use of qualitative research. It was postulated that quantitative research for this group of children had considerable limitations. The conference highlighted research which showed the need to utilise the knowledge and ability of highly experienced clinicians, bringing strong practice skills into a manageable research arena (Howe & Fearnley, 2003). However, with so many constraints upon practitioners' time and only very few settings and disciplines provided with either the time or the resources to undertake research; it is perhaps little wonder that what evidence does exist is limited and anecdotal in nature.

As Howe and Fearnley report, 'the clinicians' practice …. is still running ahead of the research evidence'. They go on to suggest that clinicians' practice appears to be supported by the limited research and theory that has so far emerged (Howe and Fearnley, 2003, p. 386). The suggestion that therapists would appear to have a competent, if limited, understanding of their world is relevant to this thesis in that it provides some validation of the approach adopted by this study which involved the therapist adopting the role of researcher. It also highlights, however, the challenge to the therapist/researcher of remaining open to emerging findings which question that world view as well as other tensions inherent in the dual role.

1.2 – Context of Study

This research was undertaken by a dual qualified Play Therapist, Theraplay practitioner and Social Worker. It has grown out of more than twenty years' experience of working with vulnerable children, over twelve years as a practitioner and seven specifically

working with Looked After Children. The therapist gained a Master of Social Work qualification in July 1997 from Edinburgh University, a Graduate Diploma in Play Therapy in July 2002 from Surrey University and an Accreditation in Theraplay in September 2009 from the Theraplay Institute, Chicago.

As a result of her experience, the therapist became aware of the limited amount of research underpinning the modality she practised in the settings in which she worked, and became interested in the idea of undertaking a study. Consequently, she initiated exploratory discussions with The Notre Dame Clinic regarding the challenges involved in such research, which would be undertaken in parallel to her ongoing practice and this led to the therapist subsequently enrolling in Strathclyde University's PhD programme.

The study therefore derives from the therapist's experience of offering Theraplay and Play Therapy to Looked After Children assessed as experiencing attachment-related difficulties. It explores the progress of children undergoing therapy using conventional questionnaire measures, coupled with the verbal feedback of parents, carers and professionals. While focusing on decision making in a multi-disciplinary mental health setting, the research highlights therapeutic decision making in therapy reviews attended by agencies external to the mental health setting, but integral to the care and wellbeing of each child.

One of the key features of this study is that the therapist not only holds the role of practitioner, but also the role of researcher, effectively becoming a participant observer.

This dual role brings with it several advantages, including an in depth knowledge of each child and their family, significant experience of this client group and therapeutic intervention as well as an understanding of the legal/procedural mechanisms, professional networks and family systems. The dual role, however, also raises a number of ethical and procedural challenges for an academic research study such as potential bias, the need for objectivity, accuracy and reliability of reporting by stakeholders.

In order to secure a credible and worthwhile outcome from research being undertaken through this less common methodology, considerable thought was given to managing these challenges. The therapist has had to take a careful and meticulous, suitably tested approach, to ensure transparent, open communication with adult participants with clear information/consent measures devised in accordance with the guidelines of the NHS Trust's Ethics Committee, triangulation of data gathered from a number of sources, and the involvement of external monitoring processes such as supervision/accountability in external agencies.

As an employee of social services, the therapist was seconded in to the NHS Trust and specifically into mental health services offering support to children and young people under the age of eighteen. The Team has a clear remit to offer support only to children removed from birth families, accommodated by the local authority at the time of referral. If children return to their birth families, their care is transferred to 'Locality Teams' within the mental health service, where their needs are addressed in the context of their

family setting. For those children who will not return home, support is offered through this highly specialised Team.

The Team comprises administration, art therapy, family therapy, psychiatry, psychiatric social work, psychology, psychotherapy and 'the Attachment Project' (described below). Those employed or seconded into the mental health service are also, at times, referred to as mental health practitioners. There are six full-time and three part-time members of staff, with other disciplines providing sessional input. The Team offers a duty system and a multi-disciplinary consultation service prior to acceptance/allocation of relevant referrals. The Team meets every fortnight and managerial/clinical supervision is provided monthly.

