Chapter 4 – Evidence and Analysis (Phase One)

4.1 – Introduction

> 'The expression "It dawned on them"," Which I am about to use, does not have anything to do the sunlight spreading out over Damocles Dock. "It dawned on them" it simply means "They figured something out".
>
> (Snicket, 2001b, p. 212).

Here we can begin to 'figure out' the importance of the Phase One data in considering the two aims of this research namely:

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

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.

Phase One of this study led to changes and modification to service provision offered through the Project as explored below. Its findings led to the development of Phase Two

in order to explore matters, not originally anticipated which had emerged. Phase Two of the study facilitates further exploration of the above aims through the continuing provision of therapy for Heather, Fergus and Angus as well as three additional children Kirsty, Callum and Eilidh. This highlights the organic nature of the study and the need for ongoing evaluation of professional practice towards the provision of excellence in therapeutic services for Looked After Children, as their needs and those of their families evolve and change.

4.4.1 - Structure of Data Analysis

Phase One of this study focuses on the first 24 sessions of therapy for Heather, Fergus and Angus through detailed case studies. Data recorded at regular therapy reviews as well as that generated through the administration of questionnaires is also presented below for each child. The final section of this chapter will then consider this data in light of the literature already collated and reviewed in chapter 2.

Key (all questionnaires):

1. (C) - Questionnaires completed by carers
2. (S) - Questionnaires completed by school
3. S.0 - Questionnaires completed prior to commencement of Therapy
4. S.12 - Questionnaires completed after 12 sessions of Therapy
5. S.24 - Questionnaires completed after 24 sessions of Therapy

4.2 – Heather (Child One)

Rhona – Adoptive Mum

Aidan – Adoptive Dad

Ishbel – Adoption Support Worker

Janet – Social Work Manager

Morag – Foster Carer

Florah – Adoptive Cousin

Jean – Post Adoption Worker

Ross – Foster Brother

4.2.1 - Decision Making (Heather)

There were four key points where the therapist made decisions regarding therapeutic input for Heather over this first twenty four session period:

Initial assessment

At the time of the initial assessment Heather had been back in Morag's care for six months following the breakdown of her first adoptive placement. She was presenting as quite emotionally chaotic, attention seeking and boisterous. Morag although initially quite reserved, became increasingly accepting of support for herself as she found Heather's behaviour challenging and difficult to manage at times. Heather had been told that a new adoptive family would be sought for her and Morag was clear that she should remain in her care until a new family was found. Heather was initially quite ambivalent about having a new family following her previous experiences and close relationship to Morag. The professional network was clear that therapeutic support was being sought to address some of Heather's attachment related difficulties which may prevent her for forming close relationships within a new family. Heather had settled well back into her

school and no problems were reported.

An assessment report was then completed (as described in Chapter 3). Based on this assessment, the presentation of the child, the views of the network, Morag's desire to keep Heather in placement, her willingness to engage in the therapeutic process and receive support, the therapist made the decision to offer Theraplay. She felt that this would directly address some of Heather's presenting behaviours, provide direct support for Morag, enhance the attachment between child and carer thus nurturing resilience as a basis for forming a more meaningful relationship within a permanent family when one was found.

Urgent review after eight sessions

After eight sessions of Theraplay an urgent review was held following concerns raised by Morag and a change in Heather's circumstances. Morag reported a closer relationship with Heather but in noting this she also reflected a need to protect them both as a new family was sought for Heather. Morag commented that she found it difficult to undertake homework tasks when Heather's behaviour had been attention seeking, defiant or challenging. Morag noted a regression in Heather's behaviour and an increase in her anxiety which appeared to be directly related to the family finding process. On reflection in supervision it was agreed that despite potentially building resilience for an adoptive placement Theraplay was facilitating an emotional closeness at a time of uncertainty.

In response to the changing needs of both child and carer Heather's therapist made the

decision to offer a period of Play Therapy, in which Heather would be given time and space to explore her anxiety in a safe and contained way. As she had responded well to Theraplay, Heather's therapist would consider offering this again in the context of her new family, once she had settled with them. The same therapist continued working with her as a level of trust had been established and Heather had been able to engage despite her early reservations.

Twelve session therapy review

A review was scheduled four sessions into Play Therapy. One adoptive family had been identified but then ruled out as they had a birth child just a little older than Heather. Morag was really struggling to engage Heather, keep her on task and focus her thinking. Heather had become increasingly attention seeking and had regressed exploring some of her thoughts and worries around having a new family. Heather's social worker was becoming increasingly concerned that a new family would not be identified for her and alternatives were sought should the placement break down. Increased support was offered to Morag both from her link worker and from Heather's therapist.

Heather engaged very quickly in the Play Therapy process, which was at least in part due to her established relationship with the therapist. She was very eager to present as good and perfect and many of the early sessions were spent trying to explore some of her internal confusion. Heather presented as a child who was trying to remain contained and manage her strong emotions, when unable to do so she would become overwhelmed by shame and guilt and the situation would escalate. The need for Heather to have an outlet

became increasingly important as her external world became more unpredictable and she desperately struggled to hold on to whatever shreds of control she could find.

Twenty four session therapy review

By session twenty four of therapeutic input (session sixteen of Play Therapy) a potential new adoptive family had been identified but they were still in the very early stages of assessment and the outcome was unclear. Morag was finding Heather's presentation increasingly challenging and was clearly indicating that she would do everything she could to maintain the placement but this was now at breaking point.

In the decision making process the therapist remained clear in her perception that it would not be within Heather's best interests to move from Morag. Whilst acknowledging the mounting pressure on the placement; Heather's close relationship with Morag was seen a strong resilience factor which if approached sensitively could be used to foster other close and meaningful relationships in the future. Also the importance of continuity, trust, being claimed and a positive ending strengthened this belief.

Morag continued to work closely with the therapist seeking advice, acknowledging the difficulties, exploring how this impacted upon their relationship, utilising strategies, seeking respite from within her own network when needed and maintain open communication with Heather. Morag was initially reluctant to fill in questionnaires feeling these were not relevant to her as a foster mum but increasingly engaged in this process as trust was developed with the therapist and the importance of this information

became clear in working together and informing discussions. School had also noted an increase in Heather's anxious behaviour within class and for the first time were seeing a small but definite decline in her behaviour and academic achievement.

Consideration was given at this time to increasing Play Therapy sessions to twice weekly, as Heather was now engaged in the therapeutic process and bringing a lot of her anxiety through play. Heather now had a much needed outlet, but this exploration was also likely to be having an impact on her presentation and behaviour as she started to connect with some of her feelings. Morag had consistently supported Heather in thinking things through and Heather had readily taken worries to Morag throughout their second placement together. As such, Heather's therapist made the decision to offer Morag more support and consultation as she worked with Heather, thus minimising any further disruption to Heather's routine.

