Chapter 3 – Rationale and Methodology

> There wasn't much in the way of inventing materials. Violet longed for a good room in which to invent things, filled with wires and gears and all of the necessary equipment to invent really top notch devices
>
> (Snicket, 2001a, p. 153).

3.1 - Introduction

This Chapter sets out how the study was designed and implemented and the factors and constraints which influenced decisions about methodology. The two phases involve six detailed case studies of therapeutic intervention for six children over a period of 12/24 sessions and two years respectively. The case studies were undertaken alongside research into the perceptions and experiences of the therapeutic process of the participating carers and other professionals, thereby addressing the two aims indentified at the outset of this research, namely to explore the impact of Theraplay/Play Therapy in work with Looked After Children and to consider the dynamic/evolving nature of therapeutic decision making in such work. 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. Four research questions were designed to structure the study and allow these aims to be explored. The study was then carefully devised in both phases to address the research questions and fulfil the aims, with the ultimate goal of adding to understanding in the field of Looked After Children.

This Chapter describes the way in which a research design was arrived at, decisions were reached on how data was to be generated and collated and the factors which influenced them. This is set out first in relation to Phase One, whose goal was to study therapeutic input 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, for three children, Heather, Fergus and Angus over the first 24 sessions of therapy. The rationale is then set out for Phase Two where three further children Kirsty, Callum and Eilidh were added, and explains how that Phase was designed and implemented.

Additionally, having reviewed what is presently known of LAC children, adversity and therapeutic input in Chapter 2, data collated in this study could then be examined against this literature base. By so doing, this study seeks to elucidate the processes and mechanisms of change within therapeutic intervention, a relatively unexplored area of research, with as much emphasis in the analysis of results on further questions raised as on possible solutions found.

This study adopts a mixed methods approach drawing substantially on the principles of qualitative research (Green *et al*, 1989) whilst also drawing on quantitative data collected from standard assessment inventories and questionnaires (Rossman & Wilson, 1994). Findings are presented as a series of case studies (Miles & Huberman, 1994), as the therapist explores in depth her work and therapeutic decision making in respect of each of the six children selected as case studies. Since the research feeds directly into professional practice, the study is also, in that sense, in line with the principles of action research (Coghlen & Brannick, 2007). The use of a range of methods of data collection arising from these different methodological approaches is in line with the principles of triangulation (Denzin *et al*, 1994) to provide significantly more robust data collection which must withstand comparison and be open to exploration in relation to a shared or divergent meaning.

3.2 - Purpose Of Study

In the Introduction the two main aims of this study were delineated as follows:

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.

3.3 - Design of Study: Initial Methodological Considerations and Scope

At its simplest this study is designed to investigate the changes seen in the presenting behaviour of the child throughout the therapeutic process and grew out of a desire to explore therapeutic intervention for Looked After Children as historically this has been an under-researched area. The therapist became increasingly aware that there is a poor research base for both Theraplay and Play Therapy particularly when working with this child population. The skill and knowledge base available within the LAC Team often exceeds the research available, not only in some forms of therapeutic intervention but also when used to inform assessments and decisions routinely made with regard to a child's or family's therapeutic needs. As such, the therapist wanted to explore this in a more rigorous fashion in the context of the limited therapeutic decision making research presently available, in an attempt to harness some of these available skills when thinking about dynamic and creative approaches.

A number of key parameters and constraints shaped the methodology. This research took place as an integral part of the therapist's day-to-day working practice and could not be allowed to disrupt the work of the LAC Team or cause interruption to or distraction from the therapeutic interventions for the children who were being studied. These constraints encouraged the therapist, when considering the research design, to look closely at the Team's operational processes, the statutory framework and logistical constraints within which they worked and the approaches and tools of therapeutic interventions, to determine not only how the study design could be devised within these requirements but also to look at what elements of Theraplay, Play Therapy and the therapeutic process could be used or adapted to further the research. She found there were therapeutic tools, such as established psychological measures, and organisational and statutory requirements such as supervision and reviews that she could draw on or incorporate into her research.

Her next task then became to identify whether these tools and elements were sufficiently robust for research purposes and, where this was not the case, to find ways to manage any problems for the integrity of the research that might arise from this, for example, researcher bias. Also, once she knew what these tools could or could not deliver in terms of research evidence, she had to work out what additional research tools she needed to find or create to supplement the data collection possibilities she had identified in the system, always acknowledging that all tools had to be able to operate within the constraints of the therapeutic environment and of her role. During the analysis of data generated by Phase One she became aware of limitations, not previously understood, of some existing tools and this led to the initiation of Phase Two where emerging findings in respect of traditional outcome measures could be explored.

Disparity in reporting began to emerge between questionnaire and oral feedback and it was recognised that additional information was required to further explore and understand the therapeutic/decision making processes. Furthermore, the potential importance of life events was emerging from the evidence gathered in Phase One and this called for careful exploration in a subsequent phase. The need to gather more data raised a number of ethical and design dilemmas as to how best to obtain this information whilst also remaining as unobtrusive as possible, given the care with which this had previously been managed. The stakeholders were consulted over a variety of options on how to further elicit the views of those most closely caring for the child. Options included an anonomysed feedback form, group discussion and ongoing analysis of therapy reviews. Everyone was content with the approach adopted.

An anonomysed feedback form would potentially go some way towards managing bias in reporting, but would also limit the amount and scope of information provided, thus somewhat defeating the purpose for which it was devised. A group discussion could seriously compromise the confidentiality of the child, as well as therapeutic integrity, unless very skilfully facilitated. Therapy reviews had been shown to be a rich medium for information gathering, assimilation, reflection and discussion, but were limited due to purpose and focus. Instead it was felt that the information recorded in ongoing therapy reviews could act as a frame of reference for any additional oral feedback generated. This would then increase the triangulation of data and add additional perspective to the idea of bias in oral feedback.

Carefully constructed and managed interviews were then considered. Much weight is given to this form of data generation and analysis in qualitative research literature (O'Conner & Zenah, 2003) especially when triangulated with other methods such as questionnaires and naturalistic reporting. Additionally, the therapist devised a time line record which was designed to facilitate discussion and act as an aide memoire, suitable both for therapeutic and research purposes.

3.3.1 - The Rationale for adopting a Two Phase Approach

It was judged that a two phase approach would strengthen resultant findings, with data from each stage standing both independently and as an aspect of the whole, layering over itself from the different phases adding to the robustness of outcomes. Both phases of this study share the same aims and set out to monitor children's progress through therapy, elicit the views of those most closely caring for them and consider the therapeutic decision making process for each child.

While it was considered that there was a risk that a two phase structure could impact on meaningfulness of results generated, potentially limiting comparability and risking a disjointed presentation, it was felt the holistic case study approach and the safeguards within it would mitigate this risk. The two phases were seen as inextricably linked to each other and to the research aims, and so it was not thought to be valid to adopt an approach where the first phase of this study should be viewed as a pilot and not presented in the main body of the thesis.

Three additional children were added to the study for two reasons: Firstly, it was hoped that questionnaires and oral data completed for these three children would layer over that generated for Heather, Fergus and Angus over their first 24 session period of therapy, thus further exploring the processes of early therapeutic intervention in line with the first aim of the study.

Secondly, in considering the first 12/24 sessions of therapy for Kirsty, Callum and Eilidh, the effectiveness of changes made to service provision at the close of Phase One could be further evaluated. As this is a practice-based study, elements of action research were implemented, and insights gained in Phase One of the research informed and influenced aspects of practice under investigation, which is ethically an important professional obligation in the ongoing quest to improve practice as explored in Phase Two.

An alternative longer term approach to the cases of the six children was also considered but then rejected. Besides lacking the advantages of the layering aspect of the two-phase approach, the purely long term study would not allow the same consideration to be given to assessing the effectiveness of changes made at the conclusion of Phase One.
Further, at this time it was impossible to gauge the long term therapeutic needs of Kirsty, Callum and Eilidh or even to know if they would be placed locally enough to allow their inclusion in a long term study. As it turned out, despite being offered Play Therapy over a total of fifteen months when Callum was placed with his adoptive parents Thora and Hamish, this was several hundred miles away, necessitating a referral to their local CAMHS and ongoing phone consultation as required. In contrast Heather, Fergus and Angus were all in long-term foster/adoptive placements, had been assessed as requiring ongoing therapeutic support and, given the longer term nature of Play Therapy intervention, were expected to remain with the therapist for at least the following two years.

Phase Two was, therefore, concerned with more than simply adding numbers to the study. Such an expansion could not have guaranteed to deliver suitable case study candidates as it is often not possible at the outset of therapy to assess the long term therapeutic needs of the child, placement suitability or geographical location. A key tenet of therapy is that to safeguard the needs of the child, the therapist must evolve with them. Seeking to mirror this approach in the adoption of a research structure which lends itself to such flexibility is an important consideration in maintaining the focus on the primacy of the child’s needs, and underpins the therapist’s decision to undertake her research in two phases, thus incorporating the flexible nature of services often required by parents and children in line with their evolving and dynamic needs.

3.3.2 - Description of Phase One

The first aim of this study was to explore the impact of the use of Theraplay and Play Therapy when supporting Looked After Children assessed as experiencing attachment-related difficulties. In order to achieve this, Phase One analyses 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. In considering ‘definable difficulties’ it was important to clarify what is meant by this term and how such difficulties are defined, measured, assessed and monitored throughout treatment, including an overview of existing screening measures and their reliability. For each child involved, documented evidence arising from screening measures implemented at the outset of therapy and throughout the first 24 sessions of therapy were analysed.

The second aim of the study was 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 reflect upon the dynamic, evolving nature of therapeutic decision making. This was achieved in Phase One by analysing existing documented evidence from therapy reviews recorded in accordance with the Trust’s and Ethics Policies. When thinking about the decision making process in the context of the presenting needs of the child, the emerging question was whether decisions should be made at the outset of therapy which will remain constant and relevant to the child throughout or, as therapy evolves, whether these decisions need to be revisited and the appropriateness of therapy reconsidered and, if so, what the implications for the child and the process are.