The Team is constituted as a Child and Adolescent Mental Health Services (CAMHS) Team, offering services designated as tier 3 and 4 mental health provision, which is geared towards children presenting at highest risk within the community, ascending to those requiring inpatient care. Its constituency is, therefore, some of the most vulnerable, traumatised and worrying children in the country. The Team ethos places considerable emphasis on individual professional expertise, the exercise of which adds value to the process of assessment and decision making in a multi-disciplinary context.

The Attachment Project is a key element of the CAMHS Team. It was set up within the Local Authority in February 2001, offering specialist attachment-based interventions to children and their families. When the founding therapist left the Project in July 2003, two

new therapists (of which the researcher is one) trained in Social Work, Play Therapy and Theraplay were employed to continue and expand this work. The Project aims to support children suffering from attachment-related difficulties and to help them in forming closer relationships within new families and to support their carers, thus enhancing the likelihood of a positive outcome in terms of placement, broader social networks and learning potential. The Attachment Project offers a variety of interventions including Theraplay and Play Therapy, two very distinct forms of therapeutic intervention, as well as intensive support to parents, families and other professionals.

In October 2003, the mental health provision for the Local Authority underwent rigorous restructuring, and specialists who had up to this point worked separately were brought together into the newly established LAC Team, along with the Attachment Project. A number of poor performance indicators in relation to national and local statistics influenced this decision including:

- an increased number of placement breakdowns in the local authority (DoH, 2003)
- increasingly bleak nationwide statistics for LAC children (Ford *et al.*, 2007)
- limited specialist mental health provision to target the specific/complex needs of LAC children (Richardson & Lelliot, 2003)
- the emotional/financial cost of placement breakdown (Health of LAC, 2003)
- an increasing body of research evidence highlighting the impact of early attachment relationships and trauma on later development (Chapter 2)
- the prolific impact poor attachment patterns can have on the LAC child's development (Chapter 2)

- poor educational outcomes as one of the lowest performing local authorities in England with high exclusion rates amongst the LAC population (Health of LAC, 2008)

Children are allocated to individual practitioners at fortnightly team meetings, and during this time consideration is given by the Team as a whole to the presenting needs of the child and the most appropriate support to be offered. All practitioners are extremely skilled in this field, having been employed on the basis of their significant experience and have remained within the Team for a minimum of five years. When a child is allocated to a specific practitioner, in this case the therapist, their mental health needs then become her direct responsibility. Decisions regarding the therapeutic care of each child are, therefore, made by individual practitioners, who are directly accountable to the Team, Manager, Supervisor and other professionals from a variety of external agencies directly responsible for the care of the child.

1.3 – Statutory Context

The statutory context of the care of the children seen by the therapist is an important consideration because of the complexities and pressures it brings to the children's situation and because it affects, and at times constrains, the nature of intervention by the therapist and other professionals, some of whom will have defined statutory responsibilities, and all of whom will be working within statutorily determined time scales. The legal status and history of each of the children in this study is shown in Table 2 (below).

Children may be subject to full care orders (Section.31, The Children Act 1989) and would receive regular LAC reviews within the care system and would have care plans. Other Looked After Children may be subject to interim care orders (Section.38) which last for eight weeks and are then renewed for up to twenty eight days at a time, frequently without a court hearing, if nothing significant has changed since the last application to renew. Some children may have been subject to emergency protection orders (Section.44) or police protection orders (Section.46) prior to being subject to interim care orders. Emergency protection orders may last up to seven days and police protection up to seventy two hours. Some children seen by the Team may be subject to adoption legislation and may have been freed for adoption or adopted. The Team also see young people who have become Looked After Children with the agreement of their parents (Section.20).

Parental responsibility for children subject to care orders may rest exclusively with the local authority, with adoptive parents or with one or both birth parents, or may be shared amongst these or other parties. The legal process and the crucial role of parenting a child are uneasy companions. The delays, demands, and formalities of the legal system and the time adults and courts take to make decisions add to the stress experienced by children and their carers.

While the day-to-day parenting role of a Looked After Child may be delegated to a relative, foster carer, prospective adopter or residential establishment, the local authority will, in all cases where a child is subject to a care order under Section.31, have parental

responsibility, exclusively or shared, for the child. Corporate bodies are not constituted in a way that makes them natural holders of parental responsibilities for a child. The distance, bureaucracy and layers of decision making between the designated social work manager and the child are inordinately complex and serve only to highlight the unnaturalness of the parenting arrangements. For example, few children living with their birth parents need seemingly interminable meetings of unfamiliar adults to be held to decide if and where they go on holiday, whether they can have a sleepover or how much pocket money they should receive, let alone who they should live with and where they should attend school.