4.2.2 –Questionnaires (Heather)

Strength and Difficulties Questionnaire (SDQ)

Table 3 – *SDQ: Raw/ Band Scores (Heather S.0-24)*

		Session Number			
		0 (S)	**0 (C)**	**12 (C)**	**24 (C)**
Emotionality	(R)	0	6	7	7
	(B)	Average	High	Very High	Very High
Conduct	(R)	10	8	10	10
	(B)	Very High	Very High	Very High	Very High
Hyperactivity	(R)	2	10	9	10
	(B)	Average	Very High	Very High	Very High
Peer Relationships	(R)	2	4	7	8
	(B)	Average	High	Very High	Very High
Prosocial Behaviours	(R)	4	5	1	2
	(B)	Low	Very Low	Very Low	Very Low
Impact on Child	(R)	0	10	9	5
	(B)	Average	Very High	Very High	Very High
Total Score	(R)	14	28	33	35
	(B)	Slightly Raised	Very High	Very High	Very High

Key (SDQ only):

1. (R) – Raw score generated from questionnaire
2. (B) – Score band (as defined in Chapter 3)

Table 4 – *SDQ: Diagnostic Prediction (Heather S.0-24)*

	Session Number			
	0 (S)	**0 (C)**	**12 (C)**	**24 (S)**
Any Diagnosis	Medium Risk	High Risk	High Risk	High Risk
Emotional Disorder	Low Risk	Medium Risk	Medium Risk	Medium Risk
Behavioural Disorder	Medium Risk	High Risk	High Risk	High Risk
Hyperactivity/ Concentration Disorder	Low Risk	Medium Risk	Medium Risk	Medium Risk

Parenting Stress Index (PSI)

Table 5 – *PSI: Score and Percentile (Heather S.0-24)*

	Session Number		
	0 (C) Score /%	**12 (C) Score %**	**24 (C) Score %**
Defensive Responding	13 / 45%	14 / 60%	21 / 79%
Parental Distress	#27 / 60%	#26 / 55%	41 / 96%
Parent – Child	33 / 97%*	33 / 97%*	37 / 99+%*
Difficult Child	47 / 98%*	52 / 99+%*	40 / 95.5%*
Total Stress	107 / 98%*	111 / 99%*	118 / 99+%*

It is worth noting that Morag was initially reluctant to complete this section due to its lack of perceived relevance for full-time foster carers.

*Any score over the 85% (except Defensive Responding) is deemed to be clinically significant, Abidin (1990)

Randolph Attachment Disorder Questionnaire (RADQ)

Table 6 – *RADQ: Score/Sub-Scores (Heather S.0-24)*

	Session Number		
	0 (C)	**12 (C)**	**24 (C)**
SSM	66*	53*	67*
SSC	42*	56*	49*
Total	66*	85*	80*
Qu. 30	5	5	5

* Clinically significant score, SSC – 33, SSM – 47, Total - 65
SSM - Sum of Scores for Maltreatment, SSC - Sum of Scores for Conduct

Marschak Interaction Method (MIM) Video Assessment

Heather and Morag undertook a MIM video assessment prior to the outset of intervention. The MIM showed clear signs of attachment related difficulties most noted in the domains of structure and nurture. However, due to the pressure upon the placement at the time Theraplay ended a second MIM video assessment was not undertaken so no comment can be made regarding possible changes observed through this tool.

4.2.3 – Reflection

Heather's questionnaires do not reflect any major changes in her presentation over the first twenty four sessions of therapy and if anything would suggest her presentation worsened. Questionnaires appear to reflect the stress Morag was under throughout this time. 'It must be remembered that the total stress index does not include stresses associated from other life roles and life events so should never be interpreted as anything more than an indication of stress level experienced within the role of parent' (PSI test manual p. 19).

The PSI suggests Morag was managing very challenging behaviour, possibly suggestive of psychopathology (not further explored due to therapeutic input), an increased risk of abuse due to frustration, the need for ongoing parental support (as received), Morag is adjusted to the parenting role whilst not experiencing personal adjustment difficulties and the need for a more intensive child orientated intervention as reported at S.0/12 but no longer present by S.24 following sixteen Play Therapy sessions (PSI test manual).

SDQ band scores remain consistently very high/high or very low; the RADQ suggests that Heather was suffering from attachment disorder; consistently high Parent-Child score (PSI) suggests that Morag perceives her bond with Heather to be under threat and the SDQ suggests a high/medium risk in all diagnosis categories throughout this period. However, it is also worth noting questionnaires completed by Heather's class teacher generally score lower than those of her carer.

Therapy was changed from Theraplay to Play Therapy at session 8 and it is worth noting a couple of minor changes in presentation at session 12. Difficult child (PSI) is at its highest level at session 12 decreasing to its lowest level at session 24. However scores remain clinically significance throughout. (RADQ) total score is highest at session 12. There are some minor changes in raw/band score of SDQ over this period. Morag reported an increased emotional closeness to Heather following 8 sessions of Theraplay which may account for the increase in emotionality (SDQ) at session 12. She also reported increased difficulties in Heather's relationships within the home which may reflect the changes seen in scores for prosocial behaviours and peer relationships. This may also be reflected in her perception of the impact these difficulties had upon Heather.

4.3 – Fergus (Child Two)

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

4.3.1 – Decision Making (Fergus)

There were four key points over the first twenty four session period where decisions were made regarding therapeutic input for Fergus:

Initial assessment

Fergus had been in the care of Effie and Dougal for four and a half years when his case was allocated within the Team and the professional network were anxious that he should receive appropriate support. Fergus presented as a very angry young man regularly lashing out, spitting or attacking others in the home, particularly his foster mum. Fergus could be very calculating and malicious in his assaults. He would regularly insist that his actions were accidental, due to his special educational needs or that Effie, Dougal or Scott were lying. Effie and Dougal although concerned by this behaviour found it difficult to enforce boundaries, accepting Fergus' assertions thus leaving him with an age inappropriate sense of omnipotence and power within the family. There were some concerns regarding sexual abuse within a previous foster placement and some inappropriate sexualised behaviour had been noted in Fergus' time with them.

Fergus' contact with Tarn and his sister was fully supervised and on the whole fairly positive. However, his contact with Rory was often poorly supervised and Tarn would use this opportunity to phone Fergus or pass messages largely pertaining to his placement and her authority. Effie and Dougal often noted a marked increase in Fergus' anxiety and challenging behaviour after these contacts.

School reported that Fergus' behaviour could be challenging and there were some historic concerns around sexualised behaviour, but on the whole they were very positive about him and tried a variety of strategies to engage him.