3.3.3 - Description of Phase Two

At the conclusion to this first phase of research, a number of questions arose regarding the longer term nature of therapy, the use of existing questionnaires as outcome measures and the impact of changes made to service provision. To address these, Phase Two of the study was devised. While the aims of the overall study remained consistent throughout, four further areas were considered to better enable the therapist/researcher to address the overall aims, in the light of the issues emerging from Phase One.

The four additional areas of study were:

- To explore Play Therapy with the original three children over a further two-year period of intervention.
- To explore the therapeutic decision making process for the original three children over a subsequent two year period of intervention.
- To explore therapeutic intervention and decision making for three additional children over their first 12/24 sessions of therapy.
- To evaluate the impact of the therapeutic decision making process in considering changes made to service provision at the close of Phase One.

In Phase Two, the perception of others involved in the care of the child and present at or with knowledge of therapy reviews, were elicited in order to consider their views of the therapeutic decision making process, in part to counteract the possible effects of researcher bias, and to add the additional dimension of triangulation to the research in line with the principles of a mixed methodological approach described by Bryman (1988)

> ‘Combining qualitative and quantitative methods brings together the strengths and benefits of each whilst reducing their respective weaknesses and limitations’ (p.126)

By continuing to administer questionnaire material throughout the subsequent two-year period of therapy, the therapist was able to gain further insight into considering the effectiveness of existing tools as screening measures. Also, by applying existing questionnaires to the three children joining the study, it was possible to consider the impact of the therapeutic decision to make changes to service provision, and to apply this information to what was hypothesised about the processes of therapy at the conclusion to Phase One.

Therapeutic input for six children in total was considered for the purposes of this study. All were referred to the LAC Team for attachment-related difficulties, allocated within the Attachment Project and assessed as requiring a service. At the outset of both phases of this study ten/twelve children respectively, were allocated to the therapist for direct therapeutic support. Ten children were chosen in total; two were eliminated due to other medical conditions and two families declined the offer to participate. In identifying the children, consideration was given to age, gender, life experiences, home circumstances and factors other than trauma/attachment affecting the emotional wellbeing of each child. Thought was given to ensuring that the children and families chosen for this study were reflective of those receiving a service from the Project and the overall LAC population within the Local Authority.

3.4 - Design of Study: Understanding the Therapeutic Environment and How it can be Utilised for Research Purposes

In this study context is of great significance. It became apparent early on that this study would be looking at phenomena and events in their context rather than phenomena and events being examined outside or divorced from their contexts, as is more common in social science research. Thus the work and therapeutic context would shape the research and the approach taken to it, eventually leading the therapist/researcher to adopt a case study approach which is particularly suited to this type of contextual, long term study, (University of Strathclyde, 2010).

Given the importance of the therapeutic context for the study, the next section describes the therapist's working environment and the Project's processes and describes how she devised a way of working within them and what elements she drew on or adapted for research purposes as she made decisions about how she would undertake her research and ensure its integrity as she fulfilled the responsibilities and requirements of her role.

3.4.1 - Understanding Play Therapy

'It is our belief that to become a competent Play Therapist, one must find a theoretical model that meshes well with both one's personality and the needs of one's particular client base' (O'Conner & Braverman, 1997).

A number of different theoretical models inform the therapist's practice, which has evolved over time and experience as described above:

- Attachment theory – gives insight and understanding of the child's internal working model, the impact of early adversity on the developing ego and of the entrenched nature of early survival strategies on the developing brain.
- Rogerian person-centred counselling – gives insight into the effect of trauma on the child's developing sense of self through the concept of ideal and perceived self. This provides a blueprint for therapeutic intervention and conveys the importance of the therapeutic alliance and the process of reflection.
- Social constructionism – in supporting children in Play Therapy it is important to have an understanding of their social constructs, to help them make sense of their trauma and in acknowledging that the therapist's social construct may be different from that of the child. To support parents/carers to understand their child's presentation and to work with you rather than against you, in co-constructing a new way of being for the child.
- Narrative Therapy – therapist and child explore problems, worries or muddles through storytelling, thus the problem is externalised, can be viewed more

symbolically and helpful endings to difficult problems can be co-constructed between child and therapist.

- Psychoanalytic Theory – therapist is mindful of the unconscious in the child’s play interaction, which is explored through reflection as opposed to interpretation.

In Play Therapy children are given space and time to explore their thoughts and feelings, worries and muddles as they perceive them. Play Therapy is non directive in nature, child centred and child led. Before sessions begin, a home visit is undertaken to explain the Play Therapy process to the child and to ascertain the child’s views on attending sessions. Days and times for sessions are agreed with the child and parent/carer. The therapy room is set out the same every week and no one is allowed to disrupt sessions (unless in emergencies). Sessions are fifty minutes in length and the child is given a five minutes marker that session is ending. During the first session rules are co-constructed between child and therapist so that the therapy room can remain a safe space. However, some rules are essential and will be introduced by the therapist such as child protection which means that sessions can not be confidential but are private.

The room is set up with a variety of toys for different ages and stages of development, allowing children to explore play at their own level of cognitive development or to regress where necessary, taking into account opportunities for:

- Embodiment – sensory play, art/craft, music, beanbags, mats for messy play, gunge, clay, towels, aprons, messy clothes, tactile materials, sand and water play (used throughout stages of play).

- Projection – play , i.e. heroes and villains, witches and wizards, cars, emergency vehicles, animals, fences and scenery, dolls house and family figures, dolls and accessories (clothes, bath and bottle), puppets and puppet theatre.
- Role – material & dressing up clothes (including emergency services), accessories (tools, camera, fairy wings, magic wand…), medical kit, food/kitchenware, phones x 2.

Children are free to choose their own play materials and activities, often flitting between stages of developmental play and cognitive stages.

Parents/carers are not present during Play Therapy sessions, so wherever possible they are supported by a co-worker to help them think about some of the issues arising in session, think through some of the presenting behaviours at home, possible strategies for managing difficult or unusual behaviour, and manage any personal issues which may arise for the parent/carer as the child enters the therapeutic process.

3.4.2 – Understanding Theraplay

As described earlier, Theraplay sets out to directly build the relationship between carer and child by including the carer in sessions from the outset. A lengthy assessment is undertaken prior to the start of therapy (see later), to ascertain the specific attachment needs of each child, and presenting behaviour is categorised according to the four domains of nurture, challenge, structure and engagement. A treatment programme is then designed specifically to target the domains identified, and playful activities are outlined for each identified domain. Child and carer are guided through these activities initially by the therapist, and then supported in undertaking them together. The environment of Theraplay is to be light and playful with specific attention paid to emotional attunement, so that the child is responded to in a way which is sensitive, giving thought to their responses both verbal and non verbal, but ensuring the child is contained, regulated and structured by the therapist.

Sessions are offered weekly, although more frequent sessions can be offered for younger children or in intensive treatment. Sessions are roughly between thirty and forty five minutes in duration, varying according to the degree of difficulty experienced by the child, the age of the child and in response to the child or parent/carer presentation.
The Theraplay room is kept quite plain to minimise distraction, and the Theraplay therapist has all the materials necessary for the session close at hand to prevent a break in activities. Physical contact is maintained, where possible throughout the session, directed by the therapist but facilitated by the parent/carer, helping to minimise anxiety and provide additional containment for the child. Sessions are structured and managed by the therapist. The child's suggestions are heard and responded to, but rarely acted upon, thus the therapist, parent/carer remains in control in such a playful way that it is not threatening or hostile to the child (Chapter 2).

Homework tasks are set at the end of each session and the carer and child are asked to undertake one of the playful or nurturing activities at home. Support is offered by the Theraplay therapist to the carer on a regular basis to discuss the process and any issues arising throughout therapy. Quarterly follow up sessions are undertaken for the year after Theraplay sessions end.

3.4.3 – Process: Assessment, Review & Decision Making

Once allocated within the Attachment Project, families undergo an in-depth assessment to look at the child's attachment relationships, the child's presenting needs, and also the family's ability to engage in any therapeutic support offered. On the basis of this assessment, decisions are made regarding the most appropriate form of therapeutic support to be offered to the child.

There are several stages within the assessment process:

1. Initial Assessment Meeting

Information regarding the Project, attachment and Play Therapy/Theraplay is sent to the carers/parents who then attend an initial meeting with other professionals. At this meeting the questionnaires are reviewed and information is updated. At the end of this meeting a work agreement is drawn up outlining tasks to be undertaken by all present and consent for treatment is also agreed. Following this meeting, either Play Therapy will commence (following a home visit to the child), or a further assessment for the suitability of Theraplay (and in some circumstances Play Therapy) to further assess the engagement of parent/carer will commence as outlined below.

2. Carer Led Attachment Assessment

Parents/carers are invited back to discuss specific difficulties and start thinking about their own attachment patterns. Discussion is informed using some of the items in the Adult Attachment Interview and Attachment Style Interview. However, these are NOT used as diagnostic tools, but as a guide to aid initial discussion and assessment. They are then introduced in more depth to Theraplay. Parents/carers are given the opportunity to go away, think about the information they have been given, and talk about their thoughts around possible Theraplay intervention, given the substantial role they would play in this process. Parents/carers are then invited back to consider in more depth their own attachment history and the Theraplay process. At this point carers may make the decision that Theraplay is not right for them either due to their own history, the demands the process will place upon them, or other unknown factors. Alternatively, the therapist may make the decision that Theraplay is not appropriate; considering another form of therapeutic intervention for child or family, or that a piece of work be completed prior to Theraplay commencing i.e. individual/couples counselling. However, at this point, if all parties are in agreement that Theraplay appears to be indicated, the worker will arrange a home visit to meet the child. At this visit the worker will explain who they are, why they are there and invite the whole family to the clinic to undertake a MIM video assessment (described below).

3. Assessment Report

An assessment report is then completed by the therapist combining all the information gathered throughout the assessment including; history, questionnaire material, MIM video assessment difficulties/needs of the child, child presentation and views of the professional network, carers and child.

4. Review

The assessment report is then shared at a review meeting which is attended by professionals and carers. If Theraplay is indicated, then the work agreement is updated, further consents sought and a treatment plan agreed, after which time Theraplay will commence.