Looked After Children may have been through a series of legal processes (Table 2), each with their own demands, uncertainties and stresses, which can add to the pressures and distress of already traumatised children who are only in the statutory care system because they have met the test of being 'at risk of significant harm' (Section.31) by remaining in their present situation.

In assessing and working with such children, the therapist has not only to comply with statutory requirements, such as court orders but also to recognise and seek to mitigate the additional trauma inflicted on these children by the very system designed to protect them. Further discussion of the impact of the statutory process on Looked After Children, including burden and standard of proof for securing a care order, is included in Chapter 2 of this study.

1.4 – Mental Health Provision, The Professional Network and The Family System

Although children's services become the main decision making body for a Looked After Child, they will often refer to external specialist services when necessary and defer to their knowledge and experience in relevant areas such as mental health. However, these specialists (including the Attachment Project and LAC Team) do not have the authority to make independent executive decisions in respect of the child, but are usually solely responsible for therapeutic or mental health decision making (including diagnosis, medication and therapy) where consent for treatment has been given.

The local authority can opt to reject the advice or recommendations of specialist services, in the same way as a birth parent can go against the advice of a dentist and refuse a filling. In these circumstances the dentist is unlikely to offer an orthodontic appliance in the place of a filling, as the purpose of these two procedures is very different. In the same way, if mental health services assess a child's therapeutic needs, they do so with appropriate knowledge, skill and experience. If social services reject these decisions, then they must accept liability for a child's ongoing mental health presentation and take responsibility for meeting their needs.

The mental health practitioner, as with the dentist, is likely to take into account a number of variables before deciding on the best course of action to be taken, but there may well be more than one possible course of action that would achieve the same end. Once a decision is made, it will have consequences and other external factors may, over time,

influence ongoing decision making, as might happen where a parent delays treatment and a filling becomes necessary in place of a scale and polish.

In therapeutic interventions the decision making process is the responsibility of the therapist alone. This study considers how decisions are made amongst the therapeutic modalities available to the therapist through the Project and the Team, and how these decisions are affected and influenced by other factors throughout the therapeutic process. It does not concern itself with the broader inter-agency decision making process, other than to consider the impact of these more global decisions upon the overall experience of the child which, in turn, has implications for their mental health presentation, e.g. the decision to suspend contact between a child and their parent will have a significant impact upon the child and, although a therapist may be asked for their opinion (Health of LAC, 2008), they are not the responsible decision making body.

The interface of the therapeutic decision making process with other relevant agencies is considered in the context of therapy reviews, where the therapist is responsible for translating the therapeutic experience of the child and the therapeutic decisions made to those seeking to promote the best interests of the child, e.g. social worker, foster carer, adoptive parents, school. The therapist must also assimilate information provided by other agencies in order to make sense of the child's internal confusion in therapy, and to assess on an ongoing basis the therapeutic needs of each child. The LAC child's professional network, present at therapy reviews (where relevant or appropriate) included together with the responsibilities of each are shown in Table 1.

Table 1 – *Agency and Responsibility to LAC Child*

Agency	Responsibility
Social Services	Overall or shared responsibility for the child and implementation of plan in line with the child's interests and agency policy and procedures
Adoptive Family	Overall responsibility for the child
Adoption Social Worker	Responsible for support to adoptive families and implementation of agency policy and procedures
Foster Carer	Responsible for the care of the child through fulfillment of day-to-day parental role
Foster Care Agency	Responsible for support and supervision to foster carers in line with agency policy and procedures
School/Nursery	Responsible for education in line with the child's needs and agency policy and procedures
G.P.	Responsible for coordinating the child's overall health needs

Each child's professional network is specific to their individual needs, for some children occupational therapy, speech therapy, educational therapy, police, mental health and other specialist services will also be involved in their care. Each professional service exists as a separate entity with its own role, procedures, mechanisms and responsibilities, goals and accountability in caring for the LAC child. Each professional service provides its own supervision, structure and accountability to individual practitioners. The onus on the professional network is to find a way of effectively working together to best meet the needs of the Looked After Child, given this diversity of background and accountability for each service represented (Working Together, 1997; Laming, 2003).