An assessment report was completed (as described in Chapter 3) and in light of this assessment, his bullying/rejecting relationship with Effie and the support needed for the carers, the therapist made the decision to offer Theraplay. It was hoped that Fergus could be supported to form closer relationships with Effie and Dougal and they could be supported to enforce clear, manageable, age appropriate boundaries in a non-rejecting and safe way. Consultation was also offered to the social worker in addressing issues of contact with the birth family and with school on a needs led basis.

Twelve session therapy review

At the twelve session review, Effie and Dougal felt that Fergus had been presenting as significantly more settled with them seeking appropriate physical closeness, spontaneously more affectionate and less rejecting of Effie. Effie also reported feeling stronger within herself and more able to stick to the clear boundaries outlined both in therapy sessions and individual sessions with the carers. However, some concerns still remained regarding consistency, engagement and following through on strategies implemented.

Fergus was able to engage in sessions and enjoyed the combination of playful, nurturing activities. Effie and Dougal at times struggled to maintain the parental role leaving the therapist to take firm control and boundary everyone in activities undertaken. Both Effie and Dougal undertook homework tasks with Fergus between sessions and Effie reported feeling a real closeness to Fergus especially when undertaking nurture tasks.

Due to a number of factors sessions were not being undertaken on a regular basis: a lot of sessions had been cancelled by Effie and Dougal; Fergus could be very controlling around attendance; there were long absences when the carers went away over holiday periods and homework tasks really suffered over these absences. In the end it took nearly ten months to complete twelve sessions.

Effie and Dougal noted a marked increase in Fergus' defiant, anxious, volatile and sexualised behaviour following ongoing contact with Rory. This behaviour presented as quite cyclic in nature and when Fergus calmed and settled back into family life (as described above) he would often disclose unsupervised contact with Tarn and fears / worries arising from this contact. At this review a clear strategy plan was agreed and tasks divided between the professional network. The therapist provided ongoing weekly Theraplay sessions, more regular consultation to the carers focussing on strategies to be implemented with in session / at home and one direct work session around sexualised behaviour with Fergus and his family.

The social worker agreed to meet with her manager to discuss issues of contact and the supervising social worker agreed to support Effie and Dougal in strategies relating to behaviour management (in consultation with therapist). Strategies were discussed in this meeting for managing Fergus' behaviour at school and regular liaison / updates with the broader professional network regarding his presentation in class were requested. Given Fergus' ability to engage in Theraplay and his ongoing difficulties at school, his therapist offered him a place in a small Theraplay Group, thus targeting both peer and family

relationships.

Urgent review after eighteen sessions

Three months later an urgent review was held following a further six family Theraplay and six group Theraplay sessions. Effie and Dougal were reporting a marked increase in violent and sexualised behaviour within the home. Both Effie and Dougal although fully acknowledging their increased closeness to Fergus were struggling with homework tasks in light of his violence and concerns still remained regarding consistent boundaries and clear parental role. Fergus had settled well into the group and was keen to finish the final two sessions with his peers.

Shortly after the twelve session review Fergus discovered Tarn was six months pregnant with her fourth child in an unsupervised phone call and an ill-advised contact officer allowed him to go to the family home unsupervised. He was shown a picture of a man Tarn said was his father and again told he would be returning to her care. At this time Effie and Dougal also decided not to adopt a young female child having discussed this with Fergus and Scott, without any consultation with therapist or network.

Following this series of events and the marked escalation of challenging behaviour his therapist made the decision to change therapeutic modality and offer Fergus Play Therapy. He clearly needed a therapeutic space that was his own to explore his worries and anxieties that laid no expectations upon him to grow closer to his carers when his emotional world was so chaotic and unpredictable. At Fergus' request Play Therapy

commenced following the final Theraplay group sessions and Inga, Psychiatric Social Worker to the Team, was identified to offer ongoing fortnightly support to Effie and Dougal. Esme had consulted with her manager and plans were agreed to reduce contact with Tarn as well as closely monitoring contact with Rory. Effie and Dougal's supervising social worker agreed to continue offering increased support and informal respite. School continued to report concerns regarding his presentation and sexualised behaviour. It was acknowledged that school had not acted upon the offer of support from the therapist and so agreed to liaise more closely with Inga.

Twenty four session therapy review

A review was scheduled six sessions into Play Therapy intervention to monitor the situation and maximise support to Fergus. At this point Effie and Dougal where once again reporting a much more settled presentation from Fergus. Fergus had quickly engaged in the therapeutic process and was bringing his internal confusion on a weekly basis as well as his murderous feelings towards his new brother. Fergus responded well to therapeutic boundaries and was showing little resistance to attending.

Inga was liaising closely with Esme and working to structure contact more clearly with Rory whilst reducing contact with Tarn. Inga continued to offer fortnightly sessions to Effie and Dougal and liaise closely with the therapist. The Team manager (Grace), Inga and Fergus' therapist met to discuss concerns raised by school and Inga wrote to clarify the need for a risk assessment within class and offer further support as requested.

4.3.2 –Questionnaires (Fergus)

Strength and Difficulties Questionnaire (SDQ)

Table 7 – *SDQ: Raw/ Band Scores (Fergus S.0-24)*

		Session Number			
		0 (S)	**0 (C)**	**12 (C)**	**24 (C)**
Emotionality	(R) (B)	1 Average	8 Very High	9 Very High	8 Very High
Conduct	(R) (B)	6 Very High	6 Very High	8 Very High	6 Very High
Hyperactivity	(R) (B)	8 High	8 High	8 High	8 High
Peer Relationships	(R) (B)	7 Very High	5 Very High	5 Very High	8 Very High
Prosocial Behaviours	(R) (B)	4 Low	6 Low	10 Average	7 Slight Low
Impact on Child	(R) (B)	2 High	10 Very High	5 Very High	0 Average
Total Score	(R) (B)	22 Very High	27 Very High	30 Very High	30 Very High

Key (SDQ only):
1. (R) – Raw score generated from questionnaire
2. (B) – Score band (as defined in Chapter 3)

Table 8 – *SDQ: Diagnostic Prediction (Fergus S.0-24)*

	Session Number			
	0 (S)	**0 (C)**	**12 (C)**	**24 (C)**
Any Diagnosis	High Risk	High Risk	High Risk	Medium Risk
Emotional Disorder	Low Risk	Medium Risk	Medium Risk	Low Risk
Behavioural Disorder	High Risk	High Risk	High Risk	Medium Risk
Hyperactivity/Concentration	Medium Risk	High Risk	Medium Risk	Low Risk

Parenting Stress Index (PSI)