Once therapy has commenced, the professional network, carers/parents and therapist continue to meet regularly. At therapy reviews, information is updated, decisions and rationale for therapeutic decision making are presented by the therapist regarding ongoing therapeutic support. The child is aware throughout therapeutic intervention that the therapist speaks to the grown ups, their views will be sought by the therapist prior to review including worries and things that would be good for the adults to know. Questionnaires are re-administered to parents/carers and a review report is completed. The child's case is also regularly reviewed and discussed in clinical and managerial supervision.

Play Therapy is reviewed initially after 6-10 sessions to consider how the child has settled and their responses to therapy. Reviews are then scheduled to take place roughly every 12 sessions for the duration of therapeutic intervention.

Theraplay is reviewed informally with parent/carer and therapist after 6 sessions. Then after 12 sessions the MIM video assessment is re-administered and later shared with parents/carers. Information from the MIM is included in the review report and a more formal review is held as outlined above. If it is agreed, a further 12 Theraplay sessions should be offered, this process is then repeated for every 12 session block of Theraplay.

A summary report is completed prior to every review, and minutes are taken by the therapist for the purposes of departmental record keeping. These records include information provided in oral reports from parents, carers and professionals.

3.5 - Using Elements of the Therapeutic Process as Research Tools

A review of the framework in which the therapist worked identified the potential value of using or adapting many of these established, validated and routinely implemented instruments which measured need, progress and change and which could be administered in the context of the therapeutic intervention without compromise to that intervention or additional stress to the child or caregiver. Using therapeutic measures and data for research purposes threw up ethical issues which had to be considered and addressed. These are discussed below. These ethical considerations also were crucial to the scope and design of the study, particularly given the operational parameters in which the therapist had to devise and implement the research.

It was immediately apparent that in looking at the decision making process the reports which were integral to the process of therapy reviews would be of considerable value to the study, and in Phase One these reports were further considered in the context of the therapeutic experience, ongoing needs of the child and the decision making process for each over their first 24 sessions of therapy. This was then further examined in light of theoretical and research knowledge identified earlier and presented in Chapter 4.

It was always recognised that the therapeutic considerations had to take priority over the research requirements. Achieving this balance in devising the study was not always easy. It was recognised that the families with whom the therapist was working were families under stress, of whom additional demands could not be made. It was also recognised that the families might have concerns that any reluctance to participate in the study would, despite reassurances, affect the nature of the service they were given, or that being asked to participate was an indicator of some serious concern by the therapist about their circumstances or parenting capacity. The dual role of the therapist was also recognised to present challenges, given that by her presence, let alone her interventions in the family systems and therapeutic process, she would be changing things.

It was recognised, however, that these dilemmas were not unique to this research. The expectations and fears of patients can be a factor in securing participation in clinical audit or trials. Researchers often face problems in evaluating the extent to which their presence, when overt, may be influencing the systems they are studying, although they rarely have the specific challenges of preserving the integrity of the therapeutic relationships. The challenges arising from the context of this research were thus considered surmountable, given the strength of the guiding principle of the primacy of therapeutic considerations, which it was felt could act as a plumb line against which all aspects of the proposed study could be tested. Where there was any concern that the therapeutic imperative would be jeopardised by a particular way of meeting a research goal, that approach would be discarded; where it was felt that the impact on the therapeutic context would not constrain the work of the therapist or the response of the family, then the research aim would be pursued.

Balancing these considerations, the therapist determined, in consultation with colleagues and supervisors, that the following elements linked to the therapeutic process could be adapted and utilised for this study in line with the mixed methodology approach adopted:

- Therapeutic reviews
- Assessment Instruments
- Questionnaires
- MIM Video Assessment
- Supervision

Additionally, other elements were grafted on to the therapeutic process and used both to inform that process as well as the research. For example for the purposes of Phase Two of this study, verbal feedback was also obtained from parents, carers and other professionals through interviews undertaken by the therapist. Verbal feedback from therapy reviews throughout this time continued to be collected and collated as above, in accordance with the Trust's recording policies. These provide an accurate record of discussions and summarised discussion points taken from this documentation (to further protect the anonimity of each child) can be found in Appendices 3 & 4 (marked S. according to the number of sessions completed at the time of each review for easy referencing). Each of these therapeutic/dual therapeutic-research elements is now considered in more detail.

3.5.1 – Interviews

In Phase Two of this study, parents/carers and at least one other key professional were approached to reflect with the therapist on therapeutic intervention offered to child and family, as well as their experiences and perceptions of the decision making process. Those interviewed were asked a set of standard questions grouped around five themes:

1. Could you think back with me to the time X started therapy and describe your child to me? Could you describe your child to me now? What are some of the changes you feel you have seen in your child over this two year/12-24 session period? What role (if any) do you feel therapy has played in your child's life over this time?
2. Having had the opportunity to look at the time line for your child, what were your initial thoughts and reflections? Which (if any) other events would you add (in black) to the time line?
3. If I asked you to think back over the 2 years/12-24 sessions of your child's therapy, could you mark on the time line (in red) where you think major decisions were made about your child? What were your initial thoughts about these decisions? What do you think led to these decisions being made? Did your view differ to the decision made, if so how? I'm just wondering whose view you think may have been most influential in these decisions? Did your view of the decision change, and if so what do you feel influenced this change?

4. Could I ask you to think back with me again now and, this time more specifically think about decisions made regarding X’s therapy, and mark these on the time line, in blue. What were your initial thoughts about these decisions? What do you think led to these decision being made? Did your view differ to the decision made, if so how? I’m just wondering whose view you think may have been most influential in these decisions? Did your view of the decision change and if so what do you feel influenced this change?
5. How do you feel therapeutic services have affected you as a parent/carer /professional? What do you feel you have learnt about yourself as a parent /carer /professional during this time?

Consideration was also given to the parents/carers’ experience of training provided and how accurately they felt that questionnaire material reflected the presentation, changes and experience of their family. In addition, those joining the research in Phase Two were also asked questions relating to assessment, training and support to try and gain insight into the changes made to service delivery, including any unforeseen or unintended consequences.

Carer/Parent – Questionnaires

1. Could you describe to me your experience of completing questionnaire material for your child?
2. Do you feel questionnaire material accurately reflects your child?
3. What if anything would you change about the questionnaires?

Carer/Parent – Training

1. Did you find the training provided useful? If yes, in what way? If no what would you have found more useful?

Carer/Parent – Assessment (Kirsty, Callum and Eilidh only)

1. Could you describe to me your experience of the assessment process prior to starting therapy?
2. Do you feel it prepared you to start therapy? If not what would have been useful?
3. Do you feel the therapeutic services offered to your child were appropriate to their needs and the needs of your family?

Heather, Fergus and Angus had been attending therapy for over two years and consideration was given to appropriate ways of helping parents/carers and other professionals to reflect without bias or the influence of the therapist. In order to assist parents to focus on the key decisions, it was decided to devise timelines of key events for each child - a specimen of which can be found in Appendix 2. Timelines containing three straight lines were drawn for each child; the first line ran through the centre of the page and showed the dates of therapy reviews (drawn to scale), the second line was drawn at the bottom of the page and contained key events in the life of the child as recalled by the therapist (drawn to scale); the third line was drawn across the top of the page and was left blank, as described below:

Figure 1 – *Time Lines*

Top line left blank for therapeutic decisions:

Middle line records therapy reviews, drawn to scale and used to record other decisions made with regard to the child:

Bottom line records major events as recalled by therapist and added to by parents, carers and other professionals:

These time lines were copied and sent out to carer/parent and professionals some time before they met with the therapist. A letter was included (Appendix 1) asking the recipient to consider the time line and reflect on this prior to meeting with the therapist. During the meeting with the therapist interviewees were invited to add on to the time lines events and decisions which they identified as having been significant.

A chronology for each child was devised, incorporating information provided by parents/carers and at least one other key professional, in interviews undertaken and time lines completed. Chronologies reflect the 2 year or 12-24 session period of therapy for all six children and are presented in Chapter 5. These chronologies were designed to allow the reader a more pictorial and accessible reference to the wealth of information generated.

3.5.2 – Qualitative Data Analysis

Summary

With the consent of all participants, interviews were recorded and then transcribed. The transcripts were then anonymised by the therapist using names from a completely different demographic area and all information relevant to Project, Team, Burgh and Trust were removed. Transcripts were read through by the therapist multiple times initially to immerse herself in the data provided and subsequently to allow themes, ideas and information relevant to Play Therapy, Theraplay, decision making and Looked After Children to organically emerge, in line with the principles of 'Thick Description' (Geertz, 2000). All data was colour coded according these themes and ideas which were then categorised within the three research questions explored (Ely, 1996). Data was then put together for each of the three interviewees involved with each child, giving rise to the initial thoughts for each child. These colour coordinated themes and ideas were then explored across all six children and then to consider the broader implications for this child population (Yin, 1994), given further consideration in the light of research presently available in relation to Looked After Children.

Data Preparation

The researcher undertook seventeen interviews in total (three in respect of each child except Eilidh where two interviews were undertaken). These interviews, with the permission of each interviewee and with explicit consent that the data generated would be used to inform this study were recoded on a small dictating machine specifically designed and purchased for this purpose. The Dictaphone was clearly visible to all interviewees, placed on a table directly in front of them, explanation that the oral data from the interview would be transcribed, anonymised and analyzed (with a mind to emergent themes and research questions) was given prior to switching on the Dictaphone. This explanation was also given to each interviewee and time allowed prior to the date of interview to allow all participants to consider their involvement and make an informed decision regarding consent.

The tapes were then transcribed by the team secretary (Morah) who is employed under the strict confidentiality policies and procedures of the NHS Trust. The data was then given to the therapist on a memory stick, she read through the data to ensure it was intact and no significant errors were immediately identifiable. In line with the Trust confidentiality policies and procedures the data was then anonymised on the premises, names from a completely different demographic area where applied and all identifiable material was removed. All original transcripts were destroyed and the tapes stored in line with the NHS recording policies for a three year period.