One of the ways this is addressed in the Project is to offer regular therapy reviews for each child, where the main focus of interagency thinking is the child's therapeutic needs. Other forums include statutory LAC reviews chaired by an independent review officer (IRO) where the main focus is an overview of the LAC child's needs, and schools will routinely chair PEP (personal education plan) meetings where the focus is the education needs of the LAC child.

Thus a multiplicity of channels must be developed to facilitate communication between agencies, whilst safeguarding against collusion between agencies. Any difficulties arising will be addressed firstly within the individual organisation within supervision (also provided to parents and carers) or Team meetings and then discussed between agencies (often at Managerial level) before being taken to the larger forums such as LAC reviews.

LAC children may remain in contact with broader family systems for a period of time, including birth parents, siblings, extended family and other significant adults such as aunts, uncles, neighbours or family friends. Some of these people may have provided support to the family or care to the child, others may have been abusive or frightening, but the fact remains that this is the child's family system. Even when full care orders are granted, the family may be involved in processes which determine important decisions about their children, such as ongoing contact, the impact of external life events and the overall emotional wellbeing of each child.

The plethora of individuals and processes involved in decision making for the child,

combined with the legacy of emotional trauma some of these relationships carry, serve to create additional and recurring pressures for the child in the therapeutic process and may prove to be disruptive to Theraplay or Play Therapy being undertaken with them.

1.5 – The Context of the Therapeutic Modalities

Theraplay is a form of therapeutic intervention which works directly on attachment relationships by having parent/child in the room together. Theraplay uses playful engaging activities to allow the child to experience some of the close nurture they may have missed in early childhood, and works to reduce the necessity for controlling, defensive behaviours constructed to protect the child in inconsistent, uncertain or dangerous early relationships. Theraplay also focuses on building close, attuned relationships through the use of reflection, affect synchrony and intersubjectivity.

Conversely, much of the therapeutic work that takes place in Play Therapy is facilitated through the therapeutic relationship which develops between child and therapist. It has long been recognised that children's earliest form of communication is through play, and that for many Looked After Children neglect and trauma often take place at a very early stage of development. Thus, the therapist encourages the child to explore their internal working model and perceptions through symbolic play, supporting them to reframe unhelpful representations of their traumatic experiences, including shame and blame. Through the therapeutic alliance the therapist effectively becomes a 'mirror' for the child's internal constructs, and during this process starts to reflect a healthier attachment representation to the child.

Thus, both forms of therapeutic intervention are thought to impact upon a child's attachment presentation, but in very different ways. Play Therapy also works upon a child's representation of trauma and The Theraplay Institute advocates trauma based therapy to complement this style of attachment based intervention, if required, and at a time appropriate to child and family.

1.6 – Design of the Research

This study takes place at the interface between research, practice, resources and knowledge. It takes into account the complexity of the needs of, and pressures on the children that it deals with, by virtue of them being in the LAC system. It was born out of a desire to reflect on and evaluate the validity of the therapeutic input offered to children attending the Project, the decision making processes around that input and to enhance services where possible, in order to better meet the needs of the children involved. It was designed to bring together the experience and skills of practitioners, with the rapidly expanding repertoire of research and theory in associated fields. In doing so, it was hoped that the new knowledge created could enhance practice, since more could be learned of the therapeutic processes of Theraplay and Play Therapy, and that others could build on this research/practice for future projects and studies. Above all, the study seeks to make some contribution to the longer term wellbeing of Looked After Children.

In the process of formulating these ideas and constructing a robust, manageable study, two aims evolved. Firstly to consider the effectiveness of Theraplay and Play Therapy intervention when working with Looked After Children with definable difficulties, and

secondly to explore the clinical decision making process within the Project. Decision making here refers to the decisions that are the responsibility of the therapist herself in relation to the process of therapy and in particular the choices between the several therapeutic modalities available within the professional context. Three children were identified at the outset of the study, and therapeutic input throughout their first 24 sessions was analysed using existing data in the form of documented evidence arising from the normal processes and procedures associated with the provision of therapy in the Attachment Project.