Table 9 – *PSI: Score and Percentile (Fergus S.0-24)*

	Session Number		
	0 (C) Score /%	**12 (C) Score %**	**24 (C) Score %**
Defensive Responding	24 / 99%	21 / 96%	16 / 80%
Parental Distress	41 / 96%*	36 / 90%*	29 / 79%
Parent – Child	31 / 96%*	26 / 86%*	37 / 99+%*
Difficult Child	43 / 96.5%*	46 / 97%*	38 / 94%*
Total Stress	115 / 99+%*	108 98%*	120 / 99+*

*Any score over the 85% (except Defensive Responding) is deemed to be clinically significant, Abidin (1990)

Randolph Attachment Difficulties Questionnaire (RADQ)

Table 10 – *RADQ: Score/Sub-Scores (Fergus S.0-24)*

	Session Number		
	0 (C)	**12 (C)**	**24 (C)**
SSM	47*	50*	43
SSC	36*	37*	35*
Total	57	64	58
Qu. 30	5	5	5

* Clinically significant score, SSC – 33, SSM – 47, Total - 65
SSM - Sum of Scores for Maltreatment, SSC - Sum of Scores for Conduct

Marschak Interaction Method (MIM) Video Assessment

Effie, Dougal and Fergus all undertook a MIM video assessment prior to the outset of intervention. The MIM showed clear signs of attachment related difficulties most noted in the domains of structure, nurture and engagement. A subsequent MIM video assessment was undertaken following 12 Theraplay sessions and observation of the 9 tasks completed suggested clear indications of improvement; most notably within the domains of nurture, engagement and in the case of Effie structure. In light of this assessment, questionnaire data completed and oral reports of carers/professionals the

additional domain of challenge was added to the treatment plan and implemented in sessions 13-18.

4.3.3 - Reflection

Therapy was changed from Theraplay to Play Therapy at session 18 and it is worth noting a couple of minor changes in presentation at session 12: Parent-Child subscale (PSI) drops to 85% which is right on the cusp of significant levels suggesting Effie and Dougal no longer perceive their bond with Fergus as under threat; the RADQ score rises to its highest level 64 which is right on the cusp of significance (65 & above) suggesting behaviours very close to indicating AD; difficult child score (PSI) and emotionality / conduct (SDQ) rise very slightly at session 12 suggesting the presence of ongoing challenging behaviour, as reflected by Effie and Dougal. It may be worth noting that Effie and Dougal were reporting a fairly settled period for Fergus at this time and an increased closeness to him (as reflected in the PSI and SDQ impact on child). Total stress levels were also slightly reduced at session 12 but remain clinically significance. An increase in prosocial behaviours would appear to correlate with Effie and Dougal's reports of increased stability and closeness.

Some changes in presentation were also noted at session 24 following a change to Play Therapy: Parent – Child (PSI) score increased dramatically going from borderline clinical significance at session 12 to its highest level (99+%) at session 24, suggesting the parent child bond is under threat, this may reflect the increase in challenging behaviour particularly towards Effie as reported at Sessions 18 & 24; Parental Distress (PSI) drops

below clinically significant levels to 70% and may reflect Effie's reports of feeling stronger in the parental role; the perceived impact upon Fergus (SDQ) drops even further and may reflect some of the frustration and disappointment Effie and Dougal felt as Fergus once again became very challenging following the birth of his younger brother and they perceived him to have limited insight into his behaviour.

Effie and Dougal report a decline in all diagnostic categories throughout the first 24 session period of therapy. RADQ scores do not indicate AD but instead suggest attachment related difficulties or possibly conduct disorder mirroring AD. The PSI suggests carer is managing very challenging behaviour, a decrease in behaviour suggestive of psychopathology, a decreased risk of abuse due to frustration, Effie and Dougal are adjusted to the parenting role whilst not experiencing personal adjustment difficulties, a need for ongoing parental support (received throughout) and at week 24 a need for a more intensive child orientated intervention (reflected in the change from Theraplay to Play Therapy at session 18) – PSI test mannual. Effie and Dougal perceive their bond to be strongest with Fergus at sessions 12 reducing significantly again by session 24. This would appear to support oral reports of the effectiveness of Theraplay whilst also reflecting the impact of external events within the birth family.

4.4 – Angus (Child Three)

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

4.4.1 – Decision Making (Angus)

There were three key points over the first twenty four session period where decisions were made regarding therapeutic input for Angus:

Initial assessment

Angus unlike either Heather or Fergus was referred for Play Therapy from within the Team. He had been fully assessed by the Senior Clinical Psychologist, Iona and was presenting as an extremely traumatised young man. Angus would regularly lash out at his carers and within school. He often talked to himself and there had been concerns that he may be hallucinating. Following detailed consideration of the information provided, close liaison with Iona, a network referral meeting and meeting with Blair and Ailsa the therapist made the decision to offer Play Therapy to Angus.

Careful consideration of therapeutic input had also been provided in supervision. Angus was clearly presenting as very traumatised but also with attachment related difficulties

due to his early experiences. Consideration was given to offering Theraplay to allow Angus a closer relationship with his carers, especially Ailsa. However, there were real concerns regarding the accessibility of such treatment for Angus given his extremely traumatised presentation. It was felt on balance, with all the information provided that Angus needed therapeutic input to work on the trauma he had experienced first, then consideration could be given to a period of Theraplay with Blair and Ailsa.

Blair and Ailsa were extremely committed to his care but needed a lot of advice and support given the level of his presenting difficulties. School really struggled with Angus' behaviour and his global learning delay. For these reasons it was agreed that Iona would remain involved in the case and would work with the carers and network.

Twelve session therapy review

Angus was initially wary of the therapy process and quite chaotic in play. He found endings extremely difficult and even with preparation several early sessions over ran. By session twelve, Angus was well established in the therapeutic process and trust was beginning to develop with therapist. Angus although still quite chaotic during sessions, was starting to bring clear themes of fear, terror and mis-trust in his play which was explored therapeutically. He was increasingly able to tolerate the reflective process and when he referred to seeing things within the room this became increasingly meaningful. Strategies and rituals for managing beginning and end of session had been established easing these transition periods.

Angus behaviour remained challenging within the home and at school and Iona continued to offer support. Play Therapy continued as Angus was engaging in the process and there was nothing to indicate a change in therapy at this point of intervention.

Twenty four session therapy review

Following twenty four sessions of Play Therapy, Angus was fully engaged in the therapeutic process. There were times that he found it hard coming through to the therapy room due to the nature of play being explored, but was able to use his strategies and rituals at these times. Angus' play was quite repetitive in nature but not as chaotic as it had been and he was really beginning to make use of the reflective process in play.