No analysis was undertaken before the researcher had available the full set of data from interviews, questionnaires and therapy reviews. This was in order to avoid the researcher being influenced by any themes or issues arising from partial data which might not be applicable or relevant when the full data set was available. It was determined because of the diverse natures of the case studies, that there was a need to have a common approach to them and the researcher took some time to consider how best to approach the analysis.

The therapist created five data sets clearly categorized and labeled in the following way:

1. The therapist made five copies of the three/two transcripts in respect of each child
2. The therapist placed the eighty five copies of interviews into individual clear plastic wallets (designed to clip into a larger folder) and attached an adhesive label to each individual wallet with the child's name and the interviewee's name (i.e. Heather – Morag)
3. A copy of each interview undertaken in respect of each child was then grouped into five data sets.

The first data set comprising the three/two interviews undertaken with respect of each child were placed in a series of six black folders which were marked externally with each child's name and control (i.e. Heather – Control). Internally the three/two plastic wallets which were marked with the child's name and the interviewees name were underlined in black to distinguish them as belonging to the control folder. This control set of data was not coded or analyzed in any way but remained unmarked for the purposes of reference and it was this copy which was supplied to the study's reliable friend to consider accuracy of reporting.

The second data set was placed in six green folders and was marked externally with the child's name followed by the words emergent themes, ideas and patterns, the adhesive labels attached to the internal wallets in these folders were highlighted in green.

The third data set was placed in six pink folders, internal labels were highlighted pink and externally labeled with the child's name and research question one (where there are identifiable problems, as indicated by consensus scores, are Theraplay and Play Therapy useful interventions).

The fourth set of data was placed in six yellow folders, internally highlighted yellow and was externally marked with the child's name then research question two (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).

The fifth and final set of data was placed in six blue folders, internally highlighted in blue and externally marked with the child's name then research question three (what is the validity and usefulness of outcome measures when considering the effectiveness of therapy).

This may seem an unnecessarily cumbersome way to approach the data analysis. However, given the therapists decision to combine a priori coding in the form of the three research questions with her wish to allow further codes to arise organically through the exploration of the data it became important to focus on each of these ideas in turn. As the therapist suffers from a registered learning disability which can affect visual stimulus and processing, it became important to ensure that the coding process did not become visually overwhelming. One way of managing this was to identify the desired coding tasks and to separate these. Hence the therapist’s decision to make five data sets and colour co-ordinated each folder in relation to the task to be completed.

Once these data sets had been made the therapist started with the green folders in an attempt to consider the emergent themes, ideas and patterns of the material generated. The therapist took each child in turn starting with Heather and finishing with Eilidh as this was the order the children had entered the study. Then for each child the therapist started with parent/carer and in the case of Heather where both Morag and Rhona were interviewed, the therapist took a chronological approach and started with Morag’s data. When considering the data from interviews undertaken with professionals the therapist started with those thought to have the most in depth therapeutic knowledge of the child due to the nature of the study and then adopted a chronological approach.

Ryan and Bernard (2003) identify two ways to start coding themes emerging through data, firstly through the use of priori ideas and secondly allowing codes to emerge from the data as it is read. Priori ideas can include: previous research or theory; research or evaluation questions in the researcher’s mind, questions and topics from the researcher’s interview schedule and the researcher’s “gut feeling” about the data or the setting. They suggest that typically when coding researchers have some codes already in mind (in the case of this study, the three research questions) and are also looking for other ideas that arise out of the data.

Detailed Example of Analysis

Starting with Morag's interview the therapist read through the data several times trying to clear all other thoughts from her mind and focus on emergent themes, ideas and patterns. Drawing on some of the work of Ryan and Bernard (2003) the therapist considered techniques to identify themes, ideas and patterns including word repetition, key words in context and metaphors / analogies used by interviewees. In line with the principles of 'pawing' the text was scanned and then marked, words circled, underlined or highlighted in green, lines used to connect up possible meaning and then the marked text was explored for patterns and significance. Where the text was marked the therapist employed the principle of 'constant comparison' going back and forth between sections to ensure that they were reflective of an idea or theme.

As different words, phases or emphasis arose in the text and a number of different themes began to become more clearly visible the therapist expanded her coding system using numbers in line with the principles of 'non-hierarchical or flat coding' which does not include sub coding. The therapist made a conscious decision to restrict the analysis of data to flat coding to prevent becoming overwhelmed by visual stimuli which, due to her learning disability, could potentially have compromised data analysis. For example themes arising in Morag's interview such as the stress of Heather's placement would be highlighted in green and numbered one. All sections of text numbered one were then 'compared' with each other to ensure consistency and authenticity for stress. On a separate sheet of paper placed at the front of the folder Morag's numbering would be written along side a significant key word or words for example No. 1 – Stress.

Using the same coding and scoring system for subsequent data themes began to emerge relevant to individual interviewees but also consistent for each child. For example No.3 – Sleep, was an issue consistent to Morag, Rhona and Ishbel. Furthermore as subsequent children's data was analyzed 'constant comparison' allowed not only consistent emergent themes, ideas and patterns for individual interviewees and children but also for all six children. For example No. 4 – School was an issue raised by all seventeen interviewees in respect of each of the six children. Once all of this data had been identified and catalogued it became possible to categorize in accordance with the three research questions and provide additional insight in line with the interview design.

The therapist then took the pink, yellow and blue folders in turn and analyzed the data using the principles described above. However, in addition as she was considering priori ideas the therapist held in mind each research question in turn and reflected these in the colour co-ordination described above. The therapist then used a coding system which reflect the research question and in particular word repetition and key word in context. For example all relevant text to Theraplay was highlighted in pink and marked No.1, all text relevant to Play Therapy was highlighted in pink and marked No. 2, all text relevant to Therapy (general) was highlighted in pink and marked No.3.

At all stages the researcher was open to amending this approach, had inconsistencies or difficulties arisen, which they did not. This approach was further safeguarded by comparing the data generated through therapy reviews with that presented during interviews undertaken. By this stage it was becoming apparent that the interview design and research questions had indeed achieved the purposed for which they were devised and substantial, consistent data had now been generated and presented under each research question for each child.

Quality Assurance to avoid researcher Bias

All anonymous, transcribed interviews were read by this study's reliable friend, Shonaugh (a qualified counsellor with extensive experience of child therapeutic intervention). Shonaugh then read the results as they appear in Chapter 5 and made comments in relation to the accuracy of data as it was presented. The therapist made alterations according to these comments and the results were then read a second time by Shonaugh to ensure that the data as it is presented is a fair and reliable representation of the transcribed interview material. This element of the design was built in to ensure that the interpretation of the evidence is consistent with information provided and that the therapist has not shown significant biases or neglected to include information pertinent to the study.

In addition Shonaugh, Grace, Annabel and Morah all read through the completed text to ensure that no identifying features remained until they were satisfied that child, family and professionals were appropriately anonymous. As previously discussed it is essential that client patient data is handled sensitively and is not unnecessarily shared beyond the therapeutic team. Of the persons involved in assisting the researcher to ensure consistency and reliability in the interpretation of the data, three had access to the material already for clinical and administrative purposes and the fourth was an external independent professional working in a similar area under strict professional codes relating to confidentiality.

3.5.3 – Assessment Instruments

The assessment instruments were an established integral part of the therapeutic process. As their results were being considered this time, as part of the Research Project, in the context of long term case studies and alongside the data from other measures such as structured interviews, questions began to arise about the adequacy and accuracy of some standard measures. The instruments and their relationship to other findings are discussed in detail in this section.

In accordance with the findings of O'Conner and Zeanah (2003), a combination of tools and sources were considered. Three assessment questionnaires were administered by parent/carers and one questionnaire was also administered by school, in an attempt to identify more accurately and quantify the difficulties for each child. The three questionnaires are briefly outlined below. Data was scored either electronically or manually. Interpretations of the data were derived from the accompanying scoring manuals and analysed accordingly.

Strengths and DifficultiesQuestionnaire (SDQ)

The SDQ is a brief behavioural screening questionnaire focusing on 3-16 year olds. The 25 items are divided into five scales; Emotional Symptoms (5 items), Conduct Problems (5 items), Hyperactivity/ Inattention (5 items), Peer Relationship Problems (5 items), Total Difficulties Score (20 items), Prosocial Behaviour (5 items) – this scale is not included in the total difficulties score as it is designed to report helpful and kind behaviour. Higher scores indicate an increased likelihood of diagnosis with total score reflecting the overall mental health of the child.

The SDQ was used in a large national survey of child and adolescent mental health (10,438 5-15 year olds) carried out by National Statistics, funded by the Department of Health (DoH), and was shown to be statistically reliable. The mean score for each of the five scales and total score was generated and means tested for age and gender. A recent study undertaken by Mathai, Anderson and Bourne (2002) looked at the use of the SDQ as a screening measure prior to admission into Child and Adolescent Mental Health Services and concluded:-

> ‘The SDQ is sensitive in detecting emotional and behavioural problems and may be utilised to screen referrals at intake’ (p. 639).

Parenting Stress Index (PSI)

In the study by Thomas *et al.* (1968) the New York Longitudinal Study (NYLS) failed to demonstrate a substantial relationship between infant-toddler temperament and subsequent behavioural function. However, existing research literature at the time demonstrated that it was possible to make gross predictions about the course of developing parent/child relationships and the child’s later development. With this in mind, Richard Abidin and his team of researchers at the University of Virginia explored the published research evidence to identify important stresses in the parenting experience.

In the PSI these factors were identified in three domains: The Child Domain (comprised of 6 subscales); The Parent Domain (comprised of 7 subscales) and Life Stress. Abidin and his team developed questions or items put together in a questionnaire format designed to identify these factors. These questionnaires were repeatedly administered and factor-analysed over a three years period by Abidin & Burke, resulting in a series of modifications. The PSI is now used around the world revealing trans-cultural replication, as well as supporting predictive, discriminant and construct validity, and over 300 research studies have now been undertaken.

In the early 1990s, the PSI short form was developed in response to growing demand for a shorter more time efficient screening tool. Through repeated administration and factor analysis, the original domains were revised and twelve questions, largely from the child and parent domain, were translated across into each of the following subscales; Parental Distress, Parental-Child Dysfunctional Interaction and Difficult Child. Reliability of the test was quickly established and much research now exists to support its validity (Abidin, 1990).