As a result of this analysis it became apparent that these aims required further in depth examination in order to evaluate the implications for future service delivery and the longer term therapeutic needs of each child. For the purposes of Phase Two a further three children were added to the study and the perspective and experiences of caregivers and professions involved in the care of these six children were examined in depth. The aims therefore remained the same throughout the study, namely:

1. To explore the impact of the use of Theraplay and Play Therapy when supporting Looked After Children assessed as experiencing attachment-related difficulties, using a number of techniques to evaluate the child's presentation prior to, throughout and at the end of intervention.
2. To explore therapeutic decision making and reflect upon the dynamic, evolving nature of this process.

1.7 – Research Sample and Questions

It was critical to the integrity of both the therapist's practice and to this study that services were provided to each child according to their presenting needs, and existing screening tools were implemented for the purpose of assessment, monitoring and outcome (a standard response for all children referred to the service), and that the needs of the children were in no way compromised by the process of this research. Through the process of therapeutic intervention, consideration was given to the effectiveness of offering Theraplay or Play Therapy to children affected by attachment-related difficulties and as the study progressed, emerging findings did shape these decisions, which, was particularly significant in relation to the early stages of therapy for the children in the second phase.

Four research questions were designed to structure the study and allow the aims to be explored:

1. Is it possible to measure and identify the mental health needs of the LAC population using existing scoring instruments?
2. Where there are identifiable problems (as indicated by consensus scores), are Theraplay and Play Therapy useful interventions?
3. 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?
4. What is the validity and usefulness of outcome measures when considering the effectiveness of therapy?

While the number of children considered in this study is small, they represent approximately one third of the therapist's caseload. The children have all experienced significant disadvantage and abuse and have had complex and stressful passages through the care system, which have exacerbated their difficulties as shown below.

Table 2 - *Legal Status and History of the Children in This Study*

Child	**Status during Therapy**	**Legal History**
Heather	Section.31 then Adopted	EPO/ICO/Section.31
Fergus	Section.31 throughout therapy	EPO/ICO/Section.31
Angus	Section.31 throughout therapy	EPO/ICO/Section.31
Kirsty	Section.31 then Adopted	EPO/ICO/Section.31
Callum	Section.31 then Adopted	EPO/ICO/Section.31
Eilidh	Section.31 throughout therapy	EPO/ICO/Section.31

(Key: EPO - Emergency Protection Order; ICO- Interim Care Order; Section.31 Children Act 1989)

The nature of their needs has meant that the therapist working with them is the only person able to undertake such a study, and that it would have been inappropriate for the therapist to have incorporated cases from her colleague therapist while working with such traumatised children. This has meant that the design of the study has been strongly influenced by the need to consider and try to resolve the issue of possible researcher bias. The emerging findings from the early work of the study, led to a second phase of the research with similar safeguards as described in Chapter 3.

1.8 – Summary of Chapter One and Structure of Thesis

This Chapter has outlined the aims, context, purpose and some of the challenges of this study, which will be further explored in succeeding Chapters. The study is about the

effectiveness of Play Therapy and Theraplay and decision making by the therapist. It takes place in an emerging field of work in which historically little research has been undertaken. The most significant feature of this research is that it has been undertaken by the therapist practitioner whose primary role in her contact with the research subjects has been clinical rather than research. This has presented particular challenges in the design and implementation of the research in order to preserve the integrity of therapeutic intervention with highly vulnerable children, while enabling a credible and valid study to be carried out. In the next Chapter, the research and theory that exists in relation to the mental health of Looked After Children, child development, attachment, trauma, Theraplay, Play Therapy, clinical decision making and screening tools will be presented. Chapter 3 will set out the methodology adopted, whilst also considering some of the ethical and design challenges for a study of this nature. In Chapter 4, the results of the first phase of study are presented and further considers the decision making process in the context of the data generated and the need for change within this evolving and dynamic setting. Chapter 5 sets out the results from the second phase of study, including feedback from interviews undertaken and ongoing questionnaire data. Chapter 6 consolidates all the data generated in light of the ongoing research available; it considers what additional insight has potentially been gained into clinical decision making and therapeutic input through the course of this study. Chapter 7 concludes the study by distilling the key findings, considering areas for future research, highlighting the contribution this study has made to theoretical as well as professional understanding and the substantial contribution this study has potentially made to the field of therapeutic input for Looked After Children with attachment-related difficulties.