Angus was beginning to presents as slightly more settled within the home and his carers were considering a holiday for the first time with him. School were continuing to struggle with Angus in class but were working closely with Iona and the assistant psychologist was going into class to undertake observations. Iona offered ongoing support and was considering a psychiatric assessment of Angus following home and school concerns. Angus therapist felt he should be given more time to engage in the therapeutic process and issues relating to school needed further resolution to properly assess his presentation and possible psychiatric needs. Play Therapy continued as Angus was engaging in the process and there was nothing to indicate a change in therapy at this point of intervention.

4.4.2 –Questionnaires (Angus)

Strength and Difficulties Questionnaire (SDQ)

Table 11 – *SDQ: Raw/ Band Scores (Angus S.0-24)*

		Session Number			
		0 (S)*	**0 (C)**	**12 (C)**	**24 (C)**
Emotionality	(R)		5	6	6
	(B)		High	High	High
Conduct	(R)		6	7	8
	(B)		Very High	Very High	Very High
Hyperactivity	(R)		10	8	9
	(B)		Very High	High	Very High
Peer Relationships	(R)		2	3	2
	(B)		Average	Slightly High	Average
Prosocial Behaviours	(R)		9	8	8
	(B)		Average	Average	Average
Impact on Child	(R)		8	10	9
	(B)		Very High	Very High	Very High
Total Score	(R)		23	24	25
	(B)		Very High	Very High	Very High

Key (SDQ only):

1. (R) – Raw score generated from questionnaire
2. (B) – Score band (as defined in Chapter 3)

Table 12 – *SDQ: Diagnostic Prediction (Angus S.0-24)*

	Session Number			
	0 (S)*	**0 (C)**	**12 (C)**	**24 (C)**
Any Diagnosis		High Risk	High Risk	High Risk
Emotional Disorder		Medium Risk	Medium Risk	Medium Risk
Behavioural Disorder		High Risk	High Risk	High Risk
Hyperactivity/Concentration		Medium Risk	Medium Risk	Medium Risk

* Despite repeated attempts it was not possible to locate questionnaires administered by Iona and completed by school at the outset of intervention.

Parenting Stress Index (PSI)

Table 13 – *PSI: Score and Percentile (Angus S.0-24)*

	Session Number		
	0 (C) Score /%	**12 (C) Score %**	**24 (C) Score %**
Defensive Responding	14 / 60%	8 / 4%#	13 / 45%
Parental Distress	32 / 82.5%	17 / 10%	22 / 30%
Parent – Child	32n/ 96.5%*	24 / 75%	21 / 60%
Difficult Child	51 / 99+%*	39 / 95%*	37 / 91%*
Total Stress	115 / 99+%*	80 / 76.6%	93 / 91%*

*Any score over the 85% (except Defensive Responding) is deemed to be clinically significant, Abidin (1990)
Defensive responding score lower than 10 suggest either '1. The parent is trying to portray an image of being competent, 2. The parent is not invested in the role of parent or 3. The parent is in fact a very competent individual' (test manual p.18)

Randolph Attachment Difficulties Questionnaire (RADQ)

Table 14 – *RADQ: Score/Sub-Scores (Angus S.0-24)*

	Session Number		
	0 (C)	**12 (C)**	**24 (C)**
SSM	62*	63*	46
SSC	47*	46*	58*
Total	69*	70*	68*
Qu. 30	5	5	5

* Clinically significant score, SSC – 33, SSM – 47, Total - 65
SSM - Sum of Scores for Maltreatment, SSC - Sum of Scores for Conduct

4.4.3 - Reflection

Angus SDQ raw/band scores show some slight changes although risk of diagnosis in all categories remained the same. There are a few changes worth noting at session 12 revealing a dip in Hyperactivity band score (SDQ), total stress (PSI) and a dramatic reduction in parental distress (PSI) with an increase in peer relationship band score (SDQ), returning to original levels by session 24 (except parental distress). This may reflect the relief Blair and Ailsa relief at receiving ongoing services accounting for the

most dramatic and lasting change in parental distress whilst also highlighting Angus' ongoing difficulties at school.

PSI scores in all categories had reduced by session twenty four, with only difficult child and total stress scores remaining clinically significant. PSI scores suggest the need for parental support (as received throughout), Blair and Ailsa are adjusted to the parenting role whilst not experiencing personal adjustment difficulties, a decrease in behaviour suggestive of psychopathology and a decreased risk of abuse due to frustration

The RADQ consistently showed scores suggestive of an attachment disorder, however the Parent – Child (PSI) scale dropped below clinically significant levels at session 12 and reduces again at session 24. This suggests that Blair and Ailsa no longer perceived their bond with Angus to be threatened whilst they continue to report behaviours indicative of ongoing attachment disorder throughout (RADQ).

Blair and Ailsa report very slight improvements in Angus presentation over the first 24 sessions of therapy and feel confident enough to consider a holiday by session 24. This may reflect changes in their perceptions as parents which may explain the most marked changes being seen in the PSI.

4.5 – Analysis of Evidence Presented in Phase One

The data regarding this first 24 session period of therapy for Heather, Fergus and Angus is analysed below in light of literature pertaining to LAC children their presentation,

needs and professional issues as presented in chapter two. In considering the impact of this data it is perhaps worth returning to the four research questions designed to structure this study and allow the aims to be explored, in doing so thought can be given to the knowledge and insight gained through this initial period.

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

All three children were found to have definite identifiable problems as reported using existing screening measures. These identifiable difficulties would appear to reflect the child's presentation in a number of settings, as reported during the initial assessment process. Given the emotional investment each child has to their family placement, it is perhaps not surprising that scores were higher as reported at home than at school. These findings would appear to be consistent with published research undertaken to date, which suggests that existing questionnaires can be used as effective screening measures within the LAC population (Meltzer *et al.* 2003). It also reflects the findings of O'Connor and Zeanah (2003) who warn against relighting too heavily on questionnaires, but to seek information from a variety of sources. Information was gathered from school, home, social services and other relevant parties during the assessment process and despite slight differences in severity of problem the presentation reported would appear to correlate fairly closely with the information provided in the questionnaire material. The issue of the effectiveness of these questionnaires as monitoring or outcome measures for LAC children has been little researched and will be further considered later in this chapter.

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

The question of the usefulness of Theraplay and Play Therapy on the surface presents as quite easy to answer. It is clear from the questionnaires completed at sessions 12 and 24 that few significant changes were seen for the three children and if anything suggest the children's presentation worsened during this time. However, all carers comment that they found coming to the clinic useful in other way suggesting that the question then becomes how do we measure difference? Given our theoretical understanding of the therapeutic process would we expect to see any definable differences at this point of therapy, and on closer examination of each child are there any identifiable changes? The answer to the first of these queries is closely linked to the final question this study poses, 'What is the validity and usefulness of outcome measures when considering the effectiveness of therapy?', and will be explored later in this chapter. To answer the second of these queries, we must return to our theoretical grounding and explore further the expectations of both Play Therapy and Theraplay in turn.