Randolph Attachment Disorder Questionnaire (RADQ)

The RADQ was developed by Elizabeth Randolph at the Evergreen Clinic, Colorado in 1991. It consists of 30 items originating from the attachment symptom checklist. The RADQ has been validity tested through a variety of statistical measures outlined within its manual. The RADQ is not to be used as a sole diagnostic tool and is designed to assist the detection of Attachment Disorder (AD) rather than Reactive Attachment Disorder

(RAD) as outlined within DSM-IV. ‘AD must meet the diagnostic criteria for both RAD and either Conduct Disorder (CD) or 7/8 symptoms of Oppositional-Defiant Disorder (ODD)’. (Randolph, 1997, p 3).

These three questionnaires are designed as screening/outcome measures for child presentation, parent/child relationship and attachment disorder. They measure different areas of difficulty and use varying questions to more effectively elicit the perceptions of those completing the measures. In using this combination of questionnaires, it was hoped to provide a more holistic insight into the presenting difficulties of each child, the perceptions of those completing the material and their experiences of parenting the children.

The purpose of administering these questionnaires is twofold in nature: firstly, at the outset of therapy to act as a screening measure and subsequently as monitoring/outcome measures. Questionnaires completed at the outset of intervention provide insight into the difficulties the child is experiencing as defined in scoring manuals, and help to inform treatment modalities/plans. When considering existing tools as screening measures, it is the scores collated prior to intervention and marked S.0 (Session 0, indicating that no sessions have yet been completed) that are considered.

Questionnaires are routinely re-administered throughout intervention as a comparative measure to quantify changes in presenting difficulties. When considering the effectiveness of existing tools as monitoring/outcome measures, this will be data generated and presented from S.12 (Session 12 or first review) onwards, and considered and compared with previous scores (monitoring) and the final score (outcome).

Marschak Interaction Method Video Assessment (MIM)

The Marschak Interaction Method, (Marschak 1960) or MIM video assessment is a specific assessment tool for Theraplay (Jernburg & Booth 2001). Parents/carers (separately) and child are asked to complete nine playful activities together. These tasks are standardised and each activity is specifically designed to help assess the child's presenting attachment behaviour, as characterised within the four domains (nurture, structure, challenge & engagement). These activities are video filmed and are later reviewed with the parents/carers.

As described earlier, this tool is administered at the outset of intervention and then after every twelve sessions of Theraplay completed. The interactions between parent/carer and child are analysed with a view to informing future treatment plans. At present there is no standardised scoring measure for this assessment and for this reason it is purely a qualitative observational assessment.

3.6 - Design of Study: Considerations in Identifying the Area of Study and Methodology

It was established in Chapter One of this study that the two forms of therapeutic intervention offered in the Attachment Project are not comparable, Theraplay works with parent and child directly in the room building attachment relationships and Play Therapy works through the established therapeutic alliance with therapist to explore trauma and attachment. Acknowledging the non-comparability of these two forms of therapeutic intervention the study instead focuses on the relationship between the intervention and change in the child's behaviour / attachment relationships and the decisions which inform and shape the intervention.

As this study is potentially one of the first of its kind in the UK there were a number of interesting methodological challenges to be faced. Initiating work in uncharted territory required innovative and integrative thinking. The over-riding priority was to address the therapeutic needs of each child and their families, the research process always had to be secondary to this consideration and care had to be taken to ensure that the integrity of the research was preserved while not allowing it to adversely influence or affect the therapeutic intervention. An approach had to be found which supported both the research intention and the therapist's responsibility to be alert to any unintended, adverse effects of the research process.

The lack of directly comparable or established methodology models implementable for this study led to the therapist looking at principles which could be adopted from similar fields in formulating her approach. A case study design was chosen for this research, as it was felt that this was an established methodology for looking at events and phenomena in context, where there were a variety of sources of evidence and variables.

‘Yin argues, case study embraces the complexity of multiple variables and potentially uses a wide range of methods and sources of evidence in order to shed light on the phenomenon being investigated’ (University of Strathclyde, 2010, p.1)

Case studies are a research methodology which allow for the researcher being part of the research context and inextricably linked to its findings, and which is particularly suitable for small samples (Kania, 2008). It was also recognised that a case study approach could handle the longer term dimensions of this research and would allow emerging hypotheses to be formulated and tested while not compromising therapeutic mechanisms and decision making. In doing so, it was hoped to minimise disruption to child and therapy, to allow input from those closest to the child and maximise on qualitative data generated in order to shed light on the phenomenon being investigated. This approach also had the advantage of inherent flexibility, allowing maximum responsiveness to ensuring the priority of the children’s varying therapeutic requirements (Pope, 1995).

In reaching the decision to adopt a case study approach, consideration was given to undertaking this research in alternative ways, such as observing therapeutic interventions by others or having others observe the therapist. However, when considered in the light of the over-riding principle of the primacy of the child’s therapeutic needs and interests, established at the outset, these options were decided against because of the potential detrimental impact the introduction of additional adults and pressures would be likely to have upon the traumatised child, the child’s right to privacy, the therapeutic alliance and the child’s experience of therapy. It was felt the introduction of third parties would fundamentally impact upon the therapeutic experience of the child, thus rendering any consideration of process or decision making meaningless. The adopted approach also had to fit in with the regular practice, processes and resources of the Team. For this reason the possibility of a co-working therapeutic team approach was also discounted, as there was no experience of this approach in the Team.

The use of recorded interviews by other therapists scrutinised by the researcher, or recorded interviews by the therapist scrutinised by other observers, was considered. It was concluded that the complexities involved in the negotiation of this process with the child and carer, who were often both at a particularly vulnerable stage at the point of intervention, would be an additional unwarranted pressure on the child and care-giver. The therapist and her colleagues were also concerned that such discussions at the outset might convey the impression to the child and caregiver that the Research Project was being given more value and priority than their needs and that their worth lay in servicing the Project.

The conclusion was reached that it was in the best interests of the children involved that the therapist would have the dual role of therapist/researcher, even though it was recognised that there would be particular demands on the therapist as researcher to avoid researcher bias. In any kind of research, where the researcher is part of the environment being studied, it is recognised that by its very existence the research process, however carefully constructed, will inevitably change the participants' intervention, and be changed by the research process. The issue for the therapist as researcher was to be alert to even subtle shifts in her approach, occasioned by the knowledge of the Research Project and to note these and consider their impact on her work. For this reason, professional and peer supervision was vital. Additionally, as researcher, she had to ensure that she was handling the data objectively. The safeguards adopted to monitor and counteract researcher bias are discussed in more detail below at 3.9.

It was then determined by the therapist, in conjunction with her colleagues that it was not feasible for the study to include all her open cases (around 20 cases). It was completely inappropriate for certain children to enter the study due to timing, additional needs and family circumstances. It was also important that the choice offered to parents about participation was experienced by them as actual choice particularly as, in engaging with the Project, they found themselves in a situation through their child’s needs, which they would not ordinarily have chosen to be in.

Consideration had been given to selecting an alternative child population for this study, e.g. those cases open to her colleague in the Project (Annabel). This was rejected due to the potential impact upon child and therapy of introducing an unknown adult as researcher. Having decided she would use her own caseload, the researcher was limited to the cases open to her that would allow her to fulfil the nature of the aims and research questions identified for exploration, with children whose interventions were least likely to be affected adversely by the research process and whose presenting problems were in the area of attachment difficulties.

It is recognised that in selecting an alternative child population a number of alternative issues could have been considered, including conditions which mirror attachment presentation and the implications of these for therapy. However, this would be a completely different and, although potentially equally valid research study, not the one selected by the therapist who needed to focus on best meeting her identified aims.

This research thus focused initially on three case studies. These were selected using factors such as the logistics of ensuring feasible data generation, a need to accurately reflect the demographics of this child population within the Local Authority and presenting features of the case. For example, some children were eliminated who had other difficulties which could mimic attachment related presentation in the child and thus interfere with meaningful consideration of change. Willingness to participate was also crucial, as care was taken to ensure no one felt any pressure to take part. The children chosen for this study were representative of the child population within the Project, and were chosen according to their place within their families, their therapeutic needs and presentation. Characteristics of the children chosen for case studies are described in more detail below.

3.6.1 - Planning, Preparation and Methodological Issues Arising

Utilising the standard tools of the therapeutic process, it was decided that in the study, change would be measured by oral reports during therapy reviews and data generated from the Strengths and Difficulties, Parenting Stress Index and Randolph Attachment Disorder Questionnaires. The therapist was thus using existing measures which she had identified as suitable for her purpose and chosen as having minimal impact or drag effect on the statutory and therapeutic processes, and being least intrusive for the children and familes. The therapist then had to confront issues of ensuring consistency and minimising bias.

It was recognised that from the child's perspective any additional contact and data gathering would have to be kept to a minimum in the light of the significant trauma each of these children has experienced and the impact which even the smallest of changes or perceived change can have upon them. The therapist opted to explore their experiences through those closest to them, using systems already in place such as therapy reviews and questionnaires routinely administered.

Written reports were completed at the time of therapy reviews in accordance with the NHS trust recording policies and kept on file. Oral reporting was used for the purposes of this study, due to the organic, naturalistic and diverse nature of discussion in this forum. These discussions were often unpredictable and could not easily be manipulated for any one desirable outcome, due to the diverse professional representation and therefore potentially provide an ideal source of data for this study. The presence of the therapist at review forums does have implications for the objectivity of this research, in terms of both influencing outcomes of the reviews and interpreting data from the reviews, but this is potentially mitigated by the other counterbalancing factors.

While the measures of change in therapeutic intervention are standard and validated instruments, the research study and its process were relatively uncharted territory, necessitating the use of ad-hoc instruments and methodologies to gather data. The therapist had to approach this part of the study with care and had to keep re-evaluating whether these shed any light or understanding on the possible mechanisms of therapy or could further illuminate the decision making process with regard to each of these three children through the first twenty four session of therapeutic input.

This testing of the data was done in three ways: firstly, by ensuring all records were accurately kept, as validated verbally by those present; secondly, in correspondence with appropriate agencies and in cross referencing with other written material generated by other agencies pertinent to each child throughout therapeutic input; thirdly, in clinical and managerial supervision where Manager and Supervisor are privy to pertinent inter and extra agency information relating to each child. The therapist was accountable to explain her processes, working and thinking around each child and to regularly update and justify therapeutic decisions made in relation to them.

3.6.2 - Assessment Instruments

Three screening/outcome measures (questionnaires) were used for the purposes of this study:

1. Strengths and Difficulties Questionnaire (SDQ) – Goodman 1997
2. Parenting Stress Index (PSI) – Abidin 1990
3. Randolph Attachment Disorder Questionnaire (RADQ) – Randolph 1997

All three screening/outcome measures (questionnaires) are accompanied by extensive scoring manuals:

1. SDQ – scored electronically at web site – www.sdq.score.net (Goodman 1997)
2. PSI – scored manually (Abidin 1990)
3. RADQ – scored manually (Randolph 1997)

The questionnaires which the therapist used for research purposes are routinely administered as part of the project procedures for screening, monitoring and outcome assessment and thus did not add any further burden or disruption to the child or family. These particular questionnaires were chosen, as they record slightly different aspects of each child's behaviour and relationship patterns, allowing a more holistic view of their ongoing presentation, needs and potentially change in different areas pertinent to the profile of the Looked After Child. It was thought that the questionnaire data completed by parents and carers would reflect their verbal feedback during therapy reviews and that change would be seen in both arenas throughout therapeutic intervention for each child. It was recognised that questionnaires would not reflect the life events affecting the child or allow for greater discussion of their individual presentation, as this is not a function of such a linear tool. The reaction of families to the questionnaires was in itself an issue which was then further explored.

It was clear at the design stage that case studies in isolation would not provide sufficiently robust data on which to base conclusions because they are more open to challenges of researcher bias. To counteract this concern, present in many forms of qualitative research, it was decided to fortify the data through triangulation from a number of sources to substantiate any potential findings. It was postulated that change would be seen for each child: however it had to be anticipated that this might not be the case, which would require further exploration, and the availability of the triangulating sources could address this need. Additionally, the findings from Phase One, which had not been anticipated, required further exploration. Therefore additional measures of the response to therapy had to be adopted and as such interviews were designed and undertaken in Phase Two of this study to supplement the tools and methodologies already being used.

3.7 - The Therapist as Researcher: Managing Bias

Throughout this research, the therapist had to manage her dual role in therapeutic sessions and multi-agency contexts. One of the most significant areas where data was gathered in this study was in multi-agency reviews. In this context, the therapist had to be mindful of her role, of the need for safeguards to promote objectivity and of her own need to be able to identify and evidence such safeguards. The therapist found that known features of the dynamics of reviews were important elements in providing safeguards against researcher bias.

Those present at therapy reviews knew and agreed that data generated from discussion would be used to inform this study. It could therefore be argued that, as the therapist was present in these reviews, bias in reporting would be seen in the feedback provided, thus limiting the usefulness of this data in considering the impact of therapeutic intervention for each child. Although there is validity in this argument, it fails to take into account a number of factors.

Firstly, the significant risk and pain of each child carried in the individual professions represented. A greater argument could therefore be presented that the risk inherent in these meetings would motivate those present beyond that of reporting bias and necessitate frank, open communication in an attempt to minimise the significant risk posed by each of these children.

Secondly, therapy reviews are a very naturalistic arena in which therapy is the main but not sole focus of interdisciplinary discussion, and therapeutic decisions are the sole responsibility of the therapist. Professionals will present issues, difficulties, concerns and dilemmas to the therapist as the mental health expert, but they all have a vested interest in ensuring their professional responsibilities are met. This often puts professionals at odds within any interdisciplinary setting and it is the therapist's responsibility in therapy reviews to manage the conflicting needs of very different professional agendas and present a mental health perspective, whilst also ensuring that the best interests and needs of the child are protected.

Thirdly, it is a well documented theory in psychoanalytic fields that Looked After Children will project the parts of themselves they struggle with in different settings into different professionals around them, Furniss (1991). The professional network of the Looked After Child has long been characterised by disputes and splitting, as these difficult feelings can be acted out in interagency settings (recognised by Lord Laming and the resultant updated Working Together guidance).

Fourthly, when considered in the context of the level of risk often seen for the Looked After Child, professionals will regularly look for blame where none is to be found. When this is combined with more recent thinking around secondary trauma stress disorder (Cairnes, 2009) which looks at the impact of trauma on those most closely caring for the child a fairly significant dynamic can develop in the interagency arena.

Fifthly, the mental health profession can, at times, be viewed as responsible for ‘stirring up’ the fragile internal world of the child, thus escalating behaviour and risk. In acknowledging these often unconscious processes the mental health professional becomes responsible to navigate through these difficulties and reference back to the global experience of the traumatised child.

These elements potentially further negate the impact of collusion between respondents and therapist, or bias when using oral reports from therapy reviews to inform thinking around the effectiveness of therapeutic intervention and equally act as a bulwark against the possibility that the therapist could ‘go native’ in this setting. (“Going native” is a term which is used for researchers who become too deeply integrated in the ‘culture’ they are exploring to effectively keep perspective in their area of study). To effectively become a participant observer, the therapist must be fully integrated in ‘the culture’ of the Looked After Child and their day to day life experiences, managed by effectively taking a therapeutic role within this culture. The risk of such an approach is that the researcher too closely identifies with the culture and loses their sense of separateness, even to the extent of becoming collusive with the subjects they are studying. The therapist in this study sought to be safeguarded from losing perspective or ‘going native’ in four ways.

Firstly, the therapist is accountable to Manager, Clinical Supervisor, Team, family and the broader professional network. If a Clinical Supervisor or Manager have concerns regarding a therapist’s practice, these concerns would be reported to Manager or Senior Manager respectively.

Secondly, there are discrete systems of accountability, support and supervision within all individual agencies to safeguard the interests of professionals, children and families. If a parent or carer was concerned about intervention, these concerns would be reported to an adoption worker or supervising social worker who would, in turn, explore these concerns simultaneously with both Therapist and Manager.

Thirdly, these systems of accountability are exposed to rigorous internal scrutiny as well as regular external review through the NHS Trust and Social Services. Following external review by the Department of Health, the NHS Trust have been awarded “Outstanding” for five consecutive years and the Team were commended in a recent Social Services review, highlighting the exceptional standards, policy and provision of care.

A fourth safeguard was the use of established systems and processes such as reviews to gather data, combined with the reliance on the persons closest to the subjects as sources of information. This potentially acts to further reduce the impact of reporting bias in therapy reviews, as this forum was already well established before any thought was given to this study and families entered this system regardless of their consent to join the research.

3.8 – The Therapist as Research Interviewer: Managing Bias

Phase Two of this study, in particular, generated a number of challenges in relation to managing bias in the therapist's role as research interviewer. A number of procedural and ethical issues had to be considered prior to the formulation of interviews and time lines.

Firstly, thought was given to who should be approached to be interviewed. It was unanimously agreed that the children themselves should not be approached due to the impact that this would potentially have in their already chaotic lives. It was then agreed that at least two of those most closely involved in the care of the child would be in the strongest position to comment upon their presentation and the likely impact of therapeutic intervention.

Secondly, consideration was then given to who should undertake these interviews. Thought was given to using a third party either distantly known or unknown to the interviewees. However, one of the purposes of this interview structure was to explore not just the processes of therapy, but also some of the disparity starting to emerge in reporting. It was recognised that, in order to achieve this goal, whoever undertook these interviews would need to have an in depth knowledge of the Project, therapeutic intervention and standardised screening tools. This clearly indicates a role for someone closely related to the work being undertaken and given the therapist’s in-depth knowledge of child and family, active working relationships and therapeutic training, it was considered by the Team that the therapist undertaking the role herself would allow for interpretation and close monitoring of responses given.

Thirdly, these working relationships, coupled with the level of risk presented by each child and the distress frequently experienced by those closest to them, require a high degree of honest, open communication which the therapist is both trained and skilled in facilitating. Where difficulties arise, the therapist must use conscious and unconscious processing to gently challenge both spoken and unspoken resistance, uncertainty and avoidance. Using these skills within the semi-structured interview setting, the therapist could facilitate discussion in accordance with the information required. Using her knowledge of and relationship with the interviewees she could challenge any discrepancies in reporting/presentation and gently encourage open, honest communication in accordance with patterns already established.

It was hoped that in employing this method of data collection the feedback from a number of respondents could be generated, adding to the triangulation of the study. Those directly involved in the care of the child would be given the opportunity to reflect on their experiences of therapy, thus directly expanding upon data generated and shedding light on discrepancies arising. With the therapist as interviewer a rich diversity of information could be generated, and any unexplored material could be extrapolated in a useful way.

However, to suggest that reporting bias does not exist where the therapist/researcher is undertaking these interviews would not only be unrealistic, but also potentially quite harmful and ultimately detrimental to the credibility of data generated. To counteract this, a number of steps were taken to try to minimise some of this bias.

Firstly, the therapist met separately with each interviewee to explain the process and how data would be analysed and ultimately used in this study. Each interviewee was then given an Information Sheet (Appendix 5), devised and approved in accordance with the guidelines of the NHS Trust Ethics Committee. Interviewees were then asked to take time to consider this information and discuss their involvement within their families and/or organisations.

Secondly, those interviewees who opted to continue were then asked to sign a Consent Form (Appendix 6) that clearly states that involvement is completely voluntary and that consent can be withdrawn at any time without impacting upon the child’s therapeutic input. Complaints procedures must be provided to all interviewees and further Information Sheets/consent provided for each child/participant to be in the study. In providing as much information and clarity as possible regarding the process, it was hoped to give interviewees maximum choice and encourage appropriate engagement.

Thirdly, interviewees were then provided with time subsequent to the interview to reflect on the process, consider responses/content of discussion and raise any concerns that may have arisen.