Play Therapy:

If we hypothesise that Play Therapy addresses the trauma of the child through play (Wilson & Ryan 2005; Cattanach 1997 and Landreth 2001) and that the child is likely to be highly defended, then in the first few weeks of therapy as a new unknown adult comes into their life, would it be fair to suggest that this child's attachment presentation is likely to be activated and their defences heightened? If so, we are likely to see a return to some of their more defended and anxious behaviour patterns (Archer 2003 and Balbernie

2001). It is these very patterns which our screening tools are designed to identify and as such, we would expect to see an increase in scores and reporting.

Over time as the child develops a relationship with their therapist, these anxious patterns should reduce allowing the child to start exploring their trauma through play. However, exploring trauma through play and reintegrating new understanding is also likely to be anxiety inducing so arousal throughout therapy may well be anticipated. However, as described by Winnicott (1971), one strong resilience factor for children is the presence of a safe and secure adult with whom they can build a meaningful relationship. This being the case, the increasing bond between child and therapist could be hypothesised to limit the arousal even through some of the toughest exploration a child is likely to undertake. However, this hypothesis could only be explored through a more longer term study.

Research into the developing brain reminds us that attachment patterns and trauma lead to the development of well established neural activity (Gerhardt 2004; Perry 2007). This being the case, if changes are seen in the attachment presentation of the child over prolonged therapeutic intervention, could it be suggested that Play Therapy has a direct impact not only upon the child's trauma presentation, but also upon their attachment relationships as reported by a third/fourth party?

Given the wealth of new research into emotional attunement and affect regulation (Schore 2003; Meins 1999; Gerhardt 2004 and Trevarthen 1993) could it be suggested that the therapist provides an 'emotional mirror' for the child giving insight into their

emotional state, as reflected in 'the other' through the process of therapy? Through the process of reflection, the child is supported to experience their internal world as reflected through the therapist, 'the same but not the same' thus building an increased and appropriate sense of self in the context of relationship (Fonagy 2001, Howe 2005). Effectively building a more integrated and secure sense of self through the therapeutic relationship (Rogers 1965, Crittenden 2000). In considering these questions it would be imperative to also consider the system within which the child is contained, as change will be influenced not only by the therapeutic alliance, but also by the network of relationships the child experiences.

If the child comes to therapy with neural pathways established following trauma and disrupted attachment experiences, which directly impact upon their presentation, then it could be argued that any changes reported in their presentation may also reflect changes in the established neural pathways.

Theraplay:

Given our original hypothesis that Theraplay works directly on the attachment presentation of the child through interaction with their carer (Jernberg & Booth 2001), would we expect to see a difference in attachment presentation and challenging behaviours as reported in questionnaires over the first 24 sessions of therapy? If, as hypothesised above, the child's attachment behaviours are activated through engagement with a relative stranger in the therapeutic setting, it could be argued that this should be significantly lessened in the Theraplay setting. Although the therapist is present in the

room the engagement between child and therapist is limited, and the emphasis is very much on the parent/carer.

So, if we are seeing limited identifiable changes in the child's presentation or their scores are in fact worsening over this period, what if anything can we draw from this? It could be suggested that Theraplay is having no identifiable impact upon the attachment relationships of the child or indeed worsening them. However, research to date (Snipp 2004, Makela & Vierikko 2005), although very limited and often unpublished, would indicate that this is not the case. Nevertheless these findings would suggest a closer look at Heather and Fergus, is indicated to consider in more depth how they responded to Theraplay as reported by their carers in therapy reviews.

Heather:

Morag reported that she felt Theraplay had brought her emotionally closer to Heather and in doing so had elicited a number of attachment behaviours; i.e. an increased need for physical closeness, a greater dependency within routine tasks well within Heather's abilities, a definable regression, an increase in attention seeking and risk taking behaviours.

Fergus:

Effie and Dougal reported a marked change in Fergus' presentation following 12 Theraplay sessions, feeling he was calmer and reporting an increased closeness to him, especially Effie. Given that Theraplay will place the maternal relationship as the focus of

intervention, this is potentially where most change would be expected to be seen. Effie also reported that she was finding it easier to remain clear and boundaried with Fergus (as reflected in the PSI parent-child score, SDQ kind/helpful behaviours and the reduced likelihood of a diagnosis in hyperactivity/concentration disorder).

It is clear to see that after 8 & 18 sessions of Theraplay (respectively), a change in the presentation of the child can be seen as reported by carer and the close network. It may also be worth noting that despite lacking a standardised scoring system, definite changes were recorded in Fergus' presentation at his second MIM video assessment following 12 sessions of Theraplay. Heather, however, did not undertake a second MIM video assessment, due to the pressures within the placement. This suggests that Theraplay elicited a closer emotional attachment between child and carer, and triggers attachment behaviours needed to facilitate the strengthening of this bond, which may go some way to explaining increased questionnaire scores. This would appear to reflect the findings of research undertaken to date on the effectiveness of Theraplay, and support the hypothesis that a change is seen in the child from the early stages of Theraplay intervention.

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

As seen above, the process of decision making for Heather and Fergus was not a static one. It could be argued that the needs of the child changed through intervention, that the most pressing issue to be addressed became their increasing anxiety and trauma, rather

than their attachment presentation, which Theraplay had gone some way to addressing. If therapeutic decision making is indeed a dynamic and evolving process, which factors (if any), directly influenced this process for Heather, Fergus and Angus over their first 24 sessions of therapy?

Carer Presentation:

Theraplay had an impact upon Morag, Effie and Dougal who all described an increased closeness to Heather / Fergus and perceived an increase in the child's emotionality (as reported in the SDQ). Morag, Effie and Dougal also described some of the difficulties in this process at times of uncertainty, change and external chaos. This may reflect the importance of the emotional well being of carers as well as children within the Theraplay process. It also once again highlights the high expectations placed upon carers or parents within Theraplay. This then has implications for the assessment and initial decision making process when considering the emotional well being of carer as well as child.

During the Theraplay process Effie and Dougal were extremely enthusiastic and playful, but would regularly defer the parental role to the therapist. Research on child development clearly shows that when children do not feel safe or contained internally, this containment is essential from the system around them (Hughes 2006). The more anxious, upset and angry Fergus became in response to the external trauma experienced, the more he acted out and the more he perceived that his system (both at home and school) could not provide boundaries or contain this behaviour, the more he spiralled out of control. This once again highlights the importance of parental support as reflected in

the PSI and has implications for the provision of services and education to carers.