Fourthly, supervisors and professional networks external to the therapy setting were also informed of interviews to be undertaken. They were provided with Information Sheets and Consent Forms to allow them to discuss these with interviewees in supervision or support sessions. This provided clear, transparent communication across agencies, empowerment outwith the therapy/interview setting and ensured that the systems in place to protect the individuals involved were informed. Supervisors took an active role in supporting interviewees with consent and refusal as required.

Fifthly, the data generated through interviews undertaken was then referenced against data generated during therapy reviews. As the therapist was present in each setting, it could be argued that reporting bias will be evident in both, thus reducing the validity of referencing these two sources of data. However, as discussed above, the level of risk and professional roles potentially reduce reporting bias at reviews and the two approaches to data gathering could be argued to be quite divergent in nature, therefore allowing greater emergence of disparity where any may exist.

Sixthly, information was gathered from at least two respondents for each child, interviews were undertaken separately and, where any divergence in the reporting between interviewees was noted, this was then used to inform and explore further discussion. However, ultimately little disparity existed between the reports of different respondents and close correspondent was also seen when interview data was referenced against the records kept at the time of therapy reviews. This suggests that reporting bias although undoubtedly present, was managed quite effectively, as it could be argued that greater disparity between interviewees and therapy review reporting would have otherwise been anticipated.

Seventhly, the data was then referenced against questionnaire material and compared with the experiences of the other therapist in the Project and found to be consistent. Beyond this the data generated was then considered by a ‘reliable friend’, with a remit to discern and highlight potential bias by the researcher, who explored raw data in relation to that presented in Chapter 5 as well as considering the design of the interview process and any potential conflict in reporting, should it emerge. Data was then also discussed with the Manager, Clinical Supervisor and colleague to ensure authenticity and professional integrity in this process. Data for each case study was thus generated from more than one screening tool and a number of different respondents, and each process and output scrutinised for signs of bias or inconsistency.

Finally, Play Therapy, like any other serious professional discipline, should be research-informed. It has been similarly argued in relation to teaching that research should be a characteristic "stance" of the educator and that we should strive to create a culture of evidence to enhance professional practice. While being aware of the potential hazards of subjective bias, the challenge for the therapist is to find ways of appropriately engaging in researching her own practice. Given that optimal conditions for therapy minimise unnecessary intrusion into the therapeutic relationship, the introduction of another person could be construed as an intrusion which could undermine the ecological validity of this study as well as potentially damaging the sensitive conditions surrounding therapy and the therapeutic relationship. Such considerations add to the wisdom of using the therapist in situ as researcher, underpinned by robust mechanisms which can be scrutinised for bias and inconsistency in a way which does not disrupt the therapeutic intervention.

3.9 – Consent and Ethical Approval

Given the nature of the children's presenting problems and circumstances and their vulnerability, in preparing to use therapeutic intervention as a vehicle for research, it was important that the study was devised and carried out in a way that was ethically appropriate and that, specifically, the process of seeking and obtaining consent was transparent and sensitive.

All those holding parental rights and responsibilities for each child were provided with information pertaining to this study, (Appendix 5) and fully informed regarding therapeutic input. Consent Forms were signed for the participation of each child within this study and additional Consent Forms were then received from parents/carers for their participation. Finally, Consent Forms were received from each of the seventeen interviewees to allow information generated to be used in this study. Ethical approval was obtained from the appropriate NHS Trust initially for Phase One of the study, and subsequently for the expanded Phase Two. Given the nature of this study, the close exploration of the child’s therapeutic experience, their early history, internal distress and experiences through the care system into long- term families, it was essential that the consent sought was properly informed.

All work based research undertaken through any NHS Trust in England must be presented to an Ethics Committee and gain full ethical approval. Therefore the therapist was duty-bound to present her proposal for work to the NHS Ethics Committee for her Trust, which comprises several senior medical staff and Heads of Department. The committee not only scrutinised the proposal of work but also Information Sheets, Consent Forms (devised in accordance with tightly regulated trust guidelines) and all screening measures routinely implemented. Some changes were requested and re-submitted to the Chair of the Ethics Committee (standard practice) before full ethical approval was granted.

In addition, the Head of Children’s Services for the Local Authority was approached for his consent to allow children and young people in the care of the State to be included within the study. This study was very well received both by the Health Trust and by the Local Authority reflecting both bodies’ interest and willingness to support research and professional development especially in the field of Looked After Children. However, the careful scrutiny of the research process by the Trust and Local Authority also reveals the care and consideration that is taken in ensuring that the interests of the child and family are protected.

Information Sheets were devised at the outset of Phase One of this research and then two further Information Sheets were created for Phase Two to reflect the long term nature of the ongoing study and also to show changes made to service provision as a result of the findings. Information Sheets followed the proforma available through the Trust Research and Development Department, and clearly document in accessible language the research to be undertaken. All parents/carers were provided with an Information Sheet at the outset of Phase One then again in Phase Two and assistance offered to ask questions along with access to an independent professional with whom they could discuss participation and its implications. Families were reassured that participation or non-participation did not affect their entitlement to service or the nature of the service they might receive. These measures ensured that any consent given was fully informed.

The therapist met with parents/carers or social workers (dependent upon who held parental responsibilities for the child) twice prior to the outset of research. In the first instance each respondent was provided with information regarding a range of therapeutic input, a copy of the Information Sheet outlining research to be undertaken and a Consent Form.

A proforma for research Consent Forms is also available to participants through the Trust research and development department. All researchers must then modify these Consent Forms in line with the research they plan to undertake and the therapist adapted hers to allow families an awareness/information on the variety of therapeutic interventions available (Appendix 6).

However, the therapist also had a clinical responsibility to assess each child for the appropriate form of therapeutic intervention and families were fully informed of the therapist's assessment and outcomes. The family was given time to think through the assessment and recommendations of the therapist, to consider a variety of options available, or seek a second opinion within Project, Team or service. Families were then given time to consider therapy and asked to meet for a second time with the therapist before being invited to give consent to participation in the research element of the Project. The Consent Forms include a clear statement of the right of all participants to withdraw from the research at any time without affecting their statutory right to appropriate intervention for their child and those who consented to participate were given a copy of their Consent Form and Information Sheet, along with a complaints form in line with Trust policy.

Information Sheets were also provided to all those being interviewed. Respondents met twice with the therapist prior to providing consent to be interviewed and for this information, suitably anonymised, to appear within this thesis. Therefore, there are two Consent Forms from those with parental responsibility for Heather, Fergus and Angus to participate in this study and one Consent Form for Kirsty, Callum and Eilidh. There are Consent Forms from the seventeen interviewees for information from interview and therapy reviews to appear within this thesis.

The therapist was also required to report back to the chair of the Ethics Committee annually to update her progress in research being undertaken. At the point of expanding this study into a second phase this proposal was again subject to ethical approval which was sanctioned by the Chair of the Ethics Committee, subject to minor changes.

In an attempt to safeguard the anonymity of the children in this study, the therapist has kept all identifying factors to a minimum. Therefore the work setting of the therapist is described only in very general terms and any demographics specifically related to the area of Team/Project have been restricted. However, to make this background information accessible and meaningful to the reader, certain facts pertinent to a full understanding of the study had to be included.

All participants are fully anonomysed and care has been taken to ensure that information included in this study shows no connection to the actual names, geographical or cultural heritage of anyone in this research.

The therapist, in discussion with her tutors, Team, Manager, Clinical Supervisor and parents (those with parental rights and responsibilities) made a conscious, informed decision not to approach the children in this study for written consent at the outset of research instead opting to gain written consent from those with parental rights and responsibilities. The reasons for this are five-fold.

Firstly, there was no planned additional data collection which directly involved the children themselves. Secondly, these children have been so badly traumatised that their ability to build and sustain relationships was initially severely compromised. As the therapeutic alliance grows and strengthens, much of the healing process takes place within this relationship. The child must use all of their available energy to play and think with the therapist. To introduce the idea of research, however child orientated this may be, will inevitably induce stress within the child, activate their defence strategies, close down their capacity to think and add to an already overwhelming burden.

This posed an ethical dilemma, contrasting the child’s right to know they are the subject of research and the therapist’s clinical responsibility to safeguard the child. This then became an issue of timing. As each child came to the end of their therapeutic journey and their internal emotional resources were (in some instances) significantly greater the therapist explored verbally and informally in her ending sessions with each child their role in the research undertaken. Each child demonstrated an understanding (dependant upon age, cognitive capacity, level of stress at ending and place in therapy) of the research process and verbally consented to remain part of the study. Heather who showed the greatest cognitive capacity at ending shared her desire that other adults should learn and understand what it is like to be a Looked After Child believing this would positively affect her experiences and those of other Looked After Children, describing how research such as this could provide a voice for vulnerable children.

This has also been explored with the Team and feeds into an ongoing discussion presently taking place surrounding more formal feedback from children, given the nature of difficulties this client group experiences.

Thirdly, the expert knowledge regarding this child population held within Project and Team is significant. Based on this clinical knowledge and research into the complex nature of the LAC child's development, it was decided that it would be inappopriate to approach these children for written consent at the outset of research.

Fourthly, it was felt that consent from each child would vary according to their place in the therapeutic journey and capacity to make this decision was also variable. Children in the therapeutic process will at times project their self hatred, disgust and darkest feelings into the play and therapist. This is an important part of the process as they externalise these feelings, see them as manageable and begin to be able to integrate them in a healthy way, which allows both good and bad into their conscious thinking. Thus, if a child is in the middle of such a phase in therapy, they will be very rejecting and negative towards their therapist, at other times they may be anxious and desperate to please; at others they may be invisible and wish the therapist only to see the good in them. Under such circumstances it would be difficult to determine how informed any consent might be.

This again potentially supports the therapist's argument that consent/feedback must be subject to timing in accordance with the needs of the child. The therapist's decision to discuss the research process and gain informal, verbal feedback from each child at the close of therapy is potentially significantly more meaningful and ethical than disrupting therapy to gain consent at the outset of research.

Finally, neither the NHS Trust nor Children's Services stipulate that written consent be sought from children under the age of 16yrs for therapy or research (although their views are taken into account throughout the therapeutic process, as described previously). In the same way as a child is not asked directly if they wish to attend the doctor or dentist, the adults around them make these decisions within their best interests. Children's Services are clear on their responsibility as corporate parent and do not feel that placing this additional pressure on a child is appropriate or necessary as long as parental consent is in place from the outset.

The area of child consent is a much researched one in which differing perspectives have evolved some suggesting that it is unethical to undertake research without the consent of the child, whist others raise concerns regarding the validity and meaningfulness of consent for children (David *et al*, 2001).

Eileen Munro in her 2001 study entitled 'Empowering Looked After Children' gained access to fifteen children through social services, undertook semi-structured interviews and concludes that children do not have enough say in the decision making process around then. She describes the risk that professionals may inadvertently 'over protect' the looked after child but sounds a cautionary note that LAC children need help to use power responsibly 'it is as much an issue of parenting as ethics' P. 20.

The Mental Capacity and Mental Health Legislation Guidelines (1999) describe:

‘Competency is something which can be developed over time by presenting the child with information appropriate to their age and level of education’.

This suggests a role for parental discretion in supporting children to make decisions which could potentially be extended to meaningful consent and support the therapist’s decision to approach each child at the end of intervention.

Ondrusek *et al* 1998 conducted a study entitled ‘The Empirical Examination of the Ability of Children to Consent to Clinical Research’. Eighteen children aged 5-18 years receiving a service from Nutritionalists at the Hospital for Sick Children, Toronto volunteered to complete some research. A second study then ran parallel to this research looking at the child’s understanding of the consent they had provided and concluded: ‘This study indicates that most children younger than 9 years of age cannot be expected to consent or assent to clinical research in a meaningful way’ P. 158.

Much child consent research pertains to clinical trials and medical procedures, which has lead the Medical Research Council (MRC) to produce The MRC Ethics Guide, Medical Research Involving Children, 2004. This guidance states that consent must be sought from those holding parental rights (Declaration of Helsinki, 2008) and recommends that consent be sought from children (UN Convention on the Rights of the Child, 1990), depending on the competence of the child, whilst also stating that ‘Verbal informed consent can be as valid as written consent for research’ P. 22.

The issue of informed consent for Looked After Children is not directly addressed instead consideration is given to the idea of competence and ‘the ability to understand and weigh up information’ P. 27. Legally there is no statute which governs the rights of those under the age of sixteen to give consent for medical treatment or research in England. These guidelines instead inform the decision making processes of all NHS Trust Ethics Committees in England who ultimately have the responsibility for ethical clearance without which research cannot take place.

3.10 - Summary of Case Studies

Heather, Fergus and Angus were identified for consideration within the first part of this study and Kirsty, Callum and Eilidh joined the study in Phase Two. The children are of slightly different ages; however, they have similar background histories, were all assessed as suffering from attachment related difficulties and complex trauma when referred to the Project.

Child One - Heather (7 year old, female)

Rhona – Adoptive Mum
Aidan – Adoptive Dad
Ishbel – Adoption Support Worker
Janet – Social Work Manager
Morag – Foster Carer
Florah – Adoptive Cousin

Heather was accommodated at the age of four following numerous Casualty and G.P presentations. She suffered repeated injuries, caused by her birth mother who was later convicted, but no acknowledgement of guilt was made to Heather. No harm has been reported to Heather's older brother or younger sister, who, remain in the care of their birth parents. Concerns were first raised by the nursery and Heather was accommodated after admission to hospital for a non-accidental spiral break to her left arm. Heather was placed with an adoptive family at the age of six. This family had two older birth sons who struggled to accept Heather and she later disclosed emotional abuse whilst in their care. She was returned to the care of her foster mother Morag and was referred to the Attachment Project. Concerns were raised regarding Heather's ability to form meaningful attachment relationships within a new family and also her history of abuse.

Child Two - Fergus (8 year old, male)

Effie – Foster Carer
Dougal – Foster Carer
Inga – Psychiatric Social Worker
Esme – Social Worker
Rory – Birth Older Brother
Stuart – Forensic Psychologist
Scott – Foster Brother
Tarn – Birth Mother

Fergus was removed from the care of his birth Mum (Tarn) aged 3 years old, following a history of chronic neglect and maternal mental ill-health. He was placed with foster carers for eighteen months but was removed from their care following concerns regarding physical and possible sexual abuse. He was placed aged five with his present foster carers Effie and Dougal, and there is presently one older foster child (Scott) also within the home. Fergus has an older brother (Rory) who was also accommodated, but remained fiercely loyalty to Tarn and was often very challenging in placement and school. The boys had contact every month but these contacts were often poorly supervised, fraught and inappropriate. He also has one younger sister who remained at home and Fergus was having supervised contact with her and Tarn four times a year. Fergus was referred to the Attachment Project following concerns regarding his presentation within his foster placement. Fergus was showing aggressive behaviour towards Effie, his behaviour was becoming increasingly difficult to manage both at home and at school (Fergus attends a special educational needs school, although this is being reassessed and a mainstream secondary placement is being sought). Fergus had real issues around control and boundaries within the home.

Child Three - Angus (7 year old, male)

Ailsa – Foster Carer
Blair – Foster Carer
Tarn – Foster Care Link Worker
Iona – Clinical Psychologist
Margaret – Consultant Psychiatrist
Janet – Social Work Manager
Malcolm – Birth Brother
Rover – Family Dog

Angus was removed from the care of his birth mother aged 3 years, following a history of chronic neglect, substance misuse and inappropriate care giving. He was placed in foster care with his older brother (Malcolm) for 2 years and during this time suffered serious physical and emotional abuse. During this time Angus's father came forward to be assessed as a long-term caregiver and contact was initiated as part of the assessment process, despite the fact that Angus had had no previous contact with Dad. During these contact sessions Angus was seriously sexually abused by his father. Angus was then placed with his present foster carers (Blair & Ailsa) when he was five years old, and was referred to the Attachment Project by the clinical psychologist (Iona) in the LAC Team a year later, due to concerns regarding his behaviour both at home and school. Angus would lash out in hysterical temper outbursts, would refuse to undertake simple tasks, suffered from night terrors and would regularly talk to himself about imaginary creatures or baddies.

Child Four - Kirsty (7 year old, female)

Duncan – Adoptive Father
Euan – Adoptive Father
Skye – Learning Support Assistant
Margaret – Consultant Psychiatrist

Kirsty was accommodated aged four, following a history of chronic neglect. Kirsty's birth mother had quite severe learning difficulties, her father worked long hours and another man also lived with the family, sharing her bedroom from an early age. Kirsty was described by her mother as a difficult baby and was persuaded by 'the lodger' to administer large quantities of sedative medication to Kirsty. As a result, when she was finally removed, Kirsty presented as frozen, watchful and extremely delayed. She progressed well in her foster placement, a busy, full household where she remained for nearly two years prior to being placed for adoption with Euan & Duncan. Kirsty was referred to the Project shortly before being placed with Euan & Duncan, as there were some concerns regarding her attachment relationships and peer interactions as highlighted in her school placement, which had been very difficult.

Child Five - Callum (5 year old, male)

Annabel – Therapeutic Social Worker
Lorne – Social Worker
Ina – Foster Carer
Bonnie – Adoption Social Worker
Thora – Adoptive Mum
Hamish – Adoptive Dad
Mhairi – Birth Sister
Coll – Birth Father
May – Birth Mother

Callum was removed from his birth family aged 3 and a half, following a history of severe and chronic neglect. Allegations of sexual abuse had previously been made against his sister's birth father (Coll) who lived with the family, the family had entrenched links with other known paedophiles in the area and there were also concerns around the unexplained death of another child in the family. Callum's birth mother (May) has a history of chronic mental health difficulties and is presently herself accommodated. When Callum was referred to the Project aged 5, he had been living with the same foster family for 18 months. Callum was described as frozen and watchful by his foster mother (Ina). Callum has a history of delay, although he has progressed very well since being removed, and his communication skills are improving. Callum was referred to the Project following concerns regarding his attachment relationships and also his very traumatised, anxious presentation. At the time of referral a family was being sought for Callum and his sister Mhairi, but there were concerns about Callum's delay and Mhairi's age as well as delays in paperwork from Social Services.

Child Six - Eilidh (13 year old, female)

Elspeth – Foster Carer
Campbell – Foster Carer
Maisie – Foster Carer Link Worker
Murdo – Birth Brother

Eilidh had been removed from her birth family aged 7 years old. She had one temporary placement for about a year with her brother (Murdo) prior to being placed in a long term foster placement, which disrupted abruptly and with little explanation after 3 years. Both children were then moved to another placement, where they had been for just over a year when first referred. Eilidh has a number of siblings and half siblings who have all been removed due to neglect and concerns regarding possible sexual abuse, as well as family connections with well known paedophiles in the area. Eilidh has moderate to severe learning difficulties and is thought to function at around six or seven years of age. Both Eilidh and Murdo were initially referred to the Project to offer consultation to the carers who were struggling with some of Eilidh's more challenging behaviour, whilst a referral was made to services locally. Eilidh was presenting with prolonged and destructive tantrums in the home as well as control issues especially around food/eating at home and school. When local services refused to accept the referral, it was agreed that a joint assessment would be undertaken with the senior psychologist (Iona), in case a referral to a more specialist eating clinic was indicated. When an eating disorder was ruled out the issue was thought to be more emotional in origin, so the case was allocated with the Project to support the carers and offer further assessment.

3.11 – Summary

The design and implementation of this study presented several challenges arising from the constraints of the operational context in which it was carried out, the vulnerability of the children and the lack of established methods in the field. The therapist's dual role as researcher was determined to be unavoidable and resulted in reflection opportunities and safeguards being devised and explored to minimise bias.

The two phases of this study developed organically, as the therapist reflected on her practice and on emerging findings. Changes were also made to service provision in line with emerging findings and feedback which supported the promotion of clinical excellence and continuing professional development. In this respect the study could be characterised as involving an element of action research in that the evidence generated in Phase 1 fed into decision making around the researcher's professional practice and that of the project and team. In order to further the two aims of this research the therapist was prepared, despite the increased workload, to expand the study and devise and implement additional methodologies in order to better test and comprehend the emerging findings. The two phases and their results will be considered sequentially in more detail below.