As Fergus and Angus entered Play Therapy Inga offered support to Effie and Dougal, whilst Blair and Ailsa comment upon their relief at receiving ongoing support from Iona. The provision of a second member of the Team has service/cost implications, and within this Team is by no means automatic, despite clear research evidence indicating the benefits of the approach (Schaffer 2008). This raises the issue of decision making being dynamic but also contained. It is not always possible to gain optimum service provision within stretched budgets, and despite identifiable needs, there is a clear limit on resources which also has a direct impact upon the decision making process.

Presentation of the Child:

Morag commented on Heather's increasingly challenging and at times unusual behaviour within the home. Effie and Dougal report an increase in Fergus attacking behaviour following the discovery of Tarn's pregnancy and unsupervised contact. Blair and Ailsa comment on a reduction in severity of Angus attacking behaviour but ongoing concerns at the level of his distress. This again highlights the often challenging presentation of LAC children having experienced trauma, emotional neglect and differing experiences of family life. This then has implications for the assessment and initial decision making process, in particular the need to consider the situation of the child and carer prior to offering therapeutic support.

Morag, Effie and Dougal all reflect that homework tasks were increasingly difficult to

undertake with Heather / Fergus, as their behaviour became more regressed, challenging or attacking. Research has shown that LAC children come with a history and legacy of trauma and separation, and that under stress the human brain reverts to long established defence strategies often on a very unconscious level (Teicher, 2002). It is likely that Heather, Fergus and Angus under pressure responded in ways which reflected their earliest defence patterns in order to elicit attention and ensure they were not forgotten or hurt (Howe, 2005). This highlights the importance of education around the presentation of the LAC child, their attachment responses, their social constructs and their defence strategies; coupled with an ongoing need to support carers (as reflected within the PSI).

In contrast to Heather and Angus, Fergus' questionnaires do reflect some small changes in his presentation as described above, and the oral reports of those present during therapy reviews suggest a greater degree of change for all three children. Given the nature of these oral reports it could be hypothesised that Theraplay enhanced both Fergus and Heather's attachment relationships. However, Theraplay did not support them in addressing trauma and in both cases this informed the decision making process which led to the provision of Play Therapy.

It was clear that Angus would not cope with Theraplay when first referred, due to his chaotic, distressed presentation which would have been exacerbated by any requirements of close physical contact in the Theraplay setting and the decision to offer Play Therapy was very clearly based on the presentation of the child at this time. The decision for all three children to remain within Play Theraplay was based on their ongoing traumatised

presentation, the fact that they settled quickly and engaged well in the therapeutic process and a clear need for safe, consistent therapeutic support.

External Life Events:

In contrast to Heather, Fergus and Angus were within their permanent placements, however, all experienced repeated external trauma, Fergus from his birth family, Heather from the family finding process and Angus through ongoing educational difficulties. This reflects the impact that external life events have upon the child, how powerfully issues of identity / loyalty are primed within them (Verrier 1993; Cairns 2002) and the importance of never underestimating this variable in the decision making process. This also reflects the need for dynamic decision making in responding not only to the needs of the child, but also in thinking creatively with other professionals working with child and their families.

It is clear to see that decision making process within the Project was indeed dynamic and evolving. The decisions made for each of the three children within this study are based on a number of factors as highlighted above, and went on to have implications for future service delivery. The evidence emerging from this phase of study would appear to be consistent with the limited existing literature on clinical decision making. Decisions were often creative and intuitive in nature informed by relevant training and experience (Patel *et al.* 2001; Leprohon & Patel, 1995; Falzer 2004). These decisions are creative in nature incorporating this expertise, negotiating difference and managing constraints (both financial and circumstantial). Therapeutic decision making may be the sole responsibility

of the therapist, but takes place in many different forums including multi-agency reviews, interdisciplinary Team meetings, clinical and managerial supervision.

The evidence emerging from Phase One is also consistent with research which indicates that the collaborative relationship between child and therapist as described for all three children as they become established in the Play Therapy process is central to the clinical decision making in offering ongoing therapeutic support (Truscott *et al.* 1999, Cloirtre *et al.* 2004, Chethik 2001, Falvey 2001, Rasmussen 2001). Given the consensus of established literature that there are many forms of therapeutic intervention available to support children experiencing attachment difficulties and trauma; there were several points throughout the decision making process for each child where consideration was given to the most appropriate form of therapy.

Although not actively following the seven stage decision making tree of Galanter and Patel (2005), there are several identifiable steps which were incorporated into the decision making process for each child. What decision is to be made? What options are there?; What information is needed to help make the choice?; What are the likely/possible consequences of each option?; How possible is each consequence?; What are the pros and cons of each decision? Decision making also drew on the principles of heuristics (short cuts in decision making based on knowledge, expertise and experience held by therapist but also the broader professional network), social judgement theory (looking at a number of possibilities for each child given the evidence provided and goals hoped for), social cognitive theory (considering and acknowledging self within decision

making, often within clinical supervision) and naturalistics (decision making in real life situations, as highlighted above).

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

The questionnaire data completed in respect of Heather, Fergus and Angus shows little evidence of change throughout the first 24 sessions of therapy and the minor changes which were reported appear to correspond fairly closely with the oral reports of carers. However, one of the dilemmas raised in this initial phase of study is that change was often noted and marked by several of those present at the review, and the carers would often report presentations not seen within the questionnaire material. So how does this disparity arise and what are the implications for implementing questionnaires as outcome measures within this study.

Morag gave greatest insight into this enigma and raised two points of interest;
Firstly some behaviours were seen at initial screening and reported within the questionnaires thus resulting in the clear indication of attachment related difficulties. However, by sessions 12 & 24 more subtle changes were noted by the carer in the review which would still warrant a similar score in questionnaire but may have different subtleties or meaning when explored within this forum. This would suggest that the questionnaires can be effective at identifying and measuring specific difficulties within the LAC population, but may not always be as sensitive to detect change within the presentation of the child, especially when the does not constitute major improvement.

This would appear to be in line with the research undertaken by Mathai, Anderson and Bourne (2004) who described the SDQ as 'sensitive in detecting emotional and behavioural problems and may be utilised to screen referrals at intake for CAMHS' (p. 639).

Secondly, Morag reflected that she felt some of the behaviours had worsened or changed, but she had already reported this behaviour at its highest score in previous questionnaires, and no further options were available. Conversely, Blair and Ailsa reflected that they felt they had seen changes and improvements in Angus, but they were not great enough to warrant a change in score on the questionnaire, or changes are so small on the questionnaire, that they are not statistically or clinically significant.

When considering this further, it may be worth noting that the raw SDQ scores, high and very high (seen often for the three children tested) account for only the top 10% of the child population. Given that all the children in this study are looked after, have experienced severe trauma and attachment difficulties, it is unlikely that we would expect their presentation to score anywhere other than in this top 10% of the child population. Given that they start at such a disadvantage, change would have to be significant to see any real changes in their questionnaire profile, given that the population against which this is calibrated are the 80% of children perceived to be average i.e. experiencing 'normal' development. The LAC population potentially have so much further to go than other children to reach this 'average' level change which is significant to child, carer and network is often too small to be picked up.

The question of the effectiveness of questionnaires as monitoring and outcome measures for therapeutic intervention with LAC children is a complex one and it must be borne in mind that this is a very small clinical sample, with any statistically significant findings requiring a larger clinical population. However, some disparity appears to have been raised in Phase One between the presentation of the child as reported in the reviews, and presentation as reported in the questionnaires. A more longer term study may help to look at the long term progress of each child, given the hypothesis that we are unlikely to see much change within the early stages of Play Therapy, and may go some way to more effectively answering the question of outcome measures. However, it has raised some valuable questions about the specific presentation of the LAC population and the sensitivity of screening tools for these children, particularly within the Theraplay modality.

4.6 – Impact upon Service Provision

If, as discussed earlier, the decision making process is a dynamic and evolving one, then it stands to reason that the approach of the Project will also be dynamic and evolving as all children will be treated with the same open minded and creative approach. The detailed examination of outcomes for Heather, Fergus and Angus, suggested that similar factors influence the decision making process namely carer characteristics, the presentation of the child, and external life events.

At the end of these first 24 sessions, factors influencing the decision making process were collated and compared with anecdotal and questionnaire data complied by Annabel (the

other worker within the Project). It was found that she had experienced similar outcomes and these three areas were also consistent in her work. Throughout this period of consultation it became apparent that the greatest impact was seen in the Theraplay process where carers are directly involved in therapy, and any attachment issues they themselves may have, would potentially be exacerbated by this involvement. The issues affecting carers in the Play Therapy setting were more related to behaviour and presentation of the child as they explored their trauma.

Four main areas were identified as impacting upon the carer in the Theraplay process: The need for a more in-depth assessment prior to therapeutic intervention, the need for clear, in-depth exploration of the carers' own attachment experiences, fuller explanation of the therapy process and the need for increased training around attachment and the presentation of the LAC child. Consideration of these findings led to 8 major changes in practice within the Project.

4.6.1 - Changes in practice from the findings of Phase One

1. It was agreed that the number of caregiver led interviews in the initial assessment should increase from two to a minimum of three, and that families should be given a lot more information around Theraplay prior to making a decision about engaging in this process.
2. The information requested from cargivers around their own attachment experiences became more detailed and focussed. It was still largely based on some of the conventional assessment tools, but also took on a practical element as

families were asked to visualise themselves in a variety of session settings.

3. Interview sessions became a lot more interactive in nature as caregivers are talked through the average Theraplay session, given examples of different activities, and role play was introduced for some families. Caregivers were then asked to visualise their child within the process, and asked to consider the impact this may have on them in light of their own attachment experiences.
4. The assessment process was modified and more time spent in preparing caregivers so that sessions themselves would run more smoothly as families would have a clearer idea of what was expected of them and how to engage. It was also hoped that caregivers would feel empowered to decline this intervention if they did not feel it was right for them, or they may struggle to engage because of their own situation or experiences.
5. Heather's case demonstrates the possible unsuitability of aspects of Theraplay for children who may remain within temporary placements for long periods of time, but for whom the future is not yet decided. In re-formulating the assessment process, the issue of permanence is one which is also now considered more fully, and the implications of service delivery measured against the individual circumstances of the child.
6. Training was also introduced as part of the assessment process for both Play Therapy and Theraplay. All caregivers and relevant agencies are now expected to attend a morning's training on attachment, the LAC child and Theraplay. Offering training to caregivers/system means that the needs and presentation of the individual child can be considered in context of theory and allowed for more in-

depth, specific discussion.

7. Training was also commissioned through the broader LAC Team for foster carers, social workers and other relevant professionals. Training provision for the Team as a whole was reviewed at this time, and the Project started offering courses more widely and within a more creative remit. Training largely focused on attachment but thought was given to expanding this programme to encompass more topics directly related to the well-being of LAC children and reach a greater audience.
8. In identifying and acknowledging the high expectations placed upon caregivers, consideration was given to offering additional support. It was not felt to be feasible within the Project to offer individual support more than once a fortnight (although phone contact was left open and available to families during office hours), and as such creative alternatives were sought. Following lengthy discussion and planning, a support group was opened to all caregivers with children receiving a service from the Attachment Project. This group is offered on a bi-monthly basis and looks at some of the issues affecting families and children.

4.7 – Reflection and Summary

The first phase of this study was designed to explore existing data relating to the first 24 sessions of therapy offered to Heather, Fergus and Angus and as can be seen, this was a time of change and consolidation for the Project. As a result this study organically progressed into its second phase and a number of questions were raised as services continued to be evaluated in line with ongoing professional development and trust wide

standards of excellence.

Firstly, Play Therapy as discussed earlier, is likely to be a longer term therapeutic intervention, and change was unlikely to be quantified in this initial period of study. Findings to date suggest that Theraplay may be indicated where attachment is the main presenting issue at referral, and Play Therapy where trauma is the main presenting issue, as supported by existing literature. By extending this initial phase of the study, it was hoped that consideration could be given to the longer term outcomes of both Theraplay and Play Therapy, and the effectiveness of Play Therapy in addressing issues of attachment.

Secondly, the issue of outcomes for the LAC child continued to be an area of uncertainty. This initial phase of study raised some questions about the use of standard outcome measures for this particular population and treatment modality and it was hoped that in continuing this study over a longer period of time the effectiveness of outcome measures could be further considered.

Thirdly, the dynamic process of decision making within the Project lead to alterations to service delivery and these changes were likely to have the most impact upon children receiving Theraplay. In continuing this study, it was hoped to look again at the outcomes of therapy, given the changes made to the process and the evolving nature of decision making.

Finally, in continuing this study it was hoped to further consider the two aims and four research questions identified at the outset allowing greater insight into service provision for looked after children assessed as experiencing attachment related difficulties.

As the study now continues into a second phase, Play Therapy input for Heather, Fergus and Angus will be explored over a subsequent two year period, to consider in more depth, longer term outcomes for each of these three children, ongoing factors affecting them and the ongoing decision making process for each through in depth investigation of the experiences and perspectives of the stakeholders. Three additional children will join the study and consideration will be given to therapeutic input offered to each throughout their first 12-24 sessions. Ongoing thought will be given to the therapeutic process, existing screening/outcomes measures, the therapeutic decision making process and in addition the impact of changes made to service delivery at the conclusion to the first phase of this